PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2019-D14

PROVIDER –
Glenbeigh Health Sources

PROVIDER NO. – 36-0245

vs.

MEDICARE CONTRACTOR –
CGS Administrators, LLC – J15

HEARING HELD –
September 25, 2018

FISCAL YEAR– 2018

CASE NO. – 18-0508

INDEX

ISSUE STATEMENT:

Whether the fiscal year ("FY") 2018 penalty imposed under the hospital inpatient quality reporting ("IQR") program was proper?[1]

DECISION:

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the FY 2018 penalty, imposed on Glenbeigh Health Sources ("Provider" or "Glenbeigh") under the hospital IQR program was improper because Glenbeigh's validation score exceeded 75 percent.

INTRODUCTION:

Glenbeigh is a specialty hospital providing treatment of adult chemical dependency located in Northeastern Ohio. On May 25, 2017, the Centers for Medicare & Medicaid ("CMS") notified the Provider that it failed to meet hospital IQR program requirements for FY 2018 and, as a result, the Provider would be subject to a payment reduction of one-fourth (1/4) of its FY 2018 Inpatient Prospective Payment System ("IPPS") Annual Payment Update ("APU").[2] In addition, the Provider would be ineligible to participate in the Hospital Value-Based Purchasing ("VBP") Program.[3] Specifically, CMS alleged that the Provider failed to meet validation requirements for clinical process-of-care measures.[4] Following the Provider's request for reconsideration, CMS upheld its decision.[5]

Glenbeigh timely appealed CMS' decision and has met the jurisdictional requirements for a hearing before the Board. The Board conducted a live hearing on September 25, 2018. Glenbeigh was represented by Lewis G. Hutchison, Vice President of Quality & Operations. CGS Administrators, LLC – J15 (the "Medicare Contractor") was represented by Edward Lau, Esq., of Federal Specialized Services.

STATEMENT OF FACTS AND RELEVANT LAW

Under IPPS, the Medicare program pays acute care hospitals predetermined, standardized amounts per discharge, subject to certain payment adjustments.[6] The standardized amounts are increased each year by the APU (otherwise known as the "market basket update") to account for increases in operating costs.[7]

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[1] Transcript, ("Tr.") at 5-6.
[2] Glenbeigh Final Position Paper, P-10 to P-12 (May 11, 2018).
[3] *Id.*
[4] *Id.* at 10-11.
[5] *See id.* at 18.
[6] *See* 42 U.S.C. § 1395ww(d); 42 CFR Part 412. IPPS hospitals are often referred to as "subsection (d) hospitals."
[7] *See* 42 U.S.C. § 1395ww(b)(3).

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003[8] amended 42 U.S.C. § 1395ww(b)(3)(B) to establish the IQR program and require each hospital to submit quality of care data "…in a form and manner, and at a time, specified by the Secretary."[9] For fiscal years 2015 and beyond, federal law specifies that a hospital that fails to report the required quality data under the IQR program is penalized by reducing the hospital's IPPS APU for the relevant year by one-quarter.[10] A hospital that is subject to this penalty during a given year is also excluded from participation in the VBP program and ineligible to receive any value-based incentive payments for that year.[11]

Following submission of the requisite quality data for a given reporting year under the IQR Program, CMS selects certain hospitals to validate the quality data submitted. The regulation at 42 C.F.R. § 412.140(d) sets forth the validation requirement under the hospital IQR Program, stating:

> (e) *Validation of Hospital IQR Program data.* CMS may validate one or more measures selected under section 1886(b)(3)(B)(viii) of the Act by reviewing patient charts submitted by selected participating hospitals.
>
> (1) Upon written request by CMS or its contractor, a hospital must submit to CMS a sample of patient charts that the hospital used for purposes of data submission under the program. The specific sample that a hospital must submit will be identified in the written request. A hospital must submit the patient charts to CMS or its contractor within 30 days of the date identified on the written request.
>
> (2) (i) A hospital meets the chart-abstracted validation requirement with respect to a fiscal year *if it achieves a 75-percent score*, as determined by CMS.[12]

So if a hospital is selected for validation, it must achieve a 75 percent score in order to pass (*i.e.*, in order to not be subject to the IPPS APU penalty).

This case focuses on the methodology used for FY 2018 to calculate this validation score and, thereby, determine if a hospital meets the 75 percent passing threshold. Significantly, there is a difference between how the validation scores for the process-of-care measures are computed and how the validation scores of Healthcare-Associated Infections ("HAIs") are computed. In this regard, CMS gave the following guidance:

> For clinical process-of-care measures, the warehouse reports whether the hospital-reported measure for each case agrees or disagrees (1 or 0) with the re-abstracted result, which is based on CDAC review of the data elements on the medical record.

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[8] Pub. L. No. 108-173, 117 Stat. 2066 (2003).
[9] *Id.* § 501(b), 117 Stat. at 2289-90. *See also* 42 C.F.R. § 412.140(c).
[10] *See* 42 U.S.C. § 1395ww(b)(3)(B)(viii)(I); 42 C.F.R. § 412.64(d)(2)(i)(C).
[11] *See* 42 U.S.C. § 1395ww(o)(1)(C)(ii)(I); 79 Fed. Reg. 49854, 50048-50049 (Aug. 22, 2014).
[12] (Emphasis added.)

> For the HAI validation, CDAC determines the number of the potential events associated with each candidate event and determines whether each potential event is an HAI event. CMS supplies CDC with the sample of cases selected to determine whether each case was reported as an event. The CMS contractor then combines the CDC and CDAC findings to score the agreement status of each case.[13]

Both the process-of-care score and HAI score are weighted and the results are combined to determine a provider's total validation score. Validation for FY 2018 payment determinations was "based on data describing hospital inpatient stays ending in Quarter 3, 2015 through Quarter 2, 2016."[14] Validation weighting for FY 2018 IQR Program payment determinations was 66.7 percent for HAIs and 33.3 percent for clinical process-of-care.[15]

As explained on the *QualityNet* website, CMS selects the hospitals for data validation annually using a random and targeted selection process. This website provides the following overview on CMS' validation process for inpatient hospitals:

> CMS verifies on a quarterly basis . . . using a standardized protocol. . . .
>
> **Quarterly Results**
>
> It typically takes approximately 4 months after each quarter's submission deadline for hospitals to see their validation results for the quarter. . . . The reports provide the validation results . . . on each selected case.
>
> **Educational Reviews**
>
> Within 30 days of validation results being posted. . ., if a hospital has a question or needs further clarification on a particular outcome, the hospital may request an educational review. If an educational review that is requested for any of the first three quarters of validation yields incorrect CMS validation results for chart-abstracted measures, the corrected quarterly score will be used to compute the final confidence level.[16]

Due to the timing of when the confidence level is calculated, the reconsideration process is to be used when there is a dispute of the fourth quarter results.[17]

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[13] Exhibit I-7 at 5.
[14] Exhibit I-7 at 1.
[15] 80 Fed. Reg. 49325, 49711 (Aug. 17, 2015).
[16] https://www.qualitynet.org/dcs/ContentServer?cid=%201228776288808&pagename=QnetPublic%2FPage%2FQnetTier3&c=Page.
[17] *Id.*

Glenbeigh was notified on May 25, 2017 that its FY 2018 IPPS APU was being reduced by one-fourth (1/4) because it failed the validation requirements.[18] Specifically, the Medicare Contractor asserts that the Provider did not achieve the required 75 percent validation score when the scores from the four quarters were annualized.[19] The parties are in disagreement regarding how the overall validation score should have been calculated.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

This dispute centers on CMS' calculation of the Provider's validation score for purposes of compliance with the regulatory 75 percent validation threshold. The individual quarterly scores are not in dispute, rather the parties dispute the calculation of the cumulative estimated reliability score of 54 percent.[20] The Medicare Contractor provided a worksheet of how the score of 54 percent was calculated.[21] The chart below illustrates that calculation.

	Other Clinical Process of Care			Health-Care Associated Infection			Aggregate Validation Score
	Score	Percent	Weighted at 33.3%	Score	Percent	Weighted at 66.7%	
3Q 2015	26 of 26	100%		0 of 0			
4Q 2015	25 of 26	96%		1 of 3	33%		
1Q 2016	12 of 12	100%		0 of 0			
2Q 2016	12 of 12	100%		0 of 0			
Total	75 of 76	99%	32%	1 of 3	33%	22%	54%

The Board reviewed this calculation, the related regulations, and manual guidance and disagrees with the accuracy of CMS' calculation of the aggregate validation score. The Board points out the methodology used to calculate the 54 percent reliability does not include an HAI score for *any* of the three quarters where the Provider reported "no events" for HAIs. The lack of credit for these three quarters results in the entire HAI score being based on one quarter of HAI data rather than four quarters and does not take into consideration that the Provider reported its "no events" 100 percent accurate for three quarters.

The Board recognizes that the CMS methodology for FY 2018 would eliminate quarters where there are no events.[22] However, the Board finds this does not comply with the guidance that CMS gave in the Federal Register on how validation scores would be calculated, including the HAI portion of the validation score. The Board points to the following statement that CMS made in 2012 in the Federal Register regarding the criteria used to evaluate whether a score passes or fails:

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[18] Glenbeigh Final Position Paper, P-10 to P-12.
[19] Tr. at 15.
[20] Glenbeigh Final Position Paper at P-1.
[21] Exhibit I-13. Note the Confidence Interval Report dated May 26, 2017 (Provider Final Position Paper at 3) shows an estimated reliability of 55 percent. The difference is due to rounding.
[22] Glenbeigh Final Position paper at P-3 (copy of CMS' confidence interval report for the Provider). *See also* Exhibit I-7 at 6 n.10 (stating that "[o]nly quarters for which the hospital had measures or candidate events are used in the calculations").

> *Comment:* Some commenters expressed preference for a quarterly score, because the commenters valued receiving timely feedback regarding their hospitals' performance.
>
> *Response:* . . . . We will continue to provide hospitals with feedback regarding the performance on validation on a quarterly basis. However, we will also continue to evaluate a hospital's validation score by combining data across **all quarters** included in the validation year and by computing a confidence interval once annually for the basis of a payment determination only.
>
> After consideration of the public comments we received, we are continuing for the FY 2015 payment determination and future years our current policy of providing hospitals with feedback quarterly and producing a single annual confidence interval per hospital.[23]

Similarly, in 2013, CMS states the following in the Federal Register: "Within each hospital for each type of HAI event *each quarter*, a random sample would be drawn from among patient episodes of care with at least one candidate event identified . . . to meet the target sample size."[24] The Board points out when the sample size cannot be satisfied for three of the four reporting quarters because the provider has no candidate events for those quarters yet still correctly reported "no events" for those quarters, basing the annual confidence interval on data from a single quarter is not an equitable way to calculate the overall annual validation score, as it does not give credit to the provider for correctly reporting "no events" in those three quarters.

Additionally, the Board points out that, in 2013 in the Federal Register, CMS provides a method for scoring no reportable HAI events stating:

> In the case when a hospital has no reportable events, the hospital would receive a score of 1/1 if none were reported to NHSN (a match), and a score of 0/1 if any were reported to NHSN (a mismatch).[25]

CMS confirmed in the Federal Register for FY 2018 that these 2013 Federal Register statements continued to be applicable.[26]

However, the Medicare Contractor does not believe this section applies to Glenbeigh as it believes the reference applies to only one period of time, which is annually.[27] In support of its position the Medicare Contractor argues that "[i]f the reference to scoring was intended to be applied on a quarterly basis, then the language would have stated 'In the case when a hospital has no reportable events, the hospital would receive a score of 4/4 if none were reported to NHSN…'

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[23] 77 Fed. Reg. 53258, 53551 (Aug. 31, 2012) (emphasis added).
[24] 78 Fed. Reg. 50496, 50831 (Aug. 19, 2013) (emphasis added).
[25] *Id.* at 50833.
[26] 79 Fed. Reg. 49854, 50268 (Aug. 22, 2014).
[27] Medicare Contractor's Post Hearing Brief, 3 (Nov. 7, 2018).

Instead the language references '…a score of 1/1 if none were reported to NHSN…'"[28] The Medicare Contractor believes Glenbeigh's annual score for HAIs of 1 out of 3 is correct.[29]

The Board disagrees with the Medicare Contractor that the score of 1/1 for no reportable events is for only one time period, which is annually, and not for a quarterly period. The Board finds that CMS' guidance in the Federal Register as well as *QualityNet* guidance clearly support quarterly scoring. Specifically, the *QualityNet* website states: "If an educational review that is requested for any of the first three quarters of validation yields incorrect CMS validation results for chart-abstracted measures, the **corrected quarterly score** will be used to compute the final confidence level."[30] Additionally, CMS states in the Federal Register that the scoring is done on a quarterly basis and combined to determine if a provider achieved a confidence interval score of 75 percent or greater.[31]

Finally, the Board finds that the methodology used by CMS does not reflect that Glenbeigh actually reported its HAIs 100 percent accurately for three quarters of the validation period. On the contrary, the CMS methodology simply ignores that Glenbeigh accurately reported no HAI events for three quarters and determined Glenbeigh's estimated reliability for HAIs based only on the fourth quarter of CY 2015. As this does not comply with CMS' guidance in the Federal Register (*i.e.*, the guidance stating that "we will also continue to evaluate a hospital's validation score by **combining data across all quarters** included in the validation year . . ."),[32] the Board finds that CMS' calculation cannot be used.

The Board recalculated Glenbeigh's validation score to be 76 percent as explained below:

	Other Clinical Process of Care			Health-Care Associated Infection			Aggregate Validation Score
	Score	Percent	Weighted at 33.3%	Score	Percent	Weighted at 66.7%	
3Q 2015	26 of 26	100%		1 of 1	100%		
4Q 2015	25 of 26	96%		1 of 3	33%		
1Q 2016	12 of 12	100%		1 of 1	100%		
2Q 2016	12 of 12	100%		1 of 1	100%		
Total	75 of 76	99%	32%	4 of 6	67%	44%	76%

Specifically, the Board recognizes that Glenbeigh reported its HAIs 100 percent accurate for three quarters, and 33 percent accurate for the other quarter, resulting in an unweighted reliability of 67 percent. The Board then applied the weighting factors for a score 44 percent for HAIs. Combining the Other Process of Care score of 32 percent with the HAI score of 44 percent results in a total annual validation score of 76 percent. Based on this revised calculation the

[28] *Id.* at 3.
[29] *Id.* at 2.
[30] https://www.qualitynet.org/dcs/ContentServer?cid=%201228776288808&pagename=QnetPublic%2FPage%2FQnetTier3&c=Page (emphasis added).
[31] 77 Fed. Reg. at 53551.
[32] *Id.* (emphasis added).

Board concludes that Glenbeigh meets the 75 percent validation score and is entitled to the full APU for FY 2018.

DECISION AND ORDER:

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the FY 2018 penalty, imposed on Glenbeigh under the hospital IQR program, was improper because Glenbeigh's validation score exceeded 75 percent.

BOARD MEMBERS PARTICIPATING:

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FOR THE BOARD:

1/31/2019

X Charlotte F. Benson

Charlotte F. Benson, C.P.A.
Board Member
Signed by: PIV