PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2019-D16

PROVIDER –
Landmark Hospital of Salt Lake City, LLC

PROVIDER NUMBER: 46-2006

vs.

MEDICARE CONTRACTOR –
Cahaba Gov't Benefit Administrators, LLC
c/o National Gov't Services, Inc.

DATE OF HEARING -
October 2, 2017

FISCAL YEAR - 2017

CASE NUMBER: 17-1255

INDEX

Page No

ISSUE STATEMENT

Whether the payment penalty that the Centers for Medicare & Medicaid Services ("CMS") imposed under the Long Term Care Hospital Quality Reporting Program ("LTCH-QRP") to reduce the Provider's payment update for Fiscal Year ("FY") 2017 by 2-percent 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 2-percent reduction of the Provider's annual payment update ("APU") for FY 2017 was proper.

INTRODUCTION

Landmark Hospital of Salt Lake City, LLC ("Provider") is a Medicare-certified long-term care hospital ("LTCH") located in Salt Lake City, Utah. The Provider's designated Medicare administrative contractor[2] is Cahaba Government Benefit Administrators, LLC ("Medicare Contractor"). On July 7, 2016, CMS determined that the Provider failed to meet the LTCH-QRP requirements and was subject to a 2-percent reduction in the FY 2017 APU because the Provider failed to properly submit certain quality data during calendar year ("CY") 2015. Specifically CMS determined that the Provider failed to timely submit all required months of complete Catheter-Associated Urinary Tract Infection ("CAUTI") and Central Line-Associated Blood Stream Infection ("CLABSI") data for CY 2015.[3]

Subsequently, the Provider requested that CMS reconsider its decision regarding the reduction to the Provider's FY 2017 Medicare payments,[4] and CMS upheld its reduction decision.[5] On March 17, 2017, the Provider timely appealed CMS' decision to the Board, and met the jurisdictional requirements for a hearing.

The Board held a live hearing on October 2, 2017. The Provider was represented by Jason M. Healy, Esq. The Medicare Contractor was represented by Joe Bauers, Esq. of Federal Specialized Services.

---

[1] Transcript ("Tr.") at 7.

[2] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate.

[3] Provider's Post-Hearing Brief 1, 3 (Nov. 16, 2017); Exhibit P-2 at 1.

[4] Provider's Post-Hearing Brief at 5; Exhibit P-3.

[5] Provider's Post-Hearing Brief at 6; Exhibit P-4.

STATEMENT OF FACTS AND RELEVANT LAW:

Federal statute, 42 U.S.C. § 1395ww(m)(5)(C), requires LTCHs to report on the quality of their services in the form, manner, and time as specified by the Secretary.[6] The implementing regulation states:

> (b) *Submission of data requirements and payment impact*. (1) Except as provided in paragraph (c) of this section, a long-term care hospital must submit to CMS data on measures specified under sections 1886(m)(5)(D), 1899B(c)(1), and 1899B(d)(1) of the Act, as applicable, in a form and manner, and at a time, specified by CMS.
>
> (2) A long-term care hospital that does not submit data in accordance with sections 1886(m)(5)(C) and 1886(m)(5)(F) of the Act with respect to a given fiscal year will have its annual update to the standard Federal rate for discharges for the long-term care hospital during the fiscal year reduced by 2 percentage points.[7]

For FY 2017 payment determinations, CMS required LTCHs to submit certain quality data to the Centers for Disease Control and Prevention's ("CDC") National Health Safety Network ("NHSN") system.[8] In this regard, LTCHs were required to submit data to the NHSN, including data relating to the following two quality measures:

> 1. National Quality Forum ("NQF") measure #0138, referred to as the Catheter-Associated Urinary Tract Infection ("CAUTI") Outcome Measure; and,
>
> 2. NQF measure #0139, Central Line-Associated Blood Stream Infection ("CLABSI") Outcome Measure.[9]

For FY 2017 payment determinations, LTCHs had to collect data related to these quality measures from January 1, 2015 through December 31, 2015. CMS required quarterly submission of data for the CAUTI and CLASBI measures with the following data submission deadlines:

Q1 (January 1 – March 31, 2015)	Due February 15, 2016
Q2 (April 1 – June 30, 2015)	Due February 15, 2016

[6] *See also* Patient Protection and Affordable Care Act, Pub. L. 111-148, § 3004(a), 124 Stat. 119, 368-369 (2010) (adding LTCH QRP statutory provisions at 42 U.S.C. § 1395ww(m)(5)).
[7] 42 C.F.R. § 412.560 (2015) (emphasis in original).
[8] 80 Fed. Reg. 49325, 49729 – 49730 (Aug. 17, 2015).
[9] *Id.*

Q3 (July 1 – September 30, 2015) Due February 15, 2016
Q4 (October 2 – December 31, 2015) Due May 15, 2016[10]

CMS determined that the Provider failed to timely submit all of the required months of CAUTI and CLABSI data.[11] This omission resulted in a 2-percent reduction in the Provider's APU for FY 2017. The Provider disagrees and claims it timely submitted all LTCH quality data to CMS during the applicable reporting period.[12]

The Provider argues that CMS' decision to reduce its FY 2017 APU is legally invalid because: (1) the Provider submitted data for all applicable quality measures by the quarterly deadlines;[13] (2) CMS failed to follow the reconsideration procedure set forth in the Federal Register when it ignored the Provider's explanation for the alleged non-compliance;[14] and, (3) CMS' reconsideration decision uses a form letter that makes only conclusory statements with no indication that CMS engaged in reasoned decision-making which is in violation of the Administrative Procedure Act ("APA").[15] Additionally, the Provider maintains that it substantially complied with LTCH QRP reporting requirements in good faith.[16]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

This case focuses on whether the Provider submitted certain CAUTI and CLABSI quality data for CY 2015 as required under the LTCH QRP in order to receive the full APU for FY 2017. More specifically, the parties dispute whether the Provider timely submitted the requisite CAUTI measure for June and July 2015, and the CLABSI measure for June and August 2015.[17]

The Provider explains that its Director of Quality Management ("DQM") was notified on February 9, 2016 that it had not submitted complete CAUTI data for June and July 2015, or complete CLABSI data for June and August 2015.[18] The DQM logged into NHSN and saw an error message stating that the Provider's reporting plans were missing for those months.[19] Despite the DQM's belief that the reporting plans had been entered into the system, the DQM re-entered the reporting plans for CAUTI for June and July 2015, and CLABSI for June and August 2015 and saved the information to the data registry.[20] The Provider asserts that its DQM checked the NHSN several times prior to the February 15, 2016 deadline to confirm that no

[10] Exhibit P-5 at 2.
[11] Provider's Post-Hearing Brief at 3; Exhibit P-2.
[12] Provider's Post-Hearing Brief at 18; Exhibit P-3 at 2.
[13] Provider's Final Position Paper, 8-10.
[14] *Id.* at 10-12.
[15] *Id.* at 12-20.
[16] *Id.* at 23-25.
[17] *Id.* at 1.
[18] Provider's Post-Hearing Brief at 21. *See also* Exhibit P-3 at 8.
[19] Provider's Post-Hearing Brief at 21.
[20] *Id.*

further error messages were generated, and that its DQM ran data validation reports in an effort to confirm that the quality data was complete and ready for submission.[21]

The Board reviewed the guidance in effect for CY 2015 related to the LTCH-QRP. Federal statute, 42 U.S.C. § 1395ww(m)(5)(C), requires LTCHs to report on the quality of their services in a form and manner, and at a time as specified by the Secretary.[22] CMS instructed LTCHs that the CAUTI and CLABSI data measures must be submitted to the CDC through the NHSN.[23] The NHSN website informed LTCHs that monthly reporting plans must be created or updated to include CLABSI and CAUTI surveillance for data to be shared with CMS.[24] CMS directed providers to http://www.cdc.gov/nhsn/cms/index.html, recommending that providers run output reports within their facilities prior to reporting deadlines and utilize provided checklists to ensure complete reporting to NHSN.[25] Specifically the CMS instructions stated:

> As a reminder, it is recommended that providers run the applicable CMS output reports within their facility *prior to each quarterly reporting deadline*. Detailed guidance on how to run and interpret these reports as well as a checklist used to ensure complete reporting into NHSN can be found at: http://www.cdc.gov/nhsn/cms/index.html.[26]

While the Provider claims that it input its CAUTI and CLASBI data (including its reporting plans) and ran the required data verification reports[27] to ensure it timely and properly submitted all required data, the Board finds that the record simply does not support this claim. The Provider submitted documentation that shows that validation reports and updates were downloaded or input *only **after*** CMS' July 7, 2016 Notice of Non-Compliance, which was well after the quarterly data submission deadlines.[28] The record contains no evidence that the Provider's CAUTI and CLASBI reporting plans were input timely and no evidence of a printed validation report on or before the February 15, 2016 data submission deadline for quarters 2 and 3 of CY 2015.

The Provider argued that the evidence it submitted "confirm that [the Provider] submitted all event data for all quality measures prior to the applicable reporting deadlines. Specifically, the 'createDate' column in each report shows that the DQM entered the quality data prior to the

---

[21] *Id.* at 22.
[22] *See also* Patient Protection and Affordable Care Act at § 3004(a), 124 Stat. at 368-369 (adding LTCH QRP statutory provisions at 42 U.S.C. § 1395ww(m)(5)).
[23] 80 Fed. Reg. at 49729 – 49730.
[24] Operational Guidance for Long Term Care Hospitals* to Report Central Line-Associated Bloodstream (CLABSI) Data to CDC's NHSN for the Purpose of Fulfilling CMS's Quality Reporting Requirements, 2 (Nov. 2014) (*available at* https://www.cdc.gov/nhsn/PDFs/CMS/LTCH-CLABSI-Guidance_2015.pdf); Operational Guidance for Long Term Care Hospitals* to Report Catheter-Associated Urinary Tract Infection (CAUTI) Data to CDC's NHSN for the Purpose of Fulfilling CMS's Quality Reporting Requirements, 2 (Nov. 2014) (*available at* https://www.cdc.gov/nhsn/PDFs/CMS/LTCH-CAUTI-Guidance_2015.pdf).
[25] Exhibit P-5 at 1.
[26] *Id.* (emphasis added).
[27] Provider's Post-Hearing Brief at 5; Tr. at 152.
[28] Exhibit P-8.

submission deadlines."[29] The Board's review of the Provider's evidence shows the original "createDates" for the June, July and August 2015 quality measures at issue in this case were prior to the submission deadline.[30] However, these "createDates" simply reflect the dates on which the admittedly incomplete data was initially input into NHSN. The record contains no documentary evidence to show when the missing reporting plans for June, July and August 2015 were input into NHSN. In fact, the monthly reporting plan documentation submitted by the Provider for June, July, and August 2015 shows a modify date of August 8, 2016, *well after* the February 15, 2016 deadline. In light of the Provider's admission that the originally submitted data did not include all the reporting requirements,[31] the Board rejects the Provider's "createDates" argument.

Additionally, the Board rejects the Provider's argument that CMS' reconsideration decision is legally invalid because CMS ignored the Provider's explanation for the alleged non-compliance and used a form letter with no indication that CMS engaged in reasoned decision-making. The Board finds no evidence that CMS ignored the Provider's explanation for its non-compliance. Rather, the Board finds that the Provider conceded its non-compliance in its request for reconsideration and provided no evidence that the Provider submitted all required data, including reporting plans, by the February 15, 2016 deadline.[32] Contrary to the Provider's allegations, CMS' reconsideration decision clearly states that "CMS reviewed the reconsideration of this LTCH" and found "that this LTCH did not provide evidence that it submitted required quality data during the required timeframes."[33] The Board concludes that CMS' reconsideration procedure in this case was sufficient.

Finally, the Board finds that the Provider's failure to submit reporting plans by the data submission deadline is not an "extenuating circumstance" entitling the Provider to relief from the 2-percent reduction to its APU. The controlling regulations at 42 C.F.R. § 412.560(c) explain that "[u]pon request of a long-term care hospital, ***CMS*** *may grant an exception or extension* with respect to the quality data reporting requirements, for one or more quarters, in the event of certain extraordinary circumstances beyond the control of the long-term care hospital…," subject to certain conditions.[34] While this regulation is directed to CMS (rather than the Board) and it requires the LTCH to submit a request to CMS, the Board notes that the key phrase in the regulation determining whether an LTCH would qualify for an exception is that the "extraordinary circumstance" must be "beyond the control of the long-term care hospital." In

[29] Provider's Post-Hearing Brief at 24 (internal citations omitted); Exhibit P-8 at 1.
[30] Provider's Post-Hearing Brief at 24; Exhibit P-8 at 1 (showing that data was initially created in the NHSN system on August 3 for June 2015, August 24 for July 2015, and October 6, 2015 for August 2015).
[31] Provider's Post-Hearing Brief at 21 (stating: "On February 9, 2016, the DQM received a notification email from NHSN stating that Salt Lake City had incomplete data for the CAUTI (NQF #0138) outcome measure for June and July 2015, and for the CLABSI (NQF #0139) outcome measure for June and August 2015. The DQM logged onto the NHSN website and did see error messages stating that the Provider was missing the reporting plans for those months, despite the DQM's belief that it had been entered into the system. The DQM reentered reporting plans for the CAUTI (NQF #0138) outcome measure for June and July 2015, and for the CLABSI (NQF #0139) outcome measure for June and August 2015, and saved the information to the data registry." (internal citations omitted)).
[32] Exhibit P-3.
[33] Exhibit P-4.
[34] 42 C.F.R. § 412.560(c) (2015) (emphasis added).

this case, the Board finds that, even if the regulation were applicable (*i.e*., the Provider had submitted a proper request to CMS), the Provider failed to demonstrate that its failure to timely submit reporting plans was an extraordinary circumstance beyond its control.[35]

The Board also recognizes that § 412.560(c)(4) (2015) provides for certain systemic or regional situations where a request need not be submitted:

> CMS may grant an exception or extension to a long-term care hospital *that has not been requested by the long-term care hospital* ***if CMS determines*** that -
>
> (i) An extraordinary circumstance *affects an entire region or locale*; or
>
> (ii) A *systemic problem* with one of CMS' data collection systems directly affected the ability of the long-term care hospital to submit quality data.

Thus, under this regulation, CMS has the authority to grant a national exception but there is no evidence that CMS has conceded that the Provider's failure to enter a monthly reporting plan qualifies as a systemic problem with data collection.

Based on the above, the Board concludes that the Provider failed to submit data for both the CAUTI and CLABSI measures in the form, manner and at the time specified by the Secretary. The Board concludes that the Provider failed to satisfy the LTCH QRP requirements that were necessary to receive a full APU for FY 2017. The Board's ruling in this case is consistent with other cases where the provider failed to enter a monthly reporting plan.[36]

---

[35] The Board recognizes that, in the preamble to the LTCH final rule published on August 19, 2013, CMS stated that, for reconsiderations relevant to FY 2015 LTCH payments, "[w] e may reverse our initial finding of non-compliance if: (1) The LTCH provides proof of compliance with all requirements during the reporting period; or (2) the LTCH provides adequate proof of a valid or justifiable excuse for non-compliance if the LTCH was not able to comply with requirements during the reporting period." 78 Fed. Reg. 50495, 50886 (Aug. 19, 2013). However, it is unclear whether CMS alone has the authority to consider a "justifiable excuse" as this discussion was not incorporated into the governing regulation at 42 C.F.R. §412.523(c)(4). The Board need not resolve this issue as it is clear that the Provider does not have (and has not established) a "justifiable excuse."

[36] *See, e.g., North Miss. Med. Ctr. v. Novitas Solutions, Inc.*, PRRB Dec. No. 2019-D7 (Dec. 21, 2018); *Conway Reg. Rehab. Hosp. v. Novitas Solutions, Inc.*, PRRB Dec. No. 2018-D42 (June 28, 2018), *declined review*, CMS Adm'r (Aug. 2, 2018); *Mary Free Bed Hosp. & Rehab Ctr. v. Wisconsin Physicians Serv.*, PRRB Dec. No. 2018-D31 (Apr. 10, 2018), *declined review*, CMS Adm'r (June 13, 2018); *Westchester Gen. Hosp. v. First Coast Serv. Options*, PRRB Dec. No. 2018-D24 (Feb. 12, 2018), *declined review*, CMS Adm'r (Mar. 20, 2018).

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the 2-percent reduction of the Provider's APU for FY 2017 was proper.

BOARD MEMBERS PARTICIPATING:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Greg Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

2/26/2019

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A