PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2019-D30

PROVIDER–
Southwest Medical Associates Hospice and Palliative Care

HEARING DATE –
February 12, 2019

Provider No.: 29-1502

Fiscal Year – 2018

vs.

MEDICARE CONTRACTOR –
National Government Services, Inc. (J-6)

CASE NO. – 18-0934

INDEX

ISSUE STATEMENT:

Whether the imposition of a two percent reduction in the fiscal year ("FY") 2018 Medicare payments for Southwest Medical Associates Hospice and Palliative Care ("SMA" or "Provider") was proper.[1]

DECISION:

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board" or "PRRB") finds that SMA did not submit its hospice quality data in the *form*, manner, and time specified by the Secretary of Health and Human Services ("Secretary") and that, therefore, the two percent reduction in its FY 2018 annual percentage update ("APU ") was proper.

INTRODUCTION:

SMA is a Medicare-certified hospice provider located in Las Vegas, Nevada. On July 13, 2017, the Centers for Medicare and Medicaid Services ("CMS") notified SMA that it failed to meet the Hospice Quality Reporting Program ("HQRP") requirements, and imposed a two-percent reduction in SMA's FY 2018 APU.[2] Specifically, CMS alleged that SMA did not correctly submit its quality data as required by statute.[3] In a letter dated August 2, 2017, SMA requested that CMS reconsider its decision. On September 27, 2017, CMS responded to the reconsideration request and upheld the payment reduction.[4]

SMA timely appealed CMS' September 27, 2017 reconsideration denial to the Board and has met the jurisdictional requirements for a hearing. Following the parties' submission of Final Position Papers, the Board approved SMA's request for a record hearing. The Provider was represented by Connor Flynn of OptumCare. The Medicare Contractor was represented by Wilson C. Leong, Esq. of Federal Specialized Services.

STATEMENT OF FACTS:

In § 122 of the Tax Equity and Fiscal Responsibility Act of 1982, Congress amended the Social Security Act ("Act") in order to provide a Medicare Hospice Benefit for Medicare beneficiaries.[5] The Medicare Hospice Benefit provides a per diem payment in one of four prospectively-determined rate categories of hospice care.[6] Subsequently, Congress further amended the Act to include an annual increase in the daily payment rate for hospice services based upon the inpatient market basket percentage increase, also known as the annual percentage update, or APU.[7]

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[1] Joint Stipulations Between The Parties ("Stipulations"), at ¶ A (Jan. 30, 2019).
[2] *Id*. at ¶ B.
[3] *Id*.
[4] *Id*.
[5] 42 U.S.C. § 1395f(i).
[6] 82 Fed. Reg. 36638, 36641 (Aug. 4, 2017).
[7] Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6005(a), 103 Stat. 2106, 2160 (1989); Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4441(a), 111 Stat. 251, 422 (1997).

Under the Affordable Care Act ("ACA"), Congress tied a hospice provider's eligibility for its full APU increase to submission of certain quality data based upon measures specified by the Secretary.[8] The ACA further mandated that a hospice's APU be reduced by two percent if that hospice failed to properly report the required quality data measures for a particular fiscal year.[9] In particular, hospices are required to submit their quality data measures in a form and manner, and at a time, specified by the Secretary.[10]

For the FY 2018 reporting year, all Medicare-certified hospices were required to comply with two reporting requirements to avoid the two percentage point penalty in their APU: (1) the Hospice Item Set ("HIS"); and (2) the Hospice Consumer Assessment of Healthcare Providers and Systems (HCHAPS).[11] This case involves the submission of HIS data reporting requirements. CMS required HIS data to be submitted through the Quality Improvement and Evaluation System ("QIES") Assessment Submission and Processing (ASAP") system. As stated in the 2016 Final Rule, beginning on or after January 1, 2016 to December 31, 2016, hospices must submit at least 70 percent of all required HIS records within 30 days of the event date (patient's admission or discharge) or the hospice would be subject to a two percentage point reduction to their market basket update for 2018. CMS explained that this threshold corresponds with the overall amount of HIS records received from the provider.[12]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW:

The determinative facts of this case are not in dispute. Both the Provider and the Medicare Contractor agree that SMA timely submitted its HIS data by the due date set by the Secretary,[13] and that SMA transmitted the data in an Excel format that was ultimately *not accepted* by CMS.[14] The record contains documentation that the data submitted by SMA was received by CMS,[15] but contains no evidence that these submissions were accepted by CMS or whether the submissions included errors identified on the Final Validation Reports.[16]

SMA contends that it complied with the data submission requirements by timely submitting the data in a manner sufficient to avoid imposition of the two point penalty.[17] The Provider argues that there is no requirement to review the Final Validation Report, and nothing in 42 U.S.C. § 1395(f)(i)(5)(C) or 42 C.F.R. § 418.312(a) that states that a particular Excel format is required by CMS.[18] The gravamen of SMA's argument is that "CMS is not authorized by law to tie the submission of HIS data in a particular Excel format to a provider's receipt of a full market update."[19]

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[8] ACA, Pub. L. No. 111-148 (2010), § 3004(c), 124 Stat. 119, 368 (2010), codified at 42 U.S.C.§ 1395f(i)(5).
[9] 42 U.S.C. § 1395f(i)(5)(A).
[10] 42 U.S.C. § 1395f(i)(5)(C). *See also* 42 C.F.R. § 418.312(a).
[11] Exhibit I-2 at 1. *See also* Stipulations at ¶ C (Jan. 30, 2019).
[12] 80 Fed. Reg. 47141, 47192 (Aug. 6, 2015) (copy included at Exhibit I-5).
[13] Provider's Final Position Paper at 3 (Oct. 5, 2018). *See also* Exhibit P-2; MAC Final Position Paper at 10 (Oct. 29, 2018).
[14] Provider's Final Position Paper at 3. *See also* MAC Final Position Paper at 10.
[15] Exhibit P-2.
[16] MAC Final Position Paper at 10. *See also* Provider's Final Position Paper at 3-4.
[17] Provider's Final Position Paper at 3.
[18] Provider's Final Position Paper at 4.
[19] *Id.* at 5.

The Board disagrees. The statute at 42 U.S.C. § 1395f(i)(5)(C) requires hospices to submit their HIS data in ***a form*** and manner, and at a time, specified by the Secretary.[20] It is undisputed that SMA's data submissions, while apparently timely filed, were not accepted by CMS because SMA did not submit its data in a form acceptable to the Secretary. Sections 3 and 5 and Appendix A of the HIS submission User's Guide ("Guide"), found on the CMS QIES website,[21] provide instructions to providers for the submission of HIS data files. These instructions explain that, once a file is uploaded, a confirmation message will display that indicates successful receipt of the file.[22] However, the Guide explicitly states that a ***confirmation message does not indicate whether errors are present*** in the submitted file which would result in their failure to be accepted.[23] The Guide is very clear that "Errors that exist in the submitted file are identified only after the Hospice system subsequently validates the file [within 24 hours]."[24] Examples of fatal errors that prevent the processing of a file or record include "Invalid Zip file format," Empty Zip file," and "Invalid XML file format."[25]

Further, the Guide advises providers to print, or otherwise note, the confirmation message in order to identify and access the corresponding Final Validation Report in the CASPER[26] Reporting application.[27] The Guide explains that the Hospice Final Validation Report "provides a detailed account of any errors found during the validation of the records in the submitted HIS file."[28] Users are instructed to review the Final Validation Report and that files with fatal errors "must be corrected and the file . . . resubmitted" for acceptance.[29] The Guide also states, "*It is recommended that you print and retain the Final Validation Reports.*"[30] To this end, each of the hospice file submission reports that the Provider submitted into the record at Exhibit P-2 includes the same recommendation for Final Validation Reports:

> Your submission file will be processed for errors within 24 hours. The Final Validation Report, which contains detailed information about your submission, may be accessed in the CASPER Reporting application. It is recommended that you print and retain the Final Validation Reports.

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[20] *See, e.g.* HIS Submission User's Guide, Ch. 3, Version 1.0, at 3-11 (Mar. 2016) (copy included at Exhibit I-6, *see* page 12) ("You must use software capable of encoding HIS records and exporting data files in accordance with CMS's standard record layout specifications for the Hospice Item Set.").
[21] Available at https://qtso.cms.gov/providers/hospice-providers/reference-manuals (note that the Table of Contents posted as of June 25, 2019 is dated March 2016). Sections 3 and an excerpt from Section 5 issued in March 2016 are included at Exhibit I-6.
[22] Exhibit I-6 at 16.
[23] *Id*. ("The confirmation message only indicates successful receipt of the file at the National Submissions Database. Errors that exist in the submitted file are identified only after the Hospice system subsequently validates the file.").
[24] *Id*.
[25] *Id*. at 23.
[26] Certification and Survey Provider Enhanced Reporting ("CASPER")
[27] Exhibit I-6 at 16.
[28] *Id*.
[29] *Id*. at 24.
[30] *Id*. at 16 (emphasis added).

The 2016 Final Rule also explained that QIES ASAP system validation edits monitor timeliness and ensure that submitted records conform to the HIS specifications informing hospices that warnings will appear on the Final Validation Reports when timing criteria have not been met.[31] In this final rule, CMS encourages hospices to submit HIS records early to allow ample time to address any technical issues encountered in the submission process, such as correcting fatal errors, and explains how reports in the CASPER system can be used for tracking HIS records.[32]

Despite being notified of the importance of validation process, the Board finds no evidence in the record to show that SMA reviewed, much less printed and retained, the Final Validation Reports to verify that the HIS data files it submitted were ultimately accepted by CMS.[33] As a result, SMA did not realize it data was not submitted in the form and manner required and, therefore, not accepted by CMS.

The Board's finding in this case is consistent with its decision in *Lightbridge Hospice v. National Government Services* ("*Lightbridge*"),[34] which held that when a provider fails to submit required quality data in the form and manner at a time specified by the Secretary, a two percent reduction in the APU is proper and appropriate.[35] SMA, like Lightbridge Hospice, is not being penalized for failing to run final validation reports. Rather, SMA's choice not to run the final validation reports led to the unfortunate result that SMA did not realize, until after the filing deadline passed, that its timely, but incorrectly formatted, data had not been accepted by CMS.

The Board concludes that, because SMA submitted HIS data using an Excel format that was unacceptable to CMS, SMA did not submit its data in the form and manner, and at a time specified by the Secretary. Accordingly, the Board finds that, in accordance with 42 U.S.C. § 1395f(i)(5)(A), CMS was correct in reducing SMA's 2018 APU by 2 percentage points.

DECISION AND ORDER:

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that SMA did not submit its hospice quality data in the *form*, manner, and time specified by the Secretary and that, therefore, the two percent reduction in its FY 2018 APU was proper.

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[31] 80 Fed. Reg. at 47191.
[32] *Id*. at 47192 - 47193.
[33] MAC Final Position Paper at 12.
[34] PRRB Dec. No. 2018-D32 (Apr. 17, 2018), *declined review*, CMS Adm'r (June 21, 2018).
[35] SMA mischaracterizes the reasons for the Board decision in *Lightbridge*. The *Lightbridge* provider was not subjected to a two percent APU reduction because it failed to review and print out the validation reports. Rather, the Board stated, "[w]hile the Board agrees that a provider is not required to review and printout the final validation reports, the Board asserts it is in the provider's best interest to run these validation reports to confirm that the quality data input passed [validation]. . . ." *Id.* at 5. Likewise, in this case, SMA is not being penalized for failing to run final validation reports. Rather, SMA's choice not to run the final validation reports led to the unfortunate result that SMA did not realize, until after the filing deadline passed, that its timely submitted data had not been accepted by CMS because the form of the data submission was not compliant with CMS requirements.

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FOR THE BOARD:

6/26/2019

X Clayton J. Nix

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