PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2022-D23

PROVIDER –
Ruston Regional Specialty Hospital

DATE OF HEARING –
March 11, 2021

PROVIDER NUMBER –
19-2022

FISCAL YEAR –
2020

vs.

MEDICARE CONTRACTOR –
WPS Government Health Administrators (J-5)

CASE NUMBER –
20-0468

INDEX

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 federal fiscal year ("FFY") 2020 by two percent 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 CMS properly reduced the annual payment update ("APU") for Ruston Regional Specialty Hospital ("Ruston" or "Provider") for FFY 2020 by two percent.

INTRODUCTION:

Ruston is a Medicare-certified long-term care hospital ("LTCH") located in Ruston, Louisiana.[2] Ruston's assigned Medicare contractor[3] is WPS Government Health Administrators ("Medicare Contractor").

By letter dated July 2, 2019, the Medicare Contractor notified Ruston that it failed to meet the LTCH QRP requirements and was subject to a two percent reduction in its FFY 2020 APU.[4] By letter dated July 16, 2019, CMS also notified Ruston that it had failed to meet the LTCH QRP requirements and was subject to a two percent reduction. CMS specifically advised Ruston that it did not submit the NQF #0431 Influenza Vaccination Coverage among Healthcare Personnel ("IVCH") data.[5]

On August 9, 2019, Ruston timely requested a reconsideration of the noncompliance decision regarding the reduction to its FFY 2020 Medicare payments.[6] CMS on September 11, 2019 [7] and the Medicare Contractor on September 17, 2019,[8] denied Ruston's reconsideration request and upheld the decision to reduce Ruston's FFY 2020 APU by two percent. On December 9, 2019, Ruston timely appealed CMS' September 11, 2019 reconsideration denial to the Board and met the jurisdictional requirements for a hearing.

The Board held a video hearing on March 11, 2021. Ruston was represented by Jason M. Healy, Esq. The Medicare Contractor was represented by Joseph Bauers, Esq. of Federal Specialized Services.

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[1] Transcript at 5 (March 11, 2021) ("Tr").
[2] Provider's Final Position Paper (hereinafter "Provider's FPP") at 3 (Dec. 28, 2020).
[3] 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 and relevant.
[4] Exhibit ("Ex.") P-2 at 1 (Dec. 28, 2020).
[5] Ex. C-1 at 1 (Jan. 15, 2021).
[6] Ex. P-3 at 1.
[7] Ex. P-6.
[8] Ex. P-7.

STATEMENT OF FACTS AND RELEVANT LAW:

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, specified by the Secretary."[9] The Secretary implemented this statutory provision at 42 C.F.R. § 412.560(b) which states:

> (b) *Data submission 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, and standardized patient assessment data must be submitted in a form and manner, and at a time, specified by CMS.
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> (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 [two] percentage points.[10]

The Fiscal Year ("FY") 2013 Inpatient Prospective Payment System Long Term Care Hospital Prospective Payment System ("FY 2013 IPPS/LTCH PPS") Final Rule adopted the IVCH quality measure (NQF #0431), starting with the LTCH QRP FY 2016 payment determinations.[11] CMS instructed LTCHs that the required data must be submitted to the Centers for Disease Control and Prevention's ("CDC's") National Health Safety Network ("NHSN") system.[12]

This case concerns the FFY 2020 payment determinations, based on the LTCH IVCH measure data reporting requirements. Specifically, LTCHs had to collect data related to the IVCH measure from October 1, 2018, through March 31, 2019, and properly submit that data to CMS by the deadline of May 15, 2019, to ensure receipt of the full FFY 2020 APU.[13]

In this regard, in April 2014, CMS issued operational guidance related to the HCP IVCH measure stating:

> The NHSN protocol provides guidance for healthcare facilities to report HCP influenza vaccination summary data from October 1 (or when the vaccine became available) through March 31, which

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[9] 42 U.S.C. § 1395ww(m)(5)(C); *see also* Patient Protection and Affordable Care Act of 2010, Pub. L. 111-148, § 3004(a), 124 Stat. 119, 368-369 (Mar. 23, 2010) (adding LTCH QRP statutory provisions at 42 U.S.C. § 1395ww(m)(5)).

[10] 42 C.F.R. § 412.560(b)(1)(2); *see also* 1395ww(m)(5)(A).

[11] 77 Fed. Reg. 53257, 53630-53631 (Aug. 19, 2012).

[12] NHSN is a secure, internet-based surveillance system maintained and managed by the CDC, and can be used by many types of health care facilities in the United States... to collect and use data about HAIs, adherence to clinical practices known to prevent HAIs, the incidence or prevalence of multidrug-resistant organisms within their organizations, and other adverse events. 77 Fed. Reg. at 53557.

[13] 78 Fed. Reg. 50495, 50858 (Aug. 19, 2013).

> includes all influenza vaccinations administered during the influenza season at the facility or elsewhere . . . .
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> ****
>
> HCP influenza vaccination summary reporting in NHSN consists of a single data entry screen per influenza season, so each time a user enters data for a particular influenza season, all previously reported data for that season will be overwritten . . . . For the purpose of fulfilling CMS quality reporting measurements reporting requirements, this summary report will only be submitted once to CMS. The summary report must be entered by May 15 for data to be shared with CMS.
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> HCP influenza vaccination summary data submitted to NHSN by May 15 will be reported by CDC to CMS for each long-term care hospital CMS Certification Number (CCN). CDC will share all in-plan HCP influenza vaccination summary data with CMS. CDC will provide a HCP influenza vaccination percentage for each reporting long term care hospital CCN.[14]

CMS also directed LTCHs to the CDC website at *http://www.cdc.gov/nhsn/cms/index.html*, and recommended that providers run output reports within their facilities *prior to* reporting deadlines and utilize the provided checklists to ensure complete reporting to NHSN.[15]

Ruston contends that it properly reported all data for the IVCH (NQF #0431) measure to the agency's designated reporting system (the CDC NHSN), by the deadline indicated in a January 2019 CDC guidance document.[16] Therefore, it maintains that it was in full compliance with the LTCH QRP.[17]

Ruston explains that it relied on a CDC guidance document from January 2019 entitled "Reporting Requirements and Deadlines in NHSN per CMS Current & Proposed Rules"[18] which stated: "Starting with October 2015 data, reporting deadline will be 4.5 months after the end of the quarter."[19] Because the collection timeframe for the IVCH measure for the FY 2020 LTCH QRP ended on March 31, 2019, Ruston contends that the applicable reporting deadline for this measure was August 15, 2019 and that it submitted all the required IVCH data to NHSN by the deadline indicated in the January 2019 CDC guidance document.[20] Ruston also notes it "did not receive any email or other correspondence from the NHSN or CMS *before* the reporting deadlines stating that [it] had incomplete or missing data for any quality measure, including the [IVCH] measure."[21]

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[14] https://www.cdc.gov/nhsn/PDFs/HCP/Operational-Guidance-LTCH-HCP-Flu.pdf.
[15] Ex. C-12 at 3.
[16] Provider's FPP at 1.
[17] *Id*.
[18] Ex. P-3 at 3-6.
[19] *Id.* at 4.
[20] Provider's FPP at 4.
[21] *Id*.

Ruston asserts that CMS established a LTCH QRP reconsideration process in 42 C.F.R. § 412.560(d)(2)(vii) with two standards of review. Ruston contends that the first standard is full compliance with the LTCH QRP requirements, under which CMS must reverse the initial finding of non-compliance when a LTCH's evidence demonstrates full compliance with all LTCH QRP reporting requirements during the reporting period. Ruston argues that it met this first standard by reporting all required IVCH data by the deadline stated in the CDC guidance document and, therefore, that the two percent penalty must be reversed.[22]

Ruston also claims that the FY 2015 IPPS Final Rule[23] stated that, as an alternative to full compliance with LTCH QRP reporting requirements during the reporting period, it could submit for reconsideration evidence demonstrating extenuating circumstances that caused noncompliance with timely reporting of the LTCH QRP requirements.[24] Ruston maintains that, even if its evidence did not demonstrate proof of full compliance, the payment penalty should be reversed under the second standard of review which, it claims, is an equitable standard.[25] Ruston maintains that it has documented excuses for failing to timely submit the IVHC data to CMS, including its belief that the CDC's January 2019 guidance document was misleading as to the applicable deadline, and that the NHSN system did not alert or notify it that its HIVC data were missing, or would not be transmitted to CMS, before the deadline.[26] Ruston avers that "CMS is tasked with evaluating the hospital's reasons for less than full compliance with the LTCH QRP"[27], and that CMS must equitably assess Ruston's extenuating circumstances.

Ruston maintains that CMS's one-page, form letter reconsideration decision failed to articulate a rational connection between the facts found and the decision to deny the reconsideration request. Further, Ruston contends that, although CMS states in the reconsideration letter that it reviewed the Provider's reconsideration request, this type of form decision is contrary to that required by the Supreme Court. Ruston believes that the Board should reverse the CMS reconsideration decision because it suffers from defects that are materially the same as the final agency decisions in *PAM Squared*[28] and *Landmark Hospital.*[29] According to Ruston, the U.S. District Court in *PAM Squared* and *Landmark*, "held that the final agency decisions at issue were arbitrary and capricious when they did not apply the correct LTCH QRP reconsideration rules."[30] Ruston points out that CMS' reconsideration decision simply upholds the imposition of the reduced FY 2020 APU while including "no discussion of the deadlines stated in the CDC guidance or the Provider's evidence of extenuating circumstances,"[31] and thereby "entirely disregarded the standards of review for the LTCH QRP reconsideration process."[32]

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[22] *Id.* at 15-16.
[23] 79 Fed. Reg. 49854, 50317 (Aug. 22, 2014).
[24] Provider's FPP at 1-2.
[25] *Id.* at 18-19.
[26] *Id.* at 19 & 23.
[27] *Id.* at 19.
[28] *PAM Squared at Texarkana, LLC v. Azar*, No. 1:18-CV-2542, 2020 WL 364782 (D.D.C. Jan. 22, 2020).
[29] *Landmark Hosp. of Salt Lake City v. Azar*, No. 1:19-CV-1227, and *Landmark Hospital of Savannah*, No. 1:19-CV-1228, 2020 WL 999454 (D.D.C. Mar. 2, 2020).
[30] *Landmark Hosp.* 442 F. Supp. 3d at 334; *PAM Squared* 436 F. Supp. 3d at 57-58; Provider's FPP at 29 (December 28, 2020).
[31] Provider's FPP at 29.
[32] *Id.*

Ruston asserts that, just as the *PAM Squared* and *Landmark* Courts found that the Board decisions were arbitrary and capricious, the Board "should now conclude here that the CMS reconsideration decision is arbitrary and capricious because it did not apply the correct standards under the LTCH QRP reconsideration rules."[33] Ruston maintains that the reconsideration decision "ignores [its] key arguments...[and] does not discuss, with any specificity, the evidence that the Provider submitted with its request for reconsideration."[34] Ruston believes it is unable to know "whether CMS actually considered any of this evidence submitted by the Provider, including the misleading January 2019 CDC guidance document."[35] Ruston argues that the Board "should therefore reverse the [r]econsideration decision because it violates the APA's arbitrary and capricious standard."[36]

Ruston claims that it received two reconsideration decisions, one from CMS and one from the Medicare Contractor, each containing a different rationale for upholding the two percent LTCH QRP penalty to its FY 2020 APU. Ruston maintains that "[the] Medicare Contractor's reconsideration decision...contains a different rationale for upholding the LTCH QRP payment penalty"[37] than that cited by CMS in its reconsideration decision. Ruston argues that its "receipt of two inconsistent reconsideration decisions created confusion as to why [its] request for reconsideration was denied."[38] Ruston contends that "[this] inconsistency and confusion confirms that the Reconsideration here... s "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law.""[39] Furthermore, Ruston asserts that receipt of two inconsistent reconsideration decisions (one from CMS and one from the Medicare Contractor) confuses the administrative record because it is unclear which decision and/or rationale was the true basis for the denial of its reconsideration request.[40]

Ruston maintains that, per the FY 2012 IPPS Final Rule,[41] the purpose of the LTCH QRP is "to promote higher quality and more efficient healthcare for Medicare beneficiaries."[42] Ruston asserts that applying a full two percent payment penalty when it did submit all required LTCH QRP data to NHSN "does not effectuate that purpose" and "is inconsistent with the intent and goals of the LTCH QRP."[43] Ruston contends that "[t]he doctrine of substantial compliance precludes application of the penalty in this case."[44] Ruston argues that the two percent cut to its FY 2020 Medicare payments "has a significant negative impact on the hospital and its ability to treat patients effectively, at a time when LTCH payments from Medicare have already been drastically reduced. Therefore, applying the payment penalty when [Ruston] timely submitted all

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[33] *Id*. at 30.
[34] *Id.* at 31.
[35] *Id.* at 32.
[36] *Id.*
[37] *Id.* at 38.
[38] *Id.*
[39] *Id.* at 39 (citing 5 U.S.C. § 706(2)(A)).
[40] *Id.* at 37-8. Citing to *Styrene Information and Research Ctr., Inc. v. Sebelius*, 944 F. Supp. 2d 71, 77 (D.D.C. 2013) (quoting *Occidental Eng'g Co. v. INS*, 753 F.2d 766, 769-70 (9th Cir. 1985)) Ruston states that, "[u]nder the APA, it is the role of the agency to resolve factual issues to arrive at a decision that is supported by the administrative record."
[41] 76 Fed. Reg. 51476, 51743 (Aug. 18, 2011).
[42] *Id.* at 40.
[43] *Id.*
[44] *Id.* at 41.

required quality data is contrary to the intent of the LTCH QRP."[45] Ultimately, Ruston requests that the Board reverse the two percent penalty and award interest under 42 U.S.C § 1395g(d) to it as part of the Board's decision.[46]

The Medicare Contractor states that, contrary to Ruston's contention, the IVCH "was late because it was submitted *after* the deadline of May 15, 2019."[47] The Medicare Contractor asserts that Ruston's argument that the January 2019 CDC document "allow [sic] for the quality measure NQF #0431 to be due 4.5 months after the end of the quarter, or August 15, 2019,"[48] fails because the IVCH is not a quarterly measure. The Medicare Contractor maintains that the IVCH "is a seasonal influenza measure encompassing two quarters (October through December and January through March)."[49] As such, the Medicare Contractor asserts that, because the influenza data is referred to in a quarterly, rather than seasonal, manner, the CDC document indicates the data would be due 4.5 months after the end of the first quarter of data collection. Thus, according to the Medicare Contractor, the due date was 4.5 months after the end Quarter 4 (December 31, 2018) on May 15, 2019. The Medicare Contractor also points out that the reporting deadline of May 15, 2019 is clearly stated in the right column of the January 2019 CDC document, where it states "Q4 (Oct.-Dec.)-Q1 (Jan.-March): May 15."[50]

The Medicare Contractor maintains that formal guidance such as the CMS LTCH Quality Reporting Program Manual, the NHSN Checklist, and the LTCH Quality Reporting Data Submission Deadlines webpage all clearly state the deadline was ***May 15, 2019***. Also, prior year IPPS final rules document the longstanding history of the IVCH measure due date being ***May 15th*** of the relevant year. The Medicare Contractor asserts that other outreach and education materials, such as links from the CMS.Gov website that include outreach and education, Medicare Learning Network ("MLN") Newsletters, webinars and live training sessions provided to LTCHs for the FY 2020 LTCH QRP program year noted that the reporting deadline for the IVCH data and period in question was May 15, 2019.[51] The Medicare Contractor asserts that Ruston "knew it missed the deadline and is trying to "twist" its interpretation of one document into the category of an "extenuating circumstance."[52] The Medicare Contractor maintains that provisions for extenuating circumstances were included at 79 Fed. Reg. 50317. Per the Medicare Contractor, "[t] his is a subjective term and the documents submitted with the reconsideration request were minimal... the overwhelming documents supporting the deadline of May 15, 2019, should override this strained interpretation."[53]

The Medicare Contractor also asserts that Ruston's witness declarations "show more negligence than explaining any extenuating circumstances."[54] The Medicare Contractor contends that "[i]t could be interpreted as negligence that the Quality Director who started on September 2, 2018,

[45] *Id.*
[46] *Id.* at 14.
[47] Medicare Contractor's FPP at 8 (Jan. 15, 2021) (emphasis added).
[48] *Id*.
[49] *Id.*
[50] *Id. at* 8-9.
[51] *Id.* at 9.
[52] *Id.* at 10.
[53] *Id.*
[54] *Id.* at 11.

did not, until February of 2019 begin the process to obtain a NHSN ID."[55] The Medicare Contractor further notes that "[e]ven after requesting access in February of 2019 it was not until the end of April 2019 [that] the Provider filed its follow up email to check on their status with the NHSN."[56]

The Medicare Contractor states further that "[t]he reconsideration process went through the proper notice and comments period, and appeared in the FY 2015 Final Rule and was applicable for FY 2016 and later payment determinations."[57] The Medicare Contractor asserts that, based on the reconsideration request, the form letter determination issued by CMS "was an adequate response that complies with the guidelines"[58] Also, the Medicare Contractor notes that Ruston "did not mention any problems obtaining access to report data through NHSN... only tries to explain why they misinterpreted the reporting deadline...[and]did not mention all of the other documents available to them that also stated the deadline of May 15, 2019."[59]

Additionally, the Medicare Contractor points out that, on the Influenza Vaccination Summary, Ruston's facility is identified as LifeCare Specialty Hospital of North Louisiana, while other references to the facility identifies the business name as Ruston Regional Specialty Hospital. The Medicare Contractor asserts that there was "no explanation with the reconsideration request as to whether these are one in the same hospital."[60] The Medicare Contractor argues that, based on the lack of evidence included with the reconsideration request, as well as the guidelines presented in the Final Rule, "the response was adequate because the reconsideration request may have been determined to be inadequate and incomplete. Additionally, the Final Rule does not require a detailed explanation of the reconsideration decision."[61]

The Medicare Contractor declares that previous case history[62] supports the application of the payment reduction. The Medicare Contractor asserts "[t]he two percent reduction to the Standard Federal Rate is the required penalty for failure to comply with the LTCH Quality Reporting Program. The program is set up for an all or nothing [determination] in regard to the two percent penalty."[63] The Medicare Contractor argues that the case against Ruston is strong because Ruston "did not timely file [the IVCH] quality data in accordance with the regulations nor has the Provider shown a justifiable excuse for missing the data submission deadline given all the guidance provided by CMS."[64] Thus, the evidence does not support a finding of extenuating circumstances to reverse the two percent payment penalty. The Medicare Contractor dismisses Ruston's equitable arguments as groundless. The Medicare Contractor requests that the Board affirm the decision to impose the two percent reduction to the Standard Federal Rate for the Provider's Medicare payment for FY 2020.[65]

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[55] *Id.*
[56] *Id.*
[57] *Id.*
[58] *Id.* at 12 (citing to 79 Fed. Reg. 50317-50318).
[59] *Id.*
[60] *Id.* at 13.
[61] *Id.* at 13.
[62] *All Care Home Health 2012 2% Reduction CIRP Grp v. BlueCross Blue Shield Ass'n*, PRRB Dec. 2013-D31 (Sept. 4, 2013); *Pacific Alliance Med. Ctr. v. Wisconsin Physicians Serv.*, PRRB Dec. 2011-D15 (Dec. 14, 2010).
[63] Medicare Contractor's FPP at 14.
[64] *Id.* at 15.
[65] *Id.*

DISCUSSION, FINDINGS OF FACT. AND CONCLUSIONS OF LAW:

This case focuses on whether Ruston met the LTCH QRP reporting requirements when it failed to submit the IVCH quality measure data to the CDC's NHSN for the October 1, 2018, through March 31, 2019 data collection period by the May 15, 2019 deadline. The Board finds that Ruston did not submit the IVCH data to the CDC's NHSN until July 10, 2019 and, as a result, its influenza vaccination data was not transmitted from CDC's NHSN to CMS by the May 15, 2019 deadline.

Ruston claims that it should not be penalized because it reported all data for the IVCH measure to the CDC NHSN by the deadline indicated in a January 2019 CDC guidance document and, thus, was in full compliance with the LTCH QRP.[66] Ruston further contends that, "[i]f CMS did not conclude that there was full compliance by Ruston with the LTCH QRP, then the evidence clearly supported a finding of "extenuating circumstances" that required reversal of the payment penalty."[67]

The Board reviewed CMS' guidance, the Final Rules and regulations in effect for the data collection period (October 1, 2018 through March 31, 2019) for the FY 2020 payment determinations. Contrary to Ruston's arguments, the Board finds that Ruston failed to comply with the LTCH QRP reporting requirements. Ruston explains that it relied on a CDC guidance document from January 2019 entitled "Reporting Requirements and Deadlines in NHSN per CMS Current & Proposed Rules"[68] which included the statement for the LTCH NHSN events for CLABSI, CAUTI, and C. Difficile LabID Events[69] that "Starting with October 2015 data, reporting deadline will be 4.5 months after the end of ***the*** quarter."[70] Because the collection timeframe for the IVCH measure for the FY 2020 LTCH QRP covering Quarter 4 (October to December 2018) through Quarter 1 (January to March 2019) ended on March 31, 2019, Ruston contends that the applicable reporting deadline for this measure was August 15, 2019 for both Quarters 4 and 1 and that it submitted all the required IVCH data to NHSN by the deadline indicated in the January 2019 CDC guidance document.[71] Ruston also notes it "did not receive any email or other correspondence from the NHSN or CMS *before* the reporting deadlines stating that the Provider had incomplete or missing data for any quality measure, including the Healthcare Personnel Vaccination measure."[72]

Ruston further argues that CMS' decision to reduce its FY 2020 APU by two percent should be reversed because: (1) "the CMS Reconsideration decision failed to follow the reconsideration process established in the regulation and preamble to the FY 2015 [IPPS] Final Rule";[73] (2) the CMS reconsideration decision "violates the most basic requirements of the Administrative

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[66] Provider's FPP at 1.
[67] *Id.* at 20.
[68] Ex. P-3 at 3-6.
[69] Each of these NHSN events were reported on a quarterly basis and had deadlines listed as 4.5 months following the close of the quarter. For example, the table specifically showed that starting with Quarter 4 2015, all Quarter 1 data were due August 15th, which is 4.5 months after the close of Quarter 1 on March 31st.
[70] Ex. P-3 at 4 (emphasis added).
[71] *Id.*
[72] *Id*.
[73] *Id.* at 12.

Procedure Act's ("APA's") arbitrary and capricious standard"; [74] and, (3) "CMS' application of the two percent payment penalty to the Provider is contrary to the congressional intent of the LTCH QRP."[75]

The statute at 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, specified by the Secretary."[76] The statute provides that a long-term care hospital that does not submit data in accordance with 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 two percentage points.[77]

In the FY 2014 IPPS Final Rule,[78] the final submission deadline for the influenza vaccination data was established as approximately 45 days after the end of the data collection period or May 15th.[79] Further, per the FY 2015 IPPS Final Rule,[80] LTCHs requesting reconsideration are "required to submit all supporting documentation and evidence demonstrating: (1) Full compliance with all [LTCHQR] Program reporting requirements during the reporting period; or (2) extenuating circumstances that affected noncompliance if the LTCH was not able to comply with the requirements during the reporting period."[81] The preamble to the Final Rule further explained that "[w]e [*i.e*., CMS] would not review any reconsideration request that fails to provide the necessary documentation and evidence along with the request."[82]

In the FY 2016 IPPS Final Rule,[83] CMS adopted and finalized the LTCH QRP reconsideration and appeal procedures for payment determinations for FY 2017 and subsequent years. CMS codified the reconsideration regulation at 42 C.F.R. § 412.560. The regulation at § 412.560(d)(2) states:

> (d) *Reconsiderations of noncompliance decisions*– . . . .
>
> (2) *Request for reconsideration of noncompliance decision*. A long-term care hospital may request a reconsideration of CMS' decision of noncompliance no later than 30 calendar days from the date of the written notification of noncompliance. The reconsideration request by the long-term care hospital must be submitted to CMS via email and must contain the following information:
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> (i) The CCN for the long-term care hospital.

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[74] 5 U.S.C. § 706(2)(A); Provider's FPP at 13.
[75] *Id.* at 14.
[76] *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)).
[77] 1395ww(m)(5)(A); *see also* 42 C.F.R. § 412.560(b)(2).
[78] 78 Fed. Reg. 50496, 50858 (Aug. 19, 2013)
[79] *Id.* (stating: "The final deadlines associated with submitting [influenza vaccination] data, approximately 45 days after the end of the data collection timeframe for the FY 2016 payment determination and subsequent years remain consistent with other measures in the LTCHQR Program . . .").
[80] 79 Fed. Reg. 49854, 50317 (Aug. 22, 2014).
[81] *Id*.
[82] *Id*.
[83] 80 Fed. Reg. 49326, 49755 (Aug. 17, 2015).

> (ii) The business name of the long-term care hospital.
> (iii) The business address of the long-term care hospital.
> (iv) Contact information for the long-term care hospital's chief executive officer or designated personnel, including each individual's name, title, email address, telephone number, and physical mailing address. (The physical address may not be a post office box.)
> (v) CMS's identified reason(s) for the noncompliance decision from the written notification of noncompliance.
> (vi) The reason for requesting reconsideration of CMS's noncompliance decision.
> (vii) Accompanying documentation that demonstrates compliance of the long-term care hospital with the LTCH QRP requirements. This documentation must be submitted electronically at the same time as the reconsideration request as an attachment to the email.

In the instant case, Ruston requested a reconsideration of CMS' noncompliance decision on August 9, 2019. In an attempt to support its argument, Ruston included with its reconsideration request documentation a copy of the January 2019 CDC guidance document, the non-compliance decision, and its NHSN Influenza Vaccination Summary report.[84] Ruston claims that it was in full compliance with the LTCH QRP because it reported all required IVCH data to the CDC NHSN by the August 15, 2019 deadline indicated in the January 2019 CDC guidance document.[85] However, as discussed more fully below, the Board finds that the deadline for reporting all data for the IVCH quality measure to the CDC NHSN was May 15, 2019, *not* August 15, 2019. Ruston did not submit the IVCH quality measure data to the CDC NHSN until July 10, 2019. Therefore, the Board finds the IVCH quality measure data was untimely submitted.

Ruston argues that it was misled by the January 2019 CDC document because the guidance document states that the reporting deadline was 4.5 months after the end of the quarter. It mistook this to mean that the reporting deadline was August 15, 2019 (4.5 months after the end of the March 31, 2019 quarter)."[86] However, the Board finds that the IVHC quality measure is not based on a ***quarterly*** measure that runs through the fully year. Rather, unlike the LTCH NHSN reporting events for CLABSI, CAUTI, and C. Difficile LabID Events, the IVHC quality measure is a seasonal influenza measure encompassing only two quarters: October through December and January through March. The Board finds in the January 2019 CDC document entitled "Reporting Requirements and Deadlines in NHSN per CMS Current & Proposed Rules," it states in the right column under NHSN event "Healthcare Personnel Influenza Vaccination (Start Q4 2014)", that the reporting deadline for "Q4 (Oct.-Dec.)-Q1 (Jan.-March): [is] May 15."[87] To this end, unlike the other NHSN reporting events, there was no column for deadlines starting "Starting Q4 2015." This information is on the page following the information upon which Ruston alleges that it relied. A reproduction of the relevant LTCH QRP information on these two pages is as follows:

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[84] Ex. P-3 at 3-6, 7-8, 11.
[85] Provider's FPP at 1.
[86] Ex. P-3 at 4.
[87] Ex. P-3 at 5; Medicare Contractor's FPP at 8-9.

Healthcare Settings	NHSN Event	CMS Reporting Deadlines	
Acute Care Facilities that participate in the CMS Hospital Outpatient Quality Reporting (OQR) Program	***Healthcare Personnel Vaccination (Start Q2014)***	*As of October 1, 2018, hospital outpatient Healthcare Personnel event data*	*OQR no longer requires departments to submit Influenza Vaccination*
Outpatient Dialysis Facilities that participate in CMS ESRD QIP Program	Dialysis Event (includes Positive blood culture, I.V. antimicrobial start, and Signs of vascular access infection)	Q1-Q4 2012 (Jan.-Dec.: 3 month minimum): April 30, 2013 Q1-Q4 2013 (Jan.-Dec: 3 month minimum): April 15, 2014	
	(Start 2012)	**Starting Q1 2014 (Jan.-Dec.: 12 month minimum):** Q1 (Jan.-March): June 30 Q2 (April-June): September 30 Q3 (Jul.-Sept.): December 31 Q4 (Oct.-Dec.): March 31	
	Healthcare Personnel Influenza Vaccination *(Start 2012)*	*As of October 1, 2018 outpatient dialysis Personnel Influenza*	*ESRD QIP no longer requires Facilities to submit Healthcare Vaccination event data*
Long-term Acute Care Facilities (LTACs) that participate in CMS LTCHQR Program *Starting with October 2015 data, reporting deadline will be 4.5 months after the end of the quarter.* Data from Q3 2015 are due [Nov.] 15, 2015. Data from Q4 2015 are due on May 15, 2016. Historical Reference	**CLABSI** (all bedded inpatient care locations) (Start Q4 2012)	**Q1 2014-Q3 2015** Q1 (Jan.-March): May 15 Q2 (April-June): [Aug.] 15 Q3 (Jul.-Sept.): [Nov.] 15 Q4 (Oct.-Dec.): [Feb.] 15	**Starting Q4 2015** Q1 (Jan.-March): [Aug.] 15 Q2 (April-June): [Nov.] 15 Q3 (Jul.-Sept.): [Feb.] 15 Q4 (Oct.-Dec.): May 15
	CAUTI (all bedded inpatient care locations) (Start Q4 2012)	**Q1 2014-Q3 2015** Q1 (Jan.-March): May 15 Q2 (April-June): [Aug.] 15 Q3 (Jul.-Sept.): [Nov.] 15 Q4 (Oct.-Dec.): [Feb.] 15	**Starting Q4 2015** Q1 (Jan.-March): [Aug.] 15 Q2 (April-June): [Nov.] 15 Q3 (Jul.-Sept.): [Feb.] 15 Q4 (Oct.-Dec.): May 15
	MRSA Bacteremia LabID Event (FacWideIN) *(Start Q1 2015)*		As of October 1, 2018, LTCHQR no longer requires LTCs to submit MRSA Bacteremia LabID event data
Q4 2012 – Q 2013: Data due 4.5 months after end of the quarter. Q1 2014 – Q3 2015: Data due 1.5 months after the end of the quarter. Q4 2015 forward: data due 4.5 months after the end of the quarter.	**C. difficile LabID Event (FacWideIN)** (Start Q1 2015)	**Q1 2014-Q3 2015** Q1 (Jan.-March): May 15 Q2 (April-June): [Aug.] 15 Q3 (Jul.-Sept.): [Nov.] 15 Q4 (Oct.-Dec.): [Feb.] 15	**Starting Q4 2015** Q1 (Jan.-March): [Aug.] 15 Q2 (April-June): [Nov.] 15 Q3 (Jul.-Sept.): [Feb.] 15 Q4 (Oct.-Dec.): May 15
			(LTAC requirements continued on next page)

Healthcare Settings	NHSN EVENT	CMS Reporting Deadlines
Long-term Acute Care Facilities (LTACs) that participate in CMS	**Healthcare Personnel Influenza Vaccination** (Start Q4 2014)	Q4 (Oct.-Dec.) – Q1 (Jan.- March): May 15
LTCHQR Program (continued)	***VAE (all bedded adult inpatient care locations)*** (Start Q1 2016)	*As of October 1, 2018, LTCHQR no longer requires LTACs to submit VAE data*

Moreover, the May 15th deadline for IVHC quality data is confirmed and reinforced in other LTCH QRP materials. In the CMS LTCH Quality Reporting Program Manual Chapter 1 Table 1-3 entitled "LTCH Care Data Set and CDC NHSN Data Collection Time Frame & Submission Deadlines for Future Years" it clearly states that the final submission deadline for NQF #0431 is May 15th, and that the deadline is "annual, not quarterly."[88] The CMS LTCH Quality Reporting Program Manual Chapter 5 also states the deadline is May 15th.[89] Further, the NHSN Checklist for HCP Reporting to CMS Hospital, IRF and LTCH Quality Reporting Programs provides "CMS Deadline for Healthcare Personnel Influenza Vaccination Summary Data: Quarter 4 & Quarter 1 of the following year (October 1-March 31): [is] May 15th."[90] The LTCH Quality Reporting Data Submission Deadlines webpage states the deadline is May 15, 2019.[91] Finally, prior year Federal Register Final Rules document the history of the IVHC measure due date as May 15th from 2014 through 2017.[92]

The Board finds that Ruston has not provided supporting evidence demonstrating full compliance with the LTCH QRP reporting requirements during the reporting period as required by the regulation at § 412.560(d)(2) and the FY 2015 Final Rule. To the contrary, Ruston's documentation shows that it did not submit its IVHC data by the May 15, 2019 deadline. Further, its NHSN Influenza Vaccination Summary Report shows that its data for the IVHC quality measure was submitted to the NHSN on July 10, 2019, nearly two months *after* the May 15, 2019 deadline. The Board concludes that Ruston failed to fully comply with the LTCHQR Program requirement to submit data in a form and manner, and at a *time,* specified by the Secretary.

Ruston contends that, even if CMS did not conclude there was full compliance with the LTCH QRP, "the evidence clearly supported a finding of extenuating circumstances that required reversal of the payment penalty."[93] The FY 2015 IPPS Final Rule provides that LTCHs requesting reconsideration are "required to submit all supporting documentation and evidence demonstrating . . . ***or*** (2) extenuating circumstances that affected noncompliance if the LTCH was not able to comply with the requirements during the reporting period. We [*i.e.,* CMS] would not review any reconsideration request that fails to provide the necessary documentation and

[88] Ex. C-6 at 6.
[89] Ex. C-7 at 3.
[90] Ex. C-9 at 1.
[91] Ex. C-10 at 1.
[92] *See* 78 Fed. Reg. at 50858 (Aug. 19, 2013); 79 Fed. Reg. at 50309 (Aug. 22, 2014); 80 Fed. Reg. at 49722-23 (Aug. 17, 2015); 81 Fed. Reg. at 57226 (Aug. 22, 2016).
[93] Provider's FPP at 20.

evidence along with the request."[94] The Board finds that the FY 2015 IPPS Final Rule explains what providers must submit to CMS in order for CMS to review the Providers' reconsideration request, although it does not address the weight CMS will give to the Providers' supporting documentation and evidence. The Board finds Ruston's argument that the use of the word "or" in the FY 2015 IPPS Final Rule means the agency's initial non-compliance decision is reversed if either statement is true (the Provider fully complied with the LTCHQR Program requirements or has extenuating circumstances that affected noncompliance) unpersuasive.[95] The FY 2015 IPPS Final Rule makes it clear that CMS would *not* review any reconsideration requests that failed to provide the necessary documentation and evidence. It did not state in the FY 2015 IPPS Final Rule that its initial non-compliance decision would be reversed simply by submitting evidence of extenuating circumstances that affected noncompliance. Ruston asserts that the reconsideration process codified at § 412.560(d) requires that CMS reverse the initial finding of non-compliance if the reasons for requesting reconsideration are supported by documentation that demonstrates compliance of the long-term hospital with the quality reporting requirements. Although this may be true, as previously stated, Ruston failed to provide evidence demonstrating full compliance with the LTCHQR requirements. Specifically, Ruston failed to meet the May 15, 2019 deadline.[96]

The Board finds that the evidence submitted by Ruston, of extenuating circumstances affecting non-compliance, does not support a reversal of the payment penalty. With its reconsideration request Ruston submitted a copy of the January 2019 CDC guidance document entitled "Reporting Requirements and Deadlines in NHSN per CMS Current & Proposed Rules." Ruston asserts that it relied on the CDC guidance document from January 2019.[97] This guidance document states: "Starting with October 2015 data, reporting deadline will be 4.5 months after the end of the quarter."[98] Ruston contends that, "[b]ecause the collection timeframe for the [IVHC] measure for the FY 2020 LTCH QRP was October 1, 2018, through March 31, 2019, the CDC guidance document led [Ruston] to believe that the applicable reporting deadline for this measure was August 15, 2019."[99] However, as previously stated, the Board finds that, within the January 2019 CDC document that Ruston references, it clearly states in the right column under NHSN event "Healthcare Personnel Influenza Vaccination (Start Q4 2014)," that the reporting deadline for "Q4 (Oct.-Dec.)-Q1 (Jan.-March): [is] May 15."[100] Although Ruston mistakenly concluded that the deadline was August 15, 2019, due to its erroneous interpretation of what 4.5 months after the end of the quarter meant, the deadline was clearly stated in the January 2019 CDC document that Ruston relied upon. Further, both CMS and the CDC posted numerous documents, including guidance and Final Rules, which list the deadline for the IVCH quality measure as May 15, 2019.[101]

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[94] 79 Fed. Reg. at 50317 (Aug. 22, 2014) (emphasis added).
[95] Provider's FPP at 10.
[96] *Id.* at 9-10.
[97] Ex. P-3 at 3-6.
[98] *Id.* at 4.
[99] Provider's FPP. at 4.
[100] Ex. P-3 at 5; Medicare Contractor's FPP at 8-9.
[101] Ruston could have found the May 15, 2019 submission deadline in the CMS LTCH Quality Reporting Program Manual Chapter 1 Table 1-3 entitled "LTCH Care Data Set and CDC NHSN Data Collection Time Frame & Submission Deadlines for Future Years", in the CMS LTCH Quality Reporting Program Manual Chapter 5, in the NHSN Checklist for HCP Reporting to CMS Hospital, IRF and LTCH Quality Reporting Programs, in the LTCH Quality Reporting Data Submission Deadlines webpage, and in prior years' Federal Register Final Rules.

At the March 11, 2021 hearing, Ruston's witness, J. Michael Parham ("Mr. Parham"), testified that he had reviewed the LTCH QRP manual.[102] Further, Mr. Parham confirmed that the LTCH QRP manual excerpts at the Medicare Contractor's Exhibits C-6 (CMS LTCH Quality Program Manual-Chapter 1) and C-7 (CMS LTCH Quality Program Manual-Chapter 5) clearly state the reporting deadline for influenza data is May 15th, not August 15th.[103] At the hearing, Mr. Parham was asked to describe the CDC document he asserted supported August 15th as the influenza data reporting deadline. First, Mr. Parham agreed that the section of the document upon which he relied referenced the CAUTI, CLASBI and C. difficile LabID Event measurement, and not the influenza data measurement. Further, Mr. Parham testified that the CDC document clearly states the influenza data reporting deadline is May 15th.[104]

The Board finds that Ruston's contention that the reporting deadline was August 15, 2019, is not supported by the evidence. Rather, the Board concludes that the evidence supports that the reporting deadline was May 15, 2019, and that the May 15th deadline for submission of the IVHC data was readily available to Ruston via CMS and CDC guidance, Final Rules, and various other documents. The Board finds that Ruston relied on its own incorrect interpretation of a CDC document and erroneously concluded that the deadline was 4.5 months after the end of the quarter. Moreover, Ruston acknowledged through Mr. Parham's hearing testimony that the CDC document it relied on clearly stated that the influenza data reporting deadline was May 15th and that Ruston was aware that the influenza vaccination data only encompassed two quarters but assumed that the submission deadline was 4.5 months after the end of the March 31, 2019 quarter, to its detriment. As CMS and CDC guidance, Final Rules and various other documents consistently published the correct deadline of May 15, 2019 and were readily available to Ruston, the Board concludes that the evidence does not support a finding of extenuating circumstances affecting non-compliance warranting a reversal of the two percent payment penalty. The Board finds that Ruston has not provided any evidence that reduces its culpability for missing the deadline.

The Board also finds that Ruston's contentions that other extenuating circumstances warranted a reversal of the payment penalty also fail. Ruston asserts "[t]he NHSN's delay in granting the Provider's new Quality Director access to the reporting system is another extenuating circumstance that interfered with the Provider's reporting of data for the [IVHC] measure."[105] The Board finds that this is not an extenuating circumstance affecting noncompliance, as Ruston's Quality Coordinator, Mr. Parham, had access to the reporting system and was able to report the influenza vaccination data for Ruston and did in fact report that data on July 10, 2019. Ruston also maintains that the failure of the NHSN system to notify Ruston that its IVHC data was missing before the May 15, 2019 deadline, or that the data would not be timely transmitted to CMS, are also extenuating circumstances that should have been considered by CMS.[106] Mr. Parham testified at the hearing that a CMS contractor would usually send such a notice to the Provider's QRP facility administrator, but he was not aware if this was done.[107] The Board finds

[102] Tr. at 29.
[103] *Id.* at 29-33.
[104] *Id.* at 37-44; *see also* Medicare Contractor's Post Hearing Brief ("Medicare Contractor's PHB") at 7 (Apr. 26, 2021).
[105] Provider's FPP at 22.
[106] *Id.* at 23.
[107] Tr. at 84-85.

that there is no evidence in the record to indicate that such notice is required to be sent nor whether such notice was ***or*** was not sent to Ruston's QRP facility administrator. As such, the Board finds that this is not an extenuating circumstance affecting Ruston's noncompliance.

Because an evidentiary hearing *de novo* was conducted, and the Board has reached its own conclusions, Ruston's remaining arguments related to the reconsideration stage and whether CMS failed to evaluate all of the evidence under both reconsideration standards of review are now moot.[108] As such, the Board need not address these arguments.

The Board has concluded that Ruston failed to fully comply with the LTCH QRP requirements to submit data in a form and manner and at a *time,* specified by the Secretary when it missed the May 15, 2019 deadline. Further, the Board finds that the evidence does not support a finding of extenuating circumstances affecting non-compliance to warrant a reversal of the two percent payment penalty. The Board concludes that the CMS penalty imposed under the LTCH QRP to reduce Ruston's payment update for FFY 2020 by two percent was proper.

DECISION:

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that CMS properly reduced Ruston's APU for FY 2019 by two percent.

BOARD MEMBERS:

Clayton J. Nix, Esq.
Gregory H. Ziegler, C.P.A
Robert A. Evarts, Esq.
Kevin D. Smith, C.P.A.
Ratina Kelly, C.P.A.

FOR THE BOARD:

9/6/2022

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

[108] *See* 42 C.F.R. § 405.1869(a) (stating that the Board has "the legal authority to fully resolve the matter in a hearing decision (as described in §§ 405.1842(f), 405.1867, and 405.1871 of this subpart)").