The Law Offices of
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Health Care Provider
Legal Alert

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Federal Court Rules that Agency Decision Affirming Quality Reporting Program Penalty Based on Typo Was Arbitrary and Capricious

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> "[E]ach of us has his cross to bear." Franz Kafka, *The Trial* 134 (Breon Mitchell trans., 1998). For the Board members and others at the Department, theirs is that if they create a Kafkaesque regulatory labyrinth for hospitals, they must be able to navigate it themselves.[1]

Quality reporting has increasingly become a significant obligation of Medicare providers where even the slightest misstep can result in a large financial penalty. Medicare providers, including hospitals, must report data on specific quality measures approved by the Centers for Medicare & Medicaid Services (CMS) on a quarterly basis, according to strict deadlines. If a provider misses a deadline for any of these quality measures, CMS can reduce its Medicare payments. For long-term care hospitals (LTCHs), the penalty is two percent of the hospital's Medicare payments for an entire year.

Medicare providers have frequently criticized CMS for the lack of a clearly defined set of requirements to avoid the payment penalty. The basis for such penalties is too vague, with too many minute requirements scattered throughout a wide variety of rulemaking documents, sub-regulatory manuals, guidance documents, specifications, instructions and other agency materials issued by different components of the Department of Health and Human Services (HHS). For LTCHs, CMS and the Centers for Disease Control and Prevention (CDC) issue such materials for two different government reporting systems, the CARE Tool and the National Health Safety Network (NHSN). The result is a convoluted web of information that Medicare providers are expected to strictly comply with or see their Medicare payments reduced.

Penalties can be appealed—first to CMS, and then to the HHS Provider Reimbursement Review Board (PRRB). CMS set forth the standards of review for such appeals in the rulemaking record, but the agency consistently ignores its own requirements and issues form letters with little or no explanation. Accordingly, most reconsiderations by CMS are unfavorable, forcing providers to appeal again to the PRRB. Unfortunately, the PRRB has been reluctant to upset the agency's determinations because the governing regulations parrot the vague language of the statute. Agency lawyers argue,

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in essence, that even the smallest infraction of any of the scattered requirements found in agency materials is enough to affirm the agency's penalty.

It is understandable that, faced with such an uphill battle, few providers would continue their challenges to the courts.[2] But what if the provider actually reported its quality data on all of the required quality measures by the applicable deadlines and was *still* penalized? This was the situation that our client faced when its hospital in Texarkana, Texas received a form letter stating that the hospital was not in compliance with the LTCH Quality Reporting Program. The hospital appealed to CMS and proved that all of its quality data were reported timely, but in another form letter, the agency refused to reverse the penalty. We then represented the provider in its appeal before the PRRB. After significant briefing, documentary evidence, and a hearing, the PRRB decided that even though the hospital reported its qualify data by the applicable deadlines, the two percent penalty was appropriate because, for at least some months for one measure, the hospital entered the wrong location code on its monthly reporting plan. Although this was not quality data, the PRRB said that the hospital did not "submit data in the form and manner, and at a time, specified by the Secretary," using the vague language of the statute and regulation. But when the PRRB considered the validity of the previous CMS appeal decision on reconsideration, the PRRB applied the wrong rule with outdated standards of review. We then took the hospital's case to court.

In a strongly worded decision, the United States District Court for the District of Columbia vacated the PRRB decision and granted summary judgment in part for the hospital.[3] The court also remanded the case to HHS to reconsider the penalty using the court's opinion. In Judge Trevor McFadden's opinion, the court decided that the PRRB decision violated the Administrative Procedure Act (APA) because the PRRB applied the wrong rule in evaluating whether the CMS reconsideration was arbitrary and capricious.

The court's opinion is a rebuke of the "Kafkaesque regulatory labyrinth for hospitals" the agency created in the LTCH Quality Reporting Program, and the agency's failure to "navigate it themselves." The court confirmed that the hospital submitted its quality data timely "to one arm of the Department of Health and Human Services, NHSN, but NHSN never sent the data to another arm of the Department because of the typo." The court also found that no one at NHSN alerted the hospital to the problem before the submission deadline. The agency argued that the hospital should have known what to enter as the location code, but the court determined that this information was "in a paragraph buried on the fourteenth page of the September 2014 'NHSN e-News' newsletter—one of the may guidance documents LTCHs are expected to adhere religiously to…"

The court refuted the agency's position that anything related to the earlier CMS reconsideration decision was off limits because the PRRB decision was the final agency decision. The court can and did review the PRRB's legal conclusions about the CMS reconsideration. The PRRB decision considered whether CMS acted arbitrarily and capriciously when it failed to address the hospital's justifications for noncompliance. The PRRB concluded that CMS did not act arbitrarily and capriciously. The hospital challenged this conclusion before the court, arguing that the PRRB decision itself was arbitrary and capricious, and the court agreed. The court found that the PRRB applied the

wrong law in the hospital's case. The agency had defended the PRRB decision as accurate in briefing before the court on the merits, but "belatedly admits that the Board erred by citing the 2013 Rule" and "Even now, the Secretary's contrition is half-hearted." The agency even went so far as to blame the hospital for the confusion at the PRRB, but the court found otherwise, stating that the hospital consistently cited the correct rule for the CMS reconsideration process and only mentioned the earlier rule to explain how CMS's reconsideration procedures have evolved. For their confusion, the court said "[t]he PRRB members have only themselves—and their fellow bureaucrats—to blame."

The court also disagreed that the agency's actions constitute harmless error. The agency argued "no harm, no foul" for the PRRB's error in applying the wrong rule, but the court called this is "an ironic argument given that this case comes to the Court because he intends to dock a hospital $278,052 because of a typo." As then-Judge Gorsuch said in a previous case, "an agency decision that loses track of its own controlling regulations and applies the wrong rules in order to penalize private citizens can never stand."[4] Likewise, the court stated here that "when a mistake infects the agency's analysis or the outcome of the adjudication, it crosses the line into arbitrary and capricious territory." The PRRB based its entire analysis of the CMS decision on the outdated rule, with an incorrect standard of review for CMS reconsiderations, which the PRRB used to conclude that the hospital was not entitled to equitable relief. The outdated rule also said that appealing to CMS first for reconsideration was voluntary, yet the correct rule said it was mandatory. The court found that "the Board's reasoning came about by reviewing the CMS reconsideration through the tainted lens of the wrong regulation." Because the PRRB relied on the incorrect regulation to affirm CMS's reconsideration decision, the court held that the hospital was entitled to summary judgment.

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[1] *Pam Squared at Texarkana, LLC v. Azar*, No. 1:18-CV-2542, 2020 WL 364782 (D.D.C. Jan. 22, 2020).
[2] Previously, there had been only one reported court decision on any of the Medicare quality reporting programs, which was decided in favor of the agency. *See PAMC v. Sebelius*, 747 F.3d 1214, 1220-1221 (9th Cir. 2014).
[3] *Pam Squared at Texarkana*, 2020 WL 364782.
[4] *Caring Hearts Pers. Home Servs. v. Burwell*, 824 F.3d 968, 970, 977 (10th Cir. 2016) (Gorsuch, J.).

About Us

The Law Offices of Jason M. Healy PLLC is a Washington, D.C. based law firm serving national and local clients. We focus primarily on legal issues affecting health care providers under Medicare and Medicaid laws and regulations. We represent health care providers in reimbursement audits, appeals, litigation, and transactions. Located in Washington, DC, just minutes from the Department of Health and Human Services, Congressional offices, and the White House, we are well positioned to provide legal support for advocacy efforts. Our Principal, Jason M. Healy, is a health care lawyer with over 20 years of experience with the array of legal issues facing health care providers.