PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2011-D16

PROVIDER –
Columbia Memorial Hospital
Hudson, NY

Provider No.: 33-0094

vs.

INTERMEDIARY –
Blue Cross Blue Shield Association/
National Government Services, Inc.

DATE OF HEARING –
July 14, 2009

Federal Fiscal Year 2009

CASE NO.: 09-1058

INDEX

ISSUE:

Was CMS' determination to reduce the Provider's inpatient prospective payment system market basket update for federal fiscal year (FY) 2009 by two (2.0) percentage points proper?

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. *See* 42 U.S.C. §§ 1395-1395cc. The Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries (FI) and Medicare administrative contractors (MAC). FIs and MACs[1] determine payment amounts due the providers under Medicare law, regulation and interpretative guidelines published by CMS. *See* 42 U.S.C. § 1395h; 42 C.F.R. §§ 413.20 and 413.24.

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system (IPPS). *See* 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412. Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments. *Id*. These standardized amounts are updated (increased) annually.

The Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program was created pursuant to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173) and updated as part of the Deficit Reduction Act of 2005 (DRA) (Pub. L. 109-171). The RHQDAPU program builds on, but is distinct from, the ongoing, voluntary Hospital Quality Initiative[2] which was intended "to empower consumers with quality of care information to make more informed decisions about their health care while also encouraging hospitals and clinicians to improve the quality of care." *See* 71 Fed. Reg. 68200, 68201 (Nov. 24, 2006); *see also* http://www.qualitynet.org – "RHQDAPU Program Overview."

Section 501(b) the MMA amended 42 U.S.C. § 1395ww(b)(3)(B) and revised the mechanism used to update the standardized amount of payment for inpatient hospital operating costs. Specifically, the statute provided for a reduction of 0.4 percentage points to the update percentage increase (also known as the market basket update) for each of FYs 2005 through 2007 for any subsection (d) hospital that did not submit data on a set of 10 quality indicators established by the Secretary[3] as of November 1, 2003. That reduction in the market basket update provided an incentive for IPPS hospitals to submit data on the 10 quality indicators. The statute also provided that any reduction of the percentage change would apply only to the fiscal

[1] FIs and MACs are hereinafter referred to as intermediaries.
[2] The Hospital Quality Initiative was also known as both the National Voluntary Hospital Reporting Initiative and the Hospital Quality Alliance (HQA).
[3] Secretary of DHHS.

year involved, and would not be taken into account in computing the applicable percentage change for a subsequent fiscal year.

Section 5001(a) of the DRA further revised the mechanism used to update the standardized amount by adding new sections 42 U.S.C. § 1395ww(b)(3)(B)(viii)(I) and (II), which provide that the payment update for FY 2007 and each subsequent fiscal year be reduced by two percentage points for any subsection (d) hospital that does not submit certain quality data in a form and manner, and at a time, specified by the Secretary.

Implementing regulations at 42 C.F.R § 412.64(d), state in pertinent part:

> (2)(i) In the case of a "subsection (d) hospital," as defined under section 1886(d)(1)(B) of the Act, that does not submit quality data on a quarterly basis to CMS, in the form and manner specified by CMS, the applicable percentage change specified in paragraph (d)(1) of this section is reduced –
>
> (A) For fiscal years 2005 and 2006, by 0.4 percentage points; and
>
> (B) For fiscal year 2007 and subsequent fiscal years, by 2 percentage points.
>
> (ii) Any reduction of the percentage change will apply only to the fiscal year involved and will not be taken into account in computing the applicable percentage change for a subsequent fiscal year.

CMS set out the RHQDAPU program procedures, including the form, manner and timing of the quality data submissions, and the appeal procedures involving a RHQDAPU determination, in the Federal Register and the *QualityNet* website.[4] CMS requires that hospitals continuously collect and submit Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey data beginning with July 2007 discharges.[5] The HCAHPS Survey data is then processed by CMS and publicly reported on a website known as *Hospital Compare*.[6] The *Hospital Compare* website allows the public to compare how well hospitals care for patients with certain medical conditions or surgical procedures based on the results from the surveys of patients asked about the quality of care they received during recent hospital stays.

A provider that is denied the complete market basket update may submit a request that CMS reconsider its decision that the hospital did not meet the RHQDAPU program requirements. A provider dissatisfied with the result of CMS' reconsideration decision may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the final determination. *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. § 405.1835. *See also* 72 Fed. Reg. 47130, 47365 (Aug. 22, 2007).

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[4] QualityNet was also known as QualityNet Exchange or QNet Exchange. *See* http://www.qualitynet.org.
[5] In accordance with the HCAHPS Quality Assurance Guidelines, v2.0, located at http://www.hcahpsonline.org. *See* 72 FR 47130, 47360 (Aug. 22, 2007).
[6] *See* http://www.hospitalcompare.hhs.gov.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Columbia Memorial Hospital (the Provider) is a small community acute care hospital located in Hudson, New York (thirty miles south of Albany, New York) and serves the residents in Columbia, Greene and Dutchess counties. The Provider's Intermediary is National Government Services, Inc.

By letter dated September 16, 2008, CMS notified the Provider that it did not meet established HCAHPS submission requirements which would result in a two percentage point reduction of the annual market basket update for FY 2009.[7] On January 23, 2009, CMS responded to the Provider's request for reconsideration, upholding its original decision to grant only the reduced market basket update based on the Provider's failure to submit data for HCAHPS.[8] On March 16, 2009 (appeal request dated March 13, 2009), the Provider timely appealed CMS' reconsideration denial to the Provider Reimbursement Review Board.[9]

The Provider was represented by Roy W. Breitenbach, Esq. of Garfunkel, Wild & Travis, P.C. The Intermediary was represented by Bernard M. Talbert, Esq. of Blue Cross Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that CMS' rigid application of RHQDAPU's requirement that data be submitted at a time specified by CMS was improper. The Provider contends that CMS' application of the penalty to this isolated incident: (i) is inconsistent with CMS' course of conduct in extending other submission deadlines; (ii) is inconsistent with the Intermediary's concession that such deadlines are flexible; (iii) only serves to frustrate RHQDAPU's intended purpose; and (iv) runs counter to principles of fairness and justice.

The Provider contends that the error was inadvertent and *de minimus*. The Provider states that it had in fact collected and processed the data for third quarter 2007 and was prepared to submit the data prior to the deadline. Upon realizing that the deadline had been missed, the Provider contacted HCAHPS only three business days later to request guidance and upload the data. The Provider argues that there is no prejudice to CMS or HCAHPS in the three day delay because survey data is not posted for nearly nine months after submission. It points out that refusal to accept the data has frustrated the purpose of RHQDAPU – to provide the public with information about hospital quality performance.

The Provider contends that CMS has flexibility in administering the RHQDAPU program, citing documented instances where CMS, through QualityNet, notified participating hospitals that it was extending deadlines. Additionally, the Provider points to the Intermediary's concession that CMS has discretion upon reconsideration requests to provide exceptions to the submission deadlines.

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[7] *See* Exhibit P-1.
[8] *See* CMS' reconsideration letter, dated January 23, 2009, attached to the Provider's appeal request dated March 13, 2009.
[9] *See* Exhibit P-2.

The Provider also contends that equitable factors should be considered in determining whether to allow the FY 2009 payment update. The Provider argues that it has participated in the HCAHPS program from its inception in 2006 without any financial incentive and that it was in full compliance with HCAHPS survey requirements prior to missing the third quarter 2007 deadline. In addition, the Provider asserts that it took its own corrective action in hiring an approved survey vendor on a going-forward basis and has been in full compliance with the HCAHPS survey ever since. Further, the Provider contends it is unfair to penalize it with the same two percentage point reduction as imposed on hospitals that do not participate in the HCAHPS survey at all.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the law gives CMS broad authority to define quality data measures and to specify the form, manner, and time, in which data will be submitted for the RHQDAPU program.[10] The Intermediary points out that these reporting requirements are clearly communicated to the affected public, by notice in the Federal Register and with an opportunity to comment through the rulemaking process.[11] The Intermediary further contends that the risk that the payment update would be reduced by two percentage points for non-compliance with the Secretary's instructions was communicated with equal clarity.[12]

The Intermediary asserts that CMS was within its broad authority to impose deadlines and enforce them, and that the two percentage point reduction was proper because the Provider did not comply with the RHQDAPU/HCAHPS timeliness requirements. The Intermediary argues the RHQDAPU program cannot be effectively administered if exceptions are made on a mercy or hardship basis.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and program instructions, the evidence presented and the parties' contentions, the Board finds and concludes that the Provider failed to satisfy the RHQDAPU program requirements. Consequently, the Provider is not entitled to the full market basket update for federal fiscal year 2009.

42 U.S.C. § 1395ww(b)(3)(B)(viii)(I) and (II) provide that the payment update for FY 2007 and each subsequent fiscal year be reduced by two percentage points for any subsection (d) hospital that does not submit certain quality data in *a form and manner, and at a time, specified by the Secretary* (emphasis added). Congress has given the Secretary broad authority in implementing the procedures and timeframes for the RHQDAPU program.

The Board finds that the Secretary has defined precisely what is required in order for the hospitals to receive the full market basket update. For FY 2009, the RHQDAPU requirements included the submission of quality data for discharges in the third quarter of calendar year 2007

[10] *See* 42 U.S.C. §1395ww(b)(3)(B)(viii); 42 C.F.R. § 412.64(d).
[11] *See* Exhibits I-3 and I-4.
[12] *See* 71 Fed. Reg. at 68201.

(July through September discharges) to the Quality Improvement Organization (QIO) Clinical Warehouse no later than January 9, 2008. It is undisputed that this deadline was missed due to the Provider's internal staff error.[13]

The Provider asserts that the RHQDAPU filing requirements are not absolute, and that CMS and the Board have some discretion in awarding equitable relief for a minor delay in the submission of data, especially in that the Provider has been otherwise fully compliant with the HCAHPS survey data requirements. While the Federal Register does indicate that CMS has some discretion with regard to data submission errors, such relief is limited:

> When a hospital reports data processing and communication errors, the errors are thoroughly researched. CMS has not held a hospital responsible for data processing and communication errors that were clearly under the control of CMS or its contractors. However, CMS does hold the hospital responsible for its own errors in data processing and communication. If the error is by the hospital's contracted vendor, the hospital is held responsible.

71 Fed. Reg. 47870, 48041 (August 18, 2006).

The Secretary has specified that staff or vendor errors do not establish a basis for an exception to the RHQDAPU timeliness standards, and in this case, the Secretary chose not to grant an exception for the Provider's oversight.[14] There is no indication in either the statute or the Federal Register that discretion to grant relief for good cause was expanded to the Board. Consequently, the Board finds it does not have the authority to award the Provider equitable relief.

The Board concludes the Provider failed to satisfy the RHQDAPU program requirements in the time specified by the Secretary, and the penalty, which is mandated by statute, is a two percentage point reduction to the full market basket update.

DECISION AND ORDER:

The Provider is not entitled to the full market basket update for federal FY 2009. CMS' denial upon reconsideration dated January 23, 2009, is affirmed.

BOARD MEMBERS PARTICIPATING:

Yvette C. Hayes
Keith E. Braganza, C.P.A.
John Gary Bowers, C.P.A.

[13] *See* Provider Position Paper at 1; Tr. at 11-13.
[14] *See* CMS' reconsideration letter, dated January 23, 2009, attached to the Provider's appeal request, dated March 13, 2009.

FOR THE BOARD:

Yvette C. Hayes
Acting Chairperson

DATE: December 15, 2010