PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2011-D28

PROVIDER –
Valley Presbyterian Hospital
Van Nuys, CA

Provider No.: 05-0126

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
First Coast Service Options - California

DATE OF HEARING –
April 29, 2009

Cost Reporting Period Ended –
Federal Fiscal Year 2008

CASE NO.: 08-2579

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ISSUE:

Did CMS properly reduce the Provider's federal fiscal year (FFY) 2008 inpatient prospective payment system market basket adjustment by two (2.0) percentage points?

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 *et seq*. 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, 1395kk-1; 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)(l)-(5); 42 C.F.R. Part 412. Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments. *Id*.

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 was updated as part of the Deficit Reduction Act of 2005 (DRA) (Pub. L. 109-171). The RHQDAPU program builds on, but is separate 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."[3]

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 FFYs 2005 through 2007 for any subsection (d) hospital that did not submit data on a set

[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] Provider Exhibit P-6.

of 10 quality indicators established by the Secretary[4] as of November 1, 2003. This provision established an incentive for IPPS hospitals to submit data on the quality indicators established by the Secretary. The statute also provided that any reduction to the percentage change would apply only to the fiscal year involved, and would not be taken into account in computing the applicable percentage increase for a subsequent fiscal year.
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Section 5001(a) of the DRA further revised the mechanism used to update the standardized amount by adding new section 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.

The statutory provisions were codified at 42 C.F.R § 412.64(d), which states in pertinent part:

> (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 2.0 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.

42 C.F.R. §412.64(d)(2).

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.[5] For FFY 2008, CMS required that hospitals gather and submit Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey data regarding 27 quality measures, including those pertaining to myocardial infarction, heart failure, and pneumonia. Such data are used to populate CMS' publicly-accessible *Hospital Compare* website.[6] In order to receive the full FFY 2008 payment update, hospitals were required to report data on a

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[4] Secretary of DHHS.
[5] QualityNet was also known as QualityNet Exchange or QNet Exchange. *See* http://www.qualitynet.org.
[6] *See* http://www.hospitalcompare.hhs.gov. 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.

continuous basis beginning in July 2007, after first participating in a Spring 2006 or March 2007 dry run of the HCAHPS. *See* 71 Fed. Reg. at 68203-04, 68207. Previously, participation in HCAHPS was not mandatory or related to the RHQDAPU program. Hospitals that were already participating in the voluntary HCAHPS program were not required to conduct a dry run, but hospitals that did not have experience collecting and submitting HCAHPS data to the Quality Improvement Organization (QIO) Clinical Warehouse were required to conduct the dry run before submitting the survey data as mandated by the RHQDAPU program. The HCAHPS dry run mirrored all aspects of the data collection process (sampling, survey administration, and data submission) but the results were not publicly reported on the *Hospital Compare* website. The dry run was a practice round for one month of survey data. *See* 71 Fed. Reg. at 68204.

A provider that was denied the full 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).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Valley Presbyterian Hospital (the Provider) is a not for profit, community acute care hospital located in Van Nuys, California. It is a Medicaid safety net hospital for the San Fernando Valley. The Provider's Intermediary is First Coast Services Options of California.

On September 27, 2007, the Provider received notice that CMS had denied the Provider's full FFY 2008 market basket update because the Provider did not meet established HCAHPS submission requirements. Exhibit P-11. The Provider submitted a timely request for reconsideration to CMS. Exhibit I-3. On January 29, 2008, CMS noted "hospital staff error" as the Provider's primary basis for reconsideration, but upheld its original decision to grant only the reduced market basket update based on the Provider's failure to participate in a HCAHPS surveys dry run in either Spring 2006 or March 2007, or submit a letter to CMS stating that the hospital had no HCAHPS-eligible discharges in March 2007. Exhibit P-1. On July 22, 2008, the Provider timely appealed CMS' reconsideration denial to the Provider Reimbursement Review Board.

The Provider was represented by Lloyd A. Bookman, Esq. of Hooper, Lundy & Bookman, Inc. The Intermediary was represented by Bernard M. Talbert, Esq. of Blue Cross Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that CMS' final determination is improper because the RHQDAPU requirements are not strict pass/fail tests, but instead may be excused; and here the Provider had reasonable grounds for its technical non-compliance and should be granted

the full payment update based on its substantial performance. The Provider further contends that CMS has flexibility in administering the RHQDAPU program and has internally established grounds upon which it will uphold or reverse reconsideration requests. *See* Exhibit P-19. The Provider argues that equitable factors should be considered in determining whether to allow the full 2008 payment update.

The Provider argues that it presented evidence that it had prolonged technology problems that interfered with its ability to participate in the March 2007 dry run and that its CMS-approved RHQDAPU vendor failed to notify the Provider of, or prepare the Provider for, the dry run.[7] Accordingly, the Provider contends that it has good cause to excuse any failure to participate in the March 2007 dry run.

The Provider also argues that the doctrine of substantial performance is applicable to this matter and precludes CMS' denial of the Provider's payment update. The Provider points out that the relationship between the Provider and CMS is contractual vis-a-vis the Medicare Provider Agreement and case law (citations omitted), and therefore it is appropriate to apply contract-based legal principles in determining the significance of the Provider's substantial performance of the contract. Specifically, the Provider contends the common law doctrine of substantial performance recognizes that minor, inadvertent breaches of contract that do not go to the "root" of the consideration, or otherwise impair the value or utility of the performance already completed and enjoyed by the complaining party, preclude the full panoply of damages normally associated therewith, thereby limiting the recovery to only those damages associated with the part of the contract not strictly complied with.

The Provider contends that it substantially complied with the RHQDAPU requirements, including perfect compliance with the core measures data submissions, a September 2007 dry run, and continuous HCAHPS data submissions beginning in October 2007 and continuing without incident for the entire FFY 2008.[8] Furthermore, the Provider maintains the breach was inadvertent and did not affect the value of the services provided to Medicare beneficiaries. Accordingly, pursuant to the doctrine of substantial performance, the Provider argues that CMS should not deny the Provider the full payment update.

The Provider also takes the position that the dry run requirement is not a valid basis to deny the Provider's payment update, because it affects the Provider's substantive right to receive a statutorily mandated level of reimbursement, and appears only in the preamble of the Federal Register and other informal CMS documents. The Provider argues that the requirement should have been subject to notice and comment periods and the formal rule-making process that results in an enforceable regulation. *See* 42 U.S.C. § 1395hh(a)(2). Also, the Provider submits that CMS did not properly establish the bases upon which non-compliance with the dry run requirement would be excused. At least some of these bases are reflected in internal CMS memoranda and were not openly communicated to providers for FFY 2008. *See* Exhibit P-19.

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[7] Tr. 90, 94-98.
[8] Tr. 101-103.

Moreover, the Provider contends that the dry run requirement is inconsistent with the enabling statute because the statute does not authorize denial of a provider's payment update for technical non-compliance of this nature. Instead, the Provider argues that the statute at 42 U.S.C. § 1395ww(b)(3)(B)(viii) states the payment update will be denied for failure to submit "data required to be submitted on measures selected under this clause." *See* Exhibit P-2. The Provider notes that CMS did not list or describe the dry run, or any test data submission, as part of the 27 quality measures required to be submitted for 2008. The Provider states that it was the process of collecting and transmitting the patient survey results that was tested by the dry run, but because the information submitted pursuant to the dry run was not shared with the public and was not used to calculate a provider's validation score, then the dry run did not include any patient data that would facilitate the purpose of the statute – to give the public information about hospital quality performance. The Provider maintains that it properly submitted data for the required quality measures, and the enabling statute does not support CMS' decision to deny the payment update solely for failure to participate in a dry run.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the enabling provisions of the law and regulations give 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. *See* 42 U.S.C. §1395ww(b)(3)(B)(viii); 42 C.F.R. § 412.64(d). The Intermediary states that these reporting requirements are communicated to the affected public, by notice and with an opportunity to comment, through the Federal Register.

The Intermediary contends that there was a clear directive in the Federal Register as to the reporting requirements. Specifically, the Intermediary maintains that a dry run was required in March 2007 for all hospitals that did not have experience collecting and submitting HCAHPS data under the 2006 voluntary initiative. *See* 71 Fed. Reg. at 68204, 68207. In addition, following the dry run, all providers had to begin reporting continuous quality data for discharges in the third calendar quarter of 2007 (July through September discharges) in order to be eligible for the full FY 2008 IPPS market basket update. *See* 71 Fed. Reg. at 68206-07. The Intermediary 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. *See* 71 Fed. Reg. at 68201.

The Intermediary contends that the imposition of the dry run requirement was within the letter and spirit of RHQDAPU. The Intermediary argues that it is a pass-fail question, and the Provider did not meet this preliminary requirement for timely submission of HCAHPS data. The Intermediary maintains that the Provider's arguments of good faith and substantial performance fall short.

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 2008.

42 U.S.C. § 1395ww(b)(3)(B)(viii)(I) and (II) provide that the payment update for FFY 2007 and each subsequent fiscal year be reduced by 2.0 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.

For FFY 2008, CMS mandated that those procedures include a dry run, either in Spring 2006 or in March 2007, as a prerequisite to submitting HCAHPS data. *See* 71 Fed. Reg. at 68204. Since HCAHPS was a new initiative, CMS decided that it was critical to hospitals, survey vendors, and CMS to acquire first-hand experience with data collection, including sampling and data submission to the QualityNet Exchange, before collecting data for public reporting. *Id*. At 68203. Although the Provider contends that the dry run requirement is inconsistent with the enabling statute because the data collected during the dry run was not publicly reported, the Board finds that this dry run requirement was clearly within the scope of CMS' authority to set the form, manner, and time for data submission.

The Provider also asserts that the dry run requirement is invalid because it was not properly promulgated under 42 U.S.C § 1395hh. The Board finds the statute is clear in establishing the legal standard of the two percentage point payment reduction. The statutory provision has been codified at 42 C.F.R. § 412.64(d). By contrast, the RHQDAPU program requirements pertain to the process, which the Secretary has published in the Federal Register and on the QualityNet Exchange website. The Board finds that the RHQDAPU requirements set forth in the Federal Register can be read in harmony with statute and regulations and are also subject to formal notice and comment periods. The Federal Register provides adequate notice for Provider compliance with the program requirements.

The Provider argues that it is entitled to the full market update because it substantially complied with the program requirements. The Board finds that the Secretary has defined precisely what is required in order for the hospitals to receive the full market update, including participation in a dry run in March 2007, with data successfully submitted to the QIO Clinical Warehouse by July 13, 2007, and beginning continuous reporting of quality data for discharges in the third calendar quarter of 2007 (July through September discharges). *See* 71 Fed. Reg. at 68204. Therefore, the doctrine of substantial performance has no application here.

It is undisputed that the Provider did not participate in a dry run until September 2007 and did not begin submitting continuous HCAHPS data for public reporting until the fourth quarter of 2007 (October to December discharges).[9] Assuming, arguendo, that the substantial performance standard could be considered in this case, the Provider's failure to

[9] Provider Final Position Paper at 4, 7.

timely submit both its dry run and its full third quarter quality data does not qualify as a "minor" error. Alternatively, the Provider argues that the two percentage point reduction is an overly harsh penalty given the circumstances, but the Board notes the percentage point reduction is mandated by statute.

The Federal Register indicates that CMS has some discretion in awarding equitable relief:

> 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 specific reasons CMS identified for granting an exception, or upholding the original determination, applicable to FFY 2008 reconsiderations comport with the examples published in the Federal Register.[10]

In this case, the Provider's technology problems and alleged failure of the Provider's vendor to notify and prepare the Provider for the dry run requirement constitutes "hospital staff error" and did not establish a basis for an exception to the RHQDAPU dry run requirement. The Secretary considered, but chose not to grant a permissive exception for the Provider's errors.[11] The Board is also not persuaded by the Provider's arguments because RHQDAPU participation requirements were publicly available through the Federal Register notices as well as QIO correspondence[12] and information posted on the QualityNet website.[13] Nonetheless, 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 that the Provider failed to satisfy the RHQDAPU program requirements in a form and manner, and at a time, specified by the Secretary.

DECISION AND ORDER:

CMS properly reduced the Provider's federal fiscal year 2008 inpatient prospective payment system market basket adjustment by two percentage points. CMS' denial upon reconsideration dated January 29, 2008, is affirmed.

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[10] *See* Exhibit P-19.
[11] *See* Exhibits I-3 and P-1.
[12] *See* Intermediary Post-Hearing Brief at 3; Exhibit I-5.
[13] *See* Exhibits P-4 and P-6.

BOARD MEMBERS PARTICIPATING:

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

FOR THE BOARD:

Yvette C. Hayes
Acting Chairperson

DATE: May 13, 2011