PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2011-D35

PROVIDER –
Saints Mary and Elizabeth Medical Center – Claremont Campus
Chicago, IL

Provider No.: 14-0094

vs.

INTERMEDIARY –
BlueCross BlueShield Association/ National Government Services, Inc.

DATE OF HEARING –
February 17, 2010

Cost Reporting Period Ended - December 31, 2009

CASE NO.: 09-1970

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ISSUE:

Whether CMS properly reduced the Provider's Outpatient Prospective Payment System (OPPS) Calendar Year (CY) 2009 market basket update 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. 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 (FIs) and Medicare administrative contractors (MACs). 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 and Part B covers outpatient 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.* In 2000, the Medicare program established the outpatient prospective payment system (OPPS) to reimburse most hospitals for the operating costs of outpatient department services. See Balanced Budget Act of 1997 (BBA) (Pub. L. No. 105-33), § 1833(t), codified at 42 U.S.C. § 1395l(t); 42 C.F.R. Part 419. Under OPPS, CMS classifies outpatient services and procedures that are comparable clinically and in terms of resource use into groups called Ambulatory Payment Classifications (APC). Medicare pays predetermined, standardized amounts per APC, subject to certain payment adjustments. *Id.*

The Hospital Outpatient Quality Data Reporting Program (HOP QDRP) was established pursuant to the Medicare Improvements and Extension Act under Division B of Title I of the Tax Relief and Health Care Act of 2006 (MIEA-TRHCA) (Pub. L. No. 109-432). Section 109(a) of the MIEA-TRHCA amended section 1833(t) of the Act by adding a new subsection (17) regarding quality reporting that affects the payment rate update applicable to OPPS payments for services furnished by hospitals in outpatient settings on or after January 1, 2009.

(A) Reduction in update for failure to report.—

[1] FIs and MACs are hereinafter referred to as intermediaries.

(i) In general.— For purposes of paragraph (3)(C)(iv) for 2009 and each subsequent year, in the case of a subsection (d) hospital (as defined in section 1886(d)(1)(B)) that does not submit, to the Secretary in accordance with this paragraph, data required to be submitted on measures selected under this paragraph with respect to such a year, the OPD fee schedule increase factor under paragraph (3)(C)(iv) for such year shall be reduced by 2.0 percentage points.

(ii) Non-cumulative application.— A reduction under this subparagraph shall apply only with respect to the year involved and the Secretary shall not take into account such reduction in computing the OPD fee schedule increase factor for a subsequent year.

(B) Form and manner of submission.— Each subsection (d) hospital shall submit data on measures selected under this paragraph to the Secretary in a form and manner, and at a time, specified by the Secretary for purposes of this paragraph.

(C) Development of outpatient measures.—

(i) In general.— The Secretary shall develop measures that the Secretary determines to be appropriate for the measurement of the quality of care (including medication errors) furnished by hospitals in outpatient settings and that reflect consensus among affected parties and, to the extent feasible and practicable, shall include measures set forth by one or more national consensus building entities.

(ii) Construction.— Nothing in this paragraph shall be construed as preventing the Secretary from selecting measures that are the same as (or a subset of) the measures for which data are required to be submitted under section 1886(b)(3)(B)(viii).

(D) Replacement of measures.— For purposes of this paragraph, the Secretary may replace any measures or indicators in appropriate cases, such as where all hospitals are effectively in compliance or the measures or indicators have been subsequently shown not to represent the best clinical practice.

(E) Availability of data.— The Secretary shall establish procedures for making data submitted under this paragraph available to the public. Such procedures shall ensure that a hospital has the opportunity to review the data that are to be made public with respect to the hospital prior to such data being made public. The Secretary shall report quality

> measures of process, structure, outcome, patients' perspectives on care, efficiency, and costs of care that relate to services furnished in outpatient settings in hospitals on the Internet website of the Centers for Medicare & Medicaid Services.

42 U.S.C. § 1395l(t)(17). The statutory provisions were codified at 42 C.F.R § 419.43(h).

CMS set out the HOP QDRP program procedures, including the form, manner and timing of the quality data submissions, and the appeal procedures involving a HOP QDRP determination, in the Federal Register and the *QualityNet* website.[2] In order to receive the full CY 2009 payment update, hospitals were required to gather data for the finalized set of seven (7) quality measures for services occurring during the second calendar quarter of 2008 (April – June 2008) and to submit this data to the CMS designated contractor by November 1, 2008. *See* 72 Fed. Reg. 66580, 66873 (Nov. 27, 2007).[3] Such data are used to populate CMS' publicly-accessible *Hospital Compare* website.[4]

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 HOP QDRP annual payment update requirements. *See* 72 Fed. Reg. 66580, 66874-75 (Nov. 27, 2007).[5] 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 receipt of the final determination. *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. § 405.1835 (2008).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Saints Mary and Elizabeth Medical Center (Provider) is a hospital located in Chicago, Illinois. The Provider's Intermediary is National Government Services, Inc.

CMS reduced the Provider's CY 2009 market basket update due to the failure to meet HOP QDRP data submission requirements for second quarter 2008, which resulted in a reduction in the Provider's expected Medicare OPPS payment for 2009. The Provider submitted a request for reconsideration of that determination to CMS, indicating that the relevant data could not be obtained due to a change in the hospital's computer system at that time.[6] By letter dated May 2, 2009, CMS upheld its prior decision to grant only the reduced market basket update based on the Provider's failure to successfully submit complete and accurate data for each required quality measure for second quarter 2008.[7]

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[2] QualityNet was also known as QualityNet Exchange or QNet Exchange. *See* http://www.qualitynet.org.
[3] Intermediary Exhibit I-1.
[4] *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.
[5] Intermediary Exhibit I-1.
[6] *See* Intermediary Exhibit I-2 at 2.
[7] *See* Intermediary Exhibit I-2 at 1.

On June 30, 2009, the Provider timely appealed CMS' reconsideration denial to the Provider Reimbursement Review Board.

The Provider was represented by Patricia Monnelly, Director of Performance Distinction, at Saints Mary and Elizabeth Medical Center. The Intermediary was represented by Bernard M. Talbert, Esq. of Blue Cross Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends the HOP QDRP data were not sent to CMS due to the fact that in January of 2008, the acute care services of St. Elizabeth Hospital were moved to St. Mary of Nazareth Hospital and the information system that remained on site was unable to retrieve the necessary patient information until the following quarter. The Provider argues that a reversal of the two percentage point reduction is warranted because it had submitted other core measures since the onset of CMS' quality initiatives, it was diligent in pursuing a resolution for this aberrant period and did ultimately submit its data, and it timely submitted the HOP QDRP indicators for the third quarter 2008 and all subsequent periods. The Provider also states that it was under the impression that this was the first time providers were submitting outpatient data and that submission for this quarter was not mandatory.

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 HOP QDRP. The Intermediary states that these reporting requirements are communicated to the affected public 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 at 72 Fed. Reg. 66580, 66873 (Nov. 27, 2007), providers were directed as follows:

> Data for the 7 quality measures finalized in this rule from services occurring during second calendar quarter of 2008 (April – June 2008) are to be collected. The submission deadline for April – June service data will be November 1, 2008.

The Intermediary points out that the Provider simply failed to submit second quarter 2008 data. The Intermediary contends that the Federal Register instructions were clear and binding, and that the Provider's arguments of a good faith miss for the applicable period, or better compliance in future and past periods, do not provide a basis to support a reversal of the two percentage point reduction.

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 HOP QDRP program requirements. Consequently, the Provider is not entitled to the full market basket update for calendar year 2009.

The Board finds the statute is clear in establishing the legal standard of the two percentage point payment reduction. 42 U.S.C. § 1395l(t)(17)(A) and (B) provide that the payment update for CY 2009 and each subsequent 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 HOP QDRP program, which the Secretary has published in the Federal Register and on the *QualityNet Exchange* website. The Board finds that the HOP QDRP 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 believed the second calendar quarter reporting to be optional and because it substantially complied with the program requirements beginning with the third calendar quarter to the present day. The Board is not persuaded by the Provider's arguments because HOP QDRP participation requirements were publicly available through the Federal Register notices and information posted on the *QualityNet* website and the Board finds that the Secretary has defined precisely what is required in order for hospitals to receive the full market basket update. For CY 2009, CMS mandated that those procedures include collecting data for the seven finalized quality measures from services occurring during second calendar quarter of 2008 (April – June 2008) and submitting the data to the OPPS Clinical Warehouse by November 1, 2008. *See* 72 Fed. Reg. 66873 (Nov. 27, 2007). It is undisputed that the Provider did not fulfill these precise requirements for the second calendar quarter,[8] and therefore the doctrine of substantial performance has no application here.

The Federal Register indicates that CMS has some discretion in awarding relief through the reconsideration process. *See* 72 Fed. Reg. 66580, 66874-75 (Nov. 27, 2007). In this case, the Secretary considered the Provider's technology problems caused by the hospital's computer system changes,[9] but chose not to grant an exception for the Provider's failure to meet the data submission requirements. There is no indication in the statute, regulations, or 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.

[8] *See* Provider Final Position Paper.
[9] *See* Intermediary Exhibit I-2.

The Board concludes that the Provider failed to satisfy the HOP QDRP program requirements in a form and manner, and at a time, specified by the Secretary.

DECISION AND ORDER:

CMS properly reduced the Provider's CY 2009 OPPS market basket update by two percentage points. CMS' denial upon reconsideration dated May 2, 2009, is affirmed.

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: June 16, 2011