PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2014-D21

PROVIDER –
Legacy Hospice and Palliative Care, LLC
Harrisburg, Pennsylvania

Provider No.: 39-1745

vs.

INTERMEDIARY –
CGS Administrators, LLC/
Blue Cross and Blue Shield Association

DATE OF HEARING -
June 2, 2014

Reporting Period Ended -
Calendar Year 2014

CASE NO: 14-0568

INDEX

ISSUE:

Whether the imposition of a two percent reduction in Legacy Hospice and Palliative Care LLC's Medicare payments for calendar year 2014 was 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 under Title XVIII of the Social Security Act, as amended ("Act"), to provide health insurance to eligible individuals. The Act was codified at 42 U.S.C. Chapter 7, Subchapter XVIII. The Centers for Medicare and 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.[2]

Section 122 of the Tax Equity and Fiscal Responsibility Act of 1982[3] established Medicare coverage for in-home hospice care for terminally ill Medicare beneficiaries who elect to receive care from a participating hospice.[4] Regulations issued to implement the statute established payment standards and procedures for hospices and include a prospective payment methodology by which a hospice would generally be paid one of several predetermined rates for each day a Medicare beneficiary was under care.[5] The rates vary depending on the level of care.[6]

Medicare's payment for hospice care is governed by 42 U.S.C. § 1395f(i).[7] On March 23, 2010, Congress enacted the Patient Protection and Affordable Care Act ("ACA").[8] ACA § 3004 amended § 1395f(i) to include quality reporting requirements for hospices.[9] As amended, § 1395f(i)(5)(C) provides that:

> For fiscal year 2014 and each subsequent fiscal year, each hospice program shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

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[1] FIs and MACs are hereinafter referred to as intermediaries.
[2] *See* 42 U.S.C. §§ 1395h, 1395kk-1; 42 C.F.R. §§ 413.20, 413.24.
[3] Pub. L. 97-248, 96 Stat. 324 (1982).
[4] 42 U.S.C. § 1395x(dd).
[5] 48 Fed. Reg. 56008 (Dec. 16, 1983); 48 Fed. Reg. 38146, 38152 (Aug. 22, 1983).
[6] 48 Fed. Reg. 38146, 38152 (Aug. 22, 1983).
[7] *See* 42 U.S.C. § 1395f(i).
[8] Pub. L. 111-148, 124 Stat. 119 (2010).
[9] *See* 124 Stat. at 368-371.

Congress also required that the data measure specified by the Secretary had to be endorsed by an entity with a contract under 42 U.S.C. § 1395aaa.[10] As amended, § 1395f(i)(5)(A)(i) provides for reductions in payments for hospice programs that fail to report data:

> For purposes of fiscal year 2014 and each subsequent fiscal year, in the case of a hospice program that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a fiscal year, after determining the market basket percentage increase under paragraph (1)(C)(ii)(VII) or paragraph (1)(C)(iii), as applicable, and after application of paragraph (1)(C)(iv), with respect to the fiscal year, the Secretary shall reduce such market basket percentage increase by 2 percentage points.

Section 1395f(i)(5)(D)(iii) required the Secretary to publish the quality measures selected for FY 2014 by October 1, 2012, at the latest.

On August 4, 2011, the Secretary published the quality data reporting requirements in the Federal Register.[11] In the Federal Register notice, the Secretary determined that for fiscal year 2014 ("FY 2014"), hospices would be required to submit data that was endorsed by the National Quality Forum ("NQF"), which held the contract with the Secretary under 42 U.S.C. § 1395aaa(a).[12] Specifically, the Secretary determined that CMS would provide a spreadsheet template to hospices as a temporary means of data submission, followed by a web interface for the data entry.[13] The Secretary selected NQF measure No. 0209, *i.e.* the percentage of patients who were uncomfortable because of pain on admission to hospice whose pain was brought to a comfortable level within 48 hours.[14] The Secretary required hospices to report: (1) whether they had a Quality Assessment and Performance Improvement ("QAPI") program that addressed at least three indicators related to patient care; and (2) the subject matter of all of their patient care indicators for the period of October 1, 2012 through December 31, 2012.[15]

The Secretary set a deadline of January 31, 2013 to submit data regarding the QAPI program and April 1, 2013 as the deadline for data submission relating to NQF measure No. 0209.[16] The Secretary also highlighted that ACA § 3004 required the Secretary to reduce the market basket update by two percentage points for any hospice that did not comply with the quality data submission requirements with respect to that fiscal year.[17]

CMS established a website with guidance on Hospice Quality Reporting. This website contained information, guidance and resources for hospices to use in determining their data submission requirements and complying with them.[18] The website also had a User Guide for Hospice

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[10] *See* 42 U.S.C. § 1395f(i)(5)(D)(i).
[11] *See* 76 Fed. Reg. 47302, 47318 (Aug. 4, 2011).
[12] *Id.*
[13] *Id.*
[14] *Id.* at 47320.
[15] *Id.* at 47322.
[16] *Id.*
[17] *Id.* at 47318.
[18] *See* Intermediary Exhibit I-8.

Quality Reporting Data Collection (the "User Guide"). Version 1.1 of this User Guide was posted on September 5, 2012, prior to the data collection period that began on October 1, 2012.[19]

The User Guide also noted that CMS had set up two telephone help desks to assist hospice providers with quality questions and technical issues.[20] The Quality Help Desk was for issues pertaining to either of the required measures or "reporting requirements, including who is required to report, hospices with multiple locations, and/or CCN issues."[21] The Quality Help Desk was accessible by email or by telephone.[22] The User Guide stated that the data collection and reporting requirements applied to *all* hospices that were Medicare certified providers as of October 1, 2012.[23] The remainder of the User Guide contained detailed information on collecting and submitting the required data.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Legacy Hospice and Palliative Care, LLC ("Provider"), located in Harrisburg, Pennsylvania, entered into an agreement with CMS as a hospice agency with an effective date of participation in the Medicare program of December 29, 2011.[24] The Provider received a CMS Certification Number ("CNN") of 39-1745. The Provider's designated intermediary was CGS Administrators, LLC ("Intermediary").

As the Provider was certified as a hospice provider prior to October 1, 2012, the requirements to to collect and submit the data to CMS by the deadlines set forth in the Federal Register were applicable to the Provider. However, the Provider failed to submit the proposed measurement for the last quarter of 2012.

On June 5, 2013, the Intermediary sent a letter to the Provider notifying the Provider that CMS had determined that the Provider was subject to a two percent reduction in payment for not meeting the data submission requirements.[25] On July 1, 2013 the Provider requested reconsideration of the reduction in payment.[26] On September 25, 2013 the Intermediary upheld the reduction in payment.[27] The Providers appealed the Intermediary's determinations to the Board and met the jurisdictional requirements of 42 C.F.R. §§ 418.311 and 405.1835-1840.

The Provider was represented by Francesca Albergato-Muterspaw of the Provider. The Intermediary was represented by Brendan G. Stuhan, Esq., of the Blue Cross and Blue Shield Association.

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[19] *See* Intermediary Exhibit I-9 (copy of User Guide which reiterates at page 4 that all of the data submission requirements and deadlines that the Secretary had specified in the Federal Register).
[20] *Id.* at 7.
[21] *Id.*
[22] *Id.*
[23] *Id.* at 5
[24] *See* Intermediary Exhibit I-1 (copy of January 17, 2012 letter from CMS to the Provider).
[25] *See* June 5, 2013 letter. Intermediary Exhibit I-5.
[26] *See* July 1, 2013 email. Intermediary Exhibit I-6.
[27] *See* September 25, 2013 letter. Intermediary Exhibit I-7.

PROVIDER'S CONTENTIONS

The Provider argues that it relied on information from a surveyor for the Pennsylvania Department of Health who stated that the data collection and submission were not applicable to it as a new provider. The Provider maintains that it did not intentionally fail to report but followed the instruction from a hospice certification surveyor and that it was reasonable to rely on this instruction. The Provider notes that it contacted the same Pennsylvania Department of Health surveyor in June, July, and August of 2012, each time being told it was not required to participate with this rule for that calendar year.[28] The Provider further asserts:

> When the rule came out in October, we went to follow-up with [the surveyor] and left two messages, did not hear from [the surveyor] at that point. And when I called, I spoke to a different surveyor, they said that we were to follow [the previous surveyor's] advice. So we followed [the previous surveyor's] advice.[29]

The Provider believes that "if there is a question on the part of our [State] surveyors, they will say to us that we need to contact Medicare for clarification. And [the surveyor] did not once, even when we double checked."[30] The Provider "request[s] that the supervising Authorities consider the weight and trust that agencies like ours place in the statements of our surveying agencies and grant a reprieve from the penalty assessed against us."[31]

INTERMEDIARY'S CONTENTIONS

The Intermediary contends that, regardless of the truth of the Provider's contentions about the advice it allegedly received from the Pennsylvania Department of Health, the Board is bound to affirm the Intermediary's adjustment by virtue of the clear and unambiguous statutory directive contained in ACA § 3004.[32] The Intermediary contends that, since it is undisputed that the Provider was certified as a hospice prior to the data collection period and undisputed that the Provider failed to submit the data timely, the two percent reduction must be imposed.[33]

The Intermediary further contends that the Provider's evidence is lacking that the Pennsylvania Department of Health actually advised the Provider as the Provider contends, and that the Provider has failed to produce evidence that advice from a Department of Health employee could bind CMS under any agency theory.[34]

The Intermediary also contends that the Provider's reliance on the advice from the Department of Health was unreasonable, and that the Provider had multiple avenues through which it could

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[28] Transcript ("Tr.") at 8, 10-11 (note that the reference to the year 2013 in the Tr. at 10 was corrected to 2012 in the Tr. at 15).
[29] Tr. at 11.
[30] Tr. at 9.
[31] Provider's Final Position Paper at 2.
[32] Tr. at 22.
[33] Tr. at 26.
[34] Tr. at 28-29, 39.

have confirmed whether or not it was required to collect and submit survey data, including contacting CMS or the Intermediary or retaining a lawyer or consultant. The MAC contends that there was nothing unfair or inequitable about imposing the two percent reduction when the Provider failed to take these basic steps to determine whether it was required to collect and submit survey data.[35]

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 the imposition of a two percent reduction in the Provider's Medicare payments for calendar year 2014 was required.

The Board finds that 42 U.S.C. § 1395f(i)(5)(C) required the Provider to submit data quality measures in the form, manner and at the time specified by the Secretary and that the Secretary notified the hospice provider community of these requirements in the August 2011 Federal Register notice and the User Guide . The Board finds that the Provider admits that it "failed to submit the required measurements for the last quarter of 2012 as required by Medicare."[36] The Board finds that § 1395f(i)(5)(A)(i) requires the Secretary to reduce the market basket percentage increase by two percent for any provider that fails to submit the requisite data quality measures on time.

While the Board recognizes that the Provider as a relatively new provider may have had some confusion about its obligations to report the requisite data quality measures,[37] the Board does not have any authority to grant the equitable relief that the Provider is in essence, is requesting. The Board's authority is limited to the statutory and regulatory requirements and to the facts and circumstances of the issues presented.[38] In connection with the 2 percentage point penalty, the Board does not have the authority to consider factors outside those specifically recognized under the statute and regulations. The Board finds that the Provider was a certified provider under the applicable statute and regulations and that this statute mandates, without exception, a 2 percent penalty if a provider fails to submit hospice quality data as specified by the Secretary.[39]

DECISION AND ORDER:

The Intermediary properly imposed a two percent reduction in the Provider's Medicare payments for calendar year 2014. The Intermediary's reduced payment amounts are affirmed.

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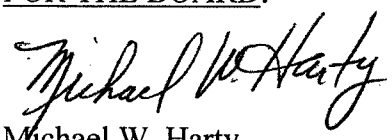
[35] Tr. at 32-34.
[36] *See* Provider's Final Position Paper at 1.
[37] Unfortunately, it appears that the Provider may have sought and relied on guidance from the state surveyor for Pennsylvania. The Board notes that state surveyors have a limited role in the Medicare program relating to the Medicare conditions of participation and have no involvement in or responsibilities related to the Medicare hospice quality reporting program. *See* 42 U.S.C. § 1395aa (copy included as Intermediary Exhibit I-10).
[38] 42 C.F.R. § 405.1867.
[39] 42 U.S.C. § 1395f(i)(5)(A)(i); 76 Fed. Reg. 47302, 47318 (Aug. 4, 2011).

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD:



Michael W. Harty
Chairman

DATE: SEP 09 2014