PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2017-D16

PROVIDER -
West Carroll Memorial Hospital

Provider No.: 19-0081

vs.

MEDICARE CONTRACTOR –
Novitas Solutions, Inc.

DATE OF HEARING
February 8, 2017

Calendar Year Ending -
December 31, 2015

CASE NO.: 15-2721

INDEX

ISSUE STATEMENT:

Whether the reduction of West Carroll Memorial Hospital's ("West Carroll" or "Provider") annual payment update for calendar year ("CY") 2015 under the hospital outpatient quality reporting ("Hospital OQR") program was proper.

DECISION:

After considering the Medicare law and regulations, the parties' contentions and the evidence submitted, the Provider Reimbursement Review Board ("Board") finds that the Centers for Medicare & Medicaid Services ("CMS") properly imposed a 2 percent reduction to the outpatient department ("OPD") fee schedule increase factor for CY 2015 for West Carroll.

INTRODUCTION:

West Carroll is a 33-bed acute care hospital located in Oak Grove, Louisiana. West Carroll's designated Medicare Administrative Contractor is Novitas Solutions, Inc. ("Medicare Contractor"). On December 24, 2014, CMS notified West Carroll that it did not comply with the requirements of the Hospital OQR program for CY 2015 and would be subject to a 2 percent reduction in its 2015 annual payment update.[1] In a letter dated January 20, 2015, West Carroll requested that CMS reconsider its decision. On May 1, 2015, CMS upheld its payment reduction decision, stating the Provider failed to meet the requirement of "[s]ubmitting complete web-based measures."[2] West Carroll timely appealed CMS' reconsideration denial to the Board and met the jurisdictional requirements for a Board hearing.[3] Accordingly, the Board held a hearing on the record on February 8, 2017. West Carroll was represented by Lindsey Franks, L.P.N. from West Carroll Health Systems. The Medicare Contractor was represented by Lauren Leong, Esq. of Federal Specialized Services.

STATEMENT OF FACTS:

Medicare pays hospitals for outpatient services through the outpatient prospective payment system ("OPPS").[4] In 2010, CMS implemented the Hospital OQR program which requires hospitals to report outpatient quality data to CMS and assesses a penalty for failure to do so.[5] The Hospital OQR program requirements and appeal procedures are communicated to hospitals in the Federal Register and on the *QualityNet* website.[6] In the CY 2014 OPPS Final Rule, the quality reporting requirements for CY 2015 payment determinations state:

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[1] *See* Medicare Contractor's Final Position Paper at 7. Although CMS' initial determination is not in the record, the Provider's January 20, 2015 Request for Reconsideration refers to a letter received which states it did not meet the Hospital OQR requirements. *See* Medicare Contractor's Exhibit I-1.
[2] *See* Medicare Contractor's Exhibit I-2.
[3] *See* Provider's May 28, 2015 Appeal Request.
[4] *See* 42 U.S.C. § 1395*l*(t).
[5] *See* 42 U.S.C. § 1395*l*(t)(17)(A)(i). *See also* 75 Fed. Reg. 71800, 72064 (Nov. 24, 2010).
[6] *See* http://www.qualitynet.org. QualityNet was also known as QualityNet Exchange or QNet Exchange.

> To participate successfully in the Hospital OQR Program, hospitals must meet administrative, data collection and submission, and data validation requirements (if applicable). Hospitals that do not meet Hospital OQR Program requirements, as well as hospitals not participating in the program and hospitals that withdraw from the program, will not receive the full OPPS payment rate update. Instead, in accordance with section 1833(t)(17)(A) of the Act, those hospitals will receive a reduction of 2.0 percentage points to their OPD fee schedule increase factor for the applicable payment year.[7]

CMS determined that West Carroll did not comply with the requirements of the Hospital OQR Program as the Provider failed to submit the required quality data, which resulted in a 2 percent payment reduction for CY 2015.[8]

DISCUSSION, FINDINGS OF FACT AND CONCLUSIONS OF LAW:

West Carroll agrees that it did not submit the required quality data.[9] In its request for reconsideration, West Carroll explains that it was a small facility and due to a personnel issue the data abstractions were not completed.[10] West Carroll's reconsideration request stated:

> We have recently lost our personnel that was currently entering our Outpatient data for the (CY) 2015. Due to this resignation we were at a loss for someone to complete our data abstractions until recently hiring a new personnel for the position.… Please bear in mind we are a 33-bed facility and have limited personnel available to complete the necessary tasks. We now have the necessary staff to meet the deadlines and requirements as evidenced by our compliance with the other core measure areas, such as Outpatient.[11]

In its appeal request West Carroll, in essence, is asking the Board for equitable relief stating that the person responsible for data submission "walked out" of the job leaving it undone, and although new personnel were able to get most of the other measures completed, there were limited personnel to accommodate with this task. In addition, a 2 percent payment reduction could be detrimental to both to itself as a small 33-bed hospital and to the community it services as it is the only hospital in the Oak Grove Community.[12]

For its part, the Medicare Contractor points out that the imposition of the 2 percentage point reduction is not optional as 42 U.S.C. § 1395*l*(t)(17)(A) states that a hospital that does not submit

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[7] *See* 78 Fed. Reg. 74826, 75108 (Dec. 10, 2013). *See also* 42 U.S.C. § 1395*l*(t)(17)(A)(i).
[8] *See* Medicare Contractor's Exhibit I-1.
[9] *See* Provider's Final Position Paper at 1.
[10] *See* Medicare Contractor's Exhibit I-1.
[11] *See id.*
[12] *See* Provider's Final Position Paper at 1.

the data required on the measures selected **shall** have the OPD fee schedule increase factor reduced by 2 percent. Further, the Medicare Contractor points out that West Carroll did not request either an extension or an exception from the data submission deadlines under 42 C.F.R. § 419.46(d) and, as a result, CMS is obligated to apply the 2 percent reduction.[13]

While empathetic to the difficulties West Carroll faced, the Board finds that it is bound by applicable regulatory and statutory authorities. The statute at 42 U.S.C § 1395*l*(t)(17) requires that each subsection (d) hospital submit outpatient quality data as determined by the Secretary and imposes a 2 percent penalty upon a provider that fails to do so. Significantly, the statute gives broad authority to the Secretary to specify the time, form and manner by which a hospital must submit the data.

The Board notes that the Ninth Circuit recently weighed in on this issue in *PAMC, Ltd. v. Sebelius.* In that case CMS ordered a 2 percent reduction in PAMC's annual payment update due to late submission of its quality data. The Board upheld CMS' decision to deny the full market basket update explaining that it lacked the authority to award equitable relief because PAMC indisputably had failed to meet the applicable deadline.[14] PAMC appealed to the Federal District Court[15] and then to the Ninth Circuit Federal Court of Appeals ("Court").[16] Both courts agreed that the Board did not have independent authority to grant equitable relief in the instance of PAMC's late submission of quality data.[17]

In its determination the Ninth Circuit cited 42 C.F.R. § 405.1867 which holds,

> In exercising its authority to conduct proceedings under this subpart, the Board must comply with all the provisions of Title XVIII of the Act and regulations issued thereunder, as well as CMS Rulings issued under the authority of the Administrator as described in § 401.108 of this subchapter. The Board shall afford great weight to interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS.

The Court further stated,

> [PAMC] claims a right to equitable relief or the benefit of the contract doctrine of substantial performance. In so doing, PAMC appears to have forgotten the aphorism: "Men must turn square corners when they deal with the Government." *Rock Island A. & L. R. Co. v. United States,* 254 U.S. 141, 143 . . . (1920). As we will discuss further, the Department has always insisted that the

[13] *See* Medicare Contractor's Final Position Paper at 8-9.
[14] *See* PRRB Dec. No. 2011-D15 at 6 (Dec. 14, 2010).
[15] *See PAMC, Ltd. v Sebelius*, 2012 WL 12886817 (C.D. CA, 2012).
[16] *See PAMC, Ltd. v Sebelius*, 747 F.3d 1214, 1215-16 (9th Cir. 2014).
[17] *Id*. at 1219.

> deadline for submitting data is a square corner, but PAMC now seeks to make it round. It is not entitled to do so.[18]

Similarly, the Board does not have the authority to make the corner "round" by considering factors outside those specifically recognized under the statute and regulations. The Board finds West Carroll clearly did not submit its outpatient quality data timely, and the statute, regulations, and relevant final rules mandate application of the 2 percentage point penalty whenever a hospital fails to submit its outpatient quality data in the form, manner, and time specified by the Secretary.[19]

DECISION:

After considering the Medicare law and regulations, the parties' contentions and evidence submitted, the Board finds that CMS properly imposed a 2 percent reduction to the CY 2015 OPD fee schedule increase factor for West Carroll.

BOARD MEMBERS PARTICIPATING:

L. Sue Andersen, Esq.
Clayton J. Nix, Esq.
Charlotte F. Benson, C.P.A.
Jack Ahern, M.B.A., CHFP
Gregory H. Ziegler

FOR THE BOARD:

/s/
L. Sue Andersen, Esq.
Chairperson

May 4, 2017

[18] *Id.* at 1217.

[19] With regard to exemptions and exceptions under 42 C.F.R. § 419.46(d), the Board notes that the hospital must initiate the process by submitting a request to CMS following the submission requirement on the QualityNet website and that CMS will grant such requests only at its discretion where CMS determines there were "extraordinary circumstances beyond the control of the hospital." As West Carroll has not argued that it qualified for an exemption/exception and the Medicare Contractor has confirmed that West Carroll did not submit such a request, the Board need not address exemptions/exceptions.