CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
St. Joseph Mercy Hospital-Oakland	**Reimbursement Determination For Cost Reporting Period Ending: June 30, 1995**
Provider	
vs.	**Review of:**
BlueCross BlueShield Association/ National Government Service-WI	**PRRB Dec. No. 2010-D42**
Intermediary	**Dated: August 5, 2010**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review, on own motion, of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in §1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). The CMS' Center for Medicare (CM) submitted comments requesting that the Board's decision on Issue No. 3 be reversed. The parties were notified of the Administrator's intention to review the Board's decision. The Provider submitted comments requesting that the Administrator modify the Board's decision as to Issue No. 3. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD DECISION

Issue No. 3 was whether the Medicare Proxy component of the disproportionate share hospital (DSH) adjustment must be remanded to the Intermediary without adjudication by the Board pursuant to CMS Ruling 1498-R.[1]

[1] The Board decision also included Issue No. 1, whether the Medicare bad debt payment was computed properly, and Issue No 2, whether the Medicaid Proxy component of the disproportionate share hospital (DSH) adjustment was computed properly. Those issues were resolved pursuant to a partial settlement and included as part of this decision for procedural reasons and are herein summarily affirmed.

The Board determined that, as to the disproportionate share hospital (DSH) payment issue, the claim of the Provider is not outside the scope of the CMS Ruling 1498-R. The Ruling apparently provides the relief the Provider seeks in that the purpose of the recalculation is to identify all Medicare patients who are entitled to Supplemental Security Income (SSI) benefits. Thus, the Board found that the claim of the Provider is subsumed in the recalculation and appeal procedure discussed in the CMS Ruling 1498-R.

The Board stated, however, that the Provider fully supported and the Intermediary did not contest the claim for 22 patients entitled to SSI during June 30, 1995, who were excluded from the calculation. The evidence demonstrated that the Provider identified 12 patients who were entitled to SSI as evidenced by the CMS SSI eligibility database. These 12 patients accounted for 73 SSI days. The Provider identified 10 patients who were entitled to SSI as evidenced by correspondence by the SSA. These 10 patients accounted for 88 SSI days. The Intermediary and the Provider agreed that the Medicaid proxy consists of 9,502 eligible days. The Board also stated that the parties agreed, if the 161 patient days for the 22 additional patients entitled to SSI were included in the Medicare proxy, the Provider would be entitled to the DSH adjustment. Thus, the Board concluded that the only remedy to implement its decision was to remand the issue to the Intermediary for a recalculation of the SSI ratio to include the 161 days in issue.

SUMMARY OF COMMENTS

CM requested that the Administrator reverse the decision of the Board as to Issue No 3, arguing that the Board did not have jurisdiction to order the specific relief regarding the SSI ratio. The review of the Administrator of the decision should be limited as to whether the Board has jurisdiction to grant the relief requested. CM stated that, although the Provider attempted to distinguish its appeal of the inclusion of a specific number of inpatient days (161) in the DSH calculation from the issues addressed in the Ruling, such an attempt is unavailing. The Provider appealed the exclusion of certain days, arguing that its claim was not related to the match process, yet the same match process resulted in the exclusion of the days at issue.

CM stated that the CMS Ruling 1498-R does not require administrative tribunals, including the Board, to make determinations on substantive issues. Instead, the CMS Ruling 1498R-1 requires compliance with its implementation procedures. Specifically, the Ruling requires the Board to make a determination that an appeal has met all jurisdictional requirements and that the appeal concerns one of the three DSH issues and it requires a remand of those appeals involving DSH reimbursement to the Intermediary. Despite these instructions, the Board chose to grant the request of the Provider to include the 161 days in the calculation.

As to the substantive claim of the Provider, the Board found that the Provider fully supported and that the Intermediary did not contest the claim regarding the 22 patients entitled to SSI during the Fiscal Year who were excluded. The CM also stated that the official SSI files from SSA were not used to substantiate the Provider's claims. The file sent to CMS from the SSA constitutes the only verifiable source of beneficiary eligibility for purposes of beneficiary eligibility data, not the data presented by the Provider to the Board, which included data from some other source.[2] CMS, and not the Intermediary, creates the Medicare fraction utilized in the hospital DSH calculation. Thus, the fact the Intermediary did dispute the SSI data is not relevant, as the Intermediary does not generate this information. Neither the Intermediary, nor the Provider, would be in a position to verify the eligibility data for SSI. Neither party receives the specific SSI eligibility data that SSA sends directly to CMS. In order for data to be utilized pursuant to the match policy of CMS, both Medicare Part A claims data from CMS and SSI eligibility data from SSA are required.[3] The Secretary rejected, pursuant to rulemaking, a proposal that would allow hospitals to furnish their own data for demonstrating the SSI eligibility of their Medicare patients. There is no support in the statute, or regulation, that CMS must recalculate the DSH adjustment based on hospital submissions of data from some other source and, therefore, CMS does not find that a recalculation of the DSH adjustment based on the Provider's data is the correct remedy.

The Provider submitted comments requesting that the Board's decision be modified and argued that its claim was not within the scope of CMS Ruling 1498-R and that the additional SSI days should be included in the DSH adjustment. Therefore, the Administrator should order the Intermediary to compute its DSH adjustment for the fiscal year ending June 30, 1995, by including the additional SSI days. Although the issue relates to the DSH percentage, the scope of the CMS Ruling 1498-R includes appeals challenging the data matching process CMS utilized calculating the DSH percentage. The data matching issue is not present in this case. The Ruling, which contemplates a remand to and reopening by the Intermediary as to a certain set of appeals, relates to the data matching process. Because the additional SSI days issue was not one the three DSH issues falling within the scope of the Ruling, the additional SSI days issue constitutes the sole DSH adjustment issue, which is an issue outside the scope of the Ruling, before the Board. The Provider stated it appealed the additional SSI day issue, and the relief it seeks is an order by the Board that the SSI percentage be recomputed to include those days. Therefore, the Board erroneously failed to find that the issue on appeal did not come within the scope of the Administrative Ruling.

The Provider claimed that remanding the appeal will not result in the relief the Provider seeks and to which the Board concluded it is entitled. Furthermore, the Board's finding

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[2] *See* 75 Fed. Reg. 50024, 50279-80 (Aug. 16, 2010)(Inpatient Prospective Payment System (IPPS) Final Rule).

[3] *See* 51 Fed. Reg. 16,772, 16,777 (May 6, 1986).

that the additional SSI days issue came within the scope of the Ruling is not supported by any evidence, much less substantial evidence that is required to support a decision. The "most accurate data" standard requires the inclusion of the additional SSI days. The Provider argued that the application of the Ruling would result in a remand of its appeal, in addition to hundreds of other cases, to the Intermediary for an indefinite period of time. In contrast, here the Board has conducted its hearing and has rendered a decision on an issue outside the scope of the Ruling for which a provider, such as itself, is entitled to receive relief.

Nothing in the record supports a finding that the Provider appealed the data matching issue. The record fully supports the finding that it appealed the addition of SSI days. The Provider argued that, as the Board properly found in its favor regarding the additional SSI days, the Board should have ordered the Intermediary and CMS to grant specific relief, i.e., the inclusion of the additional 22 patients in the SSI percentage, which would result in qualification for the DSH adjustment. The Provider also argued that the Board's decision is not governed by the Ruling because it rendered the decision before the Ruling. The Provider also argued that CMS lacks the authority under the regulatory provisions to remand the decision to the Intermediary and to reverse the decision of the Board on the merits. The Provider reiterated its arguments to the Board that if it does not receive the additional SSI days, it will not qualify for the additional DSH reimbursement, thereby jeopardizing its financial stability in troubled times.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits.

The Medicare DSH payment is a statutorily mandated payment for hospitals serving a disproportionate share of low-income patients. §1886(d)(5)(F) of the Act. Whether a hospital qualifies for DSH reimbursement, and the amount of such reimbursement, depends on, *inter alia*, the hospital's "disproportionate patient percentage (DPP). §1886(d)(5)(F)(v). Congress established a proxy for determining a hospital's DPP. The DPP is calculated by adding the following two fractions: the Medicare Fraction (also referred to as the supplemental security income or SSI Ratio or percentage) and the Medicaid fraction. Relevant to this case, the numerator of the Medicare fraction is the number of inpatient days for patients who are entitled to both Medicare Part A and to Supplemental Security Income (SSI) and the denominator is the total number of the inpatient days for patients who were entitled to Medicare Part A.

In this case, the Provider requested a hearing by letter dated February 19, 1998. The Provider appealed Adjustment No. 71 and stated that "it qualifies for the disproportionate share adjustment. Certain Medicaid eligible inpatient days were not included in the calculation." The record is not clear as to when the Provider added the issue of omitted

SSI/Medicare Part A days to the DSH calculation appeal. However, the issue was briefed in the Provider's Final Position Paper received by the Board on March 6, 2001.

Subsequently, by letter dated April 19, 2005, the Provider requested that the case be placed in abeyance pending the Board's decision in *Baystate Medical Center*. On April 25, 2005, the Provider further clarified that request, pursuant to the Board's inquiry. The Provider explained, in an April 25, 2005 letter, that: "From the provider's review of the [ ] transcript, it is clear that there is a good deal of commonality between the challenge to the computation of the SSI% in the instant case and in *Baystate Medical Center*."

By notice dated April 28, 2005, the Board granted the Provider's request and placed the Provider's case in abeyance. The Board instructed that:

> The Provider has advised the Board that the decision in *Baystate* may be relevant to the subject appeal. Once the Board has issued its decision in *Baystate* case, the provider is to notify the board, in writing and advise whether it wishes to reactive the subject appeal and reschedule the board hearing.

By letter dated may 27, 2008, the Provider requested that its case be reinstated to the active docket in light of the district court decision in *Baystate Medical Center v. Leavitt*, Case No. 06-1263 (March 31, 2008). The case was subsequently taken out of abeyance, and the Provider, *inter alia*, by letter dated December 2, 2009, submitted to the Board an *amicus curiae* brief it filed in another court case. The Provider again discussed the Intermediary's reliance on *Baystate* and its detrimental effect on the Provider's appeal in this case which also involved "the accuracy of the computation of the SSI fraction….." The Provider stated that, although the Secretary has conceded *Baystate*, the Provider's case was still pending "for more than a year after the hearing in a case where the Intermediary's sole argument has been disavowed by the Secretary."

Regarding the substance of the Provider's claims, the Intermediary argued, in its February 21, 2001 Position Paper, regarding the DSH adjustment appeal, that:

> The Provider is disputing both the patient days and the SSI percentage used in the computation of the DSH adjustment…..The SSI percentage issue will not be addressed in this paper. The Intermediary used the Supplemental Security Income (SSI) ratio as published by HCFA. The Provider is pursuing this issue with HCFA and the Social Security Administration (SSA). The Intermediary cannot make any change to the published rate without direction from HCFA.

As explained, in the Intermediary Supplemental Position Paper, the Provider required a combined disproportionate share payment percentage of 15 percent in order to qualify for a DSH payment. As the Provider had a Medicaid patient percentage of 9.9810 percent, it was required to have at least an SSI ratio of at least 5.019 percent in order to meet the 15 percent threshold. When the Provider had its SSI ratio recalculated as allowed under regulation it produced a SSI ratio of 4.81615 percent, still short of the necessary threshold

percentage needed of 5.019 percent. The Intermediary stated that the Provider, based on the subpoena response, alleged to have "matched" its records to the CMS SSI records furnished and the CMS SSI run to identify certain discharges reflected in the SSI run but not reflecting SSI status, and discharges that showed patients as SSI for other discharges included on the MEDPAR run, but were not on the MEDPAR for the specific discharges identified, but did not identify other discharges which may have been omitted but were not SSI recipients (and hence would have diluted the SSI percentage.) The Provider also used Michigan Medicaid information of patients that received SSI payments during the month of admission but which were not reported by CMS as SSI eligible on the MEDPAR.[4]

The Board held a hearing on November 5, 2008. The Provider subsequently submitted a proposed decision, by letter dated December 9, 2008, and again, inter alia, discussed the errors in the Administrator's decision in Baystate. The Provider stated however, that as to one factual aspect, the Provider's case was distinguished from Baystate. The Provider claimed that the CMS Administrator had found, in that case, that the provider had not shown that the flaws in calculating the Medicare fraction produced adverse affects, where in this case, the Provider contended that it provided undisputed evidence as to the exact impact of the flaws in its DSH calculation by the use of alternative data matching.

Relevant to this case, on April 28, 2010, CMS issued CMS Ruling 1498-R.[5] The Ruling provided notice that the Board and the other Medicare administrative appeals tribunals lacked jurisdiction over three specific types of provider appeals regarding the calculation of the Medicare disproportionate share hospital (DSH) adjustment. The CMS Ruling 1498-R, titled "Medicare Program Hospital Insurance (Part A)—Jurisdiction over appeals of disproportionate share hospital (DSH) payments and recalculation of DSH payments following remands from Administrative Tribunals" provides the following:

> The Ruling provides notice of the determination of the Centers for Medicare & Medicaid Services (CMS) that the Provider Reimbursement Review Board (PRRB) and the other Medicare administrative appeals tribunals lack jurisdiction over provider appeals of any of three issues described [therein] regarding the calculation of the Medicare disproportionate share hospital (DSH) payment adjustment. The Ruling also requires the pertinent administrative appeals tribunal (that is, the PRRB, the Administrator of CMS, the Medicare fiscal intermediary hearing officer, or the CMS

[4] Intermediary Supplemental Position Paper, pp 3-5 (October 17, 2004).

[5] The regulations, at 42 C.F.R. §401.108, state that CMS Rulings are binding on all CMS components. With respect to the scope of the Board's legal authority, the regulation at 42 C.F.R. §405.1867 states that, "[i]n exercising its authority to conduct proceedings… 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…."

> reviewing official) to remand each qualifying appeal to the appropriate Medicare contractor.

Specifically, CMS Ruling 1498-R removes jurisdiction from the respective administrative appeal tribunal of the review of three issues: 1) the calculation of the SSI fraction; 2) inpatient days where the patient was entitled to Part A benefits, but the inpatient hospital day was not covered under Part A or the patient Part A benefits were exhausted. (MSP days and exhausted benefit days for dual-eligible patients) for cost reporting periods with discharges before October 1, 2004; and 3) labor and delivery room days for cost reporting periods with discharges before October 1, 2009. The CMS Ruling explains in lengthy detail the scope of each of the issues and the implementation of the Ruling.

The Provider claims that the issue under appeal is not within the scope of the CMS Ruling. However, the Administrator finds that, after a review of the documents filed by the Provider, some of which are referenced above, the issue appealed by the Provider involved the calculation of the SSI fraction and, therefore, CMS Ruling 1498-R is applicable. As noted by CM, the Provider, while claiming its case is not a data matching case, is attempting to forward its own data matching cure to resolve the case, which is the point of the CMS ruling regarding the SSI ratio. In addition, prior to the issuance of the Ruling, the record shows that the Provider itself procedurally maneuvered and argued its case always keeping the *Baystate* case, the lead SSI data matching case, as the focal point.[6] Consequently the record does not support a finding that the issue under appeal is outside the scope of CMS Ruling 1498-R.

The Provider also claimed that the case was outside the scope of the Ruling as the Board had already decided the case prior to issuance of the CMS Ruling 1498-R in April 2010. The Provider's Representative claimed that there was a November 10, 2008 telephone communication with a Board analyst where he was informed that the Board had ruled in

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[6] For example, the Ruling stated, in part, that, in Baystate, the "district court concluded that in certain respects, CMS did not use the best available data in matching Medicare and SSI eligibility data…. CMS continues to believe that its data matching process and resultant SSI fraction and DSH payments were lawful….. In accordance with the foregoing history and determinations, CMS and the Medicare contactors will resolve each properly pending DSH appeal of the SSI fraction data matching process issue, by applying a suitability revised data matching process (as set forth below in Section 5.a. of this Ruling) for purposes of calculating the hospital SSI fraction by matching Medicare and SSI eligibility data and then recalculating the hospital DSH payment adjustment for this period. CMS action eliminates any actual case or controversy regarding the hospital previously calculated SSI fraction and DSH payment and thereby renders moot each properly pending claim in a DSH appeal involving the hospital's previously calculated SSI fraction and the process by which CMS matches Medicare and SSI eligibility data…." at 50-6.

the Provider's favor and to submit a proposed decision.[7] However, the regulation at 42 CFR 405.1871 requires that a Board hearing decision must be in writing. Consequently, the record does not support the Provider's argument that the Board decided the case prior to the issuance of the CMS Ruling 1498-R. Finally, the Provider also argued that the Administrator lacks the authority under the regulatory provisions to remand the decision to the Intermediary. The regulation governing Board procedures sets forth that the Administrator has the authority to remand a matter not only to the Board but also to any component of the Department of Health and Human Services or CMS or to an intermediary/contractor, under appropriate circumstances. *See* 42 CFR 405.1875(f)(5).

Accordingly, the Administrator orders:

That the Board's decision on the SSI ratio issue is hereby vacated in accordance with the CMS Ruling-1498-R; and

That the Provider's appeal of the SSI ratio is remanded to the appropriate Medicare contractor for resolution consistent with CMS Ruling 1498-R.

Date: 10/6/10

/s/
Marilynn Tavenner
Principal Deputy Administrator and Chief Operating Officer
Centers for Medicare & Medicaid Services

[7] It is not clear that the Intermediary was also included in this telephonic communication, but the Provider sent the Intermediary a copy of its proposed decision also referencing the November 10, 2008 telephone call that informed him of the favorable "decision." However, the anomaly of this event, as described by the Provider, may best be seen when contrasted to courts' conduct, where a party may be requested to draft an order, but such request is made in the presence of both parties, and such a request does not extend to the drafting of the memorandum opinion for the court.