PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2006-D22

PROVIDER -
Saint Anthony's Health Center
Alton, IL

Provider No.: 14-0052

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
AdminaStar Federal Illinois

DATE OF HEARING -
November 23, 2005

Cost Reporting Period Ended -
December 31, 1997

CASE NO.: 01-0820

INDEX

ISSUE:

Whether the Intermediary properly excluded patient days attributable to Medicare Health Maintenance Organization (HMO) encounters from the calculation of the Provider's disproportionate share adjustment.

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. §§1395-1395cc. 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 out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395(h), 42 C.F.R. §§413.20(b) and 413.24(b).

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the proportion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the Prospective Payment System ("PPS"). See 42 U.S.C. §1395ww(d). The PPS contains a number of provisions that adjust reimbursement based on hospital-specific factors. 42 U.S.C §1395ww(d)(5). This case involves one of those factors, the disproportionate share adjustment ("DSH"), which requires the secretary to provider increased reimbursement to hospitals that serve a "significantly disproportionate number of low-income patients." 42 U.S.C. §1395www(d)(F)(i)(I). Whether a hospital qualifies for a DSH adjustment, and how much an adjustment it receives, depends on the hospital's disproportionate patient percentage." 42 U.S.C. §1395ww(d)(5)(F)(v).

The "disproportionate patient percentage" is the sum of two fractions, the "Medicare and Medicaid fractions," expressed as percentage for a hospital's cost reporting period. 42 U.S.C. § 1395ww(d)(5)(F)(vi). This disputes involves the Medicare fraction. The Medicare fraction is also often referred to as the SSI (Supplemental Security Income). The Medicare fraction's numerator is the number of hospital patient days for patients entitled to both Medicare Part A and

SSI, excluding patients receiving state supplementation only, and its denominator is the number of patient days for patients entitled to Medicare Part A. Id.

Each provider's Medicare fraction is furnished to its intermediary by CMS and is based upon the federal fiscal year in which the provider's cost reporting periods begins.[1]

The second fraction's numerator is the number of hospital patient days for patients who were eligible for medical assistance under a State plan approved under Title XIX for such period but not eligible for benefits under Medicare Part A, and its denominator is the total number of the hospital's patient days for such period. Id., see also 42 C.F.R. §412.106(b)(4). The second fraction is frequently referred to as the Medicaid Proxy. Providers whose DSH percentages meet certain thresholds receive an adjustment which results in increased PPS payments for inpatient hospital services. SSA §1886(d)(5)(F)(ii).

At issue in this case is whether the Provider's SSI percentage should be adjusted to reflect patient days attributable to Medicare HMO encounters for purposes of calculating the DSH adjustment.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

St. Anthony's Health Center (Provider) is an acute care hospital with 183 beds that is located in Alton, Illinois. On its cost report for the fiscal year ended 12/31/97, the Provider claimed that its ratio of Supplemental Security Income (SSI) recipient patient days to Medicare Part A patient days was 7.060% for DSH purposes. Using this ratio throughout the cost reporting calculations produced an allowable DSH percentage of 8.49% and a claimed DSH payment of $1,213,585. In 1999, CMS notified the Provider that it had computed its SSI percentage for 1997 at 5.6% from CMS' paid claims data. The Provider, in turn, requested a re-determination of CMS' calculation based upon its belief that its Medicare HMO population had not been counted in the SSI calculation, and it offered patient encounter data for inclusion in the Intermediary's review. CMS responded in March, 2000 and calculated a revised SSI rate of 5.679%. The Intermediary subsequently issued an NPR for 1997 reflecting DSH reimbursement based upon CMS' 5.679%. The Provider claims that CMS' recalculation utilized the same Medicare Provider Analysis and Review ("MEDPAR") data that was originally used to calculate the SSI percentage and did not address the issue of including the SSI population enrolled in a Medicare HMO in the SSI percentage.

PARTIES' CONTENTIONS:

The Provider contends that §1886(d)(5)(F)(vi) of the Social Security Act and its implementing regulation at 42 C.F.R. §412.106(b)(1) require that the SSI percentage should include all patients entitled to both Medicare Part A and SSI. Further, the Provider contends that CMS' Final Rule at 55 Fed. Reg. 35990/94 (9/4/90) specifically states that " . . . it is appropriate to include the

1 If a provider prefers that CMS compute its SSI% using its own cost reporting period instead of the FFY, it may make such an election. Instructions for doing so are found at 42 C.F.R.§412.106(b)(3). The resulting percentage then becomes the provider's SSI % for that period

days associated with Medicare patients who receive care at a qualified HMO" in calculating the SSI/Medicare percentage. The Provider argues that the collective language of the statute, the regulation and the rule clearly demonstrates CMS' expectation that patient days associated with Medicare HMO days will be included in the calculation.

The Provider also contends that its HMO encounter data are exempt from the federal regulations governing the submission of claims to the Medicare program. The Provider argues that the HMO encounter data does not include claims for payment and, therefore, is not a claim as defined by the Social Security Act at §1128A(i)(2). Further, 42 C.F.R. §424.30 specifically exempts services "furnished on a prepaid capitation basis by a health maintenance organization" from the requirements, procedures, and time limits for claiming Medicare payments. The Provider contends that its encounter data is offered as documentation to support its claim that its SSI ratio is understated and not in pursuit of claims payment.

The Intermediary does not dispute the language of the statute or the regulations relative to the inclusion of patient HMO days. However, the Intermediary contends that 42 C.F.R. §413.20(a) requires that Providers "maintain sufficient financial records and statistical data for proper determination of costs payable under the program." The Intermediary argues that the Provider's failure to include the HMO claims data was the result of deficiencies in its own accounting capabilities. The Intermediary also argues that HMO claims data is subject to the regulatory deadlines imposed on the settlement process. The Social Security Act at §1835(a)(1) allows between one and three years to file claims, with an additional year for the last three months of a calendar year. Based upon this standard, the HMO data submitted by the Provider was timely only for the fourth quarter of calendar 1997. Those data were included in the information forwarded to CMS and, in turn, in CMS' calculation of the SSI percentage.

The Intermediary also contends that the data submitted and processed for the last quarter of 1997 did not significantly change the Provider's SSI percentage. The Intermediary argues that, while many of the claims submitted for the last three months of 1997 were duplicates or omitted critical data, they were all processed and accepted or rejected. The resulting increase in the CMS recalculated SSI percentage was .082% for the quarter accepted. Annualizing this percentage produces an increase for the year of .328 % and revises the Provider's SSI percentage from 5.597% to 5.925%. This rate is substantially below the 7.060% claimed by the Provider, and the Intermediary argues that the source of this shortfall is something other than the HMO encounter days.

The Intermediary contends further that the preamble to the final regulation addressing the computation of the SSI percentage[2] allows only a limited recalculation of the SSI percentage, and that it must be based upon internal CMS data. The Intermediary argues that, since the Provider failed to meet the regulatory deadline for submitting claims for most of 1997, it may not now substitute its own data through the appeals process and thereby obtain a new SSI percentage.

[2]51 Fed. Reg. 16772/76, dated May 6, 1986.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare Law, program guidance, the parties' arguments, and evidence contained in the record, finds and concludes as follows:

It is undisputed that the language of the statute and its implementing regulations and guidance require that HMO patient days be included in the SSI percentage. Further, the regulations at 42 C.F.R. §424.30 specifically exempt HMOs from the procedures and time limits for filing claims for Medicare payment. Given this exemption, the Board has no authority to establish or enforce a time limit on the submission of HMO data. The Board finds, therefore, that the Intermediary's rejection of the Provider's HMO data for the first three quarters of 1997 as untimely was improper. The Provider's data should be submitted to CMS to be matched through the MEDPAR program.

DECISION AND ORDER:

The Intermediary's rejection of the Provider's HMO data for the first three quarters of 1997 as untimely was improper. The Provider's data must be submitted to CMS to be matched through the MEDPAR program.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, C.P.A.

FOR THE BOARD:

DATE: May 25, 2006

Suzanne Cochran, Esq.
Chairperson