PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2007-D63

PROVIDER -
Saint Mary's Mercy Medical Center
Grand Rapids, Michigan

Provider No.: 23-0059

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
United Government Services, LLC (n/k/a
National Government Services)

DATE OF HEARING -
July 28, 2006

Cost Reporting Periods Ended -
June 30, 2000 and June 30, 2001

CASE NOs.: 03-0721 and 04-0473

INDEX

ISSUE:

Did the Intermediary properly calculate the Provider's disproportionate share payment adjustment in accordance with Medicare regulations as set forth in 42 C.F.R. §412.106?[1]

MEDICARE STATUTORY 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. §1395h, 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 portion 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.

During the cost reporting periods at issue, the Medicare statute authorized payment for inpatient hospital services rendered to Medicare beneficiaries under the inpatient prospective payment system (PPS). 42 U.S.C. §1395ww(d). Under PPS, inpatient operating costs are reimbursed based on a prospectively determined formula, taking into account national and regional operating costs. The PPS methodology 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 the hospital-specific adjustments, specifically the Disproportionate Share Hospital or DSH adjustment. The DSH adjustment is for hospitals that serve a "significantly disproportionate number of low-income patients." 42 U.S.C. §1395ww(d)(5)(F). Whether a hospital qualifies for the DSH adjustment and the

[1] The hearing held by the Board on July 28, 2006 involved two cases, one for FYE 2000 and one for FYE 2001. Both cases contained two issues: 1) IME/GME FTE resident count, and 2) DSH – computation of the SSI%. Prior to the hearing the parties agreed to an administrative resolution of Issue 1 for the FYE 2000, and after the hearing the parties also settled the first issue for FYE 2001. Consequently, the only issue addressed by the Board in this decision is the DSH – SSI% issue.

amount of the adjustment it receives depends on the hospital's "disproportionate patient percentage." 42 U.S.C. §1395ww(d)(5)(F)(v).

The most commonly used method for a hospital to qualify for the DSH payment adjustment (and the method applicable to the Provider) follows a statutory formula under which payment is based on the level of the hospital's DSH patient percentage, *i.e.*, the sum of two fractions (expressed as a percentage): the "Medicare fraction" and the "Medicaid fraction." The Medicare and Medicaid fractions are added together to determine if the hospital is entitled to receive DSH payments and, if so, the amount of such payments. This issue involves the calculation of the Provider's Medicare fraction as set forth in the regulation at 42 C.F.R. §412.106(b).

The Medicare fraction is also referred to as the "SSI fraction" because it captures the number of Medicare beneficiaries who are eligible for SSI benefits under the Social Security Act. The Medicare fraction is computed by dividing the number of patient days for patients who were entitled to both Medicare Part A benefits and SSI benefits (the numerator of the Medicare fraction) by the total number of patient days for patients entitled to benefits under Medicare Part A (the denominator of the Medicare fraction).

To calculate the numerator of the Medicare fraction, CMS determines for a particular provider the number of patient days for patients entitled to Medicare Part A and eligible for SSI by matching data from the Medicare Provider Analysis and Review (MEDPAR) file with a filed created for CMS by the Social Security Administration to identify SSI eligible individuals in a particular fiscal year. The denominator of the Medicare fraction is calculated by CMS based on Medicare claims data. CMS then notifies the hospital and its fiscal intermediary of its calculation.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Saint Mary's Mercy Medical Center (Provider) is a not-for-profit, acute care hospital located in Grand Rapids, Michigan.

In 2000, the Provider undertook a review of its Supplemental Security Income (SSI) percentage of the Medicare fraction for its disproportionate share hospital (DSH) adjustment for fiscal years ended 2000 and 2001 after questions arose in the hospital reimbursement community about whether CMS included all Medicare eligible and SSI eligible patients in the SSI percentage that CMS publishes annually.

To conduct this review, the Provider first downloaded its Medicare patients for cost reporting years 2000 and 2001. Next, the Provider obtained from CMS the file for these years. The Provider compared its total Medicare population with the data received from CMS by reviewing each patient's account history to determine their SSI eligibility status. Any patients who were verified for SSI were removed from the Provider's Medicare population to arrive at Medicare patients for whom no SSI was indicated on the CMS MEDPAR file.

This data was then reviewed against data from a database maintained by the Michigan Medicaid program. The Michigan Medicaid program has responsibility for changing cases from Medicaid to SSI based upon data received directly from the Social Security Administration. Most of the changes were automatic from the file received from the Social Security Administration. This means that when Michigan Medicaid determines whether a recipient is SSI eligible, it relies on the Social Security Administration data. Consequently, the Michigan Medicaid database matches the Social Security Administration SSI data.

The data from the Michigan Medicaid database showed whether a particular patient was eligible for Medicare Part A and Part B on a date of service. Based upon this information, the Provider verified that the SSI eligible patients identified through the Provider's review who were not included in the CMS file were, in fact, SSI eligible on the date of service. From this review, the Provider identified an additional 218 SSI eligible days for cost report year 2000 and an additional 267 SSI eligible days for cost report year 2001.[2] The Provider believes that these additional days should have been included by CMS in calculating the Provider's SSI percentage.

After completion of its review in January 2006, the Provider submitted the information to its fiscal intermediary, United Government Services, LLC (Intermediary), requesting that it review the additional eligible days for its SSI percentage. The Provider's Intermediary, in turn, transmitted this information to CMS to verify the SSI eligibility of the patients who were not included in the MEDPAR file originally provided by CMS. In response to the Provider's request, CMS only addressed fiscal year 2001 and only did so in the context of updating its run of the Provider's SSI percentage for this year based on the federal fiscal year rather than the Provider's fiscal year.[3] CMS informed the Intermediary – but not the Provider – of this recalculation which resulted in a higher percentage. Shortly before the July 2006 Board hearing in this case, the Intermediary requested that CMS review the SSI recalculation on the basis that it could not verify the recalculation, and it "appears aberrant when compared to the SSI calculated based upon the federal fiscal year. . . ."[4] CMS did, in fact, recalculate the SSI percentage for 2001 issuing a revised calculation of .60 percent with the explanation that it "is a corrected recalculation based on an error in the original."[5] Consequently, the additional days requested by the Provider have not been considered.

The Provider filed this appeal with the Board alleging that the calculation of its Medicare fraction for cost report years 2000 and 2001 was understated because CMS did not include all SSI eligible days. The Provider's filing met the jurisdictional requirements of 42 C.F.R. §§405.1835-1841.

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[2] See, Provider's Exhibits 15-I for FYE 6/30/00 (CN: 03-0721 and Exhibit 16-I for FYE 6/30/01 (CN: 04-0473).

[3] Tr. 46:14-47:9; 60:14-61:9; see also Provider Exhibit 34 – July 9, 2003 letter.

[4] Provider Exhibit 34 – March 20, 2006 letter.

[5] Provider Exhibitt 34 – June 6, 2006 letter.

The Provider was represented by Chris Rossman, Esq. and Lena Robins, Esq. of Foley & Lardner LLP. The Intermediary was represented by Bernard M. Talbert, Esq. of Blue Cross Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that it conducted a comprehensive review of the data used by CMS to calculate its Medicare fraction which accurately showed that CMS understated the number of SSI eligible days for cost report years 2000 and 2001. Its comprehensive review identified an additional 218 SSI eligible days for cost report year 2000 and an additional 267 SSI eligible days for cost report year 2001. These additional days should have been included by CMS in calculating the Provider's SSI percentage.

The Provider further maintains that CMS' own actions show that it has discretion to revise a provider's SSI percentage. Although CMS did not review in any meaningful way the revised data submitted by the Provider, it exercised its discretion to recalculate the Provider's SSI percentage for 2001, and then after the Intermediary identified an error with the percentage, recalculated it again. Thus, by correcting the Provider's SSI percentage for 2001 based upon an error in the original recalculation, the Provider contends that CMS concedes that it does, in fact, have discretion to make changes after the initial promulgation of the SSI percentage where there are errors in the percentage. This demonstrates that the SSI percentage is not fixed and can be recalculated.

The Provider further contends that in determining whether to require the Intermediary to recalculate the Provider's SSI percentage using the more accurate SSI data, the Board should follow its holding in two earlier cases that addressed this same issue. In both these cases, the Board ordered that the Intermediary recalculate the provider's DSH adjustment to use the most accurate SSI data.

In Oakwood Hospital & Medical Center (Dearborn, Mich.) v. Blue Cross Blue Shield Ass'n/United Government Services, LLC (Wis.), PRRB Dec. No. 2006-D2 (Nov. 16, 2005) (Oakwood), the Board addressed whether a hospital provider was entitled to an additional 72 SSI days. This issue was not in dispute, as it was agreed that the provider had correctly identified an additional 72 SSI days. The Board's holding was premised on whether the provider in question was entitled to expedited judicial review, to which the Board found the provider was not entitled. However, the Board discussed the question of additional SSI days, concluding it is "purely a legal question of whether CMS must recalculate the DSH adjustment using additional days." Oakwood at p. 6. That is precisely the question presented here. In Oakwood, the Board found no statute, regulation, or CMS ruling that would preclude CMS from recalculating a provider's DSH adjustment, nor is there anything that would require CMS to use a number in the DSH calculation which is proven incorrect by virtue of a successful appeal. Id.

Following its holding in Oakwood, the Board in Baystate Medical Center (Springfield, Mass.) v. Mutual of Omaha Insurance Co., PRRB Dec. No. 2006-D20 (March 17, 2006) (Baystate), expressly held that "[a]n approximation of the DSH percentage is not

permitted by statute or regulation; the law requires that the calculation be accurate." Baystate, at p. 41. Baystate alleged that the Medicare fraction was understated because both the SSI files and the MEDPAR files contained inaccurate or incomplete information, and CMS used a flawed methodology to match the data in these files.

Subsequently, the CMS Administrator modified the Board's decision and affirmed CMS' calculation of Baystate Medical Center's Medicare fractions. Baystate Medical Center v. Mutual of Omaha Ins. Co., CMS Administrator Decision (May 11, 2006). The case is currently pending in the district court. Baystate Medical Center. v. Leavitt et. al, Civil Docket No. 1:06-cv-01263-JDB. The Provider argues that although the CMS Administrator modified the PRRB's decision in Baystate, the Board is not required to follow the CMS Administrator's decision in deciding this case. See, 42 C.F.R. § 405.1867.

The Provider also contends that the CMS Administrator's holding in Baystate is distinguishable from the issue involved in this appeal in that it centered on its finding that Baystate failed to show that the alleged flaws in calculation of the Medicare fraction had an adverse impact on its DSH payments. Baystate, CMS Administrator Decision at p. 28. The Provider maintains that is not the case here, as the data it submitted demonstrates the exact number of SSI days that were not counted by CMS and shows the adverse reimbursement impact of excluding the additional SSI days.

In the Baystate decision the Board rejected the Intermediary's position that the Medicare fraction is fixed when made because that position conflicts with the statutory provisions regarding appeals to the Board and also conflicts with the Secretary's own policy statements. Baystate, at p. 6. Under 42 U.S.C. §1395oo and the regulation at 42 C.F.R. §405.1835, a provider receiving payments of amounts computed under PPS has the right to a hearing before the Board with respect to such payments provided other jurisdictional criteria are met. The DSH adjustment is an additional payment ". . . applied to . . . the hospital's DRG revenue for inpatient operating costs . . ." 42 C.F.R. §412.106(a)(2). The Board in Baystate concluded that nothing in the DSH statute or regulation specifically prohibits recalculation of the DSH fractions. Baystate, at p. 7.

As the Board discussed in the Baystate decision, CMS's own policy statements support recalculation of a provider's DSH payment percentage when it does not reflect the best available data. Disclosure of MEDPAR data used in the calculation of the DSH adjustment is permitted where "a hospital that has an appeal properly pending before the [Board] or before an intermediary, on the issue of whether it is entitled to disproportionate share hospital payments, or the amount of such payments." Baystate, at p. 7 (citing 65 Fed. Reg. 50548, 50549 (Aug. 18, 2000)). In that same Federal Register notice, the Secretary stated that disclosure under this routine use was for the purpose of:

> . . . assisting the hospital to verify or challenge [CMS'] determination of a hospital's SSI ratio (i.e., the total number of Medicare days compared to the number of Medicare/SSI days), and shall be limited to data concerning the SSI eligibility status of individuals who had stays at the

> inpatient hospital's facility during the period that is relevant to the appeal.

Id.

In addition, the Board in Baystate examined the argument that the DSH adjustment is retrospective and not prospective. Baystate, at p. 8. The Board found that the adjustment is an addition to the PPS payment based on hospital-specific data from the prior cost reporting period. Consequently, PPS concerns related to the predictability of prospectively determined PPS payment rates are not relevant to the DSH payment calculation. As the Board also discussed in the Baystate decision, an approximation of the SSI ratio is not permitted under the applicable rules. The Board could not identify "any authority in the DSH statute that permits CMS to estimate a hospital's SSI ratio. Congress acknowledged that while the Secretary would have to use historical data to estimate interim DSH payment rates for 1986, for the 'final settlement' for 1986 and subsequent years, the 'Secretary would be required to develop accurate data by October 1, 1986 on Medicare patients who are also enrolled in SSI.' " Id. at p. 8 (citing S. Rep. No. 99-146 at 291, reprinted in 1986 U.S.C.C.A.N. at 258 (emphasis in original)). The Board further found that "[c]onsistent with Congressional intent that the calculation be based on accurate data, the DSH statute directs CMS to determine the SSI fraction based upon 'the number' of days attributable to patients who were entitled to SSI and Medicare Part A benefits and 'the number' of days attributable to patients who were entitled to Medicare Part A." Id. (citing 42 U.S.C. §1395ww(d)(5)(F)(vi)(I)).

As further support, the Board found that: (i) CMS does not permit a hospital to compute the Medicaid fraction of the DSH payment adjustment based upon an estimate of the number of days attributable to patients who were eligible for Medicaid; (ii) nor does CMS permit a hospital to use estimates in a similar program. Accurate data is required for the ratio of interns and residents to beds (IRB Ratio), even though the IRB ratio is a proxy measure for the intensity of teaching in a institution, just as the DSH percentage is a proxy for the volume of service to low-income patients. Baystate, at p. 8.

The Board in Baystate also relied on the holding in Georgetown University Hospital v. Bowen (Georgetown), 862 F.2d 323 (D.C. Cir. 1988) in support of its finding that the DSH statute does not authorize CMS to compute an estimate of a hospital's SSI ratio based upon the best data available or otherwise. Id. at p. 9. In Georgetown, the D.C. Circuit held that the PPS statute required the Secretary to calculate the hospital-specific portion based on "allowable operating costs of inpatient hospital services," not "estimated allowable costs." Georgetown, 862 F.2d at 326-27. The court concluded that the Secretary was obligated to make retroactive corrective adjustments to payments made for prior cost reporting periods under a hospital-specific rate that was ultimately determined to have been erroneously calculated. Id. at 330. The court's holding in Georgetown is equally applicable to this case.

The Provider contends that the same principles as stated in Baystate are applicable to the instant case.

INTERMEDIARY'S CONTENTIONS:

The Intermediary concedes that it has not and does not intend to voluntarily review the data submitted by the Provider showing that CMS understated the number of SSI eligible days included in the Medicare fraction of its DSH payment calculation for cost reporting years 2000 and 2001. The Intermediary relies exclusively on the CMS Administrator's decision in Baystate, which concluded that the SSI percentage released through CMS to the Intermediary in the normal calculation mechanism is the correct SSI to use.

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND DISCUSSION:

After considering the evidence, the Medicare law and guidelines, and the parties' contentions, the Board finds and concludes as follows:

The Board finds that, as in Oakwood the inclusion of additional SSI days is purely a legal question of whether CMS must recalculate the DSH adjustment using additional days. There is nothing in the statute, regulations or CMS Rulings that would preclude CMS from recalculating a provider's DSH adjustment. Further, the Board finds, as in Baystate, that an approximation of the DSH percentage is not permitted by statute or regulation. The Medicare law requires the calculation to be accurate.

The Board concurs with the Provider's contention that this case is distinguishable from Baystate in which the CMS Administrator found that the provider failed to show that the flaws in calculating the Medicare fraction produced adverse affects. In this case, the Provider presented undisputed evidence of the exact number of additional SSI eligible days that CMS did not account for in its DSH calculation.

The Board finds that CMS' policy of when to recalculate the DSH SSI percentage is inconsistent. On the one hand, CMS did not review, and still refuses to review, the revised data submitted by the Provider that is subject to this appeal. On the other hand, CMS did recalculate the Provider's SSI percentage for 2001 after the Intermediary identified an "error" with the percentage. By this later action, CMS effectively concedes that it does have the discretion to make changes after its initial issuance of the SSI percentage where there are known errors.

The Board remands this case to the Intermediary to audit the additional 218 and 267 SSI eligible days for FYEs 6/30/2000 and 6/30/2001, respectively. Upon verification of the accuracy of these days, they are to be added to the DSH calculation to appropriately increase Medicare reimbursement.

DECISION AND ORDER:

The additional SSI eligible days presented by the Provider for review should be included in the Provider's DSH calculation, subject to the Intermediary's review. The Intermediary's adjustments are reversed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West
Yvette C. Hayes

DATE: August 24, 2007

FOR THE BOARD:

Suzanne Cochran
Chairperson