PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2018-D50

PROVIDER-
Pomona Valley Hospital Medical Center

Provider No.: 05-0231

vs.

MEDICARE CONTRACTOR –
Noridian Healthcare Solutions

HEARING DATE –
August 17, 2017

Cost Reporting Period Ended –
12/31/2006, 12/31/2007, 12/31/2008

CASE NOs. – 13-0430 13-0628 13-0680

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ISSUE STATEMENT:

Whether the Medicare Administrative Contractor properly calculated Pomona Valley Hospital Medical Center's disproportionate share hospital reimbursement with respect to the Provider's Supplemental Security Income percentage.[1]

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the Supplemental Security Income ("SSI") percentages used by the Medicare Contractor for Pomona Valley Hospital Medical Center's ("Pomona" or "Provider") disproportionate share hospital ("DSH") adjustment for its 12/31/2006, 12/31/2007 and 12/31/2008 cost reports were proper.

INTRODUCTION

Pomona is a Medicare-certified acute care hospital located in Pomona, California. Noridian Healthcare Solutions is Pomona's Medicare Contractor. For each of the fiscal years ("FY's") involved, 12/31/2006, 12/31/2007, and 12/31/2008, Pomona qualified for a DSH payment and the Medicare Contractor updated the SSI percentage to the percentage published by CMS for the respective year.

Pomona timely appealed the Medicare Contractor's adjustments to the Board, and met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-405.1840. The Board held a live hearing on August 17, 2017. Laurence D. Getzoff, Esq., of Hooper, Lundy & Bookman, P.C., represented the Provider. Jerrod Olszewski, Esq., of Federal Specialized Services, represented the Medicare Contractor.

STATEMENT OF THE FACTS

Under Medicare's inpatient prospective payment system ("IPPS") the Medicare program pays providers of inpatient hospital services based on predetermined, standardized amounts subject to certain payment adjustments.[2] One of these adjustments, the Medicare DSH adjustment, provides additional payments to certain qualifying hospitals that treat a disproportionate share of low income patients.[3] The Medicare DSH adjustment is calculated using two fractions known as the Medicare fraction (also referred to as the SSI percentage or SSI fraction) and the Medicaid fraction. The Medicare fraction is calculated by using: (a) in the numerator, the "number of such hospital's patient days…which were made up of patients who (for such days) were entitled to benefits under part A of the subchapter and were entitled to supplementary security income benefits…under subchapter XVI of this chapter…"[4]; and (b) in the denominator, the number of days of care that are furnished to patients who were entitled to Medicare Part A.

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[1] Transcript ("Tr") at 6-7.
[2] 42 C.F.R. Part 412.
[3] 42 U.S.C. § 1395ww(d)(5)(F)(i)(I).
[4] 42 U.S.C. 1395d(5)(F)(vi)(I); *See also* 42 C.F.R. § 412.106(b)(2)(i)(B) (copy included at Provider Exhibit P-39).

The SSI program is a federal cash assistance program for low-income individuals who are aged, blind, or disabled,[5] administered by the Social Security Administration ("SSA"). The SSI statute, generally, does not use the term "entitled" to SSI benefits. Rather, the SSI statute typically refers to whether an individual is "eligible for benefits."[6] In order to be eligible for SSI benefits, a person must be: (1) 65 years of age or older, blind or disabled; (2) a lawful resident of the United States; (3) have limited income and resources; (4) not be fleeing to avoid prosecution for a crime or violating a condition of parole; and (5) file an application for benefits.[7]

The Medicare program is an insurance program where an individual is automatically entitled to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits, or becomes disabled and had been entitled to disability benefits for 24 calendar months.[8] In addition, the Medicare program provides that certain qualifying individuals with end stage renal disease are entitled to Medicare Part A.[9]

Unlike entitlement for Medicare Part A benefits, an individual who is currently eligible for SSI benefits may later become *in*eligible for SSI benefits. In this regard, SSA conducts periodic redeterminations to ensure continued eligibility[10] and may terminate,[11] suspend,[12] or stop payments to individuals who are temporarily or permanently ineligible for payment of SSI benefits.[13] In particular, SSI eligibility may be lost if a person no longer meets the basic requirements. For example, an individual may lose SSI eligibility if the individual is no longer disabled or the individual meets one of the following reasons set forth in Sections §§ 416.207-416.216:

1. The individual fails to give the SSA permission to contact financial institutions;[14]
2. The individual fails to apply for other benefits to which the individual may be entitled;[15]
3. The individual fails to participate in drug or alcohol addiction treatment;[16]
4. The individual is absent from the United States for more than 30 days;[17] or
5. The individual becomes a resident of a public institutions or prison.[18]

Under certain circumstances, the SSA may not pay benefits for administrative reasons, including removal of a representative payee, an unknown address for the beneficiary, or because of income from a previous month.[19]

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[5] 42 U.S.C. § 1382.
[6] 42 U.S.C. §§ 1381a, 1382(a) (emphasis added).
[7] *See* 20 C.F.R. § 416.202.
[8] *See* 42 U.S.C. § 426.
[9] 42 U.S.C. § 426-1.
[10] 20 C.F.R. § 416.204.
[11] *Id.* at §§ 416.1331-1335.
[12] *Id.* at §§ 416.1320-1330.
[13] *Id.* at § 416.1320.
[14] *Id.* at § 416.207.
[15] 20 C.F.R. § 416.210.
[16] *Id.* at § 416.214.
[17] *Id.* at § 416.215.
[18] *Id.* at § 416.211.
[19] SSA Program Operations Manual ("POMS") § SI 02301.201 (describing certain SSI post-eligibility events).

After the Medicare DSH legislation was enacted in 1984, the Health Care Financing Administration ("HCFA"), the predecessor to CMS, announced that the Secretary of Health and Human Services, rather than the hospitals, would be solely responsible for computation of the Medicare fraction because the data necessary to compute the Medicare fraction is voluminous and much of the required data needed to be obtained from another agency, the SSA.[20] HCFA noted that, as of 1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records contained in the Medicare inpatient discharge file and over 5 million records in the SSI file compiled by SSA.[21] To compute the Medicare fraction, HCFA had to match individual Medicare billing records to individual SSI records.[22] Considering the administrative burdens and complexity of the data matching process, HCFA concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based on discharges occurring in the federal fiscal year.[23] HCFA/CMS notifies the Medicare contractors of the SSI fractions after they are calculated. CMS currently makes this notification by posting the resulting fractions on its website. The Medicare contractors then use the posted SSI fraction to calculate the Medicare DSH percentage used to determine the hospital's Medicare DSH adjustment.[24]

The Medicare DSH adjustment has been the subject of much litigation and *Baystate v. Leavitt*, 545 F. Supp. 2d 20 *as amended* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) ("*Baystate*"), is of particular relevance to this appeal. In *Baystate*, the court held that the Secretary's process to identify and gather the data necessary to calculate each hospital's SSI fraction was deficient. On April 28, 2010, CMS published Ruling 1498-R to respond to the court's order in *Baystate*. This Ruling stated that CMS implemented the court order by recalculating the plaintiff's SSI fractions and Medicare DSH adjustments, using a revised data matching process that used "updated and refined SSI eligibility data and Medicare records, and by matching individuals' records with reference to Social Security numbers ("SSNs") as well as HICANs [Health Insurance Claim Account Numbers] and Title II numbers."[25] The Ruling also stated that "in the FY 2011 proposed rule, CMS is proposing to adopt the same revised data matching process" for use with all hospitals and that "[i]n the forthcoming FY 2011 final rule, CMS expects to respond to public comments on the proposed new data matching process, make any changes to such matching process that seem appropriate, and adopt finally a new data matching process."[26] CMS also stated that it would "use that new data matching process in calculating SSI fractions and DSH payments for specific claims that are found to qualify for relief under this Ruling."[27]

Consistent with Ruling 1498-R, CMS published the new data matching process in the FY 2011 proposed rule published on May 4, 2010,[28] and finalized that data matching process in the final

[20] 51 Fed. Reg. 31454, 31459 (Sep. 3, 1986).
[21] *Id.*
[22] *Id.*
[23] *Id.* at 31459–31460; 42 C.F.R. § 412.106(b).
[24] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.
[25] CMS-1498-R at 5 (copy included at Provider Exhibit P-6).
[26] *Id.*
[27] *Id.* at 5-6.
[28] 75 Fed. Reg. 23852, 24002-24007 (May 4, 2010).

rule published on August 16, 2010 ("FY 2011 Final Rule").[29] Significantly, in the preamble to the FY 2011 Final Rule, CMS acknowledged a public comment requesting "that CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction."[30] This same public comment provided examples of "several SSI codes that represent individuals who were eligible for SSI but not eligible for SSI payments" asserting that these codes should be included as SSI-entitled for purposes of the data match process.[31] CMS responded in detail to this comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives* payment of SSI benefits.[32] CMS also stated that the three SSI codes denoted as C01, M01, or M02 "accurately captures all SSI-entitled individuals, during the month(s) they are entitled to receive SSI benefits."[33]

While the new data matching process established in the FY 2011 Final Rule was effective October 1, 2010, Ruling 1498-R directed that the Medicare Contractors apply "the same, unitary relief" consisting of SSI fractions that the Secretary had calculated using the new "suitably revised" data matching process to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH appeals of the SSI fraction data matching process issue.[34] The Ruling noted that hospitals dissatisfied with the initial or revised NPR issued using the new SSI ratios in the Medicare DSH adjustment calculation could seek administrative and judicial review provided they met the jurisdictional and procedural requirements of 42 U.S.C. § 1395oo, the Medicare regulations, and other agency rules and guidelines.[35]

As a result of CMS Ruling 1498-R and these regulations, CMS calculated new SSI percentages for Pomona for all of the fiscal years at issue in these appeals.[36] However Pomona contends that the new methodology CMS uses to generate the new SSI fractions, although slightly improved, still significantly understates its Medicare/SSI patient days, due to inaccurate and/or incomplete data[37] and therefore Pomona appealed the count of Pomona's qualifying Part A and SSI days.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

At the outset, Pomona notes that unlike other SSI percentage cases that have come before the Board, this case is not about "eligible" days versus "entitled" days. Rather, Pomona is challenging CMS' count of Pomona's qualifying Part A and SSI days, based on an inaccurate translation of data between agencies, human error, coding errors or other potential problems that may have led to CMS not using the best available data to calculate Pomona's SSI fraction for each of these years.[38]

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[29] 75 Fed. Reg. 50041, 50280-50281 (Aug. 16, 2010) (copy included at Medicare Contractor Exhibit I-8).
[30] *Id.* at 50280.
[31] *Id.*
[32] *Id.*
[33] *Id.* at 50281.
[34] CMS-1498-R at 6-7.
[35] *Id.* at 28, 31.
[36] Tr. at 120-122.
[37] Provider's Final Position Paper (2006) at 3-4.
[38] Provider's Post-Hearing Brief at 3.

To prove its case Pomona sought to match CMS' Medicare Provider Analysis and Review ("MedPAR") data files and other CMS supplied data with the Provider's own patient records denoting SSI eligibility, and with the State of California's records showing specific benefit "aide codes" assigned to specific patients.[39] Pomona explains the "aide codes" are assigned by SSA and then tabulated and published by the State of California Department of Health Care Services. The Provider believes that "aide codes" 10 (aged), 20 (blind), and 60 (disabled), unambiguously reflect and correspond to a patient's SSI status since the State's Medicaid program obtains patients' SSI status in real time directly from SSA.[40] The Provider believes these records are especially reliable because California provides a State Supplement amount ("SSP") that is in addition to the benefits these patients receive from SSA. The beneficiaries receive one check from SSA that includes both the SSI benefit and the State's SSP benefit.[41]

Using its data along with the State of California's records for "aide codes" 10, 20, and 60, the Provider identified the following SSI/Medicare days and asserts that its calculation of the SSI fractions using this data is more accurate then CMS' calculations:[42]

- For 2006 Pomona identified 6965 SSI/Medicare days compared to the 4886 days identified by CMS.[43]
- For 2007 Pomona identified 6665 SSI/Medicare days compared to the 4153 days identified by CMS.[44]
- For 2008 Pomona identified 6572 SSI/Medicare days compared to the 4235 days identified by CMS.[45]

Pomona points out that it made numerous efforts to obtain the source SSA data to test a sample set of patient records and learn whether or not SSA's data would confirm or disagree with Pomona's own underlying data. Pomona agreed to abide by the result of such test. Despite enlisting former government officials and members of Congress to convince CMS to investigate what Pomona believed were discrepancies in the calculations, CMS blocked Pomona's process of testing the data, and directed the Provider to the Board for relief.[46]

The Medicare Contractor believes its SSI adjustments are correct and points out that CMS revised its process of matching Medicare and SSI eligibility data, and the Provider received SSI fractions based on that revised process for each of the three fiscal years at issue.[47] Additionally the Medicare Contractor disputes that Pomona's data is more accurate than CMS' because the Provider did not explain how the SSI status codes of C01, M01, and

[39] Provider's Final Position Paper (2006) at 5.
[40] *Id.* at 5-6. Provider Exhibit P-10.
[41] *Id.* at 6-7.
[42] *Id.* at 8.
[43] *Id.*
[44] Provider's Final Position Paper (2007) at 8.
[45] Provider's Final Position Paper (2008) at 9
[46] Provider's Post-Hearing Brief at 3-4.
[47] Medicare Contractor's Post-Hearing Brief at 5.

M02 used by CMS to calculate the SSI fraction interplay with the California's "aide codes" of 10, 20 and 60. The Medicare Contractor argues that the Provider has been unable to explain how its methodology is better for determining SSI entitlement.[48]

The Board is aware that Pomona sought to obtain SSI information directly from SSA through various means and that SSA advised the Provider that no SSA data could be shared directly with the Provider.[49] In addition the Board understands that Pomona created a sample and asked CMS to rematch the unmatched patient days against official SSA records but CMS declined to do so based on workload concerns.[50] Without this information the Board recognizes Pomona's difficulty in proving that CMS significantly understated Pomona's SSI fractions for the three fiscal years under appeal, and in demonstrating that Pomona's calculations of its SSI fractions are more accurate.

After reviewing Pomona's methodology and data, the Board finds that the Provider's methodology assumes that all individuals with an "aide code" of 10, 20, or 60, will map to an SSI code of C01, M01, or M02. However, in its post hearing brief Pomona recognized that "aide codes" 10, 20, and 60, include individuals who receive a SSP payment but no SSI payment and therefore these individuals would not have an SSI code of C01, M01, or M02. The Provider estimates that its original calculation of SSI days included 1,141 SSP only days for 12/31/2006; 1,112 SSP only days for 12/31/2007; and 1,095 SSP only days for 12/31/2008,[51] and agrees that these days are not SSI eligible for purposes of the Medicare DSH calculation. Pomona eliminated these SSP only days, reducing the number of additional SSI days it is requesting to 955 days for 12/31/2006; 1,400 days for 12/31/2007; and 1,262 days for 12/31/2008.[52]

During the hearing the Board pointed to other reasons of why variances may exist between the "aide codes" used by Pomona and the SSI codes. One of the reasons is the difference in coding nursing home residents. At the hearing Pomona's witness explained that a Medi-Cal eligible person who went into a nursing home would still remain Medi-Cal eligible and remain on an aide code of 10, 20, or 60, and would be counted as SSI eligible by Pomona.[53] However, in the August 16, 2010, Federal Register, CMS explains that SSI Code E01 "represents an individual who is a resident of a medical treatment facility and is subject to a $30 payment limit, but has countable income of $30 or more. Such an individual is not entitled to receive SSI payment."[54] CMS does not include individuals with Code E01 when determining SSI eligible days. Pomona does not believe this difference represents a significant number of days,[55] and submitted some statewide statistics to backup this assertion.[56] However the Provider could have quantified from its own records the number of additional days being requested that were for patients that came to Pomona from a nursing home. Without Pomona providing an estimate of the impact of this

[48] *Id.* at 9.
[49] Provider's Post-Hearing Brief at 16.
[50] *Id.* at 16-18.
[51] Provider Exhibits P-40, P-41, and P-42.
[52] *Id.*
[53] Tr. at 339-340.
[54] 75 Fed. Reg. 50042, 50281 (Aug. 16, 2010).
[55] Provider's Post-Hearing Brief at 35.
[56] *Id.* at 36-38.

difference on the additional SSI days being requested, the Board does not and cannot know the significance of this coding difference.

Pomona's witness also testified that "Medi-Cal eligibility is month-specific… they would get eligibility the first day of the month of the application"[57] and the person would also be identified as a code 10, 20, or 60, if the person qualified for SSI/SSP.[58] This is different than the effective date for an SSI payment as the FY 2011 Final Rule states "Code E02 is used to identify a person who is not entitled to SSI payment in a month … pursuant to section 1611(c)(7) of the Act, which provides that an application for SSI benefits shall be effective on the later of the 1) first day of the month *following the date the application is filed*, or 2) the first day of the month following the date the individual becomes eligible for SSI based on that application. Such an individual is not entitled to SSI benefits during the month his or her application is filed or determined to be eligible for SSI, but, for, the following month."[59] As CMS does not include days for individuals with code E02 when determining SSI eligible days, the different effective dates represents another difference between CMS' data and Pomona's data. The Board recognizes that Pomona believes this difference would have a minimal effect on the number of SSI eligible days,[60] and explained post hearing that the Provider is not assisting patients to file for SSI benefits and uses other basis to qualify patients for Medi-Cal benefits on a first time basis.[61] However, Pomona could have estimated the potential impact that the different effective dates had on the additional days it is requesting by reviewing its records and the State's records, to determine if any of the additional days are associated with individuals whose application for Medi-Cal/SSP was submitted in same month the patient days of service occurred. Without this information the Board does not know the potential impact the different effective dates has on Pomona's data.

Further the Board points out that, while the Provider performed a detail comparison of its internal data, the Medi-Cal system data, the MedPAR SSI patient file, and multiple other data sources,[62] it did not explain or identify the potential reasons for differences between the data from these sources. While the Board understand that the Medi-Cal aide code information used by Pomona is based on real time data from SSA,[63] there is no information in the record to identify what SSI codes other than C01, M01, and M02, are translated into the "aide codes" of 10, 20, and 60.[64] As explained above the Board believes the Provider could have analyzed its data to quantify the number of patient days contained in "aide codes" 10, 20, and 60, for patients with SSI codes E01 and E02. In addition the Provider could have determined if there were any other potential reasons for the discrepancies between the "aide codes" of 10, 20, and 60, and the SSI codes of C01, M01, and M02. Specifically the Provider could have reviewed the definitions of both the SSI codes and "aide codes" and built a crosswalk or diagram to identify if there were other situations in which an individual would be assigned or remain on an "aide code" of 10, 20,

[57] Tr. at 342.
[58] Tr. at 342.
[59] 75 Fed. Reg. at 50281.
[60] Provider's Post-Hearing Brief and Declarations, Exhibit A at 2.
[61] Provider's Post-Hearing Brief at 40.
[62] Provider Exhibit P-27 contains the comparison of "aide code" days to SSI days for each year and P-20 contains the diagram of the logic and data sources used. The logic for Provider Exhibit P-20 is explained in Tr. at 54 - 80.
[63] Provider's Post-Hearing Brief at 24.
[64] Tr. at 334-338.

or 60, but the SSI code would not be C01, M01, or M02 (e.g. SSI codes beginning with the letter "S" reflect records in a "suspended" status,[65] and the Provider did not address if individuals with "S" codes get assigned or retain a code of 10, 20, or 60). Rather Pomona's witness testified that he "didn't go through the data on the dictionary from---for the SSA." and did not know if there was a one-to-one correlation with "aide codes" 10, 20, and 60, and the SSI codes of C01, M01, and M02.[66]

At the hearing the Board specifically requested a diagram of how information from SSA is translated into "aide codes" 10, 20, and 60,[67] in order to gain insight into how these aide codes relate to C01, M01, and M02. The Provider submitted Exhibits P-47 and P-55 with its post-hearing brief containing indicator value codes used by the State in assigning the "aide codes." It is unclear what the indicator value codes mean and how they relate to the SSI codes of C01, M01, and M02. The Medi-Cal Eligibility Division advised the Provider to contact SSA for the meaning of the indicator value codes.[68] This question remains unanswered as Pomona did not submit any additional information. The Board acknowledges that building a crosswalk might have been a difficult task, but finds a crosswalk is necessary to determine if the Provider's use of "aide codes" 10, 20, and 60, accurately identified only those individuals with an SSI code of C01, M01, or M02. The Board notes the Provider could have developed this crosswalk without the use of Health Insurance Portability and Accountability Act ("HIPAA") protected information, by obtaining the definitions of the various codes, and if necessary confirming the information with the appropriate authorities.

The Board finds that the Provider did not submit sufficient quantifiable data in the record to prove that the SSI percentages calculated by CMS, and used in Pomona's FYE 12/31/2006, 12/31/2007, and 12/31/2008 cost reports, were flawed. The Board affirms the SSI percentages used by the Medicare Contractor.

DECISION AND ORDER

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the SSI percentages used by the Medicare Contractor for Pomona's DSH adjustment for its 12/31/2006, 12/31/2007, and 12/31/2008 cost reports were proper.

BOARD MEMBERS PARTICIPATING:

Charlotte F. Benson, CPA
Gregory H. Zeigler, CPA, CPC-A
Robert A. Evarts, Esq.

[65] 75 Fed. Reg. at 50281
[66] Tr. at 334-338.
[67] Tr. at 400-411.
[68] Provider Exhibit P-55.

FOR THE BOARD:

/s/
Board Member

DATE: September 21, 2018