CENTERS FOR MEDICARE & MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
SAINT ANTHONY'S HEALTH CENTER **Provider** **vs.** **Blue Cross /Blue Shield Association/ Admina Star Federal Illinois** **Intermediary**	**Reimbursement Determination for Cost Reporting Period ending: 12/31/97** **Review of: PRRB Dec. No. 2006-D22 Dated: May 25, 2006**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review 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 Center for Medicare Management (CMM) submitted comments, requesting reversal of the Board's decision. Accordingly, the parties were notified of the Administrator's intention to review the Board's decision. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

BACKGROUND

The Provider is an acute care hospital with 183 beds located in Alton, Illinois. For the cost reporting period in dispute the Provider claimed, for purposes of entitlement to a disproportionate share hospital (DSH) payment, that its ratio of Supplemental Security Income (SSI) recipient patient days to Medicare Part A patient days was 7.060 percent.[1] Using this ratio, the Provider claimed an allowable DSH percentage of 8.49 percent, resulting in a claimed DSH payment of $1,213,585. In the summer of 1999, CMS notified the Provider that it had

[1] Intermediary's Exhibit I-1.

computed its SSI percentage for 1997 at 5.6 percent. By letter dated July 6, 1999, the Provider noted that its billing department had completed submission of certain patient encounter information for 1996 through June 30, 1998 and thus requested that its SSI percentage and DSH percentage be reviewed and corrected based upon this new data.[2] By letter dated July 22, 1999, the Intermediary forwarded the Provider's recalculation request on to CMS.[3] CMS processed the Provider's request under 42 C.F.R. §412.106(b)(3) and computed the Provider's SSI percentage using the Provider's cost reporting year (January 1, 1997—December 31, 1997) instead of the Federal fiscal year (FFY) (October 1, 1996— September 30, 1997). As a result, the Provider's SSI percentage increased from 5.597 percent to 5.679 percent.[4] The Provider appealed.

ISSUES AND BOARD DECISION

The issue is whether CMS' determination of the Provider's Medicare Part A/Supplemental Security Income (SSI) percentage, commonly known as the "Medicare fraction" component of the disproportionate share (DSH) percentage, was proper.

The Board held that the Intermediary improperly rejected the Provider's data for Medicare stays associated with Medicare health maintenance organization (HMO) patient days for three quarters of its cost reporting period ending on December 31, 1997. Based upon §1886(d) (5) (F) (vi) of the Social Security Act (Act) and the regulation at 42 C.F.R. §412.106(b) (1) the Board determined that Medicare HMO patient days should be included in the SSI percentage. The Board further found that 42 C.F.R. §424.30 specifically exempted HMOs from the procedures and time limits for filing claims for Medicare payment. Thus, based on this determination, Board ruled that the Provider's data for the first three quarter of the Provider cost reporting period should be submitted to CMS to be matched through the MEDPAR program.

COMMENTS

CMM commented, requesting that the Administrator review and reverse the Board's decision. CMM argued that the Board erred in interpreting the regulations regarding recalculation of the DSH Disproportionate Patient Percentage (DPP). CMM noted that the regulation at issue provides that CMS will calculate a hospital's Medicare fraction based on hospital discharge data for a FFY. However,

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[2] Intermediary's Exhibit I-2.
[3] Intermediary's Exhibit I-4.
[4] Intermediary's Exhibit I-5.

that regulation also permits a hospital to choose to have its DPP calculated based on the hospital's cost reporting period. CMM further asserted that there is no provision for re-computing the DPP based on later or corrected data. CMM explained that the sole permissible recalculation process for Medicare DSH is the one specified in 42 C.F.R. §412.106(b)(3) which permits calculating a hospital's Medicare fraction for a different time period, i.e., the hospital's cost period, rather than the Federal fiscal year. This provision is not for the purpose of using updated or corrected data.

CMM agreed with the Provider's argument that the regulations at 42 C.F.R. § 424.30, which addresses the time limitation for submitting claims, did not apply to claims associated with Medicare HMO beneficiaries when the HMO was responsible for payment. If an HMO company was responsible for paying the claim, hospitals do not have to submit a claim to their Fiscal Intermediary (FI) for payment. However, CMM noted that effective August 1, 1988; that §411 A of the Hospital Manual required hospitals to submit HMO-paid bills as no-pay bills to their FI for proper tracking. CMM explained that submission of these bills ensured the inclusion in the MEDPAR and, therefore, in the calculation of the Medicare fraction. Furthermore, CMM noted that §3600.2 B of the Intermediary Manual required that no-pay bills be submitted by December 31 of the calendar year following the year in which the services were furnished, to be reflected in either the MEDPAR or the Medicare fraction. Any bills submitted after this time frame would be automatically rejected.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

The Social Security Amendments of 1965[5] established Title XVIII of the Act, which authorized the establishment of the Medicare program to pay part of the costs of the health care services furnished to entitled beneficiaries. The Medicare program primarily provides medical services to aged and disabled persons and consists of two Parts: Part A, which provides reimbursement for inpatient hospital and related post-hospital, home health, and hospice care,[6] and Part B, which is supplemental voluntary insurance program for hospital outpatient services, physician services and other services not covered under Part A.[7] At its inception in 1965, Medicare paid for the reasonable

[5] Pub. Law No. 89-97.
[6] Section 1811-1821 of the Act.
[7] Section 1831-1848(j) of the Act.

cost of furnishing covered services to beneficiaries.[8] However, concerned with increasing costs, Congress enacted Title VI of the Social Security Amendments of 1983.[9] This provision added §1886(d) of the Act and established the inpatient prospective payment system (IPPS) for reimbursement of inpatient hospital operating costs for all items and services provided to Medicare beneficiaries, other than physician's services, associated with each discharge. The purpose of IPPS was to reform the financial incentives hospitals face, promoting efficiency by rewarding cost effective hospital practices.[10]

These amendments changed the method of payment for inpatient hospital services for most hospitals under Medicare. Under IPPS, hospitals and other health care providers are reimbursed their inpatient operating costs on the basis of prospectively determined national and regional rates for each discharge rather than reasonable operating costs. Thus, hospitals are paid based on a predetermined amount depending on the patient's diagnosis at the time of discharge. Hospitals are paid a fixed amount for each patient based on one of almost 500 diagnosis related groups (DRG) subject to certain payment adjustments.

Concerned with possible payment inequities for IPPS hospitals that treat a disproportionate share of low-income patients, pursuant to §1886(d) (5) (F) (i) of the Act, Congress directed the Secretary to provide, for discharges occurring after May 1, 1986, "for hospitals serving a significantly disproportionate number of low-income patients…"[11]

There are two methods to determine eligibility for a Medicare DSH adjustment: the "proxy method" and the "Pickle method."[12] To be eligible for the DSH payment under the proxy method, an IPPS hospital must meet certain criteria concerning, inter alia, its DPP. Relevant to this case, with respect to the proxy method, § 1886 (d)(5)(F)(vi) of the Act states that the terms "disproportionate patient percentage ("DPP")" means the sum of two fractions which is expressed as a percentage for a hospital's cost reporting period. The fractions are often referred to as the "Medicare low-income proxy" or "Medicare fraction" and the Medicaid low-income proxy", respectively, and are defined as follows:

> (I) the fraction (expressed as a percentage) the numerator of which is the number of such hospital's patient days for such period which were made

[8] Under Medicare, Part A services are furnished by providers of services.
[9] Pub. Law No. 98.21.
[10] H.R. Rep. No. 25, 98th Cong., 1st Sess. 132 (1983).
[11] Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. No. 99-272). See also 51 Fed. Reg. 16772, 16773-16776 (1986).
[12] The Pickle method is set forth at section 1886(d) (F) (i) (II) of the Act.

> up of patients who (for such days) were entitled to benefits under Part A of this title and were entitled to supplemental security income benefits (excluding any State supplementation) under title XVI of this Act and the denominator of which is the number of such hospital's patients day for such fiscal year which were made up of patients who (for such days) were entitled to benefits under Part A of this title.
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> (II) the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consists of patients who (for such days) were eligible for medical assistance under a State Plan approved under title XIX, but who were not entitled to benefits under Part A of this title, and the denominator of which is the total number of the hospital patient days for such period.

CMS implemented the statutory provisions at 42 C.F.R. §412.106 and explains that the hospital's DPP is determined by adding the results of two computations and expressing that sum as a percentage. Relevant to this case, the first computation, the "Medicare fraction" is set forth at 42 C.F.R. §412.106(b) (2) (1997). The regulation at 42 C.F.R. §412.106(b) provides that:

> (b*) Determination of a hospital's disproportionate patient percentage. (1) General rule.* A hospital's disproportionate patient percentage is determined by adding the results of two computations and expressing that sum as a percentage.
> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS-
> (i) Determines the number of covered patient days that-
> (A) Are associated with discharges occurring during each month; and
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation;
> (ii) Adds the results for the whole period: and
> (iii) Divides the number determined under paragraph (b) (2) (ii) of this section by the total number of patient days that-
> (3) *First computation: Cost reporting period.* If a hospital prefers that CMS use its cost reporting period instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request including the hospital's name provider number, and cost reporting period end date. This exception will be performed once per hospital per cost reporting period, and the resulting percentage becomes the hospital's official Medicare Part A/SSI percentage for that period.

> (4) *Second computation.* The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period…..

At issue in this case is whether the Provider's Medicare fraction should be corrected or updated to reflect patient days attributable to Medicare HMO encounters for purposes of calculating the DSH adjustment where such days were not included in the original data used to calculate the Provider's DSH adjustment. The Provider contends that its HMO encounter data are exempt from the federal regulations governing the submission of claims to the Medicare program and therefore was not required to be submitted within the specified timeframes in order to be included in the DSH calculation. The Provider argues that the HMO encounter data does not include claims for payment and, therefore, is not a claim as defined by the §1128A(i)(2) of the Act. Further, 42 C.F.R. §424.30 specifically exempts services furnished on a prepaid capitation basis by a HMO from the requirements, procedures, and time limits for claiming Medicare payments. The Provider argues that its encounter data is offered as documentation to support its claim that its SSI ratio is understated and not in pursuit of claims payments. The Board ruled that the Intermediary improperly rejected the Provider's data for Medicare stays associated with Medicare HMO patient days for three quarters of its cost reporting period ending on December 31, 1997.

Regarding the timeframes at issue in this case, a provider's Medicare fraction is calculated on a yearly basis based upon the June updates of the "MEDPAR". The MEDPAR (Medicare Provider Medicare Provider Analysis and Review) file contains data for claims for services provided to beneficiaries admitted to Medicare certified inpatient hospitals.[13] Consequently, to the extent that a provider fails to file a claim (whether pay or no-pay), that data will not be available for CMS' use in calculating a provider's DPP. There is no legal dispute regarding the inclusion of HMO days in calculating the Medicare fraction when such days are included in the June updated MEDPAR used to calculate the DSH payment. The issue here is whether the Medicare fraction should be updated or corrected when such HMO days were not timely submitted and made a part of the MEDPAR file.

After a review of the applicable statues, regulations and program instructions, the Administrator finds that 42 C.F.R. §412.106(b) only allows a limited exception for

[13] See also Baystate Medical Center, Adm. Dec. 2006-D20, May 11, 2006, p. 16, here in incorporated by reference.

recalculation of the Medicare fraction based upon a provider's cost reporting period. In contrast, no such explicit provision for recalculation of the Medicare fraction based on later, or corrected data, is set forth in the statute, nor in the regulation.[14]

The Administrator finds that the Secretary has consistently recognized the administrative burdens involved in calculating the Medicare fraction and has made policy decisions balancing the need to reduce administrative burdens and the need for timely, accurate data. The policy to consider the CMS calculated Medicare fraction not subject to updating is consistent with the sometimes competing interests of finality, timeliness, efficiency and accuracy in the administration of a large Federal program.

In arriving at this policy, the Secretary considered the administrative burdens associated with the calculation of the Medicare fraction. The Secretary necessarily examined these problems within the context of administering the entire Medicare program and not within the singular context of calculating a single hospital's DSH Medicare fraction. In implementing DSH provisions in 1986, the Secretary found that to match SSI eligibility records to Medicare bills on a Federal fiscal year on an annual basis was the most efficient approach given the scope of the program. Noting the 11 million billing records and 5 million SSI records, the Secretary specifically limited any calculations to a *yearly basis* stating that:

> The data source for computation of the SSI/Medicare percentage include the Medicare inpatient discharge file which is compiled on a Federal fiscal year basis and includes approximately 11 million billing records (this compilation is done about three or four months after the close of the Federal fiscal year and is then updated periodically as additional discharge data are received) and the SSI file that lists all SSI recipients for a 3 year period denotes the month during the period in which the recipient was eligible for SSI benefits (the SSI file includes over 5 million records.) In order to compute the SSI / Medicare percentage, the 11 million records from the discharge file must be individually matched by beneficiary number and month of hospitalization with the SSI recipient records. On a Federal fiscal year basis, this match would be performed <u>on a yearly basis</u>. (Emphasis added.)[15]

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[14] <u>Id.</u> at pp. 17-21,

[15] 51 Fed. Reg. 31454, 31459-60 (Sept 1986).

In balancing administrative efficiency and accuracy, the Secretary noted that:

> We do not believe that there are likely to be significant fluctuations from one year to the next in the percentage of patients served by hospitals that are dually entitled to Medicare Part A and SSI. Consequently, the percentage for a hospital's own experience during the Federal fiscal year should be reasonably close to the percentage specific to the hospital's cost reporting period.[16]

The Secretary, subsequently, compared the Medicare fraction based on a provider's cost reporting period and the Federal fiscal year and concluded, as predicated, that these two periods resulted in reasonably close percentages. The Secretary subsequently determined that he would afford hospitals the option to determine the number of patient days of those dually entitled to Medicare Part A and SSI for their own cost reporting periods. The Secretary concluded that:

> We do not believe Congress intended to impose cumbersome and costly administrative burden as that described above in implementing this provision. The Secretary has general rulemaking authority under section 1102 and 1871 of the Act to deal with problems of implementing and administering the Act in an efficient manner. Based on the above discussion, we believe that using the Federal fiscal year instead of a hospital's own cost reporting period is the most feasible approach to implementing provision terms of accuracy, timeliness and cost efficiency. In addition, we believe we have complied with the law by affording hospitals the option of having their SSI/Medicare percentages computed based on … the cost reporting period.[17]

In allowing for this provision, the Secretary noted that:

> [I]f a hospital has its SSI/Medicare percentage recomputed based on its own cost reporting period, this percentage will be used for purpose

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(The 2002 MEDPAR file contains over 12 million records. See, e.g., http://www.cms.gov/ IdentifiableDataFiles/05_MedicareProviderAnalysisandReviewFile.asp.)

[16] 51 Fed. Reg. 16777.

[17] 51 Fed Reg. 31459-60. (See also"[I]n the interim final rule we proposed matching SSI eligibility records to the Medicare bills on a Federal fiscal year basis because we believe this is the most efficient approach." 51 Fed. Reg. 31454 (Sept. 3, 1986))

> of it disproportionate share adjustment whether the result is higher or lower than the percentage computed based on the Federal fiscal year." (Emphasis added.)[18]

That is, a provider cannot request such a recalculation and chose the higher Medicare fraction. The regulatory language plainly does not incorporate any procedures for revising the Medicare fraction based upon later data. Rather, the regulation provides for a provider's Medicare fraction to be final, once calculated by CMS, except in the instance where a provider has requested the computation be based on its cost reporting period.

Finally, in response to the specific commenters, the Secretary had the opportunity to specifically address this issue in the final rule to the FFY 2006 final rates.[19] The Secretary specifically rejected the use of updated SSI eligibility information, for use by CMS to revise calculations of hospital DSH Medicare fractions. Consequently, the Secretary clearly had a policy of calculating the Medicare fraction based upon specific data, within certain timeframes, and not subject to later revision.

The Administrator finds that this policy is consistent with IPPS. Notably, where the Secretary has allowed for corrections of data underlying inpatient prospective payments or IPPS, the Secretary has set forth specific procedures and timeframes for doing so consistent with the aims of IPPS (e.g., wage index). In contrast, no process was implemented in the regulations at 42 CFR 412.106 for the recalculation of the CMS Medicare fraction.

Likewise, the Secretary has determined that the refusal to recalculate underlying IPPS data is also rational and consistent with the aims of the inpatient PPS. Specifically, the regulation for determining eligibility for the rural referral center status required the use of a provider's published 1981 case mix index (CMI). The Secretary refused to recalculate a provider's 1981 CMI for purposes of determining its eligibility for rural referral center status under IPPS. [20] The court in Board of

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[18] 51 Fed Reg. 31459-60.

[19] 70 Fed. Reg. 47278, 47439-47440.

[20] In reference to a specific objection raised by a commenter regarding the CMI, the Secretary announced: "We do not believe that hospitals should be allowed to substitute other criteria for the one we published in the NPRM (notice of proposed rulemaking. We selected the 1981 case-mix index for this criterion because it represents the most current published data available at the time. The basic tenet of the prospective payment system is that the rates paid to hospitals are determined prospectively and are based on the best data available at the time. Thus, a hospital knows in advance what its payment amounts will be." See 49 Fed. Reg. 34728

Trustees of Knox County Hospital v. Shalala, 135 F 2d 493 (7th Cir. 1998), specifically addressed the provider's challenge to the Secretary's use of a published 1981 case mix index (CMI). The provider argued that CMS ought to accept a recalculated CMI because its study conducted by a nationally recognized consulting firm, was based on 100 percent of the provider's 1981 Medicare discharges. In contrast, the Secretary's calculation was based in large part on the MEDPAR file, which included information concerning only 20 percent of the Provider's 1981 discharges. However, the Court accepted that the Secretary's policy serves the interests of accuracy, uniformity and administrative convenience and concluded that the Secretary's policy of relying solely on her own calculation of a provider's 1981 CMI was not arbitrary and capricious.

The Secretary, as a matter of policy, also declined to recalculate the IPPS outlier payments to account for the difference between the estimated and actual outlier payments. See e.g., 49 Fed. Reg. 234, 265-66. In response to commenters, the Secretary pointed out that this policy applied regardless of whether the aggregate outlier payments resulted in more or less than the statutory five- six percent of the total projected DRG prospective payment. Such a policy promoted finality, efficiency and certainty in the process. The court in County of Los Angeles v. Shalala, 192 F. 2d 1005 (1999), upheld this policy observing that: "while we have recognized that retroactive corrections may not ultimately undermine PPS, we have emphasized that that 'does not establish that a prospective-only policy is unreasonable.' *Methodist*, 38 F. 3d at 1232." County of Los Angeles v. Shalala, 192 F. 2d 1005, 1020 (1999).

Similarly, the Secretary's policy in only allowing the calculation of the Medicare fraction of the DPP on an annual basis in this instance promotes administrative finality and certainty in the process. The Secretary's policy is neutral in that the Medicare fraction remains the same regardless of whether a later recalculation would result in a higher or lower Medicare fraction. This neutrality ensures predictability in the process by preventing unexpected shifts in the payment rates based on later data.

Furthermore, regarding the filing of claims, under §1835 (a)(1) of the Act, Provider's may be allowed between one and three years to file claims for Medicare covered services, with an additional year for services furnished in the last three months of a calendar year. 42 C.F.R. §424.44(a) requires claims to be filed before December 31 of the year following the year of any services performed between January 1 and September 30, and December 31 of the second year following the

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34743-44 No commenters raised the issue of recalculating the Medicare fraction in the initial rule implementing the DSH Medicare fraction and, thus, the issue was not explicitly addressed in the final rule.

year of any services performed between October 1 and December 31. The regulation provides for a 6 month extension to the limit where government fault is responsible for failure to meet the deadline.

The regulations at 42 C.F.R. §424.30 entitled "Claims for Payment" states that:

> This subpart sets fort the requirements, procedures, and time limits for claiming Medicare payments. Claims must be filed in all cases except however services are furnished on a prepaid capitation basis by a health maintenance organization (HMO), a competitive medical plan (CMP), or a health care prepayment plan (HCPP). Special procedures for claiming payment after the beneficiary has died and for certain bills paid by organizations are set forth in subpart E of this part.

Accordingly, if an HMO company is responsible for paying the claim, hospitals do not have to submit a claim to the Fiscal Intermediary for payment.

However, effective August, 1, 1988, hospitals were required to submit HMO-paid bills as no-pay bill to the Fiscal Intermediary for proper tracking. Section 411 explains that "[s]ubmit bills for all stays, including those for which no program payment can be made. This assist the intermediary and [CMS] in maintaining utilization records and determining remaining eligibility." Section 411. A of the Hospital Manual states in part that:

> A. No-Payment Situations Where Bills Must be Submitted.— Situations for which bills are required include the following. If part of the admission will be paid and part not, prepare one bill covering the entire stay. Report periods where the beneficiary is liable with occurrence span code 76. Report periods when you have been found liable by the PRO before billing or otherwise thing you are liable with occurrence span code 77.
>
> ….
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> For services provided to an HMO enrollee for which an HMO has jurisdiction for payment. Since HCFA is instructing you to provide this information negotiate an agreement with the HMO for submitting to its bills it pays. Include in your agreement with HMOs a clear statement of the data elements required for proper identification of Medicare HMO'CMP enrollees and accurate submission to the intermediary.

In this case, the Provider did not submit no-pay bills to the Intermediary for three quarters of its cost reporting period ending on December 31, 1997 within the allotted timeframe. The Provider did not submit any 1997 HMO claims until the spring of 1999.[21] By that time, claims for all but the last quarter of 1997 were beyond the deadline. Therefore, this HMO data was not included in the MEDPAR data used to calculate the Provider's Medicare fraction.

The Administrator finds that the regulation precludes the recalculation of the Medicare fraction based on updated, corrected or alternative data. Further, as the Board is bound by the regulations, it is not authorize to order any recalculation of the Medicare fraction based on updated, corrected or alternative data. Consequently, the CMS calculation of the Provider's Medicare fraction is upheld.

[21] Intermediary's Exhibit I-2.

DECISION

The decision of the Board is reversed in accordance with the foregoing opinion. The Administrator finds that the CMS' determination of the Provider's Medicare fraction is proper and is hereby affirmed.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 7/19/06

/s/
Leslie V. Norwalk, Esq.
Deputy Administrator
Centers for Medicare & Medicaid Services