PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON THE RECORD
99-D36

PROVIDER -
Watsonville Community Hospital
Santa Cruz, California

Provider No. 05-0194

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association
Blue Cross of California

DATE OF HEARING-
December 29, 1998

Cost Reporting Period Ended -
June 30, 1988

CASE NO. 91-1440

INDEX

ISSUE:

Was the Intermediary's adjustment modifying the disproportionate share adjustment amount proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Watsonville Community Hospital ("Provider") is a small urban voluntary, non-profit, short term general acute hospital with 130 licensed beds located in Santa Cruz, California. The Provider was certified on July 1, 1969, its Alcohol Drug Treatment Center was certified on July 1, 1985, and its Skilled Nursing Facility was certified on September 23, 1987.

Blue Cross of California ("Intermediary") issued a Notice of Program Reimbursement (NPR) on September 26, 1990 in final settlement of the audit. The Provider disagreed with the NPR and filed a timely appeal with the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§1835-.1841 and has met the jurisdictional requirements of those regulations. The Medicare reimbursement effect is approximately $20,000.

The Provider was represented by Withbert W. Payne, President, Starcare International, Inc. The Intermediary was represented by Bernard M. Talbert, Esq., Blue Cross and Blue Shield Association, Chicago.

PROVIDER'S CONTENTIONS:

The Provider contends that the Disproportionate Share payment for the fiscal year 1988 was incorrectly computed. The two ratios (SSI Ratio and Medi-Cal Ratio) used in the calculation were inaccurate and the Intermediary's computation did not include claims paid after the audit cut-off date of April 20, 1990. The Provider points out that the first ratio (SSI ratio) is inaccurate. The Provider has, in accordance with Medicare Regulation 42 C.F.R. § 405.1853 on "Prehearing Discovery", requested the Division of Hospital Payment Policy at the Health Care Financing Administration ("HCFA") on September 20, 1994 to identify the patient days relating to those patients entitled to both Medicare Part "A" coverage and the SSI benefits which were used to determine the SSI ratio.

The Provider contends that the Privacy Act does not prohibit HCFA from releasing patient names to a hospital for purposes of verifying that hospital's Disproportionate Share Adjustment, because:

1. The hospitals patients have consented to disclosure of any information which will allow the hospital to secure payment for services. The Privacy Act provides in part:

> No agency shall disclose any records which is contained in a system of records ... to any person except pursuant to a written request by, or with prior consent of, the individual to whom the records pertains, unless disclosure of the record would be... for routine use as described in subsection (a)(7) of this section....

5 U.S.C. § 552(a), (b).

The Act defines a "routine use" as one which is compatible with the purpose for which the information was collected, and which has been published in the Federal Register, 5 U.S.C. § 552(a)(7), § 552(a)(c)(4)(D).

The Provider points out that although the Act was intended to insure that information collected by a government agency would not be widely disseminated to other agencies or nongovernmental organizations, the Act expressly allows for disclosure in situations where an individual has agreed in writing that the information may be disclosed.

The Provider points out that upon admission to it's facility a patient signs a form which allows the hospital to both release and obtain information in order to secure payment for services rendered to the patient. The form provides the patient's express written consent for the hospital to obtain information gathered by HCFA and the Social Security Administration ("SSA") regarding the patient's eligibility for programs administered by those agencies. This consent would not only apply to information needed by the hospital to obtain reimbursement for particular services provided to the patient, but also to information which would allow the hospital to receive other payments to which it is entitled as a result of treating the patient.

Since the Provider is entitled to a disproportionate share adjustment for treating patients who meet certain criteria, it must be able to verify that HCFA is accurately calculating the number of patients who meet these criteria. Therefore, the consent form signed by the patient upon admission entitles the Hospital to obtain the names of patients for purposes of verifying that its disproportionate share adjustment is accurate.

The Provider argues that the release of patient names to the Hospital is a routine use of information as defined by the statute. The Act allows for disclosure of information gathered by a government agency without the consent of the subject individual, so long as the disclosure is for a routine use. According to the routine use notice published by HCFA in the Federal Register, information gathered in connection with the Health Insurance Master record may be disclosed to:

> ... third-party contacts in situations where the party to be contacted has... information relating to the individual's ... eligibility for an entitlement to benefits under the Medicare program when... the data are needed to establish the validity of evidence or to verify the accuracy of information presented by the individual, and it concerns... the amount of reimbursement" (Office of Federal Register Privacy Act Issuance's, 1991 Compilation, 09-70-0502).

In this situation the Provider has received information from the patient relating to the patients' eligibility under the Medicare and Medicaid programs. Therefore, since the Provider is seeking to verify the accuracy of the information in order to determine the amount of reimbursement to which it is entitled, its request for the patient's name falls under the routine use described above.

The Provider points out that the regulations published by SSA provide that:

> it is (SSA's) policy to disclose information for use in other programs which have the same purposes as SSA programs, if the information concerns eligibility, benefit amounts, and other matters of benefit status in a social security program and is relevant to determining the same matters in the other program.

20 C.F.R. § 401.310 (c).

The regulations cite Medicare and Medicaid as examples of other programs to which information may be disclosed.

The Provider contends that since both HCFA and SSA have provided notice that information gathered in connection with their programs may be disclosed in order to determine eligibility for benefits, the disclosure of patient names in this situation is a "routine use" of information. The Act therefore, permits such disclosure to the hospital for purposes of verifying the accuracy of its disproportionate share adjustments.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider did not demonstrate with convincing or compelling evidence that the Intermediary's determination of DSH payments adjustments was not in accordance with 42 C.F.R.§ 412.106 and §412.320 and HCFA Pub. 13-4, Section 4198, and the Medicare settlement data, Medi-Cal days shown in the audited Medi-Cal cost report and SSI percentage data furnished by HCFA and the State cannot be relied upon for the purpose of DSH payments determination.

The Intermediary points out that its determination of the Medicaid percentage in the DSH calculation was based on the Provider's records and audited Medi-Cal cost report. Therefore, if the Provider does not furnish any updated information, the Intermediary has no basis to revise its determination.

The Intermediary points out that the Provider did not furnish alternative data, pursuant to 42 C.F.R.§ 412.106(b)(3) which states as follows:

> First computation: Cost reporting period. If a hospital prefers that HCFA use its cost reporting period instead of the Federal Fiscal year, it must furnish its intermediary, in machine readable format as prescribed by HCFA, data on its Medicare part A patients for cost reporting period....

Id.

Accordingly, HCFA (or Intermediary) proceeded with its determination of the "First Computation: Federal Fiscal year" on the basis of SSI patient days obtained from SSA in accordance with 42 C.F.R. 412.106(b)(2).

The Intermediary contends that HCFA's refusal to release SSI information requested by the Provider is in accordance with the Privacy Act. As a poverty program administered by SSA, the recipients of SSI benefits are protected under the privacy Act because the SSI beneficiaries' poverty or indigent status is not related to medical treatment. Unless each beneficiary signs a consent form to allow the release of information, the Provider does not have the right to access SSI enrollment information for the purpose of verifying the number of SSI days. In this case, the Provider did not submit any SSI beneficiaries' consent forms to HCFA or SSA for the release of such information.

The Intermediary points out that the recipients' data, which SSA has compiled and collected, served as the best available information for the purpose of determining the DSH adjustment amount. Based on this data, HCFA ensured that only those Medi-Cal patients with Federal SSI benefits are included in the computation of DSH payments, by matching the SSI file and the Medicare Provider Analysis and Review (MEDPAR) file on a monthly basis, and only those patients who received both Federal SSI benefits and Medicare Part A benefits, at the same time, were counted in the computation of the DSH payments adjustment.

The Intermediary notes that there were inherent problems related to the State Data Exchange Program between SSA and the states. In California the codes used for Medical cards, as stated in the Medi-Cal Eligibility Manual, cover a combination of different types of SSI benefits that are not specifically identified as to state or Federal benefits. As such, it is not apparent if a patient carrying a Medi-Cal card, with code of 10 or 20, is receiving only Federal SSI benefits.

It is therefore, virtually impossible for anybody to accurately determine the correct number of SSI patients for the purpose of determining the DSH payments adjustment. The Provider, therefore, should not assume that the number of SSI days is equal to the number of days used by beneficiaries who are eligible for Medi-Cal. Since the income criteria is generally higher for Medi-Cal than SSI purposes, these beneficiaries might not always be eligible for SSI.

The Intermediary points out that the Provider did not adequately support its contentions. Therefore, due to insufficient information or documentation, the Intermediary has no basis not to revise its determination, pursuant to 42 C.F.R. §§ 413.20 and 413.24 and HCFA Pub. 15-1,
§§ 2300, 2304 and 2404.2.

CITATIONS OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - 5 U.S.C.:

§552 et seq.	-	Public Information, agency rules, opinion orders, records and proceedings

2. Regulations 20 C.F.R.:

§ 401.310(c)	-	Privacy and Disclosure of Official Records

3. Regulations - 42 C.F.R.:

§ 405.1853	-	Prehearing discovery
§§405.1835-.1841	-	Board Jurisdiction
§412.106 et seq.	-	Special Treatment: Hospitals That Serve a Disproportionate Share of Low Income Patients
§412.320	-	Disproportionate Share Adjustment Factor
§413.20	-	Financial Data and Reports
§413.24	-	Adequate Cost Data and Cost Finding

3. Program Instructions - Provider Reimbursement Manual, Part I(HCFA Pub. 15-1):

§2300	-	Principle- Adequate Cost Data and Cost Finding
§2304	-	Adequacy of Cost Information
§2404.2	-	Principle- Payments to Providers

4. Medicare Part A Intermediary Manual, Part 4, Audit Procedures (HCFA Pub. 13-4):

§4198	-	Exhibits for PPS Audits

5. Other:

Office of Federal Register Privacy Act Issuances	-	1991 Compilation 09-70-0502

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board after consideration of the facts, parties' contentions and evidence presented, finds and concludes that the Provider has not disproved the accuracy of the data used in the Intermediary's calculation of the disproportionate share adjustment. The Board finds that it does not have the authority to grant the relief sought by the Provider because the data sought by the Provider to substantiate its computation are protected under the provisions of the Privacy Act. Therefore, the Board agrees with the Intermediary's determination.

The Board finds that the Provider did not submit additional data for the April 20, 1990 cut off date. The Board finds that the Provider has not clearly identified the problem in dispute. The Provider did not adequately explain the code 10, 20 and 60 type patients. The Board finds that the Provider's documentation was incomplete and that both the Provider and the Intermediary used the same Medi-Cal days. The Provider did not explain its contention that the Intermediary's data was incomplete.

The Board finds that even though the Provider was not able to validate its computation, because it was denied access to the SSI enrollment information, it does not relieve the Provider of its burden of proof. Since the Provider is unable to obtain the requisite data, the

Board finds that the data the Intermediary used in the computation which is mandated under the regulatory provisions of 42 C.F.R. § 412.106 must prevail.

DECISION AND ORDER:

The Provider did not prove that the SSI percentage used in calculating the disproportionate share adjustment was incorrect. The Intermediary's adjustment is affirmed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esq.
Martin W. Hoover, Jr. Esq.
Charles R. Barker

Date of Decision: April 07, 1999

FOR THE BOARD

Irvin W. Kues
Chairman