PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2010-D42

PROVIDER - St. Joseph Mercy Hospital – Oakland Pontiac, MI	**DATE OF HEARING -** November 5, 2008
Provider No.: 23-0029	Cost Reporting Period Ended - June 30, 1995
vs.	
INTERMEDIARY - BlueCross BlueShield Association/ National Government Services - WI	**CASE NO.:** 98-1025

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ISSUES:

1) Whether the Medicare bad debt payment was computed properly.

2) Whether the Medicaid Proxy component of the disproportionate share hospital (DSH) adjustment was computed properly.

3) Whether the Medicare Proxy component of the disproportionate share hospital adjustment must be remanded to the Intermediary without adjudication by the Board pursuant to CMS Ruling No. 1498-R.

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 to organizations 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 and 413.24.

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 receipt of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

Since 1983, the Medicare program has paid most hospital for the operating costs of inpatient hospital services under the prospective payment system (PPS). 42 U.S.C. §§1395ww(d)(1)-(5); 42 C.F.R. Part 412. Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments. Id.

One of the PPs payment adjustments is the DSH payment adjustment. The Secretary is required to provide increased PPS reimbursement to hospitals that service a "significantly disproportionate number of low-income patients." 42 U.S.C. §1395ww(d)(5)(F)(i)(I); 42 C.F.R. §412.106. Whether a hospital qualifies for the DSH adjustment, and how large an adjustment it receives depends on the hospital's "disproportionate patient percentage" (DPP). 42 U.S.C.

§1395ww(d)(5)(F)(v).

The DPP is defined as the sum of two fractions expressed as a percentage. 42 U.S.C. §1395ww(d)(5)(F)(vi). Both of these fractions look, in part, to whether the hospital's patients for such days claimed during the particular cost reporting period were "entitled to benefits" under Medicare Part A.

The first fraction used to compute the DSH payment is common known as the Medicare fraction. It is also referred to as the SSI fraction because the numerator is determined by the number of patient days for which the patient was entitled to Supplemental Security Income (SSI). The statute defines the SSI fraction as:

> (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 up of patients who (for such days) were **entitled to benefits under Part A** of this subchapter and were entitled to supplemental security income benefits (excluding and State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were **entitled to benefits under Part A** of this subchapter . . .

42 U.S.C. §1395ww(d)(5)(F)(vi)(I) (emphasis added).

The SSI fraction is computed annually by CMS, and the Medicare fiscal intermediaries are required to use CMS' calculation to compute a hospital's DSH payment adjustment. 42 C.F.R. §412.106(b)(2)-(3).

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 file 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.

The second fraction used to compute the DSH payment is the Medicaid fraction, defined as:

> (II) The fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX of this chapter, but who were **not entitled to benefits under Part A** of this subchapter, and the denominator of which is the total number of the hospital's patient days for such period.

42 U.S.C. §1395ww(d)(5)(F)(vi)(II) (emphasis added).

According to CMS' regulation, "[t]he fiscal intermediary determines . . . 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." 42 C.F.R. §412.106(b)(4).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

St. Joseph Mercy Hospital, Oakland (the Provider) is a general acute care hospital located in Pontiac, Michigan. The Intermediary is National Government Services. The cost reporting period at issue is the fiscal year ended June 30, 1995.

The Intermediary issued an NPR from which the Provider appealed several adjustments; however, some were subsequently withdrawn or settled. The sole issue presented at the hearing was whether the Medicare proxy was properly computed for DSH purposes.[1] The Intermediary determined that the Provider did not qualify for the DSH adjustment during FYE 6/30/95. The Provider appealed from that determination and met the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1840.

The Provider was represented by Kenneth R. Marcus, Esquire, of Honigman Miller Schwartz and Cohn LLP. The Intermediary was represented by Bernard M. Talbert, Esquire of Blue Cross Blue Shield Association.

STIPULATIONS:

The Provider and the Intermediary have entered into a Partial Administrative Resolution and submitted to the Board the following Stipulations:[2]

1. The Provider and the Intermediary agree with the description of facts and the proposed adjustments as set forth in the Partial Administrative Resolution

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[1] The other issues are submitted on the written record.

[2] See Stipulations dated and signed by representatives on October 28, 2008.

achieved in the captioned appeal, a copy of which is attached hereto as Exhibit 1, [in the record] and which is incorporated herein by reference (the "Partial Administrative Resolution").

2. The Provider and the Intermediary agree that the Board decision in the captioned appeal should include a determination affirming as appropriate the agreement of the Provider and the Intermediary regarding the description of facts and the proposed adjustments relating to the issues as set forth in the Partial Administrative Resolution.

3. The Intermediary is in possession of all documentation and information with which to implement the Partial Administrative Resolution, the Intermediary has obtained all requisite approvals, and the Intermediary has no questions regarding, and is otherwise aware of no impediments preventing implementation of, the Partial Administrative Resolution.

4. The Intermediary agrees to implement the Partial Administrative Resolution promptly following decision of the Board in the captioned appeal. In the event the decision of the Board in the captioned appeal is reviewed by the Administrator of the Centers for Medicare and Medicaid Services (the "Administrator"), the Intermediary agrees to implement the Partial Administrative Resolution promptly following the decision of the Administrator so long as the decision of the Administrator does not reverse the decision of the Board affirming as appropriate the agreement of the Provider and the Intermediary regarding the description of facts and the proposed adjustments relating to the issues as set forth in the Partial Administrative Resolution.

5. Implementation of the Partial Administrative Resolution shall consist of payment of the reimbursement to the Provider and issuance of an amended notice of program reimbursement to the Provider reflecting the provisions of the Partial Administrative Resolution.

THE PARTIES' CONTENTIONS and DEVELOPMENTS SUBSEQUENT TO THE HEARING:

Medicare Bad Debts & Medicaid Proxy:

In accordance with the Partial Administrative Resolution, the parties have agreed to resolve the above issues that are pending before the Board as follows:

Crossover Bad Debt – Adjustment No. 72

As a part of the administrative resolution, the Intermediary requested additional documentation in order to allow the crossover bad debts. The documentation included proof of Medicaid eligibility and proof that Medicaid would not have paid for the sampled items. After review of the additional documentation, the allowable bad debt was recalculated. Part A bad debt was increased by $75,727 to equal $91,759. Part B bad debt remained unchanged since the Provider could not locate the needed documentation.

Medicaid Days – DSH – Adjustment No. 71

At the present time, the Provider does not qualify for DSH reimbursement. However, Issue #1 – DSH SSI Percentage is going to be presented to the PRRB. If this issue is settled in the Provider's favor, a revised DSH reimbursement will be calculated using the MA [Medicaid] eligible days that have been previously agreed upon by both the Intermediary and the Provider. The MA days agreed to by both parties equals 9,502 days (paid and eligible).

Medicare Proxy or SSI Percentage:

The sole issue presented to the Board to decide in this case is whether the Medicare/SSI Proxy of 4.81615% was properly computed. The Provider contends that the computation of the Medicare proxy excludes 22 patients who were entitled to receive SSI during their inpatient stay at the Provider in FYE 6/30/1995. In a separate submission,[3] the Provider claims to have provided the necessary information and documentation identifying these patients and the applicable days.[4] The Provider asserts that using its own data and the data obtained from the State and the Social Security Administration it has discovered that the count of days used to compute the SSI percentage is understated by 161 patient days. The Provider contends that with the inclusion of these 22 additional patients and the corresponding 161 patient days it would qualify for a DSH adjustment during FYE 6/30/1995.

The SSI percentage is computed by CMS. CMS is limited to only release certain underlying data that supports the SSI percentage. See 70 Fed. Reg. 47440 (August 12, 2005).

In 2006, the Board issued *Baystate Hospital v. Mutual of Omaha Ins. Co*., PRRB Hearing Dec. No. 2006-D20 (March 17, 2006). (Medicare and Medicaid Guide (CCH) ¶ 81,468) (Provider's Supplemental Position Paper Exhibit 4). The Board found in *Baystate Hospital* that the SSI percentage used to make the DSH determination was understated because the software program

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[3] See Provider's Supplemental Position Paper at Exhibit 1 submitted as a separate volume with Attachments A through C.

[4] Provider's Exhibit 1 at Tab A identifies 12 patients (for 73 SSI days) who were entitled to SSI as evidenced by CMS' SSI Eligibility Data Base and Tab C identifies 10 patients (for 88 SSI days) who were entitled to SSI as evidenced by data from the Social Security Administration.

used to capture the patient identities and inpatient days as well, as the matching process itself, was flawed in several respects.

The Provider in this case argued that its evidence of the 161 days inexplicably omitted from its SSI calculation along with the findings already made in the *Baystate* decision showed that the Intermediary determination that incorporated the flawed SSI calculation was incorrect and understated. The Intermediary ultimately did not contest the accuracy or reliability of Provider's evidence of additional SSI days.[5] Rather it relied on the same defenses raised in *Baystate*, essentially that the calculation was an estimate using what the Secretary contended was the best available evidence at the time of the calculation and that it was not required to recalculate even if errors were subsequently discovered.

The Board's *Baystate* decision was upheld in relevant part by the United States District Court for the District of Columbia. *Baystate Medical Center v Leavitt*, 547 F. Supp. 2d 20(D.D.C. 2008). Subsequently, on April 28, 2010 the Secretary issued its Ruling No: CMS-1498-R (Ruling). The Ruling acknowledged the *Baystate* findings that the SSI calculation process was deficient and announced the Agency's intent to make changes to the data capturing and matching process according to the D.C. District Court's order. The Ruling further provided that "CMS' action eliminates any actual case or controversy regarding the hospital's previously calculated SSI fraction and DSH payment adjustment and thereby renders moot each properly pending claim in a DSH appeal involving the hospital's previously calculated SSI fraction and the process by which CMS matched Medicare and SSI eligibility data . . ." Ruling at 6. "[I]t is hereby held that the PRRB . . . lack[s] jurisdiction over each properly pending claim on the SSI fraction data matching process issue provided that such claim otherwise satisfies the applicable jurisdictional and procedural requirements for appeal" Id. at 6-7. Procedurally, it requires the Board to terminate further action[6] on cases challenging the accuracy of the SSI data capture and matching process and remand them to the Intermediary for a recalculation of the DSH payment adjustment.

In a letter dated May 6, 2010, the Provider then petitioned the Board for an order that its claim is outside the scope of the Ruling.[7] It argues, *inter alia*, that it has conclusively proved specific omissions that it seeks to have included but does not attack the general data matching process central to the *Baystate* case. The Provider further argues that a remand under the Ruling will not achieve the remedy Provider seeks – simply the addition of 161 days. Instead it may result in other changes that will be unfair to this Provider in that the Ruling provides for remand "to apply a suitably revised data matching process in determining the SSI fraction." Ruling at 7. As a

[5] Counsel for the Intermediary stated at the hearing " I tried hard to poke holes in that presentation [the Provider's evidence of omitted days] and couldn't find them so based on that information, it does identify what appear to be omissions from both sides of the numerator and the denominator." See Transcript, p.58.

[6] Board action is terminated except for a determination whether the case involves issues subject to the Ruling and whether the providers meet the jurisdictional requirements of 42 U.S.C. 1395oo(a).

[7] Re: "Provider's Request for Order that Claim is Outside the Scope of CMS-1498-R."

result, the additional payment to which the Provider has shown itself to be entitled will be even further delayed waiting among the hundreds of other pending cases to which the Ruling would apply.[8]

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:

Medicare Bad Debts & Medicaid Proxy

The Board has reviewed the Stipulation of the Parties Regarding the Partial Administrative Resolution and the evidence in the record and finds the stipulations are based on data furnished to and reviewed by the Intermediary in support of the agreements reached by the Parties as reflected by the stipulations. The Board, therefore, finds the facts and the proposed adjustments as set forth in the Partial Administrative Resolution to be accurate and hereby incorporates those as the Board's findings of fact and conclusion of law.

Medicare Proxy of SSI Percentage

The Provider fully supported, and the Intermediary did not contest, its claim regarding the 22 patients entitled to SSI during FYE 6/30/1995 that were excluded.

In summary, the evidence showed the following:

- The Provider identified 12 patients who were entitled to SSI as evidenced by the Centers for Medicare and Medicaid Services ("CMS") SSI Eligibility Data Base. These 12 patients accounted for 73 SSI days.
- The Provider further identified 10 patients who were entitled to SSI as evidenced by correspondence from the Social Security Administration. These 10 patients accounted for 88 SSI days.

As stated earlier, the parties are in agreement regarding the Medicaid Proxy. As set forth in the Partial Administrative Resolution, the parties agree that the Medicaid Proxy consists of 9,502 Medicaid eligible days. The parties agreed that if the 161 patient days for the 22 additional patients, who were entitled to SSI were included in the Medicare Proxy, the Provider would be

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[8] The Ruling also requires changes to the SSI calculation that go beyond the data matching process changes required by the D.C. District Court's *Baystate* decision; however, those issues referred to generally as dual eligible days and labor/delivery days are not at issue in this case.

entitled to the DSH Adjustment during FYE 6/30/1995. [9]

Effect of the CMS-1498-R

Application of that component of the Ruling that requires recalculation under the *Baystate* standards regarding the SSI data matching process would appear to provide the relief Provider seeks in that the purpose of the recalculation is in part to identify all Medicare patients who are also entitled to SSI benefits. In this sense, Provider's claim would appear to be subsumed in the recalculation the Ruling requires. The mechanics of how the Ruling will be applied to cases that involve only certain portions of the Ruling and, consequently, what impact that calculation will have in ways other than contemplated by the Provider in filing its appeal, if at all, is unknown to the Board. However, the terms of the Ruling are explicit in that it is intended to cover claims such as the Provider makes here. Consequently, the Board cannot grant the Provider's request to find its claim is outside the scope of the Ruling. Moreover, although the Board understands the Provider's concerns, the only remedy available to implement the Board's decision is to remand to the Intermediary for a recalculation of the SSI percentage to include the 161 days in issue.

DECISION AND ORDER

ISSUE #1 – Medicare Bad Debt

The Intermediary's determination is reversed and remanded for payment as set forth in the Partial Administrative Resolution.

ISSUES #2 and 3 - DSH Adjustment

The Intermediary's determination is reversed and remanded for recalculation to include the additional 22 SSI eligible patients and corresponding 161 patient days in the SSI percentage.

Board Members Participating:

Suzanne Cochran, Esquire
Yvette C. Hayes
Keith E. Braganza, CPA
John Gary Bowers, CPA

FOR THE BOARD

[9] Intermediary's Supplemental Position Paper, PP. 2-3.

Suzanne Cochran, Esquire
Chairperson

DATE: August 5, 2010