PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2006-D2

PROVIDER -
Oakwood Hospital and Medical Center
Dearborn, MI

Provider No.: 23-0020

Cost Reporting Period Ended -
December 31, 1998

vs.

CASE NO.: 02-1686

INTERMEDIARY -
Blue Cross Blue Shield Association/
United Government Services, LLC – WI

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Issue:

Is expedited judicial review (EJR) appropriate for the question of whether the Centers for Medicare & Medicaid Services (CMS) undercounted the patient days for patients entitled to Supplemental Security Income (SSI) which is used to compute the disproportionate share (DSH) adjustment?

Statutory and Regulatory Background:

This dispute arises under the Federal Medicare program administered by CMS, formerly the Health Care Financing Administration (HCFA). The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. CMS is the agency of the Department of Health and Human Services responsible for 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, regulations and interpretative guidelines published by CMS. See, 42 U.S.C. §1395(h), 42 C.F.R. §§413.20-413.24.

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the Prospective Payment System (PPS).[1] The regulations governing PPS require a provider of inpatient hospital services to file an annual cost report with the fiscal intermediary.[2] The fiscal intermediary — typically an insurance company — then audits the cost report and makes a final determination of the total amount of reimbursement owed by Medicare to the provider for that fiscal year. The total amount of reimbursement due the provider is set forth by the intermediary in a Notice of Program Reimbursement (NPR).[3] A provider that is dissatisfied with that determination may timely file a request for hearing before the Provider Reimbursement Review Board (Board).[4]

Disproportionate Share Hospital and Supplemental Security Income Background:

The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.[5] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased reimbursement to hospitals that serve a "significantly disproportionate number of low-income patients."[6] Whether a hospital qualifies for the DSH adjustment, and how large an adjustment it receives, depends upon the hospital's "disproportionate patient percentage."[7]

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[1] 42 U.S.C. §1395ww(d).
[2] 42 C.F.R §413.20(b).
[3] 42 C.F.R. §405.1803(a)(2).
[4] 42 U.S.C. §1395oo(a) and 42 C.F.R. §§ 405.1835- 405.1841.
[5] 42 U.S.C. §1395ww(d)(5).
[6] 42 U.S.C. §1395ww(d)(5)(F)(i)(I).
[7] 42 U.S.C. §1395ww(d)(5)(F)(v).

The disproportionate share percentage is the sum of two fractions expressed as a percentage.[8] The first fraction, referred to as the "Medicare fraction," is determined using a formula based on patient days. The numerator consists of patient days for which patients were entitled to both SSI and Medicare Part A. The denominator is the number of patient days for all patients entitled to Medicare Part A.[9] The second fraction is the Medicaid fraction and is not in dispute in this appeal.

To determine the numerator of the Medicare fraction for a particular hospital, CMS obtains a data file containing SSI eligibility information from the Social Security Administration. CMS matches the SSI eligible individuals against its own data file (MedPAR file) that contains details of Medicare inpatient hospital stays. The match of the hospital days furnished by a hospital to Medicare beneficiaries that are also eligible for SSI constitutes the numerator of the DSH fraction. This number is then divided by the total number of days for which Medicare inpatient hospital services are furnished to all Medicare Part A beneficiaries (the denominator of the DSH fraction). The Provider contends that CMS undercounted its patient days for patients entitled to SSI, resulting in its DSH adjustment for fiscal year 1998 being less than it should have been.

The Provider in this case is represented by Steven Roosa, Esq., of Reed Smith, LLP, Princeton, New Jersey. The Intermediary is represented by Bernard M. Talbert, Esq., of Blue Cross Blue Shield Association, Chicago, Illinois.

Statement of the Case and Procedural History:

The Provider filed this appeal on March 28, 2002, from a Notice of Program Reimbursement dated September 30, 2001. The appeal initially involved issues related to graduate medical education reimbursement. On February 5, 2003, the Provider added the issue of whether the SSI patient days used to calculate the DSH adjustment were correct. See, 42 U.S.C. §1395ww(d)(5)(F)(vi)(I) (the numerator of the DSH fraction consists of hospital patients days for such patients who were entitled to Medicare Part A and SSI). The graduate medical education issues have been settled, so the only issue in dispute in this case is the SSI patient days.

On July 13, 2005, the Provider requested that the Board grant EJR over the SSI issue asserting that the Board lacks the authority to decide the issue of whether the Medicare statute and regulations allow a hospital to challenge the SSI fraction. In response to the request for EJR, the Board sought additional information from the Provider regarding its request for EJR on July 20, 2005. This request for additional information affected the 30-day time limit required for a Board response to the request for EJR. See, 42 C.F.R. §405.1842(d)(3).

[8] 42 U.S.C. §1395ww(d)(5)(F)(vi).
[9] 42 U.S.C. §1395ww(d)(5)(F)(vi)(I)

In its request for additional information, the Board pointed out that there appeared to be factual issues for it to resolve and that the Provider did not provide a legal basis for its assertion that the Board does not have the authority to decide the issue, i.e., there was no legal authority regarding the Board's being bound by CMS' policy statements. The only authority cited for the Provider's position that the Board cannot decide the question of whether the DSH adjustment should be recalculated using later data obtained from CMS, is based upon arguments set forth in another Federal court case and stipulations in another case pending before the Board. It was also unclear how the referenced letter from a CMS employee stating that providers cannot calculate their own SSI percentage is applicable. It did not appear that the Provider wished to calculate its own SSI percentage; rather it appeared that the Provider wished to have CMS recalculate the percentage using the Provider's conclusions after evaluating new SSA and MedPAR data. The Provider was asked to further explain the applicability of these arguments to support its position that the Board does not have the authority to decide the legal question presented.

Provider's Response to Request for Comments:

The Provider responded on October 14, 2005 (received October 17, 2005). The parties stipulated to the facts regarding two categories of patient days at issue. The parties stipulated that there are 72 patient days for which patients were entitled to SSI but were not included in CMS' calculation of the DSH fraction. The parties also agreed that, without more information from CMS, 170 dual eligible patient days identified by the Provider cannot be included in the SSI calculation.

The Provider indicated that the only dispute with the 72 SSI days is whether CMS must revisit its calculation once it is made. The initial EJR request included a stipulation submitted in Baystate Medical Center, PRRB case numbers 96-1822, 97-1579 et al., and signed by counsel from the Office of General Counsel, which states that, among other things, the accuracy of the SSI fraction could not be the subject of a Board hearing.[10] The Provider admits that this stipulation is not the legal basis for denying that the Board has the authority to hear a case involving the calculation of the SSI fraction, rather 42 C.F.R. §412.106 is the authority. Section 412.106(b)(2)(i)(B) states that CMS "(i) determines the number of patient days. . . [that](B) are furnished to patients who during that month were entitled to both Medicare Part A and SSI." The Provider asserts that the Board can only review intermediary determinations;[11] therefore, only intermediary reimbursement and total determinations are subject to review. The Provider believes that the Board cannot review CMS' determinations such as the SSI day count, nor can the Board order CMS to recalculate the SSI fraction. Further, the Provider asserts the Board cannot review CMS'

[10] Provider's July 13, 2005 Request for Expedited Judicial Review, Ex. 5 at 2.8 (since the inception of the DSH program, CMS has computed the SSI fraction) and 3.3 (in 1995 CMS (Nancy Edwards, a CMS employee) wrote a letter stating that no provider can calculate its own SSI percentage).
[11] 42 C.F.R. §405.1801(a)(1)

decision[12] not to release the SSA files from which the data is taken to determine SSI eligibility.

Findings of Fact, Conclusions of Law and Discussion:

The Board, after consideration of the Medicare law, the Provider's comments and the stipulations of the parties, hereby denies the Provider's request for EJR. When determining whether EJR is appropriate, the Board must consider:

> (1) The controlling facts in the case;
>
> (2) The applicability of law, regulations or HFCA rulings;
>
> (3) Whether there are factual issues for the Board to resolve; and
>
> (4) Whether there are legal issues within the authority of the Board to decide.

See, 42 C.F.R. §405.1841(f). The Board has determined that, under the facts of this case, there is no statute, regulation or CMS ruling that specifically precludes granting the remedy sought by the Provider.

In this case, the Provider takes the position that the Board's authority is limited to the decision made by the Intermediary and there is no authority over CMS decisions. The Board disagrees. The Board has the authority and routinely hears cases on various exemption and exception determinations in which CMS determines whether a provider is entitled to additional reimbursement. In this particular case, the language of the August 18, 2000 Federal Register, which deals with release of information under the "routine use" exception of the Privacy Act, contradicts the Provider's position. The Federal Register permits disclosure of MEDPAR data used in the calculation of the DSH adjustment 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.

65 Fed. Reg. 50548, 50549 (August 18, 2000). Clearly, if the Board had no authority to review and make a decision regarding whether a provider is "entitled to disproportionate share payments, or the amount of such payments," then the right of appeal to the Board would be meaningless.

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[12] Provider's October 14, 2005 Supplement Submission Regarding [EJR] Ex. B (e-mail from Robyn Thomas, Ph.D., Director, Division of Quality Coordination and Data Distribution, CMS, (the SSI eligibility file is not covered by the routine use)).

72 Additional Days

There are no facts in dispute regarding the additional 72 days that the Provider has identified as additional SSI days. The issue is purely a legal question of whether CMS must recalculate the DSH adjustment using additional days. There is no statute, regulation or ruling that precludes CMS from recalculating the DSH adjustment. Nor is there a statute, regulation or ruling that requires CMS' use of a number in the DSH calculation which is proven incorrect by virtue of a successful appeal.

Dual Eligible Days

The Board finds the statement the Provider submitted regarding dual eligible days confusing. In Stipulation number 5, the parties state that "CMS . . . provided Oakwood with an additional data file that CMS obtained directly from SSA." (emphasis added) However, on pages 2-3 of the Provider's "Supplemental Submission Regarding [EJR]," the Provider states that "CMS has decided not to provide the SSA data files" and attaches Exhibit B, an e-mail from Robyn Thomas of CMS, as evidence of CMS' position. Regardless of the confusion created by these conflicting statements, based upon the Provider's characterization of the facts, a factual dispute clearly exists: were any of the 170 dual eligibles also SSI eligible. To grant a request for EJR there must be no facts in dispute.

The Provider alleges that it is impossible for the Board to resolve the factual disputes because CMS will not disclose the data necessary to permit the Board to resolve the issue. While this may eventually prove to be true, there is no evidence in the record to support this position and it does not relieve the parties of their obligation to follow the Board's procedures, such as requesting discovery or subpoenas, to attempt to obtain the critical information. The Secretary, in the Federal Register discussing the routine use of MedPAR data used to calculate the DSH adjustment, stated that:

> Disclosure under this routine use shall be 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 facility during the period that is relevant to the appeal. (emphasis added)

65 Fed. Reg. supra. The Secretary's policies as set out in the Federal Register regarding the nature and scope of an appeal challenging the SSI fraction appear to contradict the Provider's position that the Board has no authority to review DSH SSI percentage determinations or that CMS will refuse to furnish information necessary to make a correct determination. Under these circumstances, EJR is inappropriate.

Decision of the Board

The Provider's request for EJR is hereby denied. The Board finds that it can grant the remedy sought by the Provider.

This decision is not subject to review under the provisions of 42 C.F.R. §405.1875. See, 42 C.F.R. §405.1842(g)(4).

Board Members Participating

Suzanne Cochran, Esq.
Gary B. Blodgett, DDS
Elaine Crews Powell, CPA

Date of Decision : November 16, 2005

FOR THE BOARD:

Suzanne Cochran, Esq.
Chairman

Enclosure: 42 C.F.R. §405.1842