PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2006-D20

PROVIDER -
Baystate Medical Center
Springfield, MA

Provider No.: 22-0077

vs.

INTERMEDIARY -
Mutual of Omaha Insurance Company

DATE OF HEARING -
September 15-22, 2004

Cost Reporting Periods Ended -
9/30/93, 9/30/94, 9/30/95, 9/30/96

CASE NOs.: 96-1822; 97-1579; 98-1827 and 99-2061

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I. ISSUES

a) Whether the Centers For Medicare and Medicaid Services (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, is incorrect; and, if so,

b) Whether the Provider is entitled to (a) an order from the Board directing CMS to correct such determination and the Intermediary to implement and pay any additional amounts due the Provider as the result of such correction; or (b) an order from the Board granting other appropriate relief.

II. STATEMENT OF THE CASE: 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, and interpretative guidelines published by CMS. See, 42 U.S.C. §1395(h), 42 C.F.R. §§413.20-413.24.

Disproportionate Share (DSH) Background

Hospitals are paid for services to Medicare patients under a prospective payment system (PPS). Under PPS, inpatient operating costs are reimbursed based on a prospectively determined formula taking into account national and regional operating costs. The PPS legislation contains a number of provisions that adjust reimbursement based on hospital-specific factors. See 42 U.S.C. §1395ww(d)(5). This case involves one of the hospital-specific adjustments, the disproportionate share adjustment. The "disproportionate share" or "DSH" adjustment, effective in 1986,[1] requires the Secretary to provide increased PPS reimbursement to hospitals that serve a "significantly disproportionate number of low-income patients." 42 U.S.C. §1395ww(d)(5)(F)(i)(I). Whether a hospital qualifies for the DSH adjustment, and the amount of the adjustment it receives, depends on the hospital's "disproportionate patient percentage." See 42 U.S.C. §1395ww(d)(5)(F)(v).

The "disproportionate patient percentage" is the sum of two fractions (expressed as percentages), the "Medicare and Medicaid fractions," for a hospital's cost reporting period. 42 U.S.C. §1395ww(d)(5)(F)(vi). This dispute involves the Medicare fraction. The Medicare fraction is also often referred to as the SSI fraction because it captures the number of Medicare patients that are also

[1] Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. 99-272) added section 1886(d)(5)(F) to the Act and required that the Secretary make payments to those hospitals serving a disproportionate share of -low-income patients for discharges occurring on or after May 1, 1986. See 51 Fed. Reg. 16772, 16776 (May 6, 1986).

eligible for SSI. The statute at section 1395ww(d)(5)(F)(vi) establishes how the Medicare fraction is computed. The numerator of the SSI fraction consists of:

> the number of such hospital's patient days for such [cost reporting] period which were made up of patients who (for such days) were entitled to benefits under part A of this title [i.e., title XVIII – Medicare] and were entitled to supplemental security income benefits (excluding any State supplementation) under title XVI of this Act [i.e., the SSI program] . . . .

The denominator of the SSI fraction consists of:

> The number of such hospital's patient days for such [cost reporting] period which were made up of patients who (for such days) were entitled to benefits under part A of this title [XVIII – Medicare] . . . .

Implementation of the DSH adjustment

The SSI program is administered by the Social Security Administration (SSA); therefore, identifying patients who were entitled to SSI during their hospitalization requires access to SSA's SSI data.

To implement the DSH legislation, regulations provide that the number of patient days of those patients entitled to both Medicare Part A and SSI will be determined by matching data from the Medicare Provider Analysis and Review file (MEDPAR),[2] which is Medicare's database of hospital inpatients, with a file created for CMS by SSA to identify SSI eligible individuals (SSA file). The numerator of the Medicare fraction is the days that an individual was both a hospital inpatient and entitled to SSI benefits. The denominator is the total number of days of hospital inpatient care furnished to Medicare Part A beneficiaries.[3] CMS calculates the Medicare fraction and notifies the Provider.

III. The Parties

The Provider is Baystate Medical Center, a Medicare participating, general acute care hospital located in Springfield, Massachusetts. The Provider is challenging the accuracy of CMS' calculation of the SSI fraction for the fiscal years ended (FYE) September 30, 1993, 1994, 1995 and 1996.

The Intermediary is Mutual of Omaha Insurance Company.[4]

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[2] 52 Fed. Reg. 33143, 33144 (September 1, 1987) CMS uses the term PATBILL [Part A Tape Bill] file and MEDPAR [Medicare Provider Analysis and Review] file interchangeably. The Agency states that the MEDPAR file contains the same data as the PATBILL file but is in a simplified, reformatted record layout. Both files contain the same diagnostic and procedure data for up to five diagnoses and three procedures [and] 100 percent of the Medicare inpatient hospital bills. See also, 52 Fed. Reg. 33034, 33035 (September 1, 1987) (the MEDPAR file contains the same data as the PATBILL file but is in a simplified, reformatted record layout).

[3] Id.

[4] The regulations provide that neither the Secretary nor CMS can be made a party to a Board hearing. 42 C.F.R. 405.1843(b).

The Provider was represented by Christopher Keough, Esq., of the firm of Vinson and Elkins, LLP, Washington, D.C. The Intermediary was represented by Donald Romano, Esq., Office of General Counsel, Department of Health and Human Services, Baltimore, Maryland and Terry Gouger, CPA, Mutual of Omaha Insurance Company, Omaha, Nebraska.

IV. Relevant Procedural Background:

The Provider filed this appeal with the Provider Reimbursement Review Board (Board) alleging that its Medicare fraction calculation was understated because both the SSA file and the MEDPAR contained inaccurate or incomplete information and the match process itself was flawed.

Prior to the hearing the Provider engaged in extensive discovery in an attempt to obtain from CMS and SSA the specific data elements for each patient and patient day used in calculating its DSH adjustment. In 2000, the Board issued subpoenas to CMS seeking information on the specific data elements used in the DHS calculation. When CMS did not respond to the subpoenas, the Provider filed an action in Federal court.[5] Before moving to dismiss the case, CMS produced three data runs for the FYEs 1993 through 1995, but those did not correspond to the original DSH calculation for those years.[6] Ultimately, the Court dismissed the case in December of 2002 on the grounds that the Provider must seek enforcement of the subpoenas from the Board in order to exhaust its administrative remedies.[7]

While the case was pending in Federal court, the Board issued two more subpoenas in January, of 2002 at the Provider's request. One subpoena directed SSA to produce SSI entitlement records for a sample of Medicare beneficiaries who were treated by the Provider during the periods at issue. The other subpoena directed CMS to produce policies and procedures for calculating the SSI fraction for DSH. Initially, SSA refused to produce the records on privacy grounds.

On June 4, 2002, the Provider asked the Board to seek enforcement of the 2000 subpoenas. Through correspondence dated June 21, 2002, the Board asked the Department of Health & Human Services Office of General Counsel (OGC) to enforce the subpoenas on behalf of the Board. OGC did not respond to this request; however, the Provider eventually obtained SSA eligibility records for a small sample of patients that consented to the release of their information. CMS also produced various records including a memorandum asking SSA to include records for those beneficiaries that had died subsequent to the run of SSI data.[8] The Provider also obtained some SSI eligibility information from the state of Massachusetts through a separate request.

When disputes continued over whether available information was being furnished and over allegations that CMS may have destroyed some records, the Board conducted a three-day evidentiary hearing in 2003 on disputed discovery matters.[9]

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[5] Baystate Medical Center v. Thompson (D.D.C. Case No. 00-2940(PFL) December 3, 2002)
[6] Provider's April 30, 2004 Request for EJR at 13-18.
[7] Id. Ex.16. Further, the Court in Baystate found that failure to comply with a subpoena could be litigated after a final agency determination, or the Board could make application to a district court giving the court jurisdiction to enforce the subpoena.
[8] Id. Ex 40 at 960-962.
[9] The Transcript of the evidentiary is included as Provider Exhibits 41,42, and 43.

In April of 2004, the Provider requested that the Board find that expedited judicial review[10] was appropriate for the question of whether SSA should be compelled to produce the SSI data in response to subpoenas. The Board denied the request because the Provider had not sought enforcement of its later subpoenas, and the Board requested that OGC pursue an enforcement order in Federal court citing, *inter alia*, the decision in Loma Linda Medical Center v. Shalala, 907 F. Supp. 1399 (C.D. Cal.1995), and asserting that the case met the requirements for enforcement of administrative subpoenas set forth in Powell v. United States, 379 U.S. 48 (1964). OGC, through the CMS Administrator, declined to pursue enforcement.[11]

V. PARTIES' CONTENTIONS:

The Provider alleges that each component of the data collection and match process used to produce the DSH Medicare fraction was flawed. It asserts that:

(1) The match process itself was flawed because of CMS' failure to use proper patient identifiers.

(2) The SSA data file was faulty in that it omitted various categories of individuals entitled to SSI benefits.

(3) The MEDPAR either included Medicare inpatient days that should have been excluded or excluded those that should have been included.

The Provider further alleges that these problems were a product of CMS' general hostility to the DSH adjustment and CMS' failure to comply with federal standards for establishing and testing electronic records.

Without acquiescing to the Provider's assertions, the Intermediary responds that the Provider is not entitled to relief, regardless of any proof of flaws. It asserts that:

(1) the calculation is fixed when computed by CMS and cannot be recalculated to account for errors;
(2) the calculation was only intended to be an approximation, not a perfect number;
(3) the Provider waived any complaint by not commenting on proposed rules in the Federal Register about how the calculation would be made;
(4) the figure was calculated from the best available data;
(5) the Provider failed to quantify the financial impact of the flaws it asserts;[12] and
(6) the financial impact, if any, is minimal and does not justify the administrative burden imposed in recalculating the percentages.

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[10] See, 42 C.F.R. § 405.1842 Expediting Board proceedings (This regulations permits the Board, once it has determined that it has jurisdiction over an appeal, to find it lacks the authority to decide the question of law, regulation or CMS rulings relevant to the issue(s) identified by the provider.)

[11] Baystate Medical Center, Administrator's Dec. PRRB Case Nos. 96-1822, 97-1579, 98-1827 and 99-2061 (August 3, 2004).

[12] The Intermediary's position was not succinctly set forth, but the totality of the evidence presented by the Intermediary, its cross examination of Provider witnesses, and its various position papers indicate a challenge to the Provider's position on this basis.

VI. FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board is first presented with three threshold questions that could render the remaining issues moot:

(A) Whether the SSI calculation is permanently fixed when calculated;
(B) If not, whether the SSI percentage calculation can be an estimate based on the best data available;
(C) Whether Baystate waived its right to challenge because it failed to comment on proposed rules.

A. Is the SSI calculation permanently fixed when calculated?

The Intermediary argues that it uses the best data reasonably available at the time of the calculation and that subsequent information cannot be used to raise or lower percentage. In support, the Intermediary cites the regulation at 42 C.F.R. §412.106(b) that provides that CMS will calculate a hospital's Medicare fraction based on its discharge data for a federal fiscal year or, upon the provider's request, it will recalculate the Medicare fraction based on the provider's cost reporting period. There is no mention of recalculations for corrected data. The Intermediary interprets this silence as to any other recalculation to establish a mandatory limit on recalculations. In further support, the Intermediary refers us to a Federal Register commentary in which CMS responded to a suggestion that, upon recalculation for the cost report year, the provider be "held harmless" if the recalculation proved to be lower than the original calculation based on the federal fiscal year:

> Concerning the request for a "hold harmless" provision, it has been our consistent policy that a hospital that requests a recalculation of its Medicare Part A/SSI percentage based on its cost reporting period must accept the result of that calculation in place of the Federal fiscal year calculation. We believe that this policy prevents hospitals from taking advantage of the opportunity to request this procedure merely so that they can choose the higher percentage.

60 Fed. Reg. at 45812. The Intermediary asserts that this policy evinces a clear intent that the determination is final when made and not subject to change based on later data, including later data brought out in an appeal of the Medicare fraction.[13] The Intermediary's position, if correct, would essentially cut off any appeal of the Medicare fraction to the Board.

The Board concludes that the Intermediary's position that the Medicare fraction is fixed when made conflicts with the statutory provisions regarding appeals to the Board and also conflicts with the Secretary's own policy statements.

Statutory Appeal Provisions

Under section 1878(a) of the Medicare Act and the regulations at 42 C.F.R 405.1835, a provider receiving payments of amounts computed under PPS has the right to a hearing

[13] Intermediary's Final Position Paper p. 10.

before the Board with respect to such payments provided other jurisdictional criteria are met. The DSH adjustment is an additional payment "applied to . . . the hospital's . . . total DRG revenues for inpatient operating costs." 42 C.F.R. 412.106(a)(2). Nothing in the DSH statute or regulation specifically prohibits recalculation of the DSH fractions.

CMS Policy Statements

CMS' own policy statements also seriously undermine the Intermediary'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). The Secretary further stated that disclosure under this routine use was 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's facility during the period that is relevant to the appeal. (emphasis added)

Id. Clearly, this Board appeal is a "challenge" to CMS' "determination of a hospital's SSI ratio" as contemplated by the Secretary. Therefore, the Secretary's policies as set out in the Federal Register regarding the nature and scope of an appeal challenging the SSI fraction directly contradict the Intermediary's position taken in this case. Likewise, a prior court case[14] confirms that the Board hearing process would address erroneous calculations.

The Board concludes that the Secretary has clearly recognized that the Medicare/SSI fraction is appealable to the Board and is, therefore, not "fixed." Otherwise, the appeal would be meaningless.

B. Is an approximation rather than a precise determination of the SSI ratio permissible?

The Intermediary, in a position closely related to its "fixed calculation" position also contends that CMS is only required to derive an approximate, not a perfect, disproportionate patient percentage[15] because the DSH calculation is merely a proxy for the number of low-income patients treated. The Intermediary relies heavily on the same regulatory provisions that did in its "fixed calculation" argument; that is, only two calculations are discussed in the regulations, and the Secretary recognized that there might be minor fluctuations between the two but, in commentary, made it clear that the Provider was stuck with the cost report year

[14] See Loma Linda Community Hospital v. Shalala [1996-1 Transfer Binder] *Medicare & Medicaid Guide* (CCH) ¶44,030 (C.D. Cal. 1995) (noting the hospital's right to appeal the calculation of the SSI fraction under §1395ll(a).
[15] Intermediary's Final Position Paper, p. 10-11.

determination if it requested a recalculation based on that period. The Intermediary gleans from the policy expressed that the fraction need not be precise.

The Intermediary also argues that when the calculation is made usually in June for the prior Federal fiscal year (ending September 30) using SSI data through March, the data used is the latest and best available. It points out that various courts have recognized that in implementing the inpatient hospital PPS, CMS is entitled to rely on the best data available at the time it makes a determination and is not obligated to correct its determination based on later or corrected data.[16] The rationale in those cases was that changes based on later corrected data could lead to unexpected shifts in basic reimbursement rates which would erode the predictability and finality that underlie the PPS scheme.

The Board concludes that an estimate, rather than an accurate determination, is not permissible, and that CMS' process for determining the Medicare fraction is not likely to produce the best available data.

Estimate Not Permitted

The flaw in the Intermediary's argument is that, unlike the PPS rate that uses historical data from a prior cost report period to project a rate for a future period, the DSH adjustment is entirely retrospective, not prospective. It is an addition to the PPS payment based on hospital-specific data from the prior cost reporting period. Thus, the PPS-related concerns about the predictability of prospectively determined PPS payment rates are inapplicable here.

The Board is unable to find any authority in the DSH statute that permits CMS to estimate a hospital's SSI ratio. Congress acknowledged that while the Secretary would have to use historical data to estimate interim DSH payment rates for 1986, for the "final settlement" for 1986 and subsequent years, the "Secretary would be required to develop accurate data by October 1, 1986 on Medicare patients who are also enrolled in SSI." S. Rep. No. 99-146 at 291, reprinted in 1986 U.S.C.C.A.N. at 258 (emphasis added).[17] Consistent with Congressional intent that the calculation be based on accurate data, the DSH statute directs CMS to determine the SSI fraction based upon "the number" of days attributable to patients who were entitled to SSI and Medicare Part A benefits and "the number" of days attributable to patients who were entitled to Medicare Part A. 42 U.S.C. §1395ww(d)(5)(F)(vi)(I).

Likewise, CMS does not permit a hospital to compute the other component of the DSH calculation – the Medicaid fraction – based upon an estimate of the number of days attributable to patients who were eligible for Medicaid.[18] Nor does CMS permit a hospital to use estimates in a similar program for its ratio of interns and residents to beds ("IRB" ratio), even though the IRB ratio itself is simply a proxy measure for the intensity of teaching in an institution, just as the DSH percentage is a proxy for the volume of service to low-income patients.[19]

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[16] Intermediary's Final Position Paper, p. 11-12.
[17] Intermediary Exhibit 2.
[18] Gouger, Hearing Tr. at 1816.
[19] Phillips, Hearing Tr. at 1237-39; Gouger, Hearing Tr. at 1814-15.

Like the statutory directive at issue in Georgetown University Hospital v. Bowen, 862 F.2d 323 (D.C. Cir. 1988), the DSH statute does not authorize CMS to compute an estimate of a hospital's SSI ratio, based upon the best data available or otherwise. In Georgetown, the D.C. Circuit invalidated a CMS rule providing that the results of an appeal concerning a hospital's allowable operating costs in its PPS base year would be reflected only prospectively in the hospital-specific payment rate in effect during the initial four-year transition period under inpatient PPS. The PPS statute provided that the hospital-specific rate for the PPS transition period was to be calculated for each hospital based on its " . . . allowable operating costs of inpatient hospital services . . . " during a base year cost reporting period (generally, 1982). 42 U.S.C. §1395ww(b)(3)(A). However, in implementing the PPS, the Secretary adopted a regulation that purported to preclude retroactive adjustments to the hospital-specific rate in order to give effect to an appeal from an intermediary determination as to a hospital's allowable operating costs for the PPS base year. 862 F.2d at 325.

The D.C. Circuit concluded that the PPS statute required the Secretary to calculate the hospital-specific portion based on "allowable operating costs of inpatient hospital services," not "estimated allowable costs." Id. at 326-27. Accordingly, the Court concluded that the Secretary was obligated to make retroactive corrective adjustments to payments made for prior cost reporting periods under a hospital-specific rate that was ultimately determined to have been calculated in an erroneous manner.

Best Available Data

Even if the statute permitted an approximation based on the best available data, for reasons discussed, *infra*, the Board finds that CMS did not use the best available data.

C. Did Baystate's failure to comment on the proposed rules relating to the Medicare fraction calculation waive its right to challenge CMS policy?

The Intermediary also argues that that the Provider waived its right to challenge CMS policy with regard to the DSH fraction because the Provider failed to use the notice and comment period during the rule-making process to voice its objections to the DSH calculation when the proposed PPS rules were published in the Federal Register.

The Board finds that the statute and regulations[20] provide a very specific process for challenging final determinations of reimbursement - the Board hearing process. Nothing in the statute or regulations suggest that a provider's right to challenge a policy on appeal be conditioned on its commenting on proposed rules establishing or discussing the policy. Because the DSH calculation is not finalized until the cost report is settled, the dispute is not ripe for review until the NPR is received.

Having decided the threshold questions in favor of the Provider, the Board must address the remaining questions raised by the parties.

[20] 42 U.S.C. § 1395oo and 42 C.F.R. 405.1835 et seq.

D. Is the Match Process Flawed?

To understand the claims and defenses, it is necessary to also understand the data files used in the match process.

The SSA data file

SSA makes SSI eligibility determinations and maintains the SSI eligibility files. Three current or former SSA employees testified concerning SSA data and procedures. Patricia Cribbs, the Provider's witness, had recently retired from the SSA after almost 40 years.[21] She had worked in the SSI department for 24 of those 40 years and was the team leader for the SSI database analysis section. About 1988 or 1989, she "took over" preparation of the annual SSI eligibility tapes for CMS.[22]

Alan Shafer, the Provider's witness, retired from SSA after almost 34 years. Mr. Shafer held several positions with SSA but worked with SSI data in all of those positions. Among the positions he held, he was the Director of the Division of Program Information and had appeared numerous times on behalf of SSA as an expert witness on the management of information systems and the data. He also served as the Associate Commissioner and management representative to the SSI systems work group that set up the SSI system.[23]

Cliff Walsh, the Intermediary's witness, is the Branch Chief of the Master Records Support Section of the SSI System within the Social Security Administration. He has been Branch Chief for six years but has worked in that division since 1986 as the team leader of the Master Records Support Section. His branch maintains the SSI master file and its associated database.[24]

Before April of each year, generally in March, SSA prepares and sends CMS a cartridge or tape containing SSI eligibility information covering a 42-month period.[25] The 42-month period covers the 36 months in the three prior calendar years and the first six months of the calendar year in which the tape is prepared. Thus, the data included in the tape projects forward three months through the end of June in the calendar year in which the tape is created.[26] The SSA file contains select information prepared solely for CMS' use; SSA does not use the data file for any purpose.

The SSA tapes for the periods at issue include the following data for each SSI recipient who was included on each tape:

- truncated last name and first initial;
- Social Security number, which is referred to as the personal account number, or "PAN;"
- date of birth;

[21] Cribbs, Hearing TR 110.
[22] Cribbs, Evidentiary Hearing TR. 261-262 (Provider Exhibit 41).
[23] Shafer, Hearing TR. 286-288.
[24] Welsh, Hearing TR. 2156-2158.
[25] Cribbs, Evidentiary Hearing Tr. at 176-77 and 124-25.
[26] Cribbs 4/29/03 Evidentiary Hearing Tr. at 284-85.

- gender;
- the Social Security number or railroad retirement program identification number (called a "Title II number" or "CAN"), if the SSI recipient received monthly social security or railroad retirement benefits; and,
- 42 monthly indicators (ones and zeros) denoting the payment or non-payment of Federal SSI cash benefits during the period covered by the SSA tape.[27]

The program that SSA uses to prepare the annual tapes for CMS looks to the computational payment history (CMPH) field and the Federal amount (FAM) field in its permanent records to determine whether to assign a "1" or a "0" to an individual's record for a month.[28] The program will assign a "1" to a month if the CMPH field shows one of two payment codes, C01 (current pay status) or M01 (manual or forced pay), and the FAM field reflects an amount due for the month. Otherwise, the program assigns a "0" to that month.[29]

The MEDPAR File

CMS' compiles Medicare beneficiary data in the MEDPAR file. Anthony Dean had been CMS' principal MEDPAR programmer since 1995 and was responsible for producing the MEDPAR and maintaining the database.[30] CMS' MEDPAR files contain inpatient hospital stay records[31] that originate from hospital bills to Medicare fiscal intermediaries for inpatient hospital services furnished to Medicare Part A beneficiaries.[32] Until 1995, the MEDPAR records were drawn from the Common Working File (CWF).[33] The CWF contains Medicare entitlement, utilization, Medicare Secondary Payor (MSP),[34] Health Maintenance Organization (HMO)[35] and history data for each Medicare beneficiary. All Medicare Part A and Part B claims are processed through this file prior to claims payment.[36] Since 1995, the MEDPAR files have been drawn from the National Claims History (NCH) database.[37] The NCH database is a national repository of all Medicare claims processed by fiscal intermediaries.

The parties have stipulated[38] that for each included inpatient stay, the MEDPAR file contains the following data fields:

Data Elements Contained in MEDPAR

a. the hospital's Medicare provider number;

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[27] Id. at 265-271, 344-351; Dean 4/30/03 Evidentiary Hearing Tr. at 112-114.
[28] Cribbs, Hearing Tr. at 153.
[29] Cribbs, Hearing Tr. at 153-155, 191-192, 237, 242.
[30] Dean 4/30/03 Evidentiary Hearing Tr. at 53-54.
[31] Dean, 4/30/03 Evidentiary Hearing Tr. at 54-92, Provider Exhibit 42; see also Medicare Data Flow Charts, in Provider's EJR Request at Exhibit 40, pages 1069-70.
[32] Stipulations, ¶ 5.1
[33] Dean, Evidentiary Hearing Tr. at 76-78, Provider Exhibit 42.
[34] Identifies those instances where Medicare may not be the primary payor for the hospital services, for example, where a third party may be liable for payment.
[35] Indicates a Medicare beneficiary's election of Part C of Medicare in lieu of traditional fee-for-service under Part A.
[36] CMS Pub. 100-4 §3800.
[37] Dean, Evidentiary Hearing Tr. at 54-59. Provider Exhibit 42.
[38] Stipulations, ¶ 6.1

b. the patient's health insurance claim account number ("HIC" or "HICAN");[39]
c. the dates of admission to, and discharge from, the hospital;
d. the total length of the inpatient hospital stay;
e. the number of days in the stay that were covered under Medicare Part A; and
f. the number of days in the stay for which the patient was determined, through the match process described below, to be entitled to Federal SSI benefits.

The match process

Each quarter, CMS creates several separate MEDPAR files that collectively cover multiple calendar and fiscal years.[40] Over two and a quarter years, CMS performs 10 MEDPAR runs and creates 10 MEDPAR files for each Federal fiscal year, the latest of which is run in the third December after the end of the subject fiscal year. For example, the 10th and last MEDPAR file for Federal fiscal year ended September 30, 1994 was produced in a December 1996 MEDPAR run).[41] CMS matches its inpatient hospital stay records against the most recent annual SSA tape every time it creates one of these quarterly MEDPAR runs.[42]

Following its computation of the SSI fractions for a particular Federal fiscal year, generally in July or August, CMS transmits the results of the computations for each hospital (i.e., the hospital's total number of Medicare Part A covered days, its total number of Medicare/SSI days, and the resulting percentage) to the Medicare fiscal intermediaries.[43] Each intermediary is required by regulation to apply the SSI fraction computed by CMS in determining a hospital's entitlement to the DSH payment. 42 C.F.R. §§ 412.106(b)(2) and (b)(5). See also 51 Fed. Reg. 16772, 16777 (May 6, 1986) (interim final rule); 51 Fed. Reg. 31454, 31457-61 (Sept. 3, 1986) (final rule).

The fundamental requirement in determining how many SSI recipients are among a hospital's inpatient population is that the patient identifier in the SSA file must match the patient identifier in the MEDPAR file. CMS said in the preamble to the 1986 rule that it would use the Social Security number in the match. 51 Fed. Reg. 16772, 16777 (May 6, 1986)[44] stating "we believe that matching Social Security numbers on a Federal fiscal year basis is the most feasible approach." CMS knew that SSA's annual tapes include individuals' own Social Security numbers and that CMS also had Medicare beneficiaries' Social Security numbers. See Declaration of Robyn Thomas, Provider Exhibit 10, page 93. Both parties consistently acknowledged during the hearing that the Social Security number is the best unique identifier.[45]

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[39] The HIC number assigned to each Medicare beneficiary is either a Social Security number or railroad retirement number (but not necessarily the individual's own number) followed by an alpha-numeric beneficiary identification code.
[40] Dean, Evidentiary Hearing Tr. at 64-71, Provider Exhibit 42; Provider Chart, Provider Exhibit 40, page 1018-24.
[41] See Dean, Evidentiary Hearing Tr. at 64-71, Provider Exhibit 42; Provider Chart, Provider Exhibit 40, pages 1018-24.
[42] Dean, Evidentiary Hearing Tr. 67-69, 87, Provider Exhibit 42.
[43] Rosenberg, Evidentiary Hearing Tr. at 256-60, Provider Exhibit 42; SSI Ratios Published by CMS, Provider Exhibit 40, pages 1012-15.
[44] Intermediary Exhibit 4.
[45] Shafer, Hearing Tr. at 383-84, 403-406, 615-16; Dean, Hearing Tr. at 1393-95.

However, despite CMS' stated intent to use Social Security numbers as the patient match criteria, the evidence showed that CMS has never matched Social Security numbers on the SSI data tape with Social Security numbers on the MEDPAR in the calculation of the SSI ratios.

In a similar program, SSA and CMS use Social Security numbers (or PANs), as well as alternative identifiers (name and gender), to match SSA records with CMS' data in connection with SSA's monitoring of SSI recipients' residence in nursing homes.[46] When SSA set up the nursing home match process with CMS, SSA and CMS worked to identify the functional requirements for the match, and the agencies tested and validated the match program.[47] In contrast, the only criteria established for the matching process of SSI data files with MEDPAR data for hospitals were memoralized in two letters. Cribbs' understanding was that a programmer called her predecessor, who no longer works for SSA, and they decided over the phone what criteria to use. The program was already written when Cribbs took over and nothing had changed.[48]

The SSA Patient Indentifier: Title II Number or "CAN"

SSA uses claim account numbers, called Title II numbers or CANs, to track individuals' benefits under the Social Security Retirement program established under Title II of the Social Security Act.[49] The Title II number consists of two elements: the Social Security number of the Title II record holder (the person whose work history qualifies for benefits) and an alpha-numeric suffix, called a beneficiary identification code or "BIC," that denotes the relationship between the beneficiary and the Title II record holder.[50] For example, an individual, "A," may receive Title II benefits only through his or her spouse, "B," who has sufficient work history to be entitled to benefits on his or her own account. In this circumstance, "A" would be assigned a Title II number that includes "B's" nine-digit Social Security number with an alpha-numeric beneficiary identification code (such as B2) at the end.[51]

Unlike the Social Security number, a Title II number (or CAN) is not an individual unique identifier. An individual may have more than one Title II number at the same time because, as CMS acknowledges, an individual may receive Title II benefits simultaneously under or on account of more than one Title II number holder's account.[52] In addition, an individual's Title II number may change over time, for example, with marriage, divorce, death of a spouse or changes in work status.[53]

SSA's annual tapes do not include a Title II number for every individual who was entitled to SSI benefits.[54] An individual who receives SSI but does not receive Title II Social Security benefits, for

[46] Cribbs Hearing Tr. at 117-23.
[47] Cribbs Hearing Tr. at 122-23.
[48] Evidentiary Hearing TR. 263-264.
[49] Shafer, Hearing Tr. at 292-93.
[50] Shafer, Hearing Tr. at 293-94.
[51] See Shafer, Hearing Tr. at 293-94, 392-93, 400-01.
[52] CMS Discovery Response to Provider Interrogatory 29, Provider Exhibit 152, page 2976; Shafer, Hearing Tr. at 298-99; Cribbs Hearing Tr. at 158-60.
[53] Shafer, Hearing Tr. at 392-96.
[54] Cribbs, Hearing Tr. at 173; Dean, Evidentiary Hearing Tr. at 113-16, Provider Exhibit 42; Cribbs, Evidentiary Hearing Tr. at 346-49, Provider Exhibit 41.

example, may not have a Title II number displayed on his or her SSI record, and a Title II number for that individual would not appear on SSA's annual tape.[55]

SSA's Annual Tapes Include Just One Title II Number/CAN

SSA's annual tape includes a field for only one Title II number.[56] Thus, SSA's annual tapes never include more than one Title II number for individuals who receive Title II Social Security benefits under more than one Title II number, or for individuals whose Title II number changes over the course of the 42-month date range covered by an annual tape.[57]

Cribbs testified that in preparing SSA's annual tape, SSA's program takes the Title II number from the "unearned income" or "UMI" field on the SSI master record.[58] The SSA program takes the first Title II number that appears within the unearned income field within the 42-month date range covered by the tape, and it is "more than likely" that there will be more than one Title II number appearing in the unearned income field within the 42-month date range.[59] And, because the Title II numbers are usually sorted from oldest to newest in the unearned income field, the first number to appear in that field, and the number that would be put on SSA's annual tape, ordinarily would be the oldest Title II number within the 42-month date range.[60] Cribbs explained that:

> [O]n the [SSI record] they have what they call unearned income as they get Title II Social Security benefits and that's where I have to look – I look at a certain part and I have to select to see if they happen to have a type "A" [Social Security benefits] within the 42-month period and whatever their CAN [i.e., Title II number] is I just pick it up because they only have room for one so the first one wins.

Cribbs, Evidentiary Hearing Tr. at 346-47, Provider Exhibit 41; see also Cribbs, Hearing Tr. at 158-60.

The CMS Patient Identifier: HIC or HICAN Numbers

The HIC number assigned to each Medicare beneficiary is a Social Security number or railroad retirement number (but, in either case, not necessarily the individual's own number) followed by an alpha-numeric beneficiary identification code.[61] Often, an individual's HIC number is the same as his or her Title II number or CAN,[62] but while an individual can have more than one Title II number simultaneously, an individual cannot receive Medicare Part A benefits under more than one HIC number at one time.[63] In addition, because the beneficiary identification codes are "equated" in

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[55] Id.
[56] Cribbs, Hearing Tr. at 148; Provider Exhibit 80 at Provider's EJR request, page 1933.
[57] Cribbs, Hearing Tr. at 148-52; Shafer, Hearing Tr. at 383, 392-96; Walsh, Hearing Tr. at 2211; Cribbs, Evidentiary Hearing Tr. at 346-47, Provider Exhibit 41.
[58] Cribbs, Hearing Tr. at 148 .
[59] Cribbs, Hearing Tr. at 149-150.
[60] Cribbs, Hearing Tr. at 150-51.
[61] See CMS On-Line Manual, Medicare Pub. 100-1, Ch. 2, §§ 50.2 – 50.4, Provider Exhibit 158, pages 3024-27.
[62] Shafer, Hearing Tr. at 296-98.
[63] Shafer, Hearing Tr. at 300-303.

CMS' match process,[64] the equated HIC number that is used in that process is not an individual unique identifier.[65]

The first part of a HIC number, the Social Security or railroad retirement number, may or may not be the Medicare beneficiary's own Social Security or railroad retirement number.[66] For example, a married woman ("W") who is over the age of 65 may receive Medicare Part A benefits on the account of her husband ("H") if H has sufficient quarters of work to qualify for Social Security benefits. In this example, W's HIC number would include H's nine-digit Social Security number followed by an alpha-numeric beneficiary identification code indicating W's spousal relationship with H, on whose account W may receive Social Security benefits (if any) under Title II of the Act.

Alleged Flaws in the Match Process

The Provider alleges that calculation of the SSI fractions at issue are understated because the match process was flawed in at least the following four respects:

1. . . . [B]ased on the false premise that all Medicare beneficiaries receive Title II Social Security benefits, CMS drops all SSI records that did not reflect a Title II number before it matches its version of the SSI tape against inpatient hospital records. [As a result, the SSI percentage is deflated because] CMS does not match any SSI records for Medicare beneficiaries who are entitled to SSI but do not receive Title II Social Security benefits.

2. . . . [A]fter it drops the SSI records with no Title II number, CMS runs matches against the remaining SSI records on its version of the SSI tape based on just one identifier from the MEDPAR file (the HIC number) and one identifier from the SSI tape (the Title II number).

3. . . . [S]ome Medicare/SSI recipients' Title II status may change between the time of their hospitalization during a fiscal year and the later time when SSA creates the annual tape for that fiscal year. In these cases, by the time SSA creates its annual SSI tape, the new Title II number that appears in the individual's SSI record will not match the old HIC number that was given to the hospital at the time of admission and that appears on the inpatient hospital stay record on the MEDPAR file. [This alleged] error further deflates the SSI percentages.

4. CMS failed to match on multiple match criteria, including identifiers (Social Security number, name, date of birth and gender) that CMS uses in other data matches with SSA.

[64] Dean, Evidentiary Hearing Tr. at 121-22, Provider Exhibit 42.
[65] Shafer, Hearing Tr. at 529.
[66] See CMS On-Line Manual, Medicare Pub. 100-1, Ch. 2, § 50.2, Provider Exhibit 158, page 3024.

Conflicting Evidence of Patient Identifiers Used in the Match Process

Dean testimony

Anthony Dean is CMS' principal MEDPAR programmer.[67] He became involved in the MEDPAR process in 1995 when he inherited the programs used to produce the MEDPAR. He knew little about his predecessors' work on the program.[68]

Mr. Dean testified at the 2003 Evidentiary Hearing that CMS runs a program, called SSISORT, that reformats the SSI data received from SSA, drops all SSI records that do not include a Title II number, a term that he used "loosely" to refer to entitlement to Medicare,[69] and he puts the remaining SSI records in a new output file.[70]

At the 2003 Evidentiary Hearing, Dean testified that CMS' programs have used just one identifier to match the inpatient hospital stay records in the MEDPAR file with the SSI entitlement information derived from tapes obtained from SSA.[71]

> Q. What are the criteria or identifiers on which the match is run?
>
> A. The health insurance claim account number. The match program will read a stay record and look at the HICAN, health insurance claim account number, and then will go to the -- my version of the SSI file and search for the HICAN. And when there is a match, that is when the SSI calculation is performed.

Evidentiary Hearing Tr. at 121. Mr. Dean explained that the Title II number taken from the SSA file is also called a HICAN in the new file he creates after the SSISORT program is run. He further elaborated that if " . . . there is no Title II number, which is all we are, you know, on our end, that is all we are really concerned about . . . this process would not write that record out. So I wouldn't keep that record."[72]

In response to whether a Social Security number was used as a secondary criterion to assure that numbers are "lining up" in the match process, Mr. Dean responded, "No. It is strictly HICAN."[73] Dean further testified in 2003 that all other data elements on SSA's annual tapes, including the Social Security numbers, or PANs, are "useless."[74] In response to a question about whether Social Security numbers are included in the data fields on the MEDPAR, he responded that " . . . [i]t is a field we would never use . . ."[75]

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[67] Dean, 4/30/03 Evidentiary Hearing Tr. at 53.
[68] Dean, 4/30/03 Evidentiary Hearing Tr. at 108-111.
[69] Dean, 4/30/03 Evidentiary Hearing Tr. at 115.
[70] Dean, Evidentiary Hearing Tr. at 113-16, 119. Provider Exhibit 42.
[71] Dean, Evidentiary Hearing Tr. at 121-24, Provider Exhibit 42.
[72] Dean, Evidentiary Hearing Tr. at 113-14, Provider Exhibit 42.
[73] Dean, Evidentiary Hearing Tr. at 122, Provider Exhibit 42.
[74] Dean, Evidentiary Hearing Tr. at 123-24, Provider Exhibit 42.
[75] Dean, Evidentiary Hearing Tr. at 123.

In contrast, at the hearing in September 2004, Dean said that CMS runs matches against two numbers, the Title II CAN plus a HIC-like number that the CMS program creates from the Social Security number.

> We also match on a generated health insurance account number which is derived from the Social Security number on the record with the addition of A in the BIC position.

Dean, Hearing Tr. at 1340-41.

* * * * *

> We are creating a claim account number from the SSN. The claim account number consists of someone's SSN plus a BIC, beneficiary identification code. We create a HIC, health insurance claim account number, from the SSN by taking the SSN and adding the letter A to the BIC position.

Dean, Hearing Tr. at 1343. Dean stated that CMS uses two numbers for matching because "our process doesn't want to take any chances," and "[w]e want to make sure we're matching everybody that they send us."[76]

When confronted with what appeared to be inconsistencies between the 2003 Evidentiary Hearing the September 2004 Hearing, Dean asserted that the number CMS creates from the Social Security number *is* a HICAN,[77] and that when he testified in 2003, he was using the term Title II number "in a generic sense to mean eligibility for Medicare."[78]

In further contrast to his prior testimony, Dean stated that the SSISORT program does not discard all records in SSA's annual tape that do not contain a Title II number.[79] On the contrary, he said that ". . . we create a record from every record Social Security sends us by generating a HIC off of the Social Security number"[80] and " . . . we'll match against numbers that are provided in the Title 2 field and we'll match against numbers provided in the Social Security field because we generate a high CAN [sic] from that."[81] Dean elaborated that his program runs the SSA data file through the SSISORT program and " . . . we come out with a version of the SSA tape, and this version is then applied against the claims data . . . but we're not dropping claims if they're not matched and keeping claims if they are matched. It's our entire version of the SSA tape."[82]

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[76] Dean, Hearing Tr. at 1347-48.
[77] Dean, Hearing Tr. at 1348
[78] Dean, Hearing Tr. at 1390-92.
[79] Dean, Hearing Tr. at 1392-93. In 1995 deposition testimony given in the St. Louis Hospital case, Dean testified that he did not know how the match program worked at that time, Provider Exhibit 40, Deposition Tr. at 59; that he had not been given written guidelines or instructions concerning the match program. Provider Exhibit 40, Deposition Tr. at 68-69; that he did not understand the reference in the match program to Title II numbers, Provider Exhibit 40, Deposition Tr. at 79; and that he did not know what the match program did with duplicate records from SSA. Provider Exhibit 40, Deposition Tr. at 109-110.
[80] Dean, Hearing Tr. at 1391
[81] Dean, Hearing Tr. at 1392-93.
[82] Dean, Hearing Tr. at 1449.

Dean admitted that CMS cannot explain how the match ran, or what criteria were used in the match program that was run for the calculations of the SSI fractions for fiscal years 1993 and 1994,[83] nor can CMS prove how the match program ran, or what criteria were used in the match program that was run, for the calculations of the SSI fractions for fiscal years 1995 and 1996, because CMS did not have an archiving mechanism for the output.[84]

Testimony at the evidentiary hearing revealed that, contrary to CMS' prior representations about the non-availability of computer files, the information contained in most of the SSA data files and MEDPAR for the years in issue was still available as the versions Dean created after he ran the SSISORT process.[85] However, until a few days before the evidentiary hearing when counsel for the Intermediary inquired and Mr. Dean in response produced a list of the available files,[86] no one had asked Mr. Dean for the information about those files, although he did recall having had discussions about what was available with the Division Director for CMS' Division of Information Distribution in 2001.[87]

At the 2004 hearing, Dean confirmed that he was still the person primarily responsible for the matching process and for maintaining the program, but no one had yet asked him to look at the data and see if there appeared to be a problem.[88]

O'Leary and Del Pilar testimony; CMS discovery responses

Janet O'Leary had worked for CMS or its predecessor since 1977. In the mid 90's she was in the National Claims History Branch and in 1996 was its Branch Chief. Tony Dean and Joseph Del Pilar, both programmers, worked for her.[89]

CMS stated in discovery responses that Joseph Del Pilar changed the SSISORT program in 1996 so that the program would write out separate records in cases where an individual had Medicare entitlement on one HIC number and later became entitled to Medicare on another HIC number (the "Del Pilar change").[90] CMS cited Mr. Del Pilar and Mr. Dean as the persons furnishing information for the interrogatory response.[91] Mr. Del Pilar testified, however, that he merely filled in at that time for Mr. Dean and had no knowledge or understanding of the substantive changes he was asked to make by Ms. O'Leary, nor did he recollect anything about the changes.[92]

When Ms. O'Leary was questioned about the alleged changes, she also recalled very little about the Del Pilar changes.[93] She did recall, though, in some detail the "stale records" issue that was

[83] Dean, Hearing Tr. at 1335-40, 1409, 1420-26, 1439,
[84] Dean, Hearing Tr. at 1349-50.
[85] Dean, Evidentiary Hearing Tr. at 153.
[86] Dean, 4/30/03 Evidentiary Hearing Tr. at 137-38.
[87] Dean, Evidentiary Hearing Tr. at 216.
[88] Dean, Hearing Tr. at 1447.
[89] O'Leary, Hearing Tr. at 668-69.
[90] CMS Discovery Response to Provider Interrogatory 36, Provider Exhibit 152, pages 2979-81.
[91] CMS Discovery Response to Provider Interrogatory 78, Provider Exhibit 152, page 3005.
[92] Del Pilar, Hearing Tr. at 840-43, 851.
[93] O'Leary, Hearing Tr. at 772-78.

eventually corrected.[94] She identified Provider Exhibit 64 at page 1550 as her own notes from February, 1996. The notes reflect that, at that time, there was a question whether a person could have more than one SSI record in a year and O'Leary stated that they questioned whether SSA was sending all those records. But Ms. O'Leary testified at the hearing in 2004 that "Again, we have no answer to that question that I know of."[95]

In CMS' discovery response regarding the Del Pilar change, CMS stated:

> Had such change to the SSISORT program been in effect to 1996, such change would have tended to increase the numerator of the hospital's Medicare fraction for such period if an individual had a qualifying inpatient stay at such hospital, and was entitled to SSI during the month in which the discharge from such stay occurred, and appeared as entitled to SSI for such month on the tape sent by SSA to CMS for purposes of calculating the Medicare fraction for such fiscal year, and was entitled to title II on more than one account number, and if SSA did not furnish all such title II numbers to CMS.[96]

CMS does not allege that it ever corrected the SSI fractions that were computed prior to the 1996 change allegedly made by Del Pilar.

O'Leary believed that the SSA tape had the health insurance claim [HIC] number on it, stating "there would be no other way for us to identify" [the beneficiary] individually.[97] She understood the HIC number and the Title II number to be the same.[98] She acknowledged that the SSN would also be on the SSA tape but that it would not identify an individual for Medicare because Medicare uses the HIC number "which may or may not be the individual Social Security number . . . included in our claim number.[99] She believed that CMS would also have the SSN in the enrollment database in most instances, but possibly not all.[100]

With regard to Dean's testimony in 2004 that CMS matches on two numbers – the HICAN as well as a HIC-like number derived from the Social Security number - CMS' discovery response did not indicate that CMS ever matches against a number derived from the Social Security numbers included in SSA's annual tapes. CMS stated that the agency " . . . has no recollection, and no documentation concerning, whether CMS ever saw a need . . . to employ secondary or alternative matching criteria" in addition to, or in lieu of, the HICAN.[101]

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[94] See discussion *infra* at pp. 23-26, O'Leary, Hearing Tr. at 669-681.
[95] O'Leary, Hearing Tr. at 687.
[96] Interrogatory Response 36, Provider Exhibit 152, page 2980-81.
[97] O'Leary, Hearing Tr 688-89.
[98] O'Leary, Hearing TR. 691.
[99] O'Leary, Hearing TR 688-89.
[100] O'Leary, Hearing TR. 689-90.
[101] CMS Discovery Response to Provider Interrogatory 46, Provider Exhibit 152, pages 2986-87.

Implications

If the evidence is correct that CMS only matches the HICAN in the MEDPAR files and the single Title II number on SSA's annual tapes, as the 2003 testimony and CMS' discovery responses indicate, it would follow that CMS' inpatient hospital stay records would not have matched with the SSI records on SSA's annual tape for some individuals who were entitled to SSI, because SSA's annual tape never includes more than one Title II number, or CAN, for individuals who received Title II benefits under more than one Title II number.

If the SSISORT program reformats the SSI data received from SSA to drop all SSI records that do not include a Title II number, as Dean testified in 2003,[102] this creates a significant potential for error because, according to Shafer, roughly half of the records on SSA's annual tapes would not have a Title II number.[103]

The match process described in Dean's testimony at the 2003 Evidentiary Hearing is also prone to error due to changes in Medicare beneficiaries' HIC numbers over the course of a year and CMS' failure to use the only individual unique identifier, the Social Security number, in the match process.

Even if the SSI match program has always been run against both the Title II numbers and the HIC-like numbers derived from the Social Security numbers in SSA's annual tapes, as Dean now hypothesizes, the evidence shows that CMS' match process would likely still produce false negatives.

One example of a situation in which the SSI match program would fail to match is when an individual, "Jane," initially receives Title II and Medicare on her own account using her own Social Security number and an "A" beneficiary identification code (e.g., 000-00-0000A). "Jane" subsequently qualifies for Title II and Medicare on her spouse's account, using her spouse's Social Security number followed by a "B" beneficiary identification code (i.e., 111-11-1111B). After the change in the HICAN number, Jane is hospitalized. The HICAN for the period of the hospitalization would be Jane's later Title II number (111-11-1111B), which would not match the first, oldest, Title II number that SSA's program would pick up from the unearned income field on the SSI master record. That number, in this example, would be 000-00-0000A.[104]

At the Hearing, Dean initially agreed there would be no match in this first example, even assuming the SSI match program does what he now thinks it does. He later recanted his answer, based on the premise that SSA's annual tape would have the spouse's Social Security number and a "B" beneficiary identification code (i.e., 111-11-1111B) in the Title II field. Hearing Tr. at 1368-74. However, Dean's assumption is contradicted by Cribbs' testimony as to how her program actually works and how that program scans the unearned income field to pick up only the first and (oldest) Title II number. Further, Dean admits that he had never attempted to verify with SSA his supposition as to how SSA's program works.

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[102] Dean, Evidentiary Hearing Tr. at 113-16, Provider Exhibit 42
[103] Shafer, Hearing Tr. at 407-08.
[104] See Hearing Tr. at 1366-74.

A second example of a situation in which the SSI match program would fail to match is when an individual, "Jane," whose Social Security number is 000-00-0000, initially receives Title II and Medicare under a deceased spouse's account using the decedent's Social Security number followed by a "B6" beneficiary identification code (i.e., 111-11-1111B6). Jane subsequently remarries and receives Title II and Medicare on her second spouse's account, using the second spouse's Social Security number and a "B1" beneficiary identification code (i.e., 222-22-2222B1). If Jane is hospitalized after the change in her HICAN number, then the HICAN for the period of the hospitalization would be the second number (222-22-2222B1), which would not match either the first, oldest, Title II number that SSA's program would pick up and include on its annual tape (111-11-1111B6) or her own Social Security number with an "A" beneficiary identification code tagged on at the end (000-00-0000A). See Hearing Tr. at 1375-76. Dean admitted that there is no way that CMS' SSI match program would produce a match in this example, even if it actually worked the way he now thinks it might have worked.[105]

Match Process Produces Unreliable Numbers

Regardless of how the match process may have worked, there is compelling evidence that it did not, in fact, produce accurate results. CMS' witness from SSA, Cliff Walsh, confirmed that the limited SSI records that the Provider was able to obtain from SSA show several examples of SSI stays that would have been on the SSA data file and yet inexplicably were not counted as SSI days in CMS' MEDPAR data.[106] The omission of these stays from the SSI days in the numerator of CMS' calculation proves there are flaws in CMS' match process. These unexplained discrepancies in the days MEDPAR counted in the numerator and denominator coupled with the conflicts in testimony as to how the match process works convince the Board that the numbers used to calculate the DSH Medicare fraction are unreliable, regardless of the ultimate process that CMS developed. The Board cannot be sure what the match process encompasses, but the evidence is convincing that there is a great likelihood that some matches will not be picked up because of the failure to match on a unique identifier and/or multiple criteria. Even if Mr. Dean's most recent testimony is accepted, some SSI beneficiaries who qualify under another person's SSN or HIC number would not be identified. Dean admits that unless SSA gives CMS all an individual's Title II numbers, CMS will never get its match right under the match process that CMS now says it uses.[107] A more accurate match would be undertaken using beneficiaries' Social Security numbers and alternative identifiers (name and gender) when comparing the information on the SSA data tapes, which is what occurs when SSA monitors SSI recipients' residence in nursing homes.[108]

The Intermediary argues that the Board should give little weight to the Provider's evidence on shortcomings of the computer program SSA used to produce information for the CMS match. It asserts that SSA employees were not familiar with the DSH adjustment or they were at an SSA management level that would not have had hands-on, day-to-day knowledge of SSA data programs. However, the Board finds the SSA witnesses were credible. All had over 20 years of experience with SSA and were extremely knowledgeable about SSI programs and SSA's operations, including recordkeeping. In contrast, CMS'employees charged with the responsibility for implementing DSH

[105] Dean, Hearing Tr. at 1442-44.
[106] Walsh, Hearing Tr. at 2195-2208; Provider Exhibits 183, 184, 185 and 186.
[107] Dean, Hearing Tr. at 1436-37.
[108] Cribbs, Hearing Tr. 117-123.

demonstrated a lack of comprehensive knowledge of the match process, i.e., what data was included in or excluded from the SSA tapes, as well as how, when, why and to what extent the shortcoming of that data might lead to a failure to match CMS' MEDPAR file.

Other Match Criteria Must Be Used

As discussed above, CMS stated in the Federal Register when the DSH legislation was first implemented that using the Social Security number was the best identifier, and it uses the Social Security number, among other matching criteria such as a name and gender, for matching in a virtually identical program for skilled nursing providers. Dean agreed with the Provider's counsel that if CMs had the Social Security numbers of each hospital inpatient, then matching a SSN against an SSN would "of course" be a better match "in an ideal world." But, as Dean further explained, the "data out of the national claims history [from which the MEDPAR is created] is strictly based on a HICAN so a person - - a typical example, if (sic) a husband and wife where the wife never worked, she may receive Medicare utilization for years under someone else's HICAN and her Social Security number would never appear in our data so we would never match against her if we used only a Social Security number."[109] David Pfeil, the Provider's consultant, testified that, based on his consulting firm's experience in running matches with state databases in over 35 states for about 2,000 hospital fiscal years, it is necessary to run matches on multiple alternative identifiers in order to obtain accurate results.[110]

No Administrative Burden

CMS Has Social Security numbers

Robyn Thomas is the Division Director for CMS' Division of Information Distribution. She confirmed that CMS' Medicare Enrollment Data Base (like SSA's annual tape) contains Medicare beneficiaries' own Social Security numbers, their names and dates of birth.[111] In 2001, CMS, or its contractor, used a "HIC finder" program to pull Social Security numbers from the enrollment database and add them to MEDPAR files that were produced to the Provider for fiscal years 1993, 1994 and 1995 in response to the subpoenas issued by the Board in 2000 (which required Social Security numbers).[112]

There is no evidence of a significant administrative burden to create a far more accurate SSI calculation. On the contrary, the overwhelming weight of the evidence, much of it from CMS' own employees, indicates that to change the program to capture more accurate data would be routine, simple and not time consuming. It would not require access to old data, as an accurate calculation could be made using current data files.[113] The facts that CMS has developed a similar program to match SSI information for Medicare beneficiaries in nursing homes[114] and has for years run multiple matches for the same period at different times, including a time that would coincide more closely

[109] Dean, Hearing Tr. at 1393-95.
[110] Pfeil , Hearing Tr. at 1464-67, 1472-81.
[111] See Declaration of Robyn Thomas, Provider Exhibit 10, page 093.
[112] Provider Exhibit 77, page 1863.
[113] Shafer, Hearing Tr. 643; Walsh, Hearing Tr. 2216; Dean 4/30/03 Evidentiary Hearing 203-212.
[114] Cribbs Hearing Tr. 117-123.

with the settlement of the cost report, illustrate that a more reliable program is administratively and financially feasible.

E. Is the SSI data used for the Medicare fraction numerator incomplete?

Even if the match process worked properly, the Provider alleges that there are five systemic problems that caused the SSI data that CMS used to compute the SSI fractions to be incomplete.[115] These five problems are:

1. the omission of inactive SSI records at least through 1996;
2. the omission of SSI records relating to individuals who received a forced payment from an SSA field office;
3. the omission of SSI days associated with individuals whose SSI benefits were temporarily on hold or in suspense when SSA ran each year's SSI tape;
4. the omission of SSI days associated with individuals whose benefits were granted or restored retroactively after SSA ran each year's tape; and,
5. the omission of individuals who were entitled to non-cash Federal SSI benefits.

The Intermediary, without conceding that these omissions occurred, responds that, even assuming the allegations are correct, the Provider should not prevail for several reasons. It argues that:

1. The provider has not presented evidence to quantify the harm it claims;[116]
2. The impact, if any, is negligible;
3. Redesigning the computer programs to correct the claimed errors and recalculating the Medicare fraction based on the new data is administratively burdensome

(1) Omission of Inactive Records

It is undisputed that, until approximately February 1996, SSA's annual tapes omitted all SSI records that had been terminated and were inactive prior to the time when SSA transmitted the tape to CMS (the "stale records problem").

During this time period, an "accounting page" of an individual's record could be terminated, even though the individual remained entitled to SSI benefits, and that record would become inactive immediately.[117] This could occur either due to space limitations or in forced pay cases (discussed infra.).[118] In addition, the records of deceased individuals and individuals in terminated status would usually be moved into inactive files after 12 months. Records may have been moved to inactive

[115] Shafer, Hearing Tr. at 303-08.
[116] See e.g. Intermediary's Post-Hearing Brief at pp. 58-61.
[117] Shafer, Hearing Tr. at 335-36.
[118] Cribbs, Hearing Tr. at 219-23; Shafer, Hearing Tr. at 335-36.

status sooner in earlier years because of space limitation.[119]

Although the evidence is contradictory as to how the problem was discovered,[120] it is undisputed that CMS had SSA prepare new tapes beginning with the 1995 fiscal year that corrected the problem by including the stale records; that is, the records that had previously been omitted because they had become inactive were included on the data file prepared for CMS beginning with fiscal year 1995. Consequently, the dispute as to the omission of stale records is applicable only to the 1993 and 1994 periods.

After it obtained corrected SSI records from SSA in 1996, O'Leary testified that CMS created special MEDPAR files that included both the original ("old") and corrected ("new") SSI days for inpatient hospital stays in prior years.[121] The intent of this "special MEDPAR" project was to determine whether the differences were material and, if so, to recalculate prior SSI ratios.[122]

Provider's consultant, David Pfiel, testified that, as reflected on CMS' summary of its special MEDPAR files,[123] the ratio of new SSI additions to old SSI deletions was greater than 17:1 for most years.[124] He calculated the aggregate impact of the SSI additions (i.e., all PPS hospitals nationwide), net of SSI deletions, to be approximately $4 billion for years 1989 through 1996, assuming a 7-day average length of stay (ALOS) and an average value of $500 per SSI day.[125] Assuming the same ALOS and cost per day, the aggregate impact for 1993 alone would be approximately $202 million,[126] which is "extremely significant" according to CMS' witness, Ms. Rosenberg.[127] Even though the new SSI data would have increased the national average SSI ratio for 1993 by only 4.03%, from .083746 to .087779, this seemingly minor change to the SSI ratios would have a major impact on hospitals that treat a large indigent population.[128]

The Intermediary responds that the Provider's projections about the impact on the SSI patient days is purely speculation and that the Provider must quantify the impact of the stale records it alleges were

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[119] Cribbs, Hearing Tr. at 203-04, 246-47; Shafer, Hearing Tr. at 320, 622-30.

[120] Mr. Pheil testified that he worked directly with Anne Tayloe, Daryl Rosenberg and Helen Nolt from 1993 to 1995,, Hearing Tr. at 1481, when SSI days kept falling out of a hospital's SSI fraction for fiscal year 1989 throughout three successive efforts by CMS to recalculate an SSI fraction for the hospital's two campuses. , Hearing Tr. at 1518-1520. Rosenberg testified that CMS knew that there was "something wrong with the numbers" even before 1993, when Mr. Pheil began contacting them about his client's problem. Rosenberg, Hearing Tr. at 2131. Rosenberg also acknowledged that the type of situation that Mr. was addressing with CMS from 1993 to 1995 – where several records dropped out of the numerator of the SSI fraction with each successive recalculation – would definitely constitute a "red flag" that something was wrong with the data. Rosenberg, Hearing Tr. at 2148.

[121] See Provider Exhibit 64, pages 1518-20; see also O'Leary, Hearing Tr. at 685-741 (discussing CMS' preparation of the summary report regarding values of old and new SSI stays).

[122] O'Leary, Hearing Tr. at 702-03, 746-47; Provider Exhibit 64, pages 1547-48.

[123] Provider Exhibit 64, pages 1518-20

[124] Pfeil, Hearing Tr. at 1575-84. According to Shafer, this was probably a larger problem in earlier years, as reflected on CMS' summary report (Provider Exhibit 64, pages 1518-20), because SSA was more diligent in earlier years about moving terminated or stale records into "inactive" status in order to save computer space and speed up computer processing times. Shafer, Hearing Tr. at 317-19, 330-31.

[125] Pfeil, Hearing Tr. at 1570.

[126] Pfeil, Hearing Tr. at 1584-86

[127] Rosenberg, Hearing Tr. at 2113-2114.

[128] Pfeil, Hearing Tr. at 1592.

omitted from the calculation of its FY 1993 and 1994 Medicare fraction to prevail.[129] Ms. Rosenburg, CMS' computer system analyst for over thirty years,[130] agreed with Board Chair's suggestion that the only way to know what the impact would be of including the inactive records that were omitted from original calculations for fiscal years 1993 and 1994 would be to rerun the actual calculations.[131] The Intermediary points out that no pre-96 versions of the FY 93 and 94 MEDPAR files exist, making impossible the proof of a direct correlation between the alleged stale records problem and the financial impact.[132] The Intermediary argues that the CMS comparisons that the Provider relies on do not necessarily reflect the true impact of the stale records omission. It explains that because of the passage of time the record counts reflect unedited data from which stays in non-PPS units of a hospital have not been removed, and when the files were updated, more records would have had an opportunity to go stale. The newer runs would also capture other data updates such as the retroactive determinations of eligibility (discussed infra.).[133]

The uncontroverted evidence shows that CMS knew, at least by 1993, that there was a problem with the SSI data that CMS had been receiving from SSA.[134] Consequently, it is clear that CMS did not use the best data available when it calculated the SSI fractions at issue for fiscal years 1993-1996. This was due, in part, to the omission of "stale records" from the SSI data tape prepared for CMS.

It is disingenuous for the Intermediary to claim that the omission of SSI days has no significant impact or that the Provider must quantify the financial impact to prevail while CMS resisted efforts to obtain the information critical to making such proof.[135] Ms. O'Leary confirmed that the special MEDPAR files would have shown the impact of the omission of stale records (as well as other updated SSI records) by year, by hospital, and by stay.[136] The Provider pointed out that the December 1996 version of the MEDPAR showed that the Provider had 400 more SSI days while only 2600 more covered days which could be due to retroactive SSI eligibility determinations and/or restored records. [137] The Intermediary believes there is no way to know the source of the additional days,[138] and the Board agrees. Even though the ratio suggests it is unlikely, it could simply be the result of the addition of 2,600 more covered days, of which 400 were SSI days. The discrepancy could also be due to omissions in earlier SSI runs. It could be both. However, the Board does not agree that the Provider must prove the amount of financial harm caused by the flaws it has alleged have occurred. The discrepancy between the earlier calculation and the 1996 run alone illustrates that the original data was inaccurate.

While the financial impact may be relatively small when averaged over all PPS hospitals, it can have a significant impact on those PPS hospitals that serve a large low-income population. Hospitals

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[129] Intermediary's Post Hearing Brief, pp. 57-62.
[130] Rosenberg, Evidentiary Hearing Tr at 247.
[131] Rosenberg, Hearing Tr. at 2145-46.
[132] Intermediary post hearing brief, p. 58.
[133] Intermediary post hearing brief, pp. 60-62.
[134] Pfeil, Hearing Tr. at 1519-20; Rosenberg, Hearing Tr. at 2131.
[135] See Evidentiary Hearing Tr. 45-55; 63-64 (counsel and Board discussion of difficulties in obtaining information) and Evidentiary Hearing 04/30/03Tr. 118-119; 137-162 (Dean discussion available files list that he prepared shortly before the evidentiary hearing at Intermediary Counsel's request. Even though SSA's original tapes were no longer available, Dean had the versions he made that contained all the same information as in the SSA original tape).
[136] O'Leary, Hearing Tr. at 712-18.
[137] Hearing Tr. at 35-37, 874-77, 927-29.
[138] Intermediary's Post Hearing Br. at 45

must meet a certain threshold percentage of low-income patients before they qualify for the DSH adjustment. Even a fraction of a point under that threshold means they receive no DSH payment whatsoever. Once the threshold is met, however, the volume of low-income patients directly correlates to the amount of the DSH payment.

The Board finds that the omission of "stale records" is a systemic error that would tend to deflate the Medicare ratio.

As to the Intermediary's claim that it would be too burdensome to revise the program to include the omitted records and recalculate the ratio based on the corrected data, the Board finds that the evidence does not bear out the complaint. On the contrary, the evidence, even from CMS' own witnesses, overwhelmingly supports the simplicity of correcting the problem. [139]

(2) Omission of Forced Pay Cases

SSA's system is designed to generate automated SSI payments.[140] Sometimes, however, a field office needs to make a forced or manual payment on a temporary basis. In those instances, SSA will terminate the recipient's existing record, start a new record that includes $0 due in the Federal amount field (in order to stop the system from making a duplicate payment), then terminate the second record and start a third to resume system payments prospectively after the manual payment action is resolved.[141] In these cases, the earlier records, which would reflect a C01 or M01 in the CMPH field and some amount due in the FAM field, will always be terminated, and thus would never have been included in the annual tapes that SSA sent to CMS before 1996.[142] The later records, which Cribbs' program did access for the data file, would show $0 due in the FAM field for periods in which a forced payment was made by a field office. As a result, individuals who received a forced payment during the periods of their inpatient hospital stays were not shown as having been entitled to SSI for such periods on SSA annual tapes.[143]

Shafer testified that forced payments were a common occurrence during the periods at issue here.[144] Thus, the omission of all these records was a systemic and recurring error that had the effect of understating the SSI ratios.[145]

This problem was not fixed in 1996 when SSA began including all active and inactive records on the annual SSI tapes.[146] As Dean testified, CMS' matching program eliminates duplicate records on SSA's annual tapes.[147] Thus, even after SSA started sending all active and inactive records,

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[139] See discussion on administrative burden, *supra*.
[140] Shafer, Hearing Tr. at 334.
[141] Shafer, Hearing Tr. at 334-37, 474-79; Walsh, Hearing Tr. at 2177. See e.g. Provider Exhibit 182 (SSI records for "husband" whose SSI days were omitted from CMS calculation of the SSI fraction because he received a forced payment during the period of hospitalization in 1994. See also CMS Discovery Response to Interrogatory 11, Provider Exhibit 152, pp 2952-53; Shafer, Hearing Tr. at 334-337; 341-44; 474-479; Cribbs, Hearing Tr at 250-58; Walsh, Hearing Tr at 2177-94, 2206-08.
[142] Cribbs, Hearing Tr. at 250-58.
[143] See Provider Exhibit 182.
[144] Shafer, Hearing Tr. at 336, 339, 479-80.
[145] Shafer, Hearing Tr. at 339.
[146] Cribbs, Hearing Tr. at 271
[147] Dean, Hearing Tr. at 1379.

beginning in 1996, two of the three records generated in a forced pay situation would be eliminated by CMS, leaving only about a one-in-three chance of a valid match with the correct SSI record.[148]

According to Shafer, this problem could easily be fixed.[149] He explained that the signal for a forced pay situation is a C01 or M01 code in the CMPH field and $0 due in the FAM and State amount ("SAM") fields.[150] This situation only occurs when an individual is receiving a forced payment or non-cash benefits under section 1619(b) of the Social Security Act (these latter benefits are discussed further below).[151] SSA's computer program, therefore, could easily be written to create a "loop" to go back and check an individual's earlier records whenever it comes across a C01 or M01 in the CMPH field and no amount due in the FAM and SAM fields.[152]

The Intermediary does not dispute that forced pays should be properly reflected in the SSI count but contends that the impact is too small to warrant retroactive correction. It challenges Shaefer's testimony that, based on his 34 years of experience at SSA, forced pay situations were common. The Intermediary points out that there was no documentation to support his testimony and that Shafer acknowledged that he was not directly involved in the system processing of manual pays. It also argues that Cribbs' unfamiliarity with the situation may also indicate that terminated records due to forced pay are a rarity and that the Provider was only able to identify a one-day stay for which an SSI day was not counted and which involved a manual pay.[153]

The Board finds that Shafer's testimony is credible that forced pay situations are common and concludes that omission of forced pay records is a systemic error that would likely deflate the DSH Medicare percentage. For the same reasons as discussed in the section on stale records, the Intermediary's arguments regarding minimal impact and administrative burden are without merit.

(3) <u>Omission of Hold and Suspense Cases</u>

As discussed above, if there is a positive amount due in the FAM field, but any code other than C01 or M01, such as a hold or suspense code, appears in the CMPH field, then SSA's program will assign a zero to that month in the annual tape.[154] In other words, the program would assign a zero to a month if an individual's SSI benefits are temporarily on hold or in suspense when SSA prepares its annual tape.[155] Of the limited records the Provider was able to obtain, Master ID number 13111 shows days omitted from the SSI count because payments were in suspense when the tape was prepared, but those benefits were awarded retroactive to several months prior to the patients' hospital stays.[156]

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[148] Dean, Hearing Tr. at 1380-81.
[149] Shafer, Hearing Tr. at 332-34, 339-50.
[150] Shafer, Hearing Tr. at 339-44.
[151] Shafer, Hearing Tr. at 340-44.
[152] Shafer, Hearing Tr. at 339-48.
[153] Intermediary's Post-hearing Brief pp. 73-76.
[154] Cribbs, Hearing Tr. at 154-55; Cribbs, Evidentiary Hearing Tr. at 318-19, Provider Exhibit 41; <u>see also</u> Provider Exhibit 155 (SSA list of payment status codes).
[155] Cribbs, Hearing Tr. at 265-266; Shafer, Hearing Tr. at 351-64.
[156] CMS discovery Response to Provider Interrogatory 13, Provider Exhibit 152, pp 2959-60; Declaration of Alan Shafer ¶ 11, Provider Exhibit 147, pp 2888-90, Provider Exhibit P154.

SSA's list of payment status codes, Provider Exhibit 155, includes several temporary hold or suspense codes. Shafer testified that one common example is suspense code S08, used when SSA is looking for a representative payee who is able and willing to accept checks on behalf of an SSI recipient.[157] Other common examples are suspense codes S21 and H80. Code S21 is used when an individual is presumptively disabled and has received benefits on that basis for six months. After that initial six-month period, benefits are suspended until all necessary state determinations and paperwork are completed.[158] In virtually all of these cases, benefits that are temporarily in suspense after the sixth month are eventually granted retroactively for the full period.[159] Hold code H80 is used during the period in which an application for SSI benefits is pending a state eligibility determination.[160]

The exclusion of SSI days associated with individuals whose benefits were temporarily on hold or in suspense can be easily fixed by using the updated SSI data in later versions that SSA provides annually for rolling 42-month periods.[161]

The Board finds that omission of hold and suspense records is a systemic error that would likely deflate the DSH Medicare percentage. For the same reasons as discussed in the section on stale records, the Intermediary's arguments are without merit.

(4) Omission of Retroactive Awards

Shafer testified that a significant portion of all SSI benefit awards are paid on appeal.[162] Generally, appeals are pending for an average of about one year.[163] Consequently, a Medicare hospital inpatient whose SSI benefits are awarded on appeal are not picked up in CMS' calculation of the SSI fraction unless an appeal happens to be resolved before SSA prepares its annual tape in March following the end of the fiscal year.[164]

The effect of the omission of retroactive actions is not likely to be a wash, as suggested by the Intermediary, because terminations of disability benefits are seldom made retroactively and most other denials are not made retroactively.[165] In addition, CMS' 1996 summary report[166] shows that the ratio of the number of stays with new SSI days added (which would have included stays by individuals whose SSI benefits were granted or reinstated retroactively) to the number of stays with old SSI days deleted (which would have included stays of individuals whose SSI benefits were denied retroactively) was greater than 17:1 for most years.[167]

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[157] Shafer, Hearing Tr. at 352-56.
[158] Shafer, Hearing Tr. at 359-62.
[159] Shafer, Hearing Tr. at 518-21; 359-362.
[160] Shafer, Hearing Tr. at 362-63.
[161] Shafer, Hearing Tr. at 364-65.
[162] Shafer, Hearing Tr. at 370-74, 488-91; Provider Exhibit 192, pages 3382-84.
[163] Shafer, Hearing Tr. at 371.
[164] Shafer, Hearing Tr. at 375-76.
[165] Shafer, Hearing Tr. at 377-78, 501-02, 513-16.
[166] Provider Exhibit 64, pages 1518-20; Provider Exhibit 231.
[167] Pfeil, Hearing Tr. at 1575-84.

The problem with CMS' omission of retroactive awards is similar to the omission of hold and suspense cases, and the same solution applies in each case – for CMS to use the updated SSI data that SSA provides annually for a rolling 42-month period.[168]

The Intermediary asserts that most of the retroactive corrections would not involve Medicare beneficiaries.[169] The Board finds that this ignores the fact that a Medicare beneficiary might qualify for SSI for the first time because of illness or injury resulting in a hospitalization that limits their resources. The claim for SSI benefits may not be made until well after the hospitalization, and adjudication of the claim might be much later.

The Board finds that omission of retroactive awards is a systemic error that may deflate the DSH Medicare percentage if retroactive SSI awards involve Medicare beneficiaries. For the same reasons as discussed in the section on stale records, the Intermediary's arguments are without merit.

(5) Omission of Non-Cash Benefits

Section 1619(b) of the Social Security Act, as amended, 42 U.S.C. §1382h(b), establishes a work incentive for disabled individuals entitled to SSI benefits by allowing for the continuation of Medicaid benefits even though the individual's income is too high to qualify for an SSI cash payment during periods of work. With respect to this special SSI status, the implementing SSI regulation provides:

> [t]he special SSI eligibility status applies for the purposes of establishing or maintaining your eligibility for Medicaid. For these purposes, *we continue to consider you to be a blind or disabled individual receiving benefits* even though you are in fact no longer receiving regular SSI benefits or special SSI cash benefits. . . . *Special SSI eligibility status also applies for purposes of reacquiring status as eligible for regular SSI benefits or special SSI cash benefits*. (emphasis added)

20 C.F.R. § 416.264 (1995).[170] As stated in the regulation, certain qualifying disabled recipients are considered to be entitled to Federal SSI benefits even though no SSI cash payment is made, both for purposes of allowing the recipient to continue receiving Medicaid coverage and to resume receiving the SSI cash benefit when the individual is unable to work, without having to reapply.[171]

SSA's program for the annual SSI tape would assign a zero to any month in which an individual was working and not receiving a cash payment, but was considered to be receiving SSI under the 1619(b) work incentive program. As in the case of a forced payment the signal for someone who is receiving non-cash benefits under section 1619(b) of the Social Security Act is the presence of a C01 payment status code in the CMPH field and $0 due in the FAM field on the SSI master record.[172] Thus, this

[168] Shafer, Hearing Tr. at 378.
[169] Intermediary's Post-Hearing Brief at 50
[170] The 1993 and 1994 versions of the FederalRegister did not include "or special cash benefits."
[171] See Shafer, Hearing Tr. at 309-14, 379-80.
[172] Shafer, Hearing Tr. at 341, 381-82.

problem, like the forced pay problem, can be fixed by putting a "loop" in the SSA program to go back to earlier records and check for a 1619(b) indicator.[173]

The Intermediary argues that the language of the DSH regulation, 42 C.F.R. §412.106, permits only those who are entitled to SSI cash benefits to be included in the DSH calculation. The Social Security statute and regulation acknowledge that because the beneficiaries are working they are no longer receiving SSI benefits; however, they are considered entitled to benefits for the purposes of Medicaid eligibility. The Intermediary argues that the DSH statute includes in the numerator of the Medicare fraction individuals "who are entitled to supplemental security income benefits," not those who were given special SSI eligibility status despite not being eligible for benefits. Consequently, the Intermediary reasons that §1382h(b) individuals should not be included in the Medicare fraction, but to the extent that such individuals had inpatient stays and were eligible for Medicaid, they should be included in the Medicaid fraction.

The numerator of the DSH statute includes patients who are entitled to both Medicare Part A and SSI. The Board finds that, given the language of the DSH statute, §1382(h) benefits fall squarely within the DSH language for inclusion in the numerator of the DSH Medicare fraction. Likewise, the regulation, 20 C.F.R. §416.264, states that "we continue to consider you to be a blind or disabled individual receiving benefits even though you are in fact no longer receiving regular SSI benefits or special SSI cash benefits. . . . " (emphasis added). Section1382(h) beneficiaries are SSI beneficiaries and must be included in the DSH Medicare fraction.

The Board finds that omission of Section 1382(h) beneficiaries is a systemic error that may deflate the DSH Medicare percentage. For the same reasons as discussed in the section on stale records, the Intermediary's remaining arguments are without merit.

Best Available Data

The Intermediary argues that even if the DSH percentage calculated was less than accurate, it was, nevertheless, calculated using the best data available. The Provider responds that not only was the data not the best available, but the flaws in the databases and match process on which the DSH calculation relies were due, at least in part, to CMS' willful failure to comply with routine computer and data processing standards applicable to all Federal agencies and that this failure is further indicative of CMS' general hostility to the DSH legislation.

Failure to follow standards

Computer and data processing standards are established by the Federal Information Resources Management Regulations (FIRM Regulations) [174] and Office of Management and Budget (OMB) Circular No. A-130 (FIPS). FIPS 101 was the National Institute of Standards and Technology ("NIST") *Guideline for Lifecycle Validation, Verification, and Testing of Computer Software* from June 6, 1983 to February 25, 2000.[175] FIPS 101 established Federal standards for software validation, verification and testing. Validation includes examination of the correctness of the final

[173] Shafer, Hearing Tr. at 381-82.
[174] 41 C.F.R. §§ 201.100 et seq.
[175] Provider Exhibit 173.

version of the software. Verification consists of examination of the software's integrity and internal consistency both within each phase of the software's development and from one evolutionary phase of the software's development to another. Testing includes examination of the software's behavior using sample data sets. FIPS 101 anticipates that validation, verification and testing will be applied to all phases of software development: requirements, design, programming, testing, installation, operations, and maintenance.[176]

OMB Circular A-130 was established under the Paperwork Reduction Act of 1980. The Director of the OMB has authority under the Paperwork Reduction Act to develop and implement uniform information resources management policies.[177] Pursuant to that authority, OMB issued OMB Circular A-130 to establish the Federal policy for the management of Federal information resources.[178] OMB Circular A-130 stands on the fundamental principle that:

> [s]ystematic attention to the management of government records is an essential component of sound public resources management which ensures public accountability. Together with records preservation, it protects the government's historical record and guards the legal and financial rights of the government and the public.

OMB Circular, Transmittal Memorandum No. 2 at 7.h, 59 Fed. Reg. 37906, 37910 (July 25, 1994).[179]

The Provider asserts that OMB Circular A-130 extends to all Federal agencies,[180] and that it requires agencies to follow appropriate information processing standards.[181] The Provider interprets these standards to include an obligation to:

(1) "record, preserve, and make accessible sufficient information to ensure the management and accountability of agency programs, and to protect the legal and financial rights of the Federal Government." OMB Circular 8.a.(j), 59 Fed. Reg. at 37910, Provider Exhibit 176,

(2) "incorporate records management and archival functions into the design, development and implementation of information systems." OMB Circular 8.a.(k), 59 Fed. Reg. at 37910, Provider Exhibit 176. and to

(3) develop "adequate and proper documentation of agency activities." OMB Circular 8.a.(4)(a), 59 Fed. Reg. at 37911, Provider Exhibit 176.

The Intermediary responds[182] that FIPS is merely a guideline, that only some provisions (which it does not specify) are mandatory and that the OMB Circular only requires compliance with the mandatory guidelines. It further argues that it is unknown what testing may have been performed

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[176] Provider Exhibit 173 at 3150
[177] 61 Fed. Reg. 6428, 6431 (Feb. 20, 1996).
[178] OMB Circular No. A-130, effective July 2, 1993, 58 Fed. Reg. 36068.
[179] Provider Exhibit 176.
[180] OMB Circular, Appendix I at 3, 61 Fed. Reg. 6424, 6436 (Feb. 20, 1996)
[181] 59 Fed. Reg. at 37909-37910; provider Exhibit 175.
[182] Intermediary's Post Hearing Brief at pp. 81-85.

prior to Mr. Dean's tenure, as there are no records.

Whether compliance with the FIPS standards and the OMB Circular would have avoided the inaccuracies the Board has concluded exist in the data is beyond the Board's ability to determine. However, it is disingenuous for CMS to take a position that the Provider must demonstrate what financial impact the flaws in the process caused while knowing that its own record retention failures make such a showing impossible.

The cost report settlement process

The Medicare fraction is calculated relatively early in the cost report settlement process, which generally is not completed until two or three years after the end of a hospital's fiscal year.[183] During this time, the provider is, among other things, collecting information from the state concerning data for the other component of its DSH calculation, the Medicaid fraction. Billing for services rendered during the year continues – up to 30 months after the end of the provider's cost report year - and that patient data from the billing and payment process is captured in the MEDPAR file used to determine the denominator of the Medicare fraction. At the same time, the determination of Medicare patients' eligibility for SSI may still be in process and not be reflected on the SSA tape until much later.[184]

Over two and a quarter years, CMS performs 10 MEDPAR runs and creates 10 MEDPAR files for each Federal fiscal year, the latest of which is run in the third December after the end of the subject fiscal year (e.g., the 10th and last MEDPAR file for Federal fiscal year ended September 30, 1994 was produced in a December 1996 MEDPAR run).[185] CMS matches its inpatient hospital stay records against the most recent annual SSA tape every time it creates one of these quarterly MEDPAR runs.[186]

June MEDPAR Runs Used To Calculate SSI Fractions At Issue

Despite having MEDPAR runs that are updated to the time of the final cost report settlement, it is undisputed that CMS used the MEDPAR file based on the month of June following the end of the Federal fiscal year to compute the SSI fractions at issue for each year under appeal.[187] For example, CMS used the June 1996 MEDPAR run to calculate the SSI fraction for Federal fiscal year ended September 30, 1995.[188]

Even though MEDPAR is run quarterly, the SSA tape is run only once annually, and CMS always uses the annual run from the year following the end of the federal fiscal year. It is also undisputed that, because CMS always receives the annual SSA tape before April 1st, CMS' inpatient hospital stay records are never matched with SSI records relating to individuals whose SSI benefits are granted or restored after April 1 retroactively to a period within the prior Federal fiscal year.

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[183] Gouger, Hearing Tr. at 1821-22.
[184] See discussion on hold and suspense and retroactive awards, *supra.*
[185] See Dean, Evidentiary Hearing Tr. at 64-71, Provider Exhibit 42; Provider Chart, Provider Exhibit 40, pages 1018-24.
[186] Dean, Evidentiary Hearing Tr. 67-69, Provider Exhibit 42.
[187] CMS Discovery Response to Provider Interrogatory 15, Provider Exhibit 152, pages 2967-68.
[188] Id.

Ms. Tayloe, the individual responsible for DSH policy during the periods in issue,[189] apparently believed that the latest available data was being used to compute the Medicare fraction. A memo to intermediaries that she may have drafted and of which she had personal knowledge of the subject matter states, "we purposely delay processing the SSI/Medicare percentages to ensure that the majority of the Medicare discharges for a given fiscal year are included in the computation so as not to disadvantage hospitals because of incomplete data."[190]

Given the process actually used which fixes the Medicare fraction in June following the end of the FFY despite there being ongoing processes that affect the numerator and the denominator, [191] it is inevitable that the data used to calculate the Medicare fraction is incomplete and not the "best available data."

The Provider contends that the following series of events show that even after CMS knew or should have known that there were problems with the data, the agency "embarked on a course of delay, disinformation and concealment concerning the "stale records" problem."[192]

Mr. Pfeil testified that he notified CMS in 1993 about a problem going back to 1990 after CMS could not reconstruct the SSI calculation that it had previously published. Records were inexplicably being "dropped" upon recalculation when a provider requested that the DSH percentage be calculated on its cost report year. He worked with three CMS employees, Ms. Tayloe, Ms. Rosenberg and Ms. Nolte, for two years on the matter.[193] One of those employees, Ms. Rosenberg, testified in this case that CMS knew that there was "something wrong with the numbers" even before Mr. Pfeil contacted the agency about his client's problem beginning in 1993.[194] CMS eventually reached a settlement with Mr. Pfiel's client, but as far as Mr. Pfiel knew, CMS never determined the cause of the problem even though Mr. Pfiel suggested a simple, inexpensive test to identify the cause.

In June 1995, at just about the same time that CMS was settling with Mr. Pfeil's client,[195] Tayloe testified in a deposition that the SSI data used in the calculation of the SSI fraction were verified and correct.[196] However, CMS did not produce any supporting documents, and Tayloe did not indicate in her testimony that there were any documents relating to the potential for error in CMS' calculation of the SSI fraction, even though the Board subpoena in that case required production of such documents in connection with the deposition.[197]

Also in June 1995, CMS published the proposed rule to change the process for recalculation of the SSI ratio based on a hospital's cost reporting period. CMS indicated both in the proposed and final

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[189] Tayloe, Hearing Tr. at 2005-2006.
[190] Tayloe, Hearing Tr. at 2029-2030.
[191] See *infra* regarding the claims processing procedure. With regard to the denominator, Dean testified that, by the June MEDPAR run, 98% of all claims will be filed.
[192] The Provider asserts that the failure to use the best available data is intentional or due a cavalier indifference and cites Congressional statements and several Federal Courts that have reached that conclusion. Provider's Post Hearing Brief pp. 63.
[193] Pfeil , Hearing Tr. at 1481-1520.
[194] Rosenberg, Hearing Tr. at 2131, 2134, 2136.
[195] Pfeil, Hearing Tr. at 1512-18; Provider Exhibit 119.
[196] St. Louis University Hospital, Rudolph [now Tayloe]Deposition, Tr. at 9, 176, 192, 198, 200, Provider Exhibit 25.
[197] Provider Exhibit 25, page 488; see also , Hearing Tr. at 1553-64.

rule that the recalculations invariably resulted in lower SSI ratios due to problems with the requesting hospital's data.[198] It also represented that SSA, not CMS, computes the SSI fractions, and that SSA does not release the underlying SSI data to CMS.[199]

Just five months after publishing the final 1995 rule, CMS requested corrected SSI records from SSA because its MEDPAR records for prior years were "contaminated" by the omission of "stale" SSI records.[200] The agency also decided to create a separate set of "special" MEDPAR files that would include both the old and new SSI days for prior years, and from these files CMS produced smaller files showing the number of stays in which the value of SSI days increased or decreased.[201] The intent of this "special MEDPAR" project was to determine whether the differences were material and, if so, to recalculate prior SSI ratios.[202]

The special MEDPAR files would have shown the impact of the omission of stale records (as well as other updated SSI records) by year, by hospital, and by stay.[203] In the end, the special MEDPAR files were used, according to Rosenberg, "for everything [CMS] did."[204] Ms. Rosenberg testified in 2003 that "she would hope that Policy" used the corrected data to fix CMS' earlier calculations.[205]

It is undisputed, however, that CMS has no documentation concerning whether, prior to 2003, CMS notified hospitals that SSA did not include all "stale records" on the SSI tapes that it sent CMS prior to 1996 and that CMS has no record of making any adjustment to hospitals' Medicare fractions or making any payment adjustments as a result of CMS' discovery in 1996 that SSA did not include all "stale records" on the tapes it sent to CMS prior to 1996.[206] In addition, although CMS had the special MEDPAR files and SSA tapes at least as of 1997, CMS claims that it subsequently lost or destroyed those records.[207]

The Intermediary interprets the evidence regarding the stale records to show that CMS was responsive to potential problems. When Mr. Pfeil, the Provider's consultant, brought to CMS' attention that the data for one hospital seemed inaccurate, CMS investigated the issue and discovered that SSA had not been sending stale records. CMS then had SSA include the stale records beginning in FY 1995.

CMS witnesses were not able to explain why the agency did not correct its prior calculations of the SSI fractions that omitted "stale" SSA records. Every CMS witness involved in the process, except Tayloe, said that "Policy" would have made a decision as to the need to correct prior calculations,

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[198] 60 Fed. Reg. 45778, 45811-12 (Sept.1, 1995; 60 Fed. Reg. 29202, 29223-24(June 2, 1995).
[199] Id. At 45812 (Provider Exhibit 163).
[200] Provider Exhibit 64, page 1546. Memo from HCFA to SSA. "It has come to our attention that (SSI) files that we receive periodically from (SSA) do not contain stale records, that is, a record of any beneficiary that has died since the receipt of a check in an earlier entitlement period."
[201] O'Leary, Hearing Tr. at 675-76, 693-95, 699-703, 712-23; Provider Exhibit 64, pages 1518-20, 1522, 1526, 1539, 1541, 1543, 1547-48, 1550-51.
[202] O'Leary, Hearing Tr. at 702-03, 746-47; Provider Exhibit 64, pages 1547-48.
[203] O'Leary, Hearing Tr. at 712-18.
[204] Rosenberg, Evidentiary Hearing Tr. at 277, Provider Exhibit 42.
[205] Rosenberg, Evidentiary Hearing Tr. at 298-299, Provider Exhibit 42.
[206] CMS Discovery Response to Provider Interrogatory 68, Provider Exhibit 152, page 3000.
[207] Rosenberg, Hearing Tr. at 2085-87, 2095-97, 2137-40; O'Leary, Hearing Tr. at 799-800, 806, 810; Provider Exhibit 64, page 1525.

and that "Policy" included Tayloe;[208] but Tayloe alleges that she remembers nothing about the matter.[209] At the 2003 Evidentiary Hearing, Tayloe testified that although she considers herself to be "a detail-oriented person," a DSH payment issue involving "a few hundred million dollars" would "[n]ot necessarily" have left a lasting impression on her, "given the amount of money involved."[210]

The Board will not attempt to discern any CMS motives regarding DSH generally. However, the evidence clearly indicates that CMS knew or should have known at least by 1993 that there were significant inaccuracies with the data used for the DSH calculation and that those inaccuracies may have diminished the DSH payment to providers. This evidence squarely contradicts CMS' claims that it used the best available data for the DSH calculation.

F. Does the MEDPAR contain an accurate count of total Medicare days?

The third prong of the Provider's attack on the Medicare fraction calculation is that CMS does not properly account for all Medicare patient days on its MEDPAR file. Its attack is two-fold. The Provider argues that not only is the count itself flawed, but also that the types of days that CMS uses for the denominator are incorrect.

Background of the dispute

In 2001, CMS furnished to the Provider MEDPAR runs for fiscal years 1994 and 1995, even though these runs would not have been the ones used to settle the 94 and 95 cost reports. The Provider found that days counted on the MEDPAR were inconsistent with the days counted on another CMS data report that providers are required to use to file cost reports. That report, the Part A Provider Statistical & Reimbursement Report (PS&R), contains the details of the days for which a provider is paid by Medicare. Providers are required to reconcile their cost report submission to the paid claims data furnished in the PS&R. In most instances MEDPAR data and PS&R data would be the same; i.e., both would show the days Medicare covered and paid for inpatient services for each Medicare beneficiary. The PS&R is unlike the MEDPAR in that the PS&R does not purport to contain days for which Medicare provided coverage and charged the beneficiary with "utilization" of his/her available Medicare covered days but, for some technical reason, Medicare did not pay the hospital for the care. This can occur, for example, because the provider failed to timely bill Medicare for the services.

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[208] Rosenberg, Hearing Tr. at 2136; Phillips, Hearing Tr. at 1149.

[209] Tayloe, Hearing Tr. at 1931-34.

[210] Tayloe, Evidentiary Hearing Tr. at 142-43, Provider Exhibit 43. At the 2004 Hearing, Tayloe also testified that she did not recall providing the responses to written interrogatories, between May 1 and August 15, 2004, which stated that CMS did not recall the answers to several Provider interrogatories. Tayloe, Hearing Tr. at 1934-75. The witness was then admonished by a Board member for being "a bit disingenuous" in her testimony. Tayloe, Hearing Tr. at 1961. Tayloe did answer some detailed questions as to the composition of the "denominator" of the SSI fraction when she testified on direct examination by the Office of the General Counsel at the 2004 Hearing. But, on cross-examination, Tayloe professed to be unable to say what types of days are included in the denominator of the fraction. Tayloe, Hearing Tr. at 2007-15. In the end, Tayloe testified that she did not recall what "denominator" she was referring to when she testified on direct examination by OGC. Tayloe, Hearing Tr. at 2015-16.

In 2003, the Provider and Intermediary tried to reconcile the differences between the two reports, and they identified the following discrepancies:[211]

- 61[212] inpatient hospital stays that had Medicare paid days on the PS&R that were not included in the MEDPAR data; and,
- 47 stays that had Medicare days in the MEDPAR that were not included as paid Medicare days on PS&R.

61 Stays On the PS&R But Not MEDPAR

Of the 61 stays with Medicare paid days on the PS&R but not the MEDPAR, 57 stays had been paid before CMS ran the June MEDPAR files that were used to calculate the SSI fractions at issue for fiscal years 1994 and 1995.[213] 46 of these 61 stays had utilized days charged on the CWF,[214] and CMS cannot explain why the Medicare paid days for these stays are not included in the MEDPAR file.[215]

As to the remaining 15 of these 61 stays, CMS' answers to interrogatories state that the days associated with these stays were properly excluded from the MEDPAR because "utilized"[216] days were not, or should not have been counted in the CWF from which the MEDPAR report is drawn.[217] For example, 7 stays were cancelled on the CWF but were erroneously kept on the PS&R; but, the Provider points out that while most of the stays had payments that were cancelled, the CWF continued to reflect "utilized" days for some stays after payments were cancelled and some of the stays simply were not found on the CWF.[218] The Intermediary does not know from which CWF field MEDPAR pulls the data,[219] or whether the MEDPAR even looks to utilized days at all.[220]

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[211] Smith, Hearing Tr. at 884-885; See also Provider's Response to CMS' First Set of Interrogatories and Requests for Production of Documents, Provider's Responsive Documents ("Provider's Responsive Documents") pages 14R-15R & 18R, Provider Exhibit 114, pages 2295-96, 2299; CMS Discovery Responses to Provider's Interrogatories 5.A, 10.A & 10.D, Provider Exhibit 152, pages 2935-36, 2947-48, 2949-50. A detailed summary of the data reflected on the PS&R, the MEDPAR, and the CWF documents produced by the Intermediary for each of the above stays is set forth in paragraphs 12.1 - 13.15 and the accompanying tables in Appendices I and II in the Provider's Position Paper. There is no dispute as to accuracy of the information presented in the tables in Appendices I and II in the Provider's Position Paper. Gouger, Hearing Tr. at 1771.

[212] Although 61 is the number used by the parties for the reconciliation, the number was pared to 55 after the provider determined that only 55 stays were billed by the time the specific MEDPAR file that was used to calculate the Medicare fraction was completed. See Exhibit P-131 at 2638-56 and Tr. at 1721. But at the hearing, Provider's witness testified that it pared down the list based on the mistaken belief that the March version of the MEDPAR, instead of the June MEDPAR, was used.

[213] Smith, Hearing Tr. at 888-89; Gouger, Hearing Tr. at 1721.

[214] Smith, Hearing Tr. at 887.

[215] Smith, Hearing Tr. at 895; Gouger, Hearing Tr.at 1773-1777.

[216] The days which beneficiaries are entitled to either Medicare Part A coverage or SSI may not be paid because, for example, Medicare limits on the number of days for which it will pay benefits under 42 U.S.C. § 1395d(a)(1), a provider did not bill on time or the days were disallowed because a PRO disallowed the days for quality of care reasons. Those days are, nevertheless, considered utilized days and count against the beneficiary's limit.

[217] CMS Discovery Response to Provider's Interrogatory 10.A, Provider Exhibit 152, pages 2247-48.

[218] Gouger, Hearing Tr. at 1773-77; Provider's Position Paper, Appendix I, Tables 12.5, 12.8, 12.15.

[219] Gouger, Hearing Tr. at 1777, 1796.

[220] Gouger, Hearing Tr. at 1777.

47 Stays On the MEDPAR But Not PS&R

Of the 47 stays with Medicare days included in the MEDPAR but not in the PS&R, 13 stays were partially paid by Medicare as the secondary payer, 22 stays related to Medicare HMO enrollees, 5 stays were denied payment by a peer review organization, and 7 stays were denied payment because they were not timely billed.[221]

In summary, the Intermediary could not explain some discrepancies. It explained other differences between the PS&R and the MEDPAR as not being a discrepancy at all but rather as properly reflecting the distinction between paid and utilized days.

The Provider offers as a resolution to these problems with the MEDPAR data that CMS be required to substitute the PS&R figures in the calculation. Although it acknowledges that the PS&R will only identify paid days, not utilized days, it contends that using paid days is consistent with CMS' prior interpretations of what should be in the denominator. The Provider further asserts that the CMS position in this case on utilized days is so inconsistent with its earlier interpretations that the new position was merely contrived to explain away the discrepancies in the MEDPAR data.

The Intermediary asserts that the law specifies that MEDPAR be used, and there is no authority to substitute the PS&R. The Intermediary further argues that even if "paid" days were the proper standard, the question whether hospital days were paid has to be answered from the patient's perspective. That is, even though the Provider may not have received payment, responsibility for payment for the care did not shift to the patient, and the days were considered "utilized" or "covered" for purposes of Medicare's limits on the number of days it covers a patient's hospitalization.

Paid v. Covered or Utilized Days

Both parties' written submissions and testimony at the hearing present a spirited debate over whether CMS had a longstanding interpretation of counting only paid days in the denominator of the Medicare fraction. While the Board finds the evidence as to CMS' past position to be confusing, it finds that the resolution lies in the statute and regulation.

The statute specifies that the Medicare fraction denominator 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. (emphasis added)

42 U.S.C. §1395ww(d)(5)(F)(vi). Relevant portions of the 1996 version of the DSH regulation, 42 C.F.R. §412.106(b), described the calculations of the Medicare fraction as follows:

> (*2*) *First computation: Federal fiscal year*. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, HCFA—

[221] Smith, Hearing Tr. at 889-91.

(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. (emphasis added)

The Board concludes that the statute's use of "entitled to benefits" and the regulation's reference to "covered" patient days is consistent with the Intermediary's position. The DSH Medicare fraction denominator properly includes covered or utilized days even though the hospital may not have received payment.

MEDPAR v. PS&R

The preamble to the May 6, 1986 final rule implementing the statutory DSH provision stated that "the number of patient days of those patients entitled to both Medicare Part A and SSI will be determined by matching the data from the Medicare Part A Tape Bill (PATBILL) file with [SSA's] SSI file." [222] In a later Federal Register, the Secretary clarified that PATBILL is the functional equivalent of the MEDPAR file.[223] Various other preambles to regulations also specify that MEDPAR is to be used for the DSH calculation,[224] but there are no references to use of the PS&R as the source of the denominator of the Medicare fraction.

Although the preambles do not have the force of law, the Board finds that the references to using MEDPAR in various preambles clearly reflects the Secretary's intent to use MEDPAR for the DSH calculation. That, coupled with our finding that the denominator is to include covered or utilized days as well as paid days, rules out use of the PS&R, as it only contains days for which payment was made to the provider.

MEDPAR does not consistently count all Medicare days

The Board's determinations regarding what should be in the MEDPAR does not resolve remaining questions of whether the MEDPAR, as constituted, produces an accurate DSH calculation. As described above, the discrepancies that the Intermediary was unable to explain are compelling evidence that the MEDPAR count of total Medicare days for the denominator is unreliable but the cause could not be established. Treatment of certain categories of days sheds some light on MEDPAR's deficiencies.

Medicare Secondary Payor Days

In the parties' reconciliation of differences between days counted in the PS&R and the MEDPAR, they identified 13 Medicare secondary payer ("MSP") stays that were counted as Medicare days in

[222] 51 Fed. Reg.16772 (May 6, 1986); See Intermediary 's Final Position Paper, Exhibit I-4.

[223] See, 52 Fed. Reg. 33143, 33144 (September 1, 1987) ("we use the two names [PATBILL and MEDPAR] interchangeably" and "[t]he MEDPAR file contains the same data as the PATBILL file but is a simplified, reformatted record layout"). See also, 52 Fed. Reg. 33034, 33035 (September 1, 1987) (the MEDPAR File contains the same data as the PABILL but is in a simplified, reformatted record layout).

[224] See Intermediary's Post-hearing Brief at pp. 15-16.

the MEDPAR to the extent that Medicare actually made payment.[225] The Provider does not challenge the inclusion of those paid days, but the Provider contends that CMS' confusion as to which MSP days should be counted is symptomatic of larger problems with the calculation of the SSI fraction. During the course of this case, CMS reversed its answers to interrogatories asking whether MSP days should be counted in the denominator of the SSI fraction, and at the hearing, CMS' witness, Phillips, initially disagreed with CMS' revised interrogatory responses but then recanted his testimony.[226]

Health Maintenance Organization Days

The Provider does not claim that HMO days are not properly included in the count but complains of the inadequancy of the CMS database to accurately identify HMO days and of inconsistencies in the way HMO days are treated. According to the Provider, the 22 HMO stays that were counted in the MEDPAR were identified only because the Provider billed them in error under the fee for service program[227] and they were therefore, denied. [228]

The Provider complains that CMS has known from the beginning that few HMO days were actually counted in the SSI fraction because hospitals and HMOs had little incentive and no contractual obligation to submit no-pay bills for HMO stays.[229] The Provider further asserts that CMS' discussions of how HMO bills were to treated failed to give adequate notice that it was necessary to submit no-pay bills in order to have Medicare HMO days included in the DSH calculation.[230] The Provider also points to CMS' acknowledgement in other contexts that the fiscal intermediaries do not necessarily know what to do with no-pay bills for HMO days even when they are submitted:

> [I]nformation on these [Medicare HMO] beneficiaries is not retained separately in intermediary records from other no-pay bills. *The intermediary would need the beneficiary's health insurance claim number in order to be able to identify an HMO enrollee. Consequently the hospital is generally in a better position to identify HMO and CMP enrollees than the intermediary.* (emphasis added)

55 Fed. Reg. 35990, 35996-97 (Sept. 4, 1990), Provider Exhibit 179.

Finally, it appears that the MEDPAR field for HMO days has not even been used since 1995. In the September 4, 1990 Federal Register, CMS published a notice that it had been counting HMO days in the SSI fraction since 1987.[231] The notice explained that "as of December 1, 1987, a field was included on the [MEDPAR] file that allows us to isolate those HMO days that are associated with

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[225] Smith, Hearing Tr. at 891-92.

[226] Smith, Hearing Tr. at 892-93; Phillips, Hearing Tr. at 1089-92, 1158-60; CMS Discovery Response to Provider's Interrogatory 1.F, Provider Exhibit 152, pages 2929, 2932; CMS Revised Discovery Responses, Provider Exhibit 239.

[227] See Provider's Position Papers, p.56-57.

[228] Smith, Hearing Tr. at 893-895; Gouger, Hearing Tr. at 1796-1797; see also Provider's Position Paper, Appendix II, Table 13.8.

[229] 1991 GAO Report, Provider Exhibit 180, pages 3315-16; HCFA Fact Sheet: Medicare Review of Risk Based HMOs (February 11, 1991), Provider Exhibit 181; Phillips, Hearing Tr. at 1265-68, 1075-80. See also 55 Fed. Reg. 35990, 35994 (September 4, 1990).

[230] See 55 Fed. Reg. at 35994 (Sept. 4, 1990), Provider Exhibit 179; Providers position paper, pp 56-57.

[231] 55 Fed. Reg. 35990, 35994, Provider Exhibit 179.

Medicare patients. Therefore, since that time, we have been including HMO days in SSI/Medicare percentage."[232] But CMS' MEDPAR programmer, Dean, testified that the field on MEDPAR for HMO days "hasn't been used since the time that I started running the MEDPAR [in 1995]."[233] Therefore, HMO days could not have been included in the SSI fraction in any case, even if a no-pay bill had been submitted.

The Board concludes that the failure to count HMO days as Medicare patient days results in an inaccurate DSH calculation.

Alleged inconsistent treatment of HMO days

The Provider asserts that prior to 1998 the inclusion of HMO days in the MEDPAR data is inconsistent with the treatment of HMO days for other Medicare payment purposes, such as the payment for graduate medical education ("GME") and Medicare cost apportionment statistics.[234] For periods prior to 1998, HMO days were excluded from all aspects of the Medicare cost report and were not counted as Medicare days in the calculation of the Medicare patient load for GME payment purposes[235] even though the statutory definitions of the two programs are very similar.

The DSH statute defines the Medicare/SSI fraction by reference to days associated with patients who are "entitled to benefits under part A" of the Medicare statute. 42 U.S.C. §1395ww(d)(5)(F)(vi)(I). The GME statute defines the Medicare patient load as including days associated with "patients with respect to whom payment may be made under part A." 42 U.S.C. §1395ww(h)(3)(C). But CMS construes the GME statute to exclude Medicare HMO days from the calculation of the Medicare patient load for GME for periods prior to 1998, because HMO days "are recorded as non-Medicare days" for all Medicare apportionment purposes. 54 Fed. Reg. 40286, 40294-95 (Sept. 29, 1989). The Provider notes that CMS has never explained the reason for this inconsistent treatment of Medicare HMO days, see 54 Fed. Reg. 40294-95; 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990), Provider Exhibit 179, but the effect of CMS' inconsistency is to always decrease Medicare payment to hospitals, both by excluding HMO days from the calculation of the Medicare patient load for GME and by including HMO days in the SSI fraction and excluding them from the Medicaid fraction that is used to compute the DSH payment.

There is no evidence that including the HMO days in the DSH calculation results in a diminished payment to the hospital as the Provider suggests. As the Provider acknowledges, the preambles to the regulations specifically provide for HMO days to be included in the DSH calculation. 55 Fed. Reg. 35990, 35994, and the Board finds that inclusion is not inconsistent with the statute and regulations. Whether the inclusion or exclusion of HMO days in another program is proper is not before the Board in these cases.

Financial impact

The Intermediary argues that the Provider has not made the requisite show of harm based on the discrepancies between the MEDPAR and the PS&R. It points out that the records analyzed did not

[232] Id.
[233] Dean, Hearing Tr. at 1387.
[234] Smith, Hearing Tr. at 894-95.
[235] Johnson, Hearing Tr. at 977-78; Gouger, Hearing Tr. at 1798-99; Phillips, Hearing Tr. at 1293-96

reveal any discrepancies for 1993 and 1996 and that the 1994 and 1995 discrepancies are only about 3 stays per thousand.[236]

The Provider asks the Board to draw an inference that its Medicare fraction is understated due to the use of the MEDPAR because, in later years, the PS&R day count and the MEDPAR day count came closer together and, as that occurred, the Provider's Medicare fraction rose. However, the Provider's witness admitted that one could not conclude a cause and effect relationship between the congruency of the MEDPAR and the PS& R and the higher Medicare fraction.[237] The Intermediary also points out that Medicare fractions rose generally throughout the 1990s across the state and nation.

The Intermediary asks us to draw an inference that changes in the day count will not necessarily change the Medicare fraction. It relies on a CMS study done early in the program that compared SSI/Medicare percentages for providers using the Federal fiscal year with using the providers' cost report year. After conducting a statistically valid test, CMS concluded that:

> These results indicate a high degree of correlation between SSI/Medicare percentages computed based on the Federal fiscal year and those computed by hospital cost reporting period.[238]

While we do not dispute CMS' findings, we fail to see the correlation. The comparison was from one period to another using what the evidence has shown here are likely to be inaccurate numbers in both; therefore, no inferences can be drawn from the study.

In summary, the Board concludes that the calculation of the denominator of the Medicare fraction is likely to be inaccurate; however, it is not possible to determine whether the inaccuracies would decrease the Medicare fraction.

VII. DECISION AND ORDER:

The Board finds and concludes the following:

1. There is no statutory or regulatory impediment to recalculating the DSH percentage as the statute and regulations do not require use of the June MEDPAR following the end of the prior Federal fiscal year.

2. An approximation of the DSH percentage is not permitted by statute or regulation; the law requires that the calculation be accurate.

3. The Provider did not waive its right to challenge CMS' DSH calculation on appeal by failing to comment on proposed regulations discussing how the calculation would be done.

4. The match process between CMS' MEDPAR and the SSI data file is flawed in that:

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[236] Intermediary's Post-Hearing Brief p. 26, fn 19.
[237] Smith, Hearing Tr. 905-906.
[238] Intermediary's Post Hearing Brief p. 27; 51 Fed. Reg. At 31459 (Exhibit P-160).

- It fails to match SSI eligible beneficiaries who do not receive Title II numbers
- It fails to use multiple identifiers
- It fails to match on a unique identifier
- It fails to match SSI eligible beneficiaries whose Title II number changes within the year.

5. The flawed match may deflate the DSH percentage.

6. The SSI data used for the Medicare percentage numerator is incomplete in that it omits the following SSI eligible beneficiary records:

- Prior to FFY 1995, inactive SSI records (stale records)
- Records relating to individuals who received a forced or manual payment
- Records of individuals whose benefits were temporarily on hold or in suspense when SSA ran the tape for CMS
- Records of SSI days associated with individuals whose benefits were granted or restored retroactively after SSA ran each year's tape
- Records of individuals who were entitled to non-cash Federal SSI benefits.

7. The incomplete SSI data tends to deflate the DSH percentage.

8. Data used for the calculation of DSH is not the best available data.

9. The denominator of the Medicare calculation is inaccurate as revealed by unexplained discrepancies.

10. The denominator of the Medicare fraction is to include utilized or covered days, not paid days only.

11. The PS&R is not appropriate for determining the denominator because it does not include utilized days; MEDPAR is the database required to be used.

12. HMO days are required to be counted in the Medicare fraction.

13. The Provider is not required to quantify the financial impact of each of the flaws identified, nor is it required to show an exact number of incorrectly counted days.

14. The impact of the inaccuracies in the DSH calculation is likely to be significant, especially for some hospitals.

15. There is no significant administrative burden to redesigning the computer programs to capture accurate information and to accurately match SSI data with MEDPAR data.

The Intermediary's determination of the DSH Medicare percentage is reversed and this case is remanded to the Intermediary to recalculate the DSH Medicare percentage consistent with this decision.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West

FOR THE BOARD:

DATE: March 17, 2006

Suzanne Cochran
Chairman