PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2007-D2

PROVIDER -
JFK–Raritan Bay–Hunterdon 03 Wage Index Group
Middlesex and Hunterdon Counties, New Jersey
Provider Nos.: 31-0108; 31-0039 and 31-0005

vs.

INTERMEDIARY -
BlueCross BlueShield Association/ Riverbend Government Benefits Administrator

DATE OF HEARING -
December 7, 2004

Cost Reporting Period Ended -
September 30, 2003

CASE NO.: 03-0482G

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ISSUE:

Whether it was proper for the Centers for Medicare & Medicaid Services (CMS) to include the 1999 information for Memorial Medical Center at South Amboy in the 2003 calculation of the Middlesex-Somerset-Hunterdon, New Jersey Metropolitan Statistical Area (MSA) Wage Index.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a health care provider.

The Medicare program provides health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with the program's administration. 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 providers under Medicare law and interpretative guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20(b) and 413.24(b).

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider, and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

For cost reporting periods beginning before October 1, 1983, short-term acute care hospitals were reimbursed based upon the actual reasonable costs they incurred to furnish health care services to Medicare beneficiaries. However, for cost reporting periods beginning on or after October 1, 1983, these hospitals became subject to Medicare's Prospective Payment System (PPS) for inpatient hospital services. Under PPS, Medicare discharges are classified into diagnostic related groups (DRGs), and a fixed payment rate is established for each group based upon resource use or intensity. 42 U.S.C. §1395ww(d), 42 C.F.R. §412.60.

The actual payment amount under PPS for inpatient hospital services is the sum of a national DRG prospective payment rate and a regional DRG prospective payment rate. 42 U.S.C. §1395ww(d)(2). Pursuant to 42 U.S.C. §1395 ww(d)(3)(E), the Secretary of Health and Human Services (Secretary) is required to annually adjust the proportion of hospitals' costs which are attributable to wages and wage-related costs of the national and regional DRG rates for area differences in hospital wage levels. Accordingly, a PPS

hospital's reimbursement is based, in part, upon an adjustment reflecting a wage index for the area in which the hospital is located. The Secretary has generally distinguished the geographical areas for this purpose by using Office of Management and Budget criteria for urban areas, called metropolitan statistical areas (MSAs) and, for rural areas, non-MSAs.

Regulation 42 C.F.R. §412.63(w)(1) explains that CMS will establish a wage index adjustment factor based upon a survey of hospital wage data, as follows:

> *Adjusting for different area wage levels*. (1) HCFA adjusts the proportion (as estimated by HCFA from time to time) of Federal rates for inpatient operating costs computed under paragraph (j) of this section that are attributable to wages and labor-related costs for area differences in hospital wage levels by a factor (established by HCFA based on survey data) reflecting the relative level of hospital wages and wage-related costs in the geographic area (that is, urban or rural area as determined under the provisions of paragraph (b) of this section) of the hospital compared to the national average level of hospital wages and wage-related costs. The wage index is updated annually.

CMS explains that it performs an intensive review of the wage data it collects to establish the annual wage index adjustment factors. This review is conducted mostly through the use of edits designed to identify aberrant data. The data elements that result in specific edit failures are revised or verified by the fiscal intermediaries and any providers with unresolved data elements are removed from the data file. With respect to the development of the fiscal year 2003 wage index, CMS states in 67 Fed. Reg. 50023 (August 1, 2002):

> We removed data for 36 hospitals that failed edits. For 14 of these hospitals, we were unable to obtain sufficient documentation to verify or revise the data because the hospitals are no longer participating in the Medicare program, are under new ownership, or are in bankruptcy status, and supporting documentation is no longer available. We identified 22 hospitals with incomplete or inaccurate data resulting in zero or negative, or otherwise aberrant, average hourly wages. Therefore, the hospitals were removed from the calculation.

Also, in response to public comment regarding the verification of data used to develop the 2003 wage index, CMS stated:

> We have always maintained, subject to limited expectations, that any hospital that is in operation during the data collection period used to calculate the wage index should be included in the database, since the hospital's data reflect conditions occurring in that labor market area during the period surveyed (59 FR 45353).

> While we also believe it is appropriate to eliminate data for terminated hospitals when there is reason to believe that the data are incorrect, and the data cannot be verified due to the hospital's closure, if the wage data for a terminated hospital does not fail any of our edits for reasonableness, the hospital's data are included in the calculation of the area's wage index.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

JFK Medical Center, Raritan Bay Medical Center, and Hunterdon Medical Center (Providers) are PPS hospitals located in the Middlesex-Somerset-Hunterdon, New Jersey MSA, or MSA 5015. Riverbend Government Benefits Administrator (Intermediary) completed its focus audits/desk reviews of the Providers' wage indices for the cost reporting periods beginning during federal fiscal year (FFY) 1999 (that is, beginning on or after October 1, 1998 and before October 1, 1999). The final results of its review and any corrections were submitted to CMS for inclusion in the calculation of the final FFY 2003 wage index file published in 67 Fed. Reg. 50178, (August 1, 2002)).

On June 5, 2002, JFK Medical Center (Provider) wrote to CMS to request the removal of Memorial Medical Center of South Amboy (South Amboy) FFY 1999 wage data from the FFY 2003 wage index calculation because South Amboy closed in June 1999. On July 30, 2002, CMS replied that the Provider's request was denied. In a letter to CMS dated September 15, 2002, the Provider requested reconsideration of the denial and a response to specific issues raised.

The Providers appealed their fiscal year 2003 wage indices to the Board pursuant to 42 C.F.R. §§405.1835-405.1841 and met the jurisdictional requirements of those regulations. The amount of Medicare funds in controversy is approximately $511,000.[1]

The Providers were represented by Michael F. Berkey, Esquire. The Intermediary was represented by Bernard M. Talbert, Esquire, Associate Counsel, Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Intermediary contends that keeping South Amboy's data in the calculation of the Providers' wage indices for MSA 5015 is consistent with CMS policy. CMS found that South Amboy had been in operation during most of FY 1999, its wage data had been consistent and verifiable over the last three years, and its data had not been found to be aberrant or erroneous.[2] The Intermediary argues that South Amboy's data did not fail the edit checks, and that a three-year trend analysis of its average hourly wage (AHW) showed no aberrancies (in FY 2001 AHW was $20.19, in FY 2002 AHW was $21.72, and in FY 2003 AHW was $23.03).

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[1] Providers' Position Paper at 1. Exhibit P-6.

[2] Intermediary's Position Paper at 4. Exhibits P-6.

The Providers believe the wage information for South Amboy should not have been included in the calculation of their wage indices because it contained incorrect and aberrant data that could not be corrected due to South Amboy's closure in June of 1999, and that the wage indices should be calculated based upon the six remaining hospitals located in their MSA during 1999. The wage indices at issue were developed from hospital data collected from Medicare cost reports beginning in FFY 1999.

The Providers contend that it is unreasonable to include South Amboy's data in the wage index calculation because it contains two instances of erroneous data and four examples of aberrant/atypical data that cannot be investigated because the hospital closed. These errors/aberrancies are: (1) inclusion of physician Part A salaries with no corresponding fringe benefit costs, (2) no contract labor costs reported as in prior years, (3) a fringe benefit factor of 33 percent as compared to a fringe benefit factor in the low 20 percent range reported by the other hospitals in the MSA, and (4) an average hourly rate below that of other hospitals.[3]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of Medicare law and guidelines, parties' contentions, and evidence presented, the Board finds and concludes as follows:

The sole issue in this case is whether the wage data for South Amboy should be included in the calculation of the wage index for the Middlesex-Somerset-Hunterdon, New Jersey MSA for FFY 2003.

The Board notes that neither the enabling statute nor regulation explicitly addresses the process by which a provider or group of providers can request the exclusion of another facility's data from the wage index calculation. (See e.g., 42 U.S.C. §1395 ww(d)(3)(E) and 42 C.F.R. §412.63(w)). Moreover, there seems to be no formal process that CMS uses for this purpose. Instead, the record shows that an informal process permitting CMS to exclude unverifiable or aberrant data from the wage index calculation evolved from the comment and response portion of 67 Fed. Reg. 50023 (August 1, 2002), section D, entitled Verification of Wage Data From the Medicare Cost Report. According to the Federal Register, this informal process includes the following steps:

1. CMS obtains wage data from Worksheet S-3, Parts 2 and 3 of the applicable cost reports;

2. The Intermediary performs an intensive review of the data, mostly through the use of edits designed to identify aberrant data;

3. Intermediaries are asked to revise or verify data elements that result in specific edit failures, and to include all resolved data elements in the wage index calculations.

[3] Providers' Post-Hearing Brief at 8 and 10. Exhibits P-12 and P-16.

CMS goes on to explain how it dealt with certain unresolved data for the FFY 2003 wage index calculations. For wage data that failed edits that could not be resolved because the hospitals were no longer participating in the program or were in bankruptcy, etc., CMS removed the data for those hospitals from the calculations.

The only wage index edit process evidenced in the record is the Hospital Wage Index Desk Review Program used by the intermediaries (Exhibit P-12 at 6). The Intermediary suggests that a macro type edit system is also employed by CMS, however, there is no evidence in the record documenting this system. Accordingly, the Board concludes that the desk review program is integral to the overall edit scheme. The stated purpose of the program is "to ensure the mathematical accuracy of the data on Worksheet S-3, Parts II and III, as well as to detect any aberrancies that fall outside of HCFA's established thresholds for possible resolution. . . ." (Exhibit P-12 at 6 para. 3).

Applying the informal process outlined above to the instant case, the Board finds that South Amboy's wage data should be excluded from the wage index calculation at issue. It is undisputed that South Amboy's cost report contained certain wage data elements that exceeded HCFA's established thresholds and were flagged for resolution by the desk review program. These elements included Medicare Part A physician salaries with no corresponding wage-related costs; no contract labor costs and hours in the current period even though contract labor costs and hours were reported in the prior period; and, the ratio of wage-related costs to gross salaries exceeded the CMS prescribed range (Exhibit P-12 at 6,11, and 12. These elements could not be resolved because the facility had closed. The Board notes that the Hospital Wage Index Desk Review Program consists of three sections: (1) clerical mathematical checks, (2) comparison to prior years, and (3) wage index calculations and analysis. The entire second section, which requires a comparison of current period data to the prior period, could not be resolved. The Intermediary's auditor concluded that an accurate comparison of costs and hours could not be made because the prior period was a full cost reporting period and the current period was a short reporting period covering only eight months. "Additionally since prov. [Provider] terminated. . ., no additional documentation was supplied or able to be requested." Exhibit P-12 at 18.[4]

Finally, the Board notes that a timeliness argument was raised at the hearing, although not broadly developed by either party. Nevertheless, the Board reviewed this matter and found it irrelevant to the case. The issue stems from the Intermediary's submission of Exhibit I-3, which is a sample of a letter intermediaries were instructed to send to each PPS hospital they service.[5] In part, the letter explains that hospitals had until February 8, 2002, to request corrections to their FFY 2003 wage index data. The February deadline does not apply to this case because it applies to hospitals wishing to correct their own

[4] The Providers argue that South Amboy's cost report also contains examples of aberrant data that should be considered in deciding whether or not South Amboy should be included in the wage index calculation. However, since the Board has decided this case based upon the unresolved data elements flagged by the desk review program, the Board finds it unnecessary to address the purported aberrancies.

[5] According to CMS, intermediaries received this directive on December 19, 2001 (See 67 Fed. Reg. 31437 (May 9, 2002)).

data; not to a hospital or group of hospitals appealing the exclusion of another provider's wage data. Because there is no statutory or regulatory administrative process applicable here that providers must exhaust,[6] the publication of the wage index in the Federal Register itself triggers the Providers' right to appeal to the Board.[7] Moreover, the evidence illustrates that the Intermediary's timeliness challenge is not consistent with CMS practice. Exhibit P-15 at 2 shows that on April 5, 2002, after the February 8, 2002 deadline, CMS received a request from a group of hospitals to exclude the wage index data for another hospital from the FFY 2003 wage index calculation. This request was granted by CMS on July 17, 2002 (Exhibit P-15 at 3). The Board, therefore, concludes that there is no impediment to the Providers' challenging the wage index.

DECISION AND ORDER:

Memorial Medical Center at South Amboy's wage data was improperly included by CMS in the calculation of the Middlesex-Somerset-Hunterdon, New Jersey MSA wage index for FFY 2003. This case is remanded to CMS for the re-calculation of the Providers' 2003 wage index excluding South Amboy's wage data, and for the revision of the Providers' program payments affected by the re-calculation.

Board Members Participating:
Suzanne Cochran, Esquire
Dr. Gary B. Blodgett
Elaine Crews Powell, C.P.A
Anjali Mulchandani-West
Yvette C. Hayes

FOR THE BOARD:

DATE: October 11, 2006

Suzanne Cochran, Esq.
Chairman

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[6] See e.g. *Chicago 98-00 MSA Wage Index Group v. Mutual of Omaha Insurance Co*, PRRB Dec. No. 2006-D7, December 15, 2005. Where a hospital failed to exhaust administrative procedures established to correct a hospital's own data, the Board lacked jurisdiction for the appeal of the provider whose data was in issue. However, other providers in the MSA who were impacted by the incorrect data had no administrative remedies to exhaust and, therefore, had jurisdiction pursuant to 42 U.S.C. §1395oo(a) and the regulations at 42 C.F.R 405.1835. Those authorities provide that a provider receiving payments in amounts computed under PPS has the right to a hearing before the Board with respect to such payments provided other jurisdictional criteria are met. The "amount of payment" for PPS hospitals is defined at §1395oo(d) to include the wage index.

[7] *District of Columbia Hospital Wage Index Group Appeal*, Medicare and Medicaid Guide (CCH), HCFA Adm. Dec. January 15, 1993 ¶41,025, involved a group of D.C. hospitals that challenged inclusion of Maryland and Virginia hospital data in the calculation of their wage index. The Board had dismissed for lack of jurisdiction. The HCFA Administrator found that publication of the wage index is a "final determination" appealable to the Board.