CENTERS FOR MEDICARE & MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
BAYSTATE MEDICAL CENTER **Provider** **vs.** **MUTUAL OF OMAHA INSURANCE COMPANY** **Intermediary**	**Reimbursement Determination for Cost Reporting Periods ending: 09/30/93, 09/30/94, 09/30/95 And 09/30/96** **Review of: PRRB Decision 2006-D20 Dated: March 17, 2006**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in §1878(f)(1) of the Social Security Act (Act), as amended (42 USC 1395oo(f)). The Intermediary and the CMS' Center for Medicare Management (CMM) commented, requesting reversal of certain parts of the Board's decision. The parties were notified of the Administrator's intention to review the Board's decision. The Provider commented, requesting affirmation of the certain parts of the Board's decision and modification on other parts of the Board's decision. Accordingly, this case is now before the Administrator for final agency review.

ISSUES AND BOARD DECISION

The issues, as stated by the Board, involve:

(1) whether the 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

(2) 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.

The Board, reversing the Intermediary's determination of the DSH Medicare percentage, remanded the case to the Intermediary to recalculate the DSH Medicare percentage consistent with the Board's decision. The Board found that the statute and regulations do not require the use of the June Medicare Provider Analysis and Review file (MEDPAR) following the end of the prior Federal fiscal year. The Board concluded that there is no statutory or regulatory impediment for recalculating the DSH percentage. In addition, the Board noted that the law requires that the DSH percentage calculation must be accurate. Moreover, the Board stated that the Provider did not waive its right to challenge CMS' DSH calculation on appeal because it failed to comment on proposed regulations regarding the calculation.

With respect to data, the Board found that the match process between CMS' MEDPAR and Supplemental Security Income (SSI) data file is flawed in several respects and the flawed match may deflate the DSH percentage. In addition, the SSI data used for the Medicare percentage numerator is incomplete because it omits several SSI eligible beneficiary records and incomplete SSA data tends to deflate the DSH percentage. The Board noted that the data used for the calculation of DSH is not the best available data. The Board found that the denominator of the Medicare calculation is inaccurate and the denominator of the Medicare fraction is to include utilized or covered days, not paid days only. In addition, health maintenance organization (HMO) days are required to be counted in the Medicare fraction. Further, the Provider Statistical & Reimbursement Report (PS&R) is not appropriate for determining the denominator because it does not include utilized days; MEDPAR is the data base required to be used. The Board also concluded that 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. Finally, the Board found that there is no significant administrative burden to redesigning the computer programs to capture accurate information and to accurately match SSI data with MEDPAR data.

COMMENTS

CMM COMMENTS

Recalculation of Medicare DSH DPP

CMM commented, requesting that the Administrator review the Board's decision. CMM argued that the Board erred in interpreting the regulations regarding recalculation of the DSH Disproportionate Patient Percentage (DPP). CMM noted that the regulation at issue provides that CMS will calculate a hospital's Medicare fraction based on hospital discharge data for a Federal fiscal year. However, that regulation also permits a hospital to choose to have its DPP calculated based on the hospital's cost reporting period. CMM further asserted that there is no provision for recomputing the DPP based on later or corrected data. CMM explained that the sole permissible recalculation process for Medicare DSH is the one specified in 42 CFR 412.106(b)(3) which permits calculating a hospital's Medicare fraction for a different time period, i.e., the hospital's cost period, rather than the Federal fiscal year, not for the purposes of using updated or corrected data. In supplemental comments, CMM also pointed out that CMS has applied a similar policy in the context of outlier payment determinations, and that his policy has been upheld in several court cases.

Moreover, CMM argued that the regulations do not provide for the intermediary to calculate Medicare fractions. The Intermediary does not have access to either data set that is utilized for the calculation. Thus, the Board has neither the authority to order a recomputation based on updated or corrected data, nor to order the Intermediary to perform such a recomputation.

Use of June Version of the MEDPAR

With respect to use of the June MEDPAR, CMM pointed out that for each of years at issue, as well as for prior years, CMS put hospitals on notice each year, through the publication of the PPS rule, that the June update of the previous fiscal year was being used to derive payment information, including DSH entitlement. CMM noted, however, that no hospital including the Provider in this case, has ever complained that the Medicare fraction should be calculated on the basis of a later version of the MEDPAR. Thus, CMM maintained that the Provider should be precluded from complaining now that it was improper to use the June MEDPAR updates. CMM, citing to several court cases, stated that such a holding is consistent with case law.

Section 1619(b) Individuals

With respect to individuals who fall under section 1619(b) of the Act, CMM asserted that the Board erred in its interpretation of the regulation. The regulation at 42 CFR 412.106(b)(2) provides that the Medicare fraction is the percentage of Medicare inpatient days associated with beneficiaries who were also entitled to SSI benefits. CMM pointed out that individuals who fall under section 1619(b) are not entitled to receive SSI benefits. CMM noted that section 1619(b) was enacted so that certain individuals whose eligibility for Medicaid is predicated on their eligibility for SSI would not lose Medicaid coverage. The DSH statute and regulations include in the numerator of the Medicare fraction individuals who were entitled to SSI, not individuals who were given a special SSI eligibility status despite not being eligible for SSI benefits. CMM pointed out that the Provider in this case is attempting to establish a new category of individuals it defines as eligible for SSI by saying that such individuals.

Matching Process

Retroactive SSI Awards

With respect to the matching process and data, CMM contended that, generally, the Provider was not able to quantify the effect of the claimed systematic errors on its Medicare DSH payments. Specifically, CMM noted, with respect to retroactive SSI awards, that not all retroactive grants or denials of SSI entitlement will be captured in the SSR that is used to calculate a particular hospital's Medicare fraction. However, the inclusion of retroactive grants and denials of SSI entitlement would have minimal impact on a hospital's Medicare fraction. Further, CMM argued that the Provider could not offer any documentation demonstrated the frequency with which manual or forced pay situations occur.

CMM argued that the Provider was attempting to demonstrate that there are a substantial number of retroactive awards of SSI eligibility to Medicare beneficiaries based on statistics concerning disability awards. CMM pointed out that disability appeals are not relevant to the issues of subsequent awards of SSI to Medicare beneficiaries. CMM stated that Medicare entitlement is based on attainment of age 65 or older, or disability, or end-stage renal disease (ESRD). In addition, SSI eligibility is based on attainment of age 65 or older, or disability, or blindness, and the requisite lack of income and resources. Thus, CMM reasoned that a situation where a Medicare beneficiary is in the hospital, not eligible for SSI at that time and not counted in the numerator, but then wins a disability appeal establishing SSI eligibility should occur very rarely.

CMM also pointed out that the great majority (approximately 87 percent) of Medicare beneficiaries are entitled on the basis of age. A Medicare beneficiary who is age 65 or older is eligible for SSI on the basis of age if the beneficiary has the requisite lack of income and resource. Thus, if the beneficiary has too much income/resources to qualify for SSI, filing for SSI on the basis of disability is not going to matter, as the income and resources test applies irrespective of whether someone is aged or disabled. Individuals pursing disability appeals for purposes of SSI are not aged individuals. In support, CMM claimed that although the Provider's witness testified that SSA will allow certain income of disabled individuals to be excluded from income/resource limits, the witness could not stated how many such individuals there were, how may individuals were Medicare beneficiaries or even how many patients of the Provider.

Moreover, CMM argued that the standards for establishing disability for Medicare purposes are essentially the same for establishing disability for SSI purposes. If an individual was entitled to Medicare on the basis of disability, the individual would be entitled to SSI on the basis of disability (assuming the income/resources requirements are met.) Thus, the individuals obtaining successful appeals of SSI disability denials are not Medicare beneficiaries. Finally, CMM acknowledged that some beneficiaries entitled to Medicare on the basis of ESRD could be pursuing appeals of SSI disability denials. However, ESRD Medicare beneficiaries represent only .002 percent of Medicare beneficiaries. Therefore, CMM concluded that the Provider has failed to demonstrate that retroactive awards of SSI eligibility will be significant and will outnumber retroactive disallowances of SSI eligibility.

Manual or Forced Pay of SSI Benefits

CMM noted that the Provider claims that CMS' matching process is flawed because the process is unable to account for instances in which an SSI beneficiary receives payment as a result of a Social Security field office employee manually ordering the payment to be made and, thus, is not reflected in the social security record (SSR) However, CMM argued that the Provider offered no documentation to demonstrate the frequency with which manual or forced pay situations occur. In fact, the Provider's witness testified that she had never seen a forced pay situation and was only able to identify a one-day stay from its 1994 cost year, for which an SSI day was not counted and which involved a manual pay. Thus, CMM concluded that it is reasonable, given the small number of stays missed due to manual pays and given the prospective manner in which CMS handles other data corrections, to make any needed fix prospectively.

State Records

The stale record problem involves the problem with respect to certain records not being transmitted from SSA once a person had been deceased for a certain time period. CMM pointed out that the Intermediary has demonstrated that the average number of stale records omitted for a given provider was not more than three or four records per year, per hospital. CMM explained that prior to 1996, SSA eliminated records (commonly referred to as "stale records") from the SSR for individuals who had subsequently passed away. However, beginning with the FY 1995 Medicare fractions, no stale records were omitted from any Medicare fraction calculation. Thus, the problem of stale records is limited to the Provider's 1993 and 1994 cost year.

When CMS realized the problem, it fixed the problem prospectively. CMS did not recalculate the Medicare fraction prior to 1995 because information at that time suggested that the problem did not significantly affect individual provider's DSH adjustment amounts. CMM stated that the evidence still supports this calculation. CMM argued that the Provider failed to provide evidence that the omission of such records significantly affected their Medicare DSH payments for those years. CMM stated that with respect to FYs 1993 and 1994, neither the specific versions of the MEDPAR used to calculate the Provider's Medicare fractions, nor any other pre-1996 version of the FYs 1993 and 1994 MEDPAR files exist.

CMMS pointed out that CMS matched updated SSI information with existing MEDPAR files that had no SSI days associated with them after taking the updated SSI information into account. (Exhibit P-64.) This data was updated data and not just the restored data so one cannot determine what portion of the record count was due to restored stale records and what portion was due to updates in individual SSI eligibility status. The record also contains unedited data for which about 4 percent would be legitimately dropped out each year. The MEDPAR versions used for matching were later versions of the original file and therefore could be expected to have had more missing stale records that the version that was used to perform the actual calculation, The more time which elapsed between the hospital stay and the compilation of the SSA tapes increased the number of patients that may have died and or otherwise become inactive and eventually dropped from the SSA records.

However, based on the information contained in the record for FYs 1993 and 1994, CMM argued that the record reflects that the average sized hospital with the average SSI population would have had about four stale records omitted from its calculation for FY 1993. Moreover, the numbers for FY 1994 are even less significant and would be about three stale records each.

Supporting these findings is also the fact that the data for the Medicare fraction for all hospitals rose each year by about the same percentage. If a significant number of stale records had been omitted, one would have expected a large increase between FY 1994-1995 and then a steady rise from 1995 onward. But that is not shown from the statistics, further supporting the contention that the omitted records were not significant. Thus, CMM concluded that as the stale records problem was not significant, it was reasonable for CMS not to have recomputed the Provider's Medicare fractions to include any stale records consistent with its general IPPS practice of prospective corrections.

Beneficiaries without Title II Numbers

With respect to the Provider's argument that CMS failed to match SSI beneficiaries who do not receive Title II numbers to Medicare stays in the MEDPAR, CMM explained that CMS generates a Title II number from each social security number on the SSR tape. Thus, if a record on the SSR does not already contain a Title II number, CMS uses the Title II number it has created in the matching process. Finally, only one stay was identified which is less than 1/6th of one percent of the sample.

Burden of Proof

CMM argued that the Provider has failed to show that any of the alleged defects in the matching process had any material effect on its payments. For Medicare reimbursement purposes, a Provider always has the burden of proving entitlement to payment. In this case, the Provider has been unable to provide that it is entitled to additional DSH payments. Moreover, CMM noted that despite the Provider's selective request for updated SSI records, it found only 10 individuals, representing just 12 stays, who were not credited with SSI days in the MEDPAR data, but who, according to the updated SSI data, were eligible for SSI at the time of discharge. The Provider has failed to show that ny of the 12 stays should have been credited with SSI days but were not by CMS.

Other Issues

Despite the Board's conclusion that CMS' process for determining the Medicare fractions produced estimates as opposed to accurate determinations, CMM argued that the Medicare fractions are not estimates. Rather, the Medicare fractions are approximations which are permissible and were achieved. An approximation equates with accuracy. Although an approximate calculation may not be 100 percent precise, it is accurate. Thus, CMM stated that the Medicare fractions are accurate.

Moreover, CMM argued that under the Board's decision, CMS would have to continually update the MEDPAR and maintain those versions forever. Such a requirement is not set forth in the statute, or regulations and should not be implied. To do so would be unreasonable and impose a significant administrative burden on CMS. Moreover, CMM argued that the Board's suggestion that only a minimal amount of work would be necessary for CMS to recomputed the Medicare fractions, transmit the information, recalculate payments and make any adjustments for changes to a hospital's Medicare fraction for all hospitals is misleading and underestimates CMS' responsibilities. Rather, the whole of CMS' PPS implementation scheme needs to be considered when evaluation administrative burden.

Finally, CMM concluded that in addition to the significant administrative burden, there is no evidence to support the contention that the use of updated or corrected data would produce more favorable results to either the Provider or any other hospital. CMM noted that when using updated data, the denominator could change as well as the numerator. Thus, in some instances, a hospital may actually lose entitlement to a DSH payment.

INTERMEDIARY COMMENTS

HMO Days

The Intermediary commented, requesting that the Administrator's review of the Board's decision. The Intermediary explained that it did not agree with the Board's findings on both the numerator and denominator of the Medicare fraction, but that it was addressing only the Board's decision on the denominator. The Intermediary argued that the Board erred in its finding that the MEDPAR count of total Medicare days for the denominator was unreliable since the Intermediary was unable to explain the discrepancies between the MEDPAR and the PS&R. The Intermediary explained that 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 (MSP), 22 stays related to Medicare HMO enrollees, five days were denied payment by peer review and seven stays were denied payment because they were not timely billed.

With respect to Medicare secondary payer (MSP) stays, the Intermediary noted that the Provider contended that CMS reversed its position as to whether the MSP stays should be counted in the denominator. However, as the Intermediary's witness testified, MSP stays were properly counted MEDPAR based on the utilized days for the stays. Further, concerning HMO days, the Intermediary noted the Provider's assertion that CMS did not adequately notify providers that they were to bill no-pay bills in order to have Medicare HMO days included in the DSH

calculation. However, the Intermediary pointed out that section 411 of the Medicare Hospital Manual directs that a no-payment bill must be submitted for services provided to an HMO enrollee for which an HMO has jurisdiction for payment. Thus, contrary to the Board's finding, it is the Provider's responsibility to submit HMO and other no-pay bills in order to properly reflect the Medicare beneficiaries' inpatient hospital utilization. This no-pay bill will then be reflected in the MEDPAR file.

Accuracy of MEDPAR

With respect to the accuracy of the MEDPAR, the Intermediary argued that, contrary to the Board's finding, the MEDPAR is extremely reliable. The Intermediary noted there were no differences in data between the two files for fiscal years ending (FYEs) 1993 and 1996, and that there were only 40 unexplained differences in FYEs 1994 and 1995. Thus, of the 35,000 stays for the four fiscal years, the Intermediary explained 34,960 stays which is 99.89 percent of the stays. The Intermediary argued that to the extent that the unexplained stays were erroneously excluded from the MEDPAR, these few stays clearly represent abnormal situations, not pervasive or systemic problems with the accumulation system.

Moreover, the Intermediary argued that it is impractical to require intermediaries and/or providers to explain every transaction on the cost report, including the Medicare fraction. Due to limited resources, intermediaries engage in sampling techniques to audit cost reports. Many cost reports are not reviewed due to materiality. Materiality is a judgmental concept which applies when differences between cost report years do not require further review, which claimed amounts are not significant and when resources do not permit further review. The Intermediary noted that the Board hears only cases that are within monetary limits. These limits are to reduce administrative burdens on entities due to limited resources. Likewise, the Intermediary should not be placed in the position of explaining every difference since this is not practical due to the age of the claims, a change of the intermediary that processed the claims, and the resources that would have to be expended.

Further, the Intermediary contended that the MEDPAR is extremely accurate. The Intermediary noted that filed and audited cost reports cannot be considered a perfect reflection of amounts due providers or amounts due Medicare, otherwise there be not need to file amended cost reports, or request reopenings and appeals. Thus, the standard for accuracy is not perfection. The lack of explanation for 40 differences cannot be considered to reflect inaccuracies in the denominator, as perfection is not the standard. The Intermediary asserted that under the Board's definition of accurate, the MEDPAR file must be absolutely perfect in order to be accurate, i.e., "free from mistake or error." However, the Intermediary argued that

the entire Medicare payment and cost reporting scheme is predicated on the standard of "a degree of conformity of a measure of a standard." The Intermediary pointed out that in cost allocations, the cost reporting forms use B-1 statistics. By supplying good documentation, those statistics can certainly allocate costs accurately. However, they will not perfectly allocate these costs. For example, the Intermediary wrote it would be absurd to believe that the use of accumulated costs to allocate administrative and general costs (A&G) perfectly measures each department's utilization of A&G resources. However, this measure is certainly considered reasonable and accurate.

In sum, the Intermediary argued that, based on the statement of issue in this case, the focus of this case is whether the Medicare fraction is incorrect. The burden of proof is to be placed on the Provider. The Provider in this instance has not proven that the MEDPAR data is inaccurate (the synonym for incorrect). The Intermediary maintained that it was not its burden, but yet, the Intermediary in fact did prove that the MEDPAR data is accurate.

PROVIDER'S COMMENTS

The Provider commented, requesting that the Board's decision be affirmed, in part, and modified/clarified, in part. The Provider argued that the Board's decision should be modified/clarified to reverse the Intermediary's determination regarding the Medicare/SSI fraction, to remand to CMS for recalclulation, and to direct the Intermediary to apply the recalculated percentage in the revised DSH payment determination for each fiscal year at issue. In addition, the Provider asserted that the Board's decision should be modified/clarified to include only Medicare paid days in the denominator of the fraction and to exclude days after an individual has exhausted Part A benefits or days for which no Medicare payment is made. Finally, the Provider argued that the Board's decision should be modified/clarified to exclude Medicare HMO days from the denominator of the Medicare/SSI fraction.

MEDPAR/SSI

With respect to the remaining portions of the Board's decision, the Provider urged that the Administrator affirm the Board's decision. The Provider argued that in the interest of justice and sound administrative policy, affirmation would resolve this matter now without judicial intervention. The Provider asserted that contrary to CMS' argument, CMS has performed several recalculations of the fraction as part of a settlement in a prior case. The evidence showed that the Social Security Administration (SSA) reran SSI data for CMS after a Federal district court had ruled that a plaintiff hospital was entitled to obtain the data. Further, the Provider claimed that CMS' MEDPAR programmer testified that CMS performed

MEDPAR runs and these runs are matched against annually updated SSI data. However, CMS has not used the later runs for purposes of establishing the Medicare/SSI fractions that are used to compute DSH payments in cost report settlements.

Further, the Provider claimed that recalculations should be performed because, if the errors and omissions in CMS' calculations are immaterial, as suggested, then CMS will be able to clear out the thousands of pending cases on this issue. Hospitals are not going to expend scarce resources to appeal and to pursue recalculations on an immaterial issue. However, if the problems with CMS' calculations are material, as the evidence showed, then it would be better to fix the problem now without necessity of court intervention. The Provider also argued that contrary to CMS' longstanding DSH policy of using the best data available, the record shows that CMS knew there were problems with the calculations.

Stale Records

With respect the specific data issues, the Provider argued that CMS knew it had a problem with the SSI data and failed to investigate or correct the source of the problem. Rather, CMS maintained that the SSI data was verified and correct. Further, the Provider alleged that CMS announced a change in the process for requesting recalculations and failed at that time to disclose problems with the SSI data. The Provider noted that CMS created "special" MEDPAR records that would include both the old and the new SSI days for the prior years. From these special files, CMS produced extracts showing the numbers of hospital stays in which the number of computed SSI days increased or decreased. The Provider claimed that CMS' witness testified that the intent of the special MEDPAR project to determine whether the differences were material. The Provider argued that the special MEDPAR files showed the impact of the omission of the stale SSI records by year, by hospital and by patient stay. However, CMS failed to disclose the omission of stale records and failed to ever pay hospitals additional DSH. Moreover, the Provider claimed that CMS has continually failed to provide specific SSI data to the Provider.

Title II

With respect to the matching process, the Provider argued that, although CMS stated it uses individual social security numbers (SSN) in the match process, in fact, CMS has never used SSNs to match the SSI records against the inpatient hospital stay records. The Provider asserted that the testimony in the record reveals that unless SSA gives CMS all an individual's Title II numbers, CMS will never get the match right under the match process it currently uses. Further, the Provider claimed that CMS admitted that it was aware not later than February 1996 that

there were flaws in its match process. Had a change been effected prior to 1996 it would have increased the numerator of the hospital's Medicare/SSI fraction. However, CMS did not correct the SSI fractions and did not disclose this problem to the hospitals.

HMO Days

With respect to the Medicare days counted in the denominator, the Provider argued, citing several examples, that CMS has been inconsistent. CMS has stated that the Medicare/SSI fraction includes only Medicare "paid" days which is consistent with CMS' established interpretation of "entitled." However, CMS has been inconsistent as to the treatment of days attributable to Medicare beneficiaries who have exhausted Part A benefits. The Provider maintained that, likewise, CMS' treatment of Medicare HMO days has been inconsistent. The Provider stated that CMS issued a statement indicating that Medicare HMO days had been counted in the Medicare/SSI fraction since 1987. However, the Provider pointed out CMS knew as early as 1987 that the data it would need to count Medicare HMO days in the Medicare/SSI fraction was not being reported to CMS.

Finally, the Provider claimed that Medicare HMO days were counted in the MEDPAR only in cases when the HMO patient stays were billed under Part A fee-for-service and payment was denied. In fact, based on CMS' calculations of the Medicare/SSI fraction for the Provider only above one one-thousandth of the total Medicare days represent HMO days.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

The Social Security Amendments of 1965[1] established Title XVIII of the Act, which authorized the establishment of the Medicare program to pay part of the costs of the health care services furnished to entitled beneficiaries. The Medicare program primarily provides medical services to aged and disabled persons and consists of two Parts: Part A, which provides reimbursement for inpatient hospital and related post-hospital, home health, and hospice care,[2] and Part B, which is supplemental voluntary insurance program for hospital outpatient services, physician services and other services

[1] Pub. Law No. 89-97.
[2] Section 1811-1821 of the Act.

not covered under Part A.[3] At its inception in 1965, Medicare paid for the reasonable cost of furnishing covered services to beneficiaries.[4] However, concerned with increasing costs, Congress enacted Title VI of the Social Security Amendments of 1983.[5] This provision added §1886(d) of the Act and established the inpatient prospective payment system (IPPS) for reimbursement of inpatient hospital operating costs for all items and services provided to Medicare beneficiaries, other than physician's services, associated with each discharge. The purpose of IPPS was to reform the financial incentives hospitals face, promoting efficiency by rewarding cost effective hospital practices.[6]

These amendments changed the method of payment for inpatient hospital services for most hospitals under Medicare. Under IPPS, hospitals and other health care providers are reimbursed their inpatient operating costs on the basis of prospectively determined national and regional rates for each discharge rather than reasonable operating costs. Thus, hospitals are paid based on a predetermined amount depending on the patient's diagnosis at the time of discharge. Hospitals are paid a fixed amount for each patient based on one of almost 500 diagnosis related groups (DRG) subject to certain payment adjustments.

Concerned with possible payment inequities for IPPS hospitals that treat a disproportionate share of low-income patients, pursuant to Section 1886(d) (5) (F) (i) of the Act, Congress directed the Secretary to provide, for discharges occurring after May 1, 1986, "for hospitals serving a significantly disproportionate number of low-income patients…"[7]

There are two methods to determine eligibility for a Medicare DSH adjustment: the "proxy method" and the "Pickle method."[8] To be eligible for the DSH payment under the proxy method, an IPPS hospital must meet certain criteria concerning, inter alia, its disproportionate patient percentage or DPP. Relevant to this case, with respect to the proxy method, Section 1886 (d)(5)(F)(vi) of the Act states that the terms "disproportionate patient percentage" means the sum of two fractions which is expressed as a percentage for a hospital's cost reporting period. The fractions are often referred to as the "Medicare low-income proxy" or "Medicare fraction" and the Medicaid low-income proxy", respectively, and are defined as follows:

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[3] Section 1831-1848(j) of the Act.
[4] Under Medicare, Part A services are furnished by providers of services.
[5] Pub. Law No. 98.21.
[6] H.R. Rep. No. 25, 98th Cong., 1st Sess. 132 (1983).
[7] Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. No. 99-272). See also 51 Fed. Reg. 16772, 16773-16776 (1986).
[8] The Pickle method is set forth at section 1886(d)(F)(i)(II) of the Act.

> (I) the fraction (expressed as a percentage) the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under Part A of this title and were entitled to supplemental security income benefits (excluding any State supplementation) under title XVI of this Act and the denominator of which is the number of such hospital's patients day for such fiscal year which were made up of patients who (for such days) were entitled to benefits under Part A of this title.
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> (II) the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consists of patients who (for such days) were eligible for medical assistance under a State Plan approved under title XIX, but who were not entitled to benefits under Part A of this title, and the denominator of which is the total number of the hospital patient days for such period. (Emphasis added.)

CMS implemented the statutory provisions at 42 CFR 412.106 (1994) and explains that the hospital's disproportionate patient percentage is determined by adding the results of two computations and expressing that sum as a percentage. Relevant to this case, the first computation, the "Medicare fraction" is set forth at 42 CFR 412.106(b)(2)(1994). The regulation at 42 C.F.R. §412.106(b) provides that:

> (b*) Determination of a hospital's disproportionate patient percentage.* (1) *General rule*. A hospital's disproportionate patient percentage is determined by adding the results of two computations and expressing that sum as a percentage.
> (2) *First computation: Federal fiscal year*. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
> (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;
> (ii) Adds the results for the whole period: and
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of patient days that—
> (3) *First computation: Cost reporting period*. If a hospital prefers that CMS use its cost reporting period instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request including the hospital's name provider number, and cost reporting period end date. This exception will be performed once per

> hospital per cost reporting period, and the resulting percentage becomes the hospital's official Medicare Part A/SSI percentage for that period.
> (4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period…..

The Provider has challenged the calculation of its Medicare fraction in determining its DSH adjustment payment in this case.[9] The regulation provides for CMS to transmit the Medicare fraction for a provider to the Intermediary. A provider may elect to have the Medicare fraction calculated based upon the Federal fiscal year or its cost reporting period.

Of particular interest to the providers in this case was the social security records provided by SSA to CMS to conduct the calculation. The SSI file includes 42 months of data and is run for CMS on a yearly basis.[10] Each year, around early April, SSA sends to CMS a file that contains a list of all individuals who were entitled to SSI benefits for any month during the past 39 or 40-month period, or who are projected to be entitled to SSI for either or both of the next two or three months.[11] CMS identifies the Medicare beneficiaries from among the individuals listed on the SSA file, and matches the resulting file of Medicare/SSI beneficiaries against its Medicare patient stay information for the previous Federal fiscal year.[12] CMS then computes the Medicare fraction for all inpatient PPS hospital cost reporting periods that began during the previous FFY.[13]

The SSA tapes for the periods at issue are described as follows:[14] For each SSI recipient on the tape there is: truncated last name and first initial; social security number, date of birth, gender, social security number or railroad retirement

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[9] Under the Administrative Procedure Act, the proponent of the rule has the burden of proof. 5 USC 556(d). Thus, a provider has the burden to establish its claim for reimbursement before the Board. In this instance, the Provider has the burden of proof to support its claim for additional DSH payments by a preponderance of the evidence. (Fairfax Hospital Association v. Califano, 585 F. 2d 602 (4th Cir. 1978) CMS/HCFA Ruling79-60c.)

[10] Exhibit P-42 at 1232, Transcript of Oral Hearing (Tr.) at 124-25.

[11] Exhibit P-41 at 1181, Tr. at 175-78.

[12] Exhibit P-42 at 1221-22.

[13] Exhibit P-42 at 1225.

[14] Board's decision at page 10-11, Provider's Position Paper pp. 15-16.

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 (one and zeros) denoting the payment or non-payment of the Federal SSI cash benefits during the period covered by the SSA tape.

For each of the years at issue, the providers received their Medicare DSH fractions based on June updates of the "MEDPAR."[15] The MEDPAR (Medicare Provider Analysis and Review) files contains data from claims for services provided to beneficiaries admitted to Medicare certified inpatient hospitals. The accumulation of claims from a beneficiary's date of admission to an inpatient hospital where the beneficiary has been discharged represents one stay. A stay record may represent one claim or multiple claims. Approximately 95 percent of inpatient stays involve a single claim. Prior to 1995, the stay records were based on the CMS Common working file.[16] Since 1995, the MEDPAR is drawn from the National Claims History data base.[17] The national claims history files contains "utilized days" The national claims history file is compiled from the common working file.[18] The common working file similarly contains utilized days.[19]

For each inpatient stay, the MEDPAR file contains the following data fields showing: 1) the hospital's Medicare provider number; 2) the patient's health insurance claim account number, which is sometimes referred to as the HIC or HICAN, 3) the dates of admission to or discharge for the hospital, 4) the total length of the inpatient hospital stay, 5) the number of days in the stay that were covered under Medicare Part A, and 6) the number of days in the stay for which the patient was determined through the match process described above to be eligible for SSI.

The MEDPAR data and the subsequent SSI match is described as follows:[20] CMS attempts to match information from the SSI tape that it receives from SSA on the basis of Medicare Health Insurance Claim Numbers (HICANs)[21] CMS attempts to match the HICAN under which the patient stay is recorded with the HICAN that is provided by SSA in the "Title II field" of the SSI tape.[22] CMS also attempts to match the HICAN under which the patient stay is recorded with a HICAN from the

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[15] Tr. 2039-40.
[16] Dean Evidentiary Hearing Tr. 76-78, P-42, Tr. 1218-1219, P-13 at 118, Tr 1414.
[17] Dean E.H. Tr, 54-59)
[18] P-42, Tr. 1219; P-13 at Tr. 116, Tr. 1727)
[19] Tr. 1726.
[20] See Intermediary Post-Hearing Brief, pp 4-6 and the Intermediary Post-Hearing, Brief, Exhibit 1, Parties Stipulations.
[21] Exhibit I-8 at 60, Tr. 1340, 1345.
[22] Tr. at 1340.

SSI tape that is generated by CMS.[23] CMS generates this HICAN by taking the Social Security Number on the SSI record and appending a beneficiary identification code ("BIC").[24] The BIC that is added is an "N" which is later converted to an "A".[25] By matching based on two health insurance claim account numbers, CMS is able to match beneficiaries who are entitled to Medicare on the basis of someone else's account number (such as the account number of a spouse) as well as those who are entitled to Medicare on the basis of their own account.[26]

I. The Medicare fraction is not subject to revision pursuant to updated or corrected data.

The Board reasoned that a policy prohibiting the recalculation of the SSI ratio would be contrary to the statute as it would nullify providers' rights to appeal. In addition, the Board pointed to language in the preamble indicating that the Secretary recognized a right to challenge the SSI calculation and, hence, that the Medicare fraction could be recalculated. Consequently, the Board concluded that the regulation did not preclude the recalculation of the Medicare fraction. The Administrator finds that, as set forth below, the regulation does not provide for a recalculation of the SSI ratio based upon updated or later data once it is completed by CMS.

A. The plain language of regulation does not provide for recomputation based on later data.

The Administrator disagrees with the Board's conclusion that the regulation allows for a recalculation of the Medicare fraction for updated or later data. A review of the applicable law and regulations show that the Secretary did not intend for the DSH calculations to be recomputed or recalculated based upon later, or corrected, data.

On its face, the regulation does not allow for further recalculations of a provider's SSI ratio beyond that explicitly prescribed in the regulation. As the regulation shows, only a limited exception for recalculation of the Medicare fraction based upon a provider's cost reporting period is allowed. Notably, this limited exception was based on the explicit time period (a provider's cost reporting period) which was set forth in the statute. In contrast, no such explicit provision for recalculation

[23] Tr. at 1341.
[24] Tr. at 1341, 1343.
[25] Tr. at 1343.
[26] Tr. at 1347-48.

of the Medicare fraction based on later, or corrected data, is set forth in the statute, nor in the regulation.

The Secretary has consistently recognized the administrative burdens involved in calculating the Medicare fraction and has made policy decisions balancing the need to reduce administrative burdens and the need for timely, accurate data. The policy to consider the CMS calculated Medicare fraction not subject to updating is consistent with the sometimes competing interests of finality, timeliness, efficiency and accuracy in the administration of a large Federal program.

In arriving at this policy, the Secretary considered the administrative burdens associated with the calculation of the Medicare fraction. The Secretary necessarily examined these problems within the context of administering the entire Medicare program and not within the singular context of calculating a single hospital's DSH Medicare fraction. In implementing DSH provisions in 1986, the Secretary found that to match SSI eligibility records to Medicare bills on a Federal fiscal year on an annual basis was the most efficient approach given the scope of the program. Noting the 11 million billing records and 5 million SSI records, the Secretary specifically limited any calculations to a *yearly basis* stating that:

> The data source for computation of the SSI/Medicare percentage include the Medicare inpatient discharge file which is compiled on a Federal fiscal year basis and includes approximately 11 million billing records (this compilation is done about three or four months after the close of the Federal fiscal year and is then updated periodically as additional discharge data are received) and the SSI file that lists all SSI recipients for a 3 year period denotes the month during the period in which the recipient was eligible for SSI benefits (the SSI file includes over 5 million records.) In order to compute the SSI / Medicare percentage, the 11 million records from the discharge file must be individually matched by beneficiary number and month of hospitalization with the SSI recipient records. On a Federal fiscal year basis, this match would be performed on a yearly basis. (Emphasis added.)[27]

In balancing administrative efficiency and accuracy, the Secretary noted that:

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[27] 51 Fed. Reg. 31454, 31459-60 (Sept 1986).
(The 2002 MEDPAR file contains over 12 million records. See, e.g., http://www.cms.gov/IdentifiableDataFiles/05_MedicareProviderAnalysisandReviewFile.asp.)

> We do not believe that there are likely to be significant fluctuations from one year to the next in the percentage of patients served by hospitals that are dually entitled to Medicare Part A and SSI. Consequently, the percentage for a hospital's own experience during the Federal fiscal year should be reasonably close to the percentage specific to the hospital's cost reporting period.[28]

The Secretary, subsequently, compared the Medicare fraction based on a provider's cost reporting period and the Federal fiscal year and concluded, as predicated, that these two periods resulted in reasonably close percentages. The Secretary subsequently determined that he would afford hospitals the option to determine the number of patient days of those dually entitled to Medicare Part A and SSI for their own cost reporting periods. The Secretary concluded that:

> We do not believe Congress intended to impose cumbersome and costly administrative burden as that described above in implementing this provision. The Secretary has general rulemaking authority under section 1102 and 1871 of the Act to deal with problems of implementing and administering the Act in an efficient manner. Based on the above discussion, we believe that using the Federal fiscal year instead of a hospital's own cost reporting period is the most feasible approach to implementing provision terms of accuracy, timeliness and cost efficiency. In addition, we believe we have complied with the law by affording hospitals the option of having their SSI/Medicare percentages computed based on … the cost reporting period.[29]

In allowing for this provision, the Secretary noted that:

> [I]f a hospital has its SSI/Medicare percentage recomputed based on its own cost reporting period, this percentage will be used for purpose of it disproportionate share adjustment <u>whether the result is higher or lower than the percentage computed based on the Federal fiscal year.</u>" (Emphasis added.)[30]

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[28] 51 Fed. Reg. 16777.

[29] 51 Fed Reg. 31459-60. (<u>See also</u> "[I]n the interim final rule we proposed matching SSI eligibility records to the Medicare bills on a Federal fiscal year basis because we believe this is the most efficient approach." 51 Fed. Reg. 31454 (Sept. 3, 1986))

[30] 51 Fed Reg. 31459-60.

That is, a provider cannot request such a recalculation and chose the higher Medicare fraction. The regulatory language plainly does not incorporate any procedures for revising the Medicare fraction based upon later data. Rather, the regulation provides for a provider's Medicare fraction to be final, once calculated by CMS, except in the instance where a provider has requested the computation be based on its cost reporting period.

Finally, in response to the specific commenters, the Secretary had the opportunity to specifically address this issue in the final rule to the FFY 2006 final rates.[31] The Secretary specifically rejected the use of updated SSI eligibility information (which the commenter argued may include retroactive approvals etc.), for use by CMS to revise calculations of hospital DSH Medicare fractions. Consequently the Secretary clearly had a policy of calculating the SSI fraction based upon specific data, within certain timeframes, and not subject to later revision.

B. Policy is consistent.

This policy is consistent with IPPS. Notably, where the Secretary has allowed for corrections of data underlying inpatient prospective payments or IPPS, the Secretary has set forth specific procedures and timeframes for doing so consistent with the aims of IPPS (e.g., wage index). In contrast, no process was implemented in the regulations at 42 CFR 412.106 for the recalculation of the CMS Medicare fraction.

Likewise, the Secretary has determined that the refusal to recalculate underlying IPPS data is also rational and consistent with the aims of the inpatient PPS. Specifically, the regulation for determining eligibility for the rural referral center status required the use of a provider's published 1981 case mix index (CMI). The Secretary refused to recalculate a provider's 1981 CMI for purposes of determining its eligibility for rural referral center status under IPPS.[32] The court in Board of

[31] 70 Fed. Reg. 47278, 47439-47440.

[32] In reference to a specific objection raised by a commenter regarding the CMI, the Secretary announced: "We do not believe that hospitals should be allowed to substitute other criteria for the one we published in the NPRM (notice of proposed rulemaking. We selected the 1981 case-mix index for this criterion because it represents the most current published data available at the time. The basic tenet of the prospective payment system is that the rates paid to hospitals are determined prospectively and are based on the best data available at the time. Thus, a hospital knows in advance what its payment amounts will be." See 49 Fed. Reg. 34728 34743-44 No commenters raised the issue of recalculating the SSI ratio in the initial rule implementing the DSH SSI calculation and thus the issue was not explicitly addressed in the final rule.

Trustees of Knox County Hospital v. Shalala, 135 F 2d 493 (7th Cir. 1998), specifically addressed the provider's challenge to the Secretary's use of a published 1981 case mix index (CMI). The provider argued that CMS ought to accept a recalculated CMI because its study conducted by a nationally recognized consulting firm, was based on 100 percent of the provider's 1981 Medicare discharges. In contrast, the Secretary's calculation was based in large part on the MEDPAR file, which included information concerning only 20 percent of the Provider's 1981 discharges. However, the Court accepted that the Secretary's policy serves the interests of accuracy, uniformity and administrative convenience and concluded that the Secretary's policy of relying solely on her own calculation of a provider's 1981 CMI was not arbitrary and capricious.

The Secretary, as a matter of policy, also declined to recalculate the outlier payments to account for the difference between the estimated and actual outlier payments. See e.g., 49 Fed. Reg. 234, 265-66. In response to commenters, the Secretary pointed out that this policy applied regardless of whether the aggregate outlier payments resulted in more or less than the statutory five- six percent of the total projected DRG prospective payment. Such a policy promoted finality, efficiency and certainty in the process. The court in County of Los Angeles v. Shalala, 192 F. 2d 1005 (1999), upheld this policy observing that: "while we have recognized that retroactive corrections may not ultimately undermine PPS, we have emphasized that that 'does not establish that a prospective-only policy is unreasonable.' *Methodist*, 38 F. 3d at 1232." County of Los Angeles v. Shalala, 192 F. 2d 1005, 1020 (1999).

Similarly, the Secretary's policy in this instance promotes administrative finality and certainty in the process. The Secretary's policy is neutral in that the SSI ratio remains the same regardless of whether a later recalculation would result in a higher or lower Medicare fraction. This neutrality ensures predictability in the process by preventing unexpected shifts in the payment rates based on later data. The agreement between the Provider and the Consultant acknowledges this possibility in providing for the Consultant to be liable for any decreases in the Provider's DSH payment as a result of litigation.[33]

Thus, the Administrator finds that the regulation precludes the recalculation of the Medicare fraction based on updated or corrected data. Further, as the Board is bound by the regulations, it is not authorize to order any recalculation of the SSI ratio based on updated or corrected data.

[33] Intermediary Exhibit I-10, p. 11.

C. Provider's appeal rights not nullified.

The Administrator also disagrees with the Board's conclusion that the Secretary could not have intended to adopt such a policy as it would nullify providers' appeal rights and that the Secretary had acknowledged providers' rights to challenge the SSI calculation and have its Medicare fraction recalculated in preamble language. The fact that the Secretary acknowledges the providers' rights to appeal the SSI calculation does not negate the Secretary's policy that the SSI ratio is not intended to be corrected with later data. The Secretary explicitly released the data for providers' challenging the Medicare fraction on appeal. Notably, the data was not released in order to allow providers the option of having its Medicare fraction recalculated based on corrected or later data.

The provider in Methodist Hospital of Sacramento, 38 F. 3d 1225 (1994), also argued that the right to appeal necessarily assumes the right to have corrections implemented retroactively in its case. A policy of prospective only corrections in that case, the provider argued, was not consistent with the appeal provisions. However, the court noted that:

> Congress' decision to retain certain appealable review procedures from a prior reimbursement regime does not necessarily imply congressional intent to maintain identical remedies. In PPS, Congress created a radically new method for determining Medicare reimbursement. Georgetown II, 862 F. 2d at 239, as well as a new method for handling reimbursement payments. See Washington Hosp. Center v Bowen, 254 U.S. App. D.C. 94, 795 F. 2d 139, 146 (D.C. Cir. 1986). Here the Secretary decided to alter the retroactive effect of appellate proceedings, a decision congress left open in the 1983 amendments. This choice does not limit the availability of judicial or administrative review itself.

Likewise, the Secretary's policy here does not limit the availability of judicial or administrative review in this case. The Secretary's policy regarding the basis for the Medicare fraction is appealable and subject to judicial review, just as the Secretary's IPPS prospective-only policy was subject to review in Methodist Hospital of Sacramento, 38 F. 3d 1225 (1994). Moreover, the Provider may challenge the "type" of day included in the calculation and the process for determining the Medicare fraction. Consequently, the Board incorrectly relied on this basis to determine that the regulation could not be interpreted to preclude the recalculation of the Medicare fraction based on later data.

II. CMS has historically used best available data in computing IPPS payments.

A. The Board erred regarding the precision of the calculation.

The Board erred in finding that CMS was required to conduct a precise calculation and, thus, that the Medicare fraction could be corrected with later data. As a practical matter, the Board decision means that the Medicare fraction would be always subject to recalculations based on later updated data. In reaching this conclusion, the Board found that an estimate, rather than an accurate determination, was not permissible. The Board further concluded that, even if CMS were allowed to use the "best available data", CMS' process for determining the Medicare fraction was not likely to produce the best available data.

The Administrator finds that the Intermediary properly argued that CMS' Medicare fraction must be based on the "best available data." This is consistent with the Secretary's various pronouncements stating that a basic tenet of the prospective payment system is that the rates are based on the best data available at the time.[34] The best available data is "accurate" data in fact for purposes of payments under IPPS. The Secretary specifically stated that, with respect to the Medicare DSH fraction, his goal is to obtain reasonably accurate but not perfect calculations.[35]

The Administrator finds that the Board inappropriately relied on Georgetown University Hospital v. Bowen, 862 F. 2d 323 (D.C. Cir. 1988), in concluding that the Medicare fraction must, in effect, be calculated consistent with reasonable cost payment methodology. The Board noted that the D.C. Circuit Court of Appeals concluded that the IPPS statute required the Secretary to calculate the hospital-specific portion based on "allowable operating costs of the inpatient hospital services" not estimated allowable costs." Id at 326-27. Consequently, the Board stated that the court required the Secretary 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.

However, with respect to Georgetown, the Administrator finds that the court expressly recognized the distinction between the payment provisions under the hospital-specific component of IPPS and those under IPPS. The court found that

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[34] See 49 Fed. Reg. 34728 34743-44.
[35] 51 Fed Reg. 16777.

the hospital-specific portion of the IPPS rate retained and incorporated the previous reasonable-cost regime into the IPPS rate during the transition period. The Georgetown II court stated that:

> We note that when PPS statute instructs the Secretary to determine "allowable operating costs per discharge" under the new prospective payment methodology … It involves an entirely different sense of the term: costs that are allowable under the new system may not be subject to retrospective revision, but that certainly does not mean that the same must be true when the statute refers to costs that were allowable under an entirely different methodology. Georgetown II, 862 F. 2d at 327 n.11.

Thus, the Georgetown II ruling with respect to the IPPS hospital-specific rate would not be relevant to the analysis in this instant appeal.[36] The payment provision under this appeal involves an adjustment to an IPPS payment adjustment. The DSH payment does not involve the prior reasonable cost methodology, but is purely an IPPS methodology.

The Board also erroneously finds a correlation between the DSH payment and the reasonable cost methodology as the DSH payment is based on hospital-specific data from a prior cost reporting period. Thus, the Board found that the payment is retrospective in nature. However, IPPS rates are generally based on historical data. For example, the wage index is based on hospital-specific data from retrospective cost reporting period from four years earlier. Consequently, the fact that the DSH payment methodology is based on historical data does not make it equivalent to the reasonable cost payment methodology.

In addition, despite the intended prospective nature of IPPS, a provider is still subject to the reconciliations of payments in year end settlements.[37] Such

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[36] See also Los Angeles at 43 ("Nor is it accurate to claim that as the hospitals do, that outlier payments are entirely divorced from PPS. As an initial matter, the provisions resulting to outliers are contained in the same subsection of section 1395ww as those establishing the PPS regime. See 1395ww(d). Moreover, Congress established outlier payments not as a distinct reimbursement methodology but as a carefully crafted supplement to PPS. For that reason Georgetown II, which concerned retroactive adjustments under the pre-PPS "reasonable cost" system—clearly a payment methodology lacking any relationship to PPS—is inopposite."Id. n. 43

[37] The Secretary explained the method of payment: ''The process we will use for making payments to hospitals that serve a disproportionate share of low income patients will be similar to the process we use to make the additional payment for the indirect medical education costs; that is we will make interim payments based

reconciliations do not negate the character of IPPS. The Administrator disagrees with the Board's conclusion that the concerns of predictability, timeliness and finality that underlie the IPPS payment are not present with respect to the IPPS DSH payment. The Secretary's policy to determine that Medicare fraction based on certain timely data ensures that the Medicare fraction remains the same regardless of whether a later recalculation would result in a higher or lower Medicare fraction. The possibility that this decrease in its Medicare fraction could occur in requesting a recalculation in this case was obviously contemplated by the Provider. The Provider's consultant agreed to be liable to the Provider for any loss of disproportionate share hospital payments that would occur as a result of a decrease in the SSI percentage.[38]

Further, various other payments which are prospective in nature are dependent upon predicted DSH payments.[39] The Administrator concludes that, consistent with other payment aspects of the IPPS methodology, the Secretary is not bound to arrive at payments reflective of the retrospective reasonable cost methodology, but rather may make payment determinations based on the "best available data." and that to do so in this case is consistent with the underlying goals of IPPS.

The Board's decision seems to suggest that there are no acceptable rates of error that can be allowed in calculating the Provider's Medicare fraction. But even under reasonable cost methodology, costs are often determined, not through discrete direct costing to Medicare, but through a step-down method using a cost allocation statistic resulting, in effect, an estimate of the costs to be allocated to Medicare. Therefore, the Board's standard applied in this case even seems to exceed even that required under a reasonable cost payment methodology.

The Board's decision also provides for the possibility of a DSH calculation never being permanently determined. Under the Board's reasoning, a hospital with a DSH appeal pending would always be entitled to have the most recent version of the MEDPAR used to calculate the DSH payment, regardless of the number of

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on the latest available data subject to a year-end settlement on a cost reporting period basis. For purposes of making these interim payments, the initial determination of a hospital's eligibility for this payment will be made by the hospital's Medicare fiscal intermediary based on Medicaid statistical data as reported on the hospital's most recent cost report and the SSI and Medicare data to be supplied by HCFA's central offices. See 51 Fed. Reg. 16772 (May 6, 1986).

[38] Intermediary's Exhibit I-10 at p. 11.

[39] See 42 CFR 412.80(c) with respect to the calculation of outlier payments. Further, during the cost years at issue, the IPPS rule was required to be published by September 1 of each FFY, thus, the latest data available to CMS was the June update of the MEDPAR for the previous year.

years that had passed since the cost reporting period was closed, as long as it had an appeal pending.

In addition, the Board's finding that CMS must have complete accuracy in the counting of SSI days, allows the provider to challenge each and every day included or not included in the SSI calculation. This standard subjects CMS to a case-by-case adjudication of each and every stay, each and every day and each and every patient. Such a standard is inconsistent with the general basic tenets of IPPS and the efficient administration of the Medicare program. The Board erroneously determined that the use of the word "number" in the DSH statute thus requires absolute precision in the Medicare fraction when in fact the word in and of itself is not a synonym for precision.

Based on the scope of the number of stays involved in each Medicare fraction for each year over the entire Medicare program, the Administrator finds that the Board's standard is not reasonable and is contrary to the best available data standard used to allow for the efficient administration of the Medicare program. The Board's standard is not consistent with the reality of the 11 million claims reported in 1986 and 12 million reported claims in 2004 which underlies the DSH payment.

The U.S. Supreme Court recognized in Califano v. Boles, 443 U.S. 282 (1979), n. 1, that: "a process of case-by-case adjudication that would provide a perfect fit in theory would increase administrative expenses to a degree that benefit levels would probably be reduced, precluding a perfect fit in fact. Matthews v. Lucas, 427 U.S. 495, 509 (1976) Weinberger v. Salfi, 422 U.S. 749, 776-777 (1975)." Id at n.1 In that case, the court noted that:

> The magnitude of the task of the Social Security Administration in attaining accuracy and promptness in the actual allocation of benefits pursuant to classifications of beneficiaries under federal law is not amenable to the full trappings of the adversary process: fairness can best be assured by Congress and the Social Security Administration through sound management techniques and quality control designed to achieve acceptable rates of error. Id. at 546.

The Provider attacks the CMS management of the DSH program and the lack of documentation of the oversight of its quality control methods in calculating the Medicare fraction. The Board alleges willful failure by the agency (without any supporting evidence) to comply with the routine computer standards. However, the record shows that, despite these alleged problems, the policies and methods used by CMS resulted in an acceptable rate of error, to the extent of being an

almost nonexistent rate of error. In the end, the Provider has failed to demonstrate that these alleged problems had any impact on its DSH reimbursement.

III. The Secretary stated through rulemaking that he will use the June updates of the MEDPAR matched to the SSI data to calculate the Medicare fraction.

CMS has stated that it would calculate the Medicare fraction based on the June update of the MEDPAR.[40] The policy has been pronounced in various Federal Registers that the providers would receive there Medicare fraction based on the June updates of the MEDPAR.[41] The use of the June MEDPAR Data was subject to notice and rulemaking procedures.[42] The use of the June MEDPAR updates corresponded to the best data available at the time the annual IPPS rule was to be published each year.[43] The Provider is precluded from using any other data but the June MEDPAR data, for calculating the Provider's SSI ratio.[44] Similarly, the Board is precluded from granting any relief to have the calculation performed with data other than the June MEDPAR update.

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[40] Tr. 2039-40.

[41] Tr. 12039; 60 Fed. Reg. 45778, 45924 (Sept.1, 1995); 59 Fed Reg. 45330, 45494 (Sept 1, 1994) 58 Fed Reg. 46270, 46456 (Sept.1, 1993) 57 Fed. Reg. 39746, 39986 (Sept. 1, 1992). See 51 Fed. Reg. 16772 (May 6, 1986)("The number of patients days of those patients entitled to both Medicare Part A and SSI will be determined by matching data from the Medicare Part A Tape Bill file and the Social Security Administration SSI file."

[42] See e.g. Methodist Hospital of Sacremento v Shalala, 38 F 2d 1225, 1229-35 (D.C. Cir. 1994); Jewish Hospital v Secretary, 19 F. 2d 270, 272-76 (6th Cir.) (where courts have found agency statements in preamble portion of the Federal Register publication constituted agency statutory interpretation). Compare Health Insurance Ass'n of America v Shalala, 23 F 3rd 412, 423 (D.C. Cir 18994) (where agency statement found to be nonbinding even though published in the code of federal regulations.)

[43] See, e.g., 60 Fed Reg. 45778, 45924 (Sept. 1, 1995)(referring to more recent hospital data in the June 1994 MEDPAR update).

[44] Universal Health Services v. Thompson, 363 F.3d 1013 (9th Cir. 2004) ("because the hospitals failed to raise the arguments advanced in the cases in annual notice-and-comment rulemaking determining the outlier thresholds that directly affected their Medicare reimbursement notice we conclude that arguments have been waived.") Texas Oil and Gas Ass'n v. EPA, 161 F. 3d 923 (5th Cir. 1998) (arguments that agency rule was arbitrary and capricious were waived by failure to raise them during notice and comment period. Nader v. NRC, 523 F. 2d 1045 (D.C. Cir. 1975).

However, without waiving any of the foregoing positions adopted by the Administrator, the Administrator addresses the various issues raised by the Provider and the factual and legal findings made by the Board below. This includes the data to be used in the Medicare fraction and, in particular, the data used in the numerator and the data used in the denominator and the related SSI records match.

IV. The Provider failed to demonstrate that the Secretary did not use the best data available in the denominator or numerator of the Medicare Fraction

A. Denominator. The Provider challenges the use of the MEDPAR data to compute the Medicare fraction and its effect on the denominator of the fraction. The Provider claims that the PS&R should be used because the PS&R uses days paid to the provider. If the PS&R is used, the denominator will be smaller resulting, at least theoretically, in an increase in the Provider's DSH SSI patient percentage. The Intermediary argues that the covered/utilized days should be used and that the MEDPAR is the best data available.

The Administrator agrees with the Board with respect to this finding that the "denominator of the Medicare calculation is to include utilized or covered days, not paid days only."[45] The Board also correctly determined that the "PS&R is not appropriate for determining the denominator because it does not include utilized days; MEDPAR is the data base required to be used."[46] However, the Administrator disagrees with the Board's finding that the MEDPAR data used is "inaccurate as revealed by unexplained discrepancies."[47] In addition, the Board stated that "it is not possible to determine whether the inaccuracies would decrease the Medicare fraction." However, the Administrator finds that, in fact, the Provider failed to demonstrate by a preponderance of the evidence that any of the alleged flaws in the calculation of the denominator would have an adverse impact on its DSH payment.

1. The Type and number of Days in the Denominator of the Medicare Fraction

With respect to the types of days that belong in the denominator of the Medicare fraction, the Provider argued that CMS should have used the PS&R file to do its calculations, because the PS&R contains days paid to the Provider. The Provider believes that the denominator should include only those days for which a provider

[45] Board Decision p. 42.
[46] Board Decision p. 42.
[47] Board Decision p. 42.

receives payment from Medicare, rather than days that are covered by Medicare and charged as utilized days to the patient.[48]

The Provider asserted that, although the regulations speak of "covered days," CMS has interpreted "covered days" to mean "paid day." The Provider also argued that the MEDPAR files used by CMS to compute the Medicare fraction for years 1993-1995 (1) omitted some patient days that were covered and paid under Part A; and (2) included some patient days that were not covered nor paid under Part A.

Relying on the statute's use of "entitled to benefits" and the regulation's reference to "covered" patient days, the Board held that the MEDPAR file should be used for the DSH Medicare fraction denominator calculation. Moreover, the Board concluded that the Medicare/SSI fraction should include Medicare covered/utilized days. The Secretary's reference to the MEDPAR file in various Federal Register preambles to the regulations indicated that the Secretary intended to use the MEDPAR file for the DSH Medicare fraction denominator calculations.

However, the Board concluded that the use of the MEDPAR count of total Medicare days for the denominator was unreliable since the Intermediary was unable to explain the discrepancies between: those days on the MEDPAR file but not on the PS&R report; and those days on the PS&R report but not on the MEDPAR file. However, it is unclear from the Board's finding what was suppose to be done with respect to the denominator when the SSI fraction was ordered to be recalculated by the Board.

2. The preamble requires the use of the MEDPAR.

First, with respect to whether CMS should use the PS&R or the MEDPAR file, as the source for the denominator of the Medicare fraction, the preamble to the final rule implementing the DSH adjustment states 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 Part A Tape Bill (PATBILL) file with the Social Security Administration's (SSA's) SSI file.[49]

[48] Utilized days are Medicare benefit days available to the patient, whereby the patient is not responsible for payment. See §1812 of the Act; 42 C.F.R. § 409.60 et. seq.

[49] 51 Fed. Reg. 16772 at 16777 (May 6, 1986).

In the September 1, 1987 preamble to the final rule, the Secretary stated that the PATBILL file was the functional equivalent of the Medicare Provider Analysis and Review (MEDPAR) file. The Secretary stated that:

> We regret any confusion created by our reference in the May proposed notice to the PATBILL as our source file for our analysis. 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 diagnosis and three procedures 100 percent of Medicare inpatient hospital bills. Although we use the two names interchangeably, technically we use the MEDPAR FILE.[50]

In addition, the preambles to the September 4, 1990 and September 1, 1995 final rules on DSH identify the MEDPAR by name as the source for the denominator of the Medicare fraction. Thus based on the above passages, the Administrator agrees with the Board's determination that the MEDPAR file should be used as the source of the denominator of the Medicare fraction. In contrast, the Administrator finds that there is no reference in the Federal Register (or elsewhere, for that matter) to the PS&R as the source for the denominator of the Medicare fraction.

In addition, the Secretary again explained that it was appropriate to continue to use the MEDPAR for Medicare DSH calculation in response to commenters in the final FFY 2006 IPPS rule. The Secretary explained that:

> We believe it is appropriate to continue to use the MEDPAR for Medicare DHS calculations. Principally, as documented in the Federal Register the MEDPAR system has been the Medicare Part A data source for the Medicare DSH calculation since the implementation of the DSH adjustment. More importantly, the MEDPAR system and the PS&R do not necessarily contain the same data. The MEDPAR system contains utilized days and the PS&R contains days paid tp the provider by Medicare. The PS&R does not contain certain types of days that should be included in the denominator of the Medicare fraction, such as covered days that were paid by a Medicare managed care organization (MCO). For these

[50] 52 Fed. Reg. 33143, 33144 (September 1, 1987). See also 52 Fed. Reg. 3304, 3305 (September 1, 1987) ("[t]he MEDPAR file contains the same data as the PATBILL file but is in a simplified, reformatted record layout"). See also 52 Fed. Reg. at 22080, 22085 (Jun 10, 1987).

> reasons, we are not proceeding with the commenters recommendations at this time.[51]

Accordingly, the Administrator finds that the CMS properly used the MEDPAR for the calculation of the Provider's Medicare fraction in this case.

D. Specific records.

Finally, the Board relies on the provider allegations that the reconciliation of MEDPAR and PS&R records show that the CMS' data was flawed. In June 2001 CMS furnished the Provider with MEDPAR data for FY 1993, 1994 and 1995. In the Spring of 2003, the Provider and the Intermediary attempted to reconcile differences for the fiscal years 1994 and 1995 between the numbers of Medicare days reflected in the MEDPAR data which CMS furnished to the Provider in June 2001 and the numbers of Medicare paid days reflected on the Part A PS&R reports which the Intermediary furnished to the Provider in 1999 (referred to as the 2003 reconciliations).

The reconciliation showed Medicare paid days associated with 61 stays on the intermediary Part A PS&R that are not included in CMS MEDPAR data and that 47 stays included in the CMS MEDPAR data were not included in the Intermediary Part A PS&R for the FYEs 1994 and 1995. There was no difference between the MEDPAR and PS&R for FYEs 1993 and 1996. There were approximately 35,000 stays on the PS&R for all four years involved. Without addressing whether any of the 61 stays were incorrectly omitted, the record shows that approximately 99.82 percent of the stays were accepted by both parties as accurately represented. The Administrator finds that this percentage shows that the MEDPAR data used to construct the denominator was the best available data. Moreover, the Provider failed to demonstrate by a preponderance of the evidence that the data used in the denominator of the DSH fraction had an adverse impact on it DSH reimbursement.

3. The Type of Days in the Denominator of the Medicare Fraction

a. Paid v. Covered/Utilized Days

Next, with regard to whether CMS should use "paid days" or "covered/utilized days" the Administrator agrees with the Board's determination that the Medicare/SSI fraction should include Medicare covered/utilized days.

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[51] 70 Fed. Reg. 47278, 47441 (August 12, 2005).

The regulations at 42 C.F.R. §412.106(b), describe the calculation of the Medicare fraction as:

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

In the May 6, 1986 final rule implementing the DSH adjustment CMS stated that:

> [I]f a Medicare beneficiary is eligible for SSI benefits (excluding state supplementation only) during a month in which the beneficiary is a patient in the hospital, the covered Medicare Part A inpatient days of hospitalization in that month will be counted for the purpose of determining the hospitals Disproportionate patient percentage."[52] (Emphasis added.)

In the August 11, 2004 final rule CMS stated that the denominator of the Medicare fraction included only covered days:

> Section 1886(d) (5) (F) of the Act provides for additional payments for hospitals that serve a disproportionate share of low income patients. A hospital's disproportionate share adjustment is determined by calculating two patient percentages (Medicare Part A/Supplemental Security Income (SSI) covered days to total Medicare covered days, and Medicaid but not Medicare Part A covered days to total inpatient hospital days), adding them together and comparing that total percentage to the hospital's qualifying criteria. (Emphasis added.)

Finally, the preamble to the final rule revising the Medicare hospital inpatient prospective payment systems stated that CMS' policy has been that "only covered patient days are included in the Medicare fraction."[53]

In this case, the Provider argued that the Medicare fraction should include only paid days instead of covered/utilized days. The Board disagreed with the

[52] 51 Fed. Reg. 16772 at 16777 (May 6, 1986)
[53] 69 Fed. Reg. 48916 at 49098 (Aug. 11, 2004)

Provider's contention and held that the Medicare fraction denominator properly included covered/utilized days even though the hospital may not have received payment.[54] The Administrator agrees with the Board's determination that the Medicare/SSI fraction includes Medicare "covered/utilized days" in the denominator of the DSH calculation. The Administrator finds that the regulation at 42 C.F.R. §412.106(b) and the various preamble text cited above, clearly state that the denominator is made up of "covered days." The Administrator finds that CMS considers "covered days" to mean days for which the beneficiary was entitled to have payment made by Medicare.[55]

The Administrator further finds that, CMS has never considered "covered days" to mean only days for which the provider has received payment from Medicare. For example, days for which the provider is denied payment due to technical reasons are nevertheless counted as "covered days" that are charged to the beneficiary as utilized days.[56] Such technical reasons include, the provider's failure to bill timely, or the care rendered was substandard in quality. Thus, the Administrator finds that it makes sense to charge the beneficiary with utilized days with respect to these technical denials because the beneficiary is having his or her care covered by Medicare - i.e., the provider is prevented by the Medicare statute from billing the beneficiary.[57] (Emphasis added.) The Administrator finds that CMS has

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[54] Board Decision at 38.

[55] A letter from Nancy Edwards, then Acting Director, Division of Hospital Payment Policy, describes the denominator of the Medicare fraction as including "covered patient days utilized by patients under Medicare Part A." Provider's Exhibit P-40 at 1093.

[56] Medicare Intermediary Manual §3620.D.6.

[57] Section 1886(a) (1) of the Act states that, under the terms of its provider agreement, a provider agrees:

> (A)(i) not to charge, except [for coinsurance and deductibles]. Any individual or any other person for items or services for which such individual is entitled to have payment made under this title (or for which he would be so entitled if such provider of services had complied with the procedural and other requirements under or pursuant to this title …),
>
> ***
>
> (K) not to charge any individual or any other person for which payment under this title is denied under section 1154(a)(1)(B) [that the quality of service did not meet professionally recognized standards of health care].

consistently interpreted "covered days" to mean, days for which the beneficiary's care is covered by (or paid by) Medicare and for which utilization is charged to the beneficiary. Therefore, CMS properly included covered days, instead of paid days in the calculation of the Provider's Medicare fraction.

b. No-Pay Days: HMO/MSP Days.

The Administrator also finds that days paid by Health Maintenance Organization (HMO) under contract with Medicare are days that are not paid to the provider by Medicare but are covered days. Such days are covered under Medicare because HMOs are required to cover inpatient hospitalization services, and utilization is charged to the beneficiary for such days.[58] CMS has interpreted "covered days" in the context of the denominator of the Medicare fraction to include HMO days. In the September 4, 1990 final rule CMS stated:

> [W]e believe it is appropriate to include [in the denominator of the Medicare fraction] the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs and, therefore, were unable to fold this number into the calculation. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that are associated with Medicare patients. Therefore, since that time, we have been including HMO days in SSI/Medicare percentages.[59]

The Provider asserted that Medicare HMO days should be excluded from Medicare/SSI fraction. The Provider asserted that CMS did not adequately notify Providers that they were to bill no-pay bills in order to have Medicare HMO days included in the DSH calculation.

The Board held that there was no evidence that including HMO days in the DSH calculation resulted in a diminished payment to the hospital as the Provider suggests. The Board further found that inclusion of HMO days was not inconsistent with the statute or the regulations. Finally, the Board held whether CMS included or excluded HMO days in another program was irrelevant and not properly before the Board in the present case.

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[58] See 42 C.F.R. §417.101(a) (2) (ii); See also the Medicare Health Maintenance Organization/Competitive Medical Plan Manual §2102.

[59] 55 Fed. Reg. at 35994 (Sept. 4, 1990)

The Administrator agrees with the Board's determination and finds that § 411 of the Medicare Hospital Manual dated 09/89, entitled Submitting Inpatient Bills in No-Payment Situations states that Provider's are to "submit bills for all stays, including those for which no program payment can be made." This section further requires Providers to submit no-payment bills "for services provided to an HMO enrollee for which an HMO has jurisdiction for payment."[60] The Administrator finds that the Provider has the responsibility to submit its HMO (and other) no-pay bills in order to properly reflect the Medicare beneficiaries inpatient hospital utilization, which will then only be reflected in the MEDPAR file.

Finally, the Administrator finds that days in which Medicare was the secondary payer (MSP) are also covered days counted in the MEDPAR file based upon the utilized days for the stays. The Provider argued that CMS reversed its position as to whether or not MSP stays should be counted in the denominator.

The record shows that as of April 1, 1995, MSP claims did not appear on the PS&R report type 110, which is used to settle cost reports, but instead, appeared on an adjunct version of the PS&R, i.e., PS&R report type 11A, which was not used to settle the cost report. Section of the Medicare Intermediary Manual, Part 3, sets forth rules for determining the amount of covered days where Medicare is the secondary payer. Section A.3. states that if the primary payer pays an amount for Medicare covered services that is equal to or less than the deductible and coinsurance that would apply if Medicare was the primary payer, the number of days in the stay equal the number of covered days (provided that the beneficiary has not exhausted coverage). The same section also provides, however, that if the primary payer pays an amount that is more than the deductible and coinsurance that would apply if Medicare was the primary payer, the number of covered days in the stay are determined on a pro rata basis. Accordingly, the Administrator finds that the days in which Medicare was the secondary payer are also covered days counted in the MEDPAR file based upon the utilized days for the stays.

[60] Section 411 of the Medicare Hospital Manual Publication 10, dated 09/89. See also Intermediary's Exhibit I-20.

B. Numerator. The Administrator finds that the Board erroneously concluded that there were systematic errors in CMS' matching process which entitled the Provider to a recalculation of its SSI fraction based on new data and a new matching protocol for the SSI days. The Administrator finds that the Provider failed to show by a preponderance of the evidence that CMS' method for computing the Medicare fraction was flawed and had an impact on its DSH reimbursement.

Regarding the number of days that were computed for the numerator, the Provider alleges that there were matching flaws in the data by pointing to specific records. In addition, the Provider's consultant puts forth several theories on the matching process to show that either SSA did not provide complete data to CMS or that CMS failed to properly match data that SSA did provide. In addition, the Provider argues, as a matter of policy, that certain days either should have been included or not included, as a matter of policy. The following days are at issue: 1) retroactive SSI determinations/holds and suspensions; 2) manual or forced SSI payments; 3) Title II matching problems (beneficiaries without Title II numbers) 4) stale records from the SSI data; and 5) Section 1619(b) of the Social Security Act.

The Board acknowledges that each intermediary is bound to apply the Medicare fraction computed by CMS in determining a hospital's entitlement to the DSH payment. The Board ruled with respect to the numerator of the Medicare fraction that "the match process between CMS' MEDPAR and SSI data is flawed;" that "the flawed match may deflate the DSH percentage;" that "the incomplete SSI data tends to deflate the DSH percentage;" that "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."[61] "The Board concluded that the Intermediary's determination of the Medicare percentage [Medicare fraction] is reversed and this case is remanded to the Intermediary to recalculate the DSH Medicare percentage [Medicare fraction] consistent with this decision."[62] The Administrator disagrees with the Board's finding and order.

1. Provider failed to demonstration that CMS' data was not accurate.

The record shows that there was a lengthy and contentious disagreement about the release of data. Eventually, the Provider did request and receive 627 individual-specific SSI eligibility records from SSA in an attempt to demonstrate that flaws in the data matching impacted its DSH payment.[63] This involved 569 records for

[61] Board Decision, pp. 41-42.
[62] Board Decision, p 42.
[63] Tr 635-36, 645.

deceased individuals[64] and 58 records of individuals that consented to have the information released.[65] The Provider reviewed all 627 records.

The Provider did not attempt to use any statistical sampling methodology. The Provider only requested records for individuals for whom the MEDPAR data that it received from CMS indicated no SSI days were associated with their stay.[66] That is, the Provider only requested those records that could only increase its Medicare DSH payments if later information was different from the original record. The Provider also only requested records for those individuals that the Provider, based on State Medicaid data believed were, or likely were, eligible for SSI.

The record shows that the selected records involved 10 individuals, representing 12 stays who were not credited with SSI days in the MEDPAR data but who according to the updated SSI data were eligible for SSI at the time of discharge. The Intermediary did not concede that any of these days were erroneously excluded from the day count.[67] However, even assuming that these days were improperly excluded in the original calculation, this means that approximately 1.59 percent of the individuals failed to match from a sample constructed from the individuals that indicated no SSI days were associated with the stay. Based on this sampling which should have captured a disproportionate number of errors in the data to the Provider's favor, the Administrator finds that the Provider failed to demonstrate that the data used in calculating the numerator of the Medicare fraction was not the best available data and that its reimbursement was affected by these errors.

2. Retroactive determinations/suspensions/holds

The Provider also challenged the data by specifically arguing that, at least theoretically, the CMS match does not capture all of the Provider's SSI days because the SSI record is created before certain retroactive determinations are made or that the data match does not account for "suspensions" and "holds." The Provider argues that later MEDPAR and SSI records should be used in the DSH calculation. CMS' policy recognizes that not all retroactive determinations made on SSI entitlement (whether granting or denying) would be included in the SSI record forwarded to CMS. However, CMS has determined that such actions would have a minimal impact on a provider's Medicare DSH fraction which combined with the need for finality in the process, makes the use of later data impractical and no more accurate.

[64] Tr. 425.
[65] Tr 637.
[66] Tr. 652.
[67] See Intermediary Post-hearing brief, pp. 39-40.

In response to specific commenters, the Secretary addressed the use of updated SSI eligibility information that may include retroactive grants or denials of eligibility, to revise calculations of hospital DSH Medicare fractions. The Secretary responded that:

> We understand that many hospitals are concerned that later data matches may produce a different Medicare fraction. However, we believe that there needs to be administrative finality to the calculation of a hospital's Medicare fraction. CMS has previously stated that its goal is to obtain reasonably accurate but not perfect calculations (51 Fed. Reg. 16777). Additionally, our data have shown that 98 to 99 percent of SSI eligibility determinations are made and remain unchanged 6 months after the end of the Federal fiscal year. There will be a minimum of 6 months between the end of the hospital's cost reporting period and April 1 date that we have receive SSI eligibility information. The time lag between the close of a hospital's cost reporting period and the April 1 date that we receive eligibility information could actually be much longer for many hospitals. For a hospital with an October 1 to September 30 cost reporting period, we will use the SSI eligibility information from 6 months after its year ends. However, we will be using SSI eligibility from 17 months after a hospital's year ends with a November 1 to October 31 cost reporting period. Given the time between the end of hospital's cost reporting periods and when we are furnished with SSI eligibility information for that period, we believe it is highly unlikely that a subsequent data run will produce data that is significantly different than one completed 6 months after the end of the Federal fiscal year.
>
> Therefore, we will use the SSI eligibility information provided to CMS by SSA 6 months after the end of the Federal fiscal year (or April 1) to calculate the DSH Medicare fraction. We will match these data to the MedPAR system once and conduct no further matches after that time. For cost reporting periods that span 2 Federal fiscal years, a hospital will receive the data for the 2 Federal fiscal years once the data from the second year have been matched against the SSI data available to CMS 6 months after the end of that year. Although it is possible that these data will be available up to 17 months after the cost reporting period has ended, hospitals will continue to be permitted to use the data to determine whether they prefer to base their calculations on data from the Federal fiscal year or their cost reporting period. The calculation from the requested

> time period will be used in the final settlement for the cost reporting period.[68]

However, the Board concluded that: "the omission of retroactive awards is a systematic error that *may* deflate the DSH Medicare percentage *if* retroactive awards involve Medicare beneficiaries."[69] However, the Administrator finds that the Provider has failed to demonstrate by a preponderance of the evidence that such omissions have had any impact on its DSH reimbursement.

The Provider, for support, refers to one stay in the sample of 627 patients, where it alleged that "the stay was included in the denominator reflected in the CMS MEDPAR data, but that the SSI days were omitted from the numerator because the individual's SSI payments appear to have been in suspension in March 1995 when SSA prepared the annual SSI tape for fiscal year 1994."[70] Without conceding whether this is true, the Administrator finds that this stay represents 1/6 of one percent of the sample. In addition, because the Provider did not chose SSI records for individuals who were credited with SSI days and only requested records of individuals who were not credited with SSI days, the sample could not show instances where individuals lost their SSI eligibility retroactive to the month of discharge.[71]

Moreover, while it is not the Intermediary's burden to demonstrate that these days were not a factor in deflating the Provider's Medicare fraction, the Intermediary presents arguments that in fact would support such a conclusion. The Provider's consultant argues that the most likely reason for a suspension of benefits is for representative payee development or the need to obtain a valid address.[72] However, if this were true, the SSI Annual Statistical Report, 2002[73] shows that for 1994-1996, the number of recipients whose SSI eligibility was suspended for whereabouts unknown or no representative payee numbered about 100,000 for each year. In contrast, the number of SSI recipients whose eligibility was terminated due to income and resource predeterminations was about 500,000-600,000 each year. As such, the number of retroactive disallowances outnumbers the number of retroactive awards. Even in the worse case scenario, were all of the 100,000 retroactively allowed suspensions involve Medicare beneficiaries and none

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[68] 70 Fed. Reg. 47278, 47439-47440.
[69] Board Decision at p 29.
[70] Provider's Position Paper at 43-44.
[71] The Provider did not request SSI data for FYs for which the original MEDPAR files that produced the original calculations existed. The Provider requested the SSI data for files for which only the December 1996 update existed.
[72] Tr. 356, 358.
[73] Exhibit I-17.

of the approximately 500,000 retroactive disallowances involve Medicare beneficiaries, the allowances would represent less than one percent of all 12 million stays.

The Intermediary also logically concluded that the scenario in which a Medicare beneficiary is in the hospital, is not eligible for SSI at that time and thus is not counted in the numerator of the fraction for the June MEDPAR and subsequently wins a disability appeal establishing SSI eligibility for the month of discharge would be rare. Individuals pursuing appeals of determinations that they are not disabled for purposes of SSI typically are not aged individuals. Similarly, the standards for establishing disability for Medicare purposes are essentially the same for establishing disability for SSI purposes.[74] Thus, it is reasonable to assume that the individuals successful in appeals of SSI disability denials are not comprised of Medicare beneficiaries.[75]

The Board rejects the Intermediary's position, as it alleges the Intermediary 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 the adjudication of the claim might be much later. However, the Board ignores the fact that there is always a delay in the transmission of the SSA data, making it more likely the individual would have already received an initial favorable determination when the SSI match is made based on diminished income. The Medicare beneficiaries qualification for SSI benefits based on age and income makes it significantly less likely that there will be further adjudication unlike a disability claim by a younger individual. Therefore, the Intermediary properly concluded that individuals pursuing appeals of disability determinations are most likely not to be Medicare beneficiaries.

[74] Compare section 223(d) of the Social Security Act with section 1614(a)(3)(A) of the Act. Compare 20 CFR 404.1505 with 416.905 and 416.906.

[75] In addition, ESRD Medicare beneficiaries only make up .002 percent of Medicare beneficiaries. Exhibit P-195 at 3393.

3. Manual or forced pay of SSI Benefits.

The Provider alleges that the matching process is flawed because the matching process is unable to account for instances in which an SSI beneficiary received payment as a result of an SSA Field Office manually ordering the payment be made and, thus, that Medicare/SSI individual is not included in the numerator of the Medicare fraction.. The Provider's witness testified that she had never seen a forced pay situation.[76] In contrast, the Provider's consultant testified that it occurred frequently, although he could not provide any independent corroborating evidence and admitted that he had no personnel experience with the systems for processing manual pays.[77] Subsequently, there was conflicting testimony as to the frequency of manual pays and whether a manual pay would always result in a terminated record.[78] The Provider showed only one stay not counted because it involved a manual payment. This omission is .15 percent, significantly less than one percent of the entire "sample" selected from records most likely to exaggerate any omissions. The Administrator finds that the Provider has failed to demonstrate that the data used by CMS for the calculation of the Medicare fraction adversely impacted the Provider's reimbursement due to the omission of SSI days because of manual or forced payments to that the CMS calculation was improper.

[76] Tr. 161-162.
[77] Tr. 478-790.
[78] Tr. 222-225.

4. Beneficiaries without Title II numbers.

The Provider alleges that CMS failed to match SSI beneficiaries who do not receive Title II numbers to Medicare stays in the MEDPAR. The Provider maintains that these records are eliminated from the social security records before the matching process begins. However, the CMS programmer responsible for the SSI/MEDPAR match program confirmed that CMS generates a Title II number from each social security number on the SSR tape. Therefore, if a record on the social security tape does not contain a Title II number, CMS uses the Title II number it has created from the individual's social security number in the matching process.

CMS writes two HICANs from the SSA record, one based on the social security number and one from the Title II field. For example, where a wife was originally entitled to Medicare based on her husband's account and subsequently becomes entitled to Medicare based on her own account and had an inpatient stay while entitled to Medicare based on her own account the following would occur. In this case, CMS would take the SSN from the SSN field of the SSR and append a Medicare beneficiary Identification Code (BIC) of A to it. This action creates a HICAN based on the individual's own earnings (HICAN1). CMS also identifies a HICAN from Title II field on the SSA records thus regardless of whether the hospital stay is with HICAN1 of HICAN 2, the individual will be identified as an SSI beneficiary.[79] In addition, the CMS programmer stated that CMS does not eliminate records for individual for whom no numerator appears in the Title II or CAN field.[80]

The Administrator also notes that the Secretary specifically declined, as a matter of policy, to adopt a commenter's request that CMS allow hospitals to choose the data file CMS would use to conduct the SSI eligibility/MEDPAR data match. Similar to the Provider's arguments in this case, the commenter suggested that hospitals be allowed to request that the data match be made by social security number, health insurance claim account number (HICAN), name, gender, date of birth, or Title II identifier, or a combination of the factors. The Secretary explained that:

> We do not use social security numbers to conduct the SSI/MedPAR data match because the social security numbers are used on a "wage earner" basis that is not necessarily specific to an individual Medicare beneficiary (or hospital patient) The HICAN are unique to each

[79] Tr. 1340-1, 1343, 1347-1348.
[80] Tr. 389-92.

> beneficiary. Because of this we do not have social security numbers for every Medicare beneficiary in the MEDPAR data.
>
> In addition, we do not agree that individual hospitals should be given the choice to run the SSI/ MEDPAR data match by alternative criteria. Such variations between providers would result in an inconsistent matching methodology and inconsistent DSH Medicare fraction calculations, among providers.[81]

The Administrator notes that, to the extent that the Provider may have identified a scenario for which the Medicare beneficiaries' SSI days would not be credited (e.g., remarried widow on second husband's account) the Provider only identified one instance in the sample drawn to exaggerate any such errors, where this occurred, a percentage of .15 percent, significant less than one percent. Therefore, the Administrator finds that the Secretary's policy determination not to use alternative identifiers is supported by the record in this case.

5. Stale records

Up until approximately February 1996, SSA's annual tapes did not include SSI records that had been "terminated" and were inactive prior to the time of SSA transmission of the tapes to CMS. Based upon this policy, the Provider claims that it was arbitrary and capricious to have used the MedPAR data matched with the SSI data. However, the record in this case shows that stale records were not a significant issue for providers, especially those in the Provider's circumstances, that had their Medicare fractions calculated on the basis of the Federal fiscal year instead of their cost years.

The Administrator notes that the Provider's opening statement included an observation that there were "[f]ive hundred thousand terminations a year that will become inactive … and all of those were [] omitted from the calculations at issue here. At least for fiscal years '93, '94."[82] The Provider has only about 9,000 discharges annually. By stating that such records were "omitted," the Provider appears to be saying that the records would have otherwise been reflected in CMS' calculation of the Medicare fractions. Such a statement is unsupportable. The Provider elicited testimony from one of its witnesses that there were 500,000 termination actions a year during FYs 1993 to 1996, but even assuming this

[81] See 70 Fed Reg. 47440-47441 (August 12, 2005).
[82] See Tr. at 61-62.

unsubstantiated statement is accurate, the Provider's witness did not say how many of the terminations involved Medicare beneficiaries who had inpatient stays.[83]

In 1996, upon learning that SSA had not been supplying it with stale records, CMS obtained updated SSI records from SSA. These records included the stale records restored.[84] CMS matched this updated SSI information with existing MEDPAR files, and kept a record count of the number of stays in the existing MEDPAR files that had no SSI days associated with them as compared to the number of stays in the MEDPAR file that had SSI days associated with them after taking the updated SSI information into account. These record counts can be found at Provider's Exhibit No. 64, pp. 1518-1520, at places indicated by the line, "old equal to zero, new not equal to zero."

CMS also kept a record count of the number of stays in the existing MEDPAR files that had SSI days associated with them as compared to the number of stays in the MEDPAR file that had no SSI days associated with them after taking the updated SSI information into account. These record counts appear in Provider's Exhibit No. 64, pp. 1518-1520, at the places indicated by the line, "old not equal to zero, new equal to zero."

CMS kept track of how many stays for which both the existing MEDPAR files, and the MEDPAR files after taking the updated SSI information into account, showed SSI days, but for which the number of SSI days were not the same for one file as compared to the other. These record counts appear in Provider's Exhibit No. 64, at pp. 1518-1520, at the places indicated by the line, "both not equal to zero."

In addition, to be taken into consideration is the fact that the record counts display unedited data.[85] Prior to calculating the Medicare fractions of hospitals each year based on the MEDPAR file, CMS runs the MEDPAR file through a series of edits which are designed to identify and edit out stays that do not belong in the calculation prior to calculation, e.g., stays in a PPS-excluded area of the hospital

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[83] See Id. at 323-324.

[84] The SSI information which SSA supplied in 1996 did not include simply stale records restored to historical data (e.g., the same data supplied to CMS in, say, 1993, with the addition of stale records), but rather included updated data (i.e., data reflecting any retroactive changes in individuals' SSI eligibility) plus restored stale records. See Tr. at 2045-46. Because the SSI data supplied by SSA to CMS in 1996 was updated data, and not just restored stale records data, one cannot tell what portion of the "old not equal to zero, new equal to zero" record counts are due to restored stale records and what portion is due to updates in individuals' SSI eligibility status Tr.2050-52.

[85] See Tr. at 2050-52.

such as a rehabilitation unit.[86] The Intermediary witness testified that approximately 450,000-500,000 records drop out each year due to her use of edits, and that this would have been true during the years at issue in this case.[87] Thus, the total record counts of about 12 million for FYs 1993-1996[88] are overstated by about 4 percent. All else being equal, that would also mean that the "old equal to zero, new not equal to zero" and "old not equal to zero, new equal to zero" counts would also be overstated by about the same percentage, but, naturally, we have no way of determining whether the actual percentage would be greater or lesser for any given year or any given hospital.

The existing MEDPAR files that were matched with the updated SSI data were not the versions that were used to perform the original calculations, but instead were later versions of the same FY files. The importance of this is that the later versions of a MEDPAR file for a given fiscal year can be expected to have had more missing stale records than the version used to perform the original calculations. That is true because, with respect to the later versions, more time would have elapsed between the hospital stay and the compilation of the SSI tape, and thus, there is a greater opportunity for a patient to have died or otherwise to have had his/her record become inactive and then stale.

In examining the "old not equal to zero, new equal to zero" figures for FYs 1993 and 1994 that appear in Exhibit No. P-64 at 1529, the "old not equal to zero, new equal to zero" count is 2,497. The Provider alleges that the number of retroactive SSI awards are much greater than the retroactive terminations of SSI, but for this purpose it is assumed that the retroactive awards are equal to the retroactive terminations (2,497), and that the remaining portion of the 48,616 "old equal to zero, new not equal to zero" record count, or 46,119, represents stale records. Reducing the 46,119 by four percent to account for the records that would have been edited out by Ms. Rosenberg leaves a total of 44,274 stale records prior to any adjustment for the fact that the version of the FY 1993 MEDPAR under comparison here was the December 1995 version, and not the June 1994 version.

In addition, the June 1994 version of the MEDPAR would have been matched with the SSI tape sent to CMS at the end of March or beginning of April 1994, or in other words, the June 1994 version would have been matched with an SSI tape that was created 12 months after the middle of the fiscal year. The December 1995 version of the MEDPAR would have been matched with the SSI tape sent to CMS at the end of March or beginning of April 1995, and thus, would have been matched with an SSI tape that was created 24 months after the beginning of the

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[86] See Exhibit No. P-40 at 735, Exhibit No. P-40 at 1275-76.
[87] See Tr. at 2050-52.
[88] Exhibit No. P-64 at 1528-30.

fiscal year, a period twice as long. Assuming that an equal number of records became stale each year, that means the 44,274 figure should be reduced by half, and that the number of stale records that did not get picked up in the match of the June 1994 MEDPAR with the SSI tape were about 22,150. Because there were approximately 5,200 PPS hospitals around this time,[89] that would mean that the average size hospital with the average SSI population would have had about four stale records omitted from its calculation, some more, some less, some zero.

The Administrator finds that the figures for 1994 are even less significant.[90] The version of the FY 1994 MEDPAR file under comparison in Exhibit No, P-64 is the March 1996 update, which would have been matched on the basis of the tape that SSA sent to CMS at March-end or beginning-April 1995, which is the same tape that would have been matched against the June 1995 version of the FY 1994 MEDPAR. This explains why the "old not equal to zero, new equal to zero" count is zero (there would be no subsequent terminations reflected if there has not been any change in the SSI tape), and also explains why the "old equal to zero, new not equal to zero" record count is only 17,070 records." A reduction of the 17,070 records by four percent to account for records that would have been edited out by Ms. Rosenberg leaves a total of 16,387 stale records. Dividing that number by the approximate number of 5,200 PPS hospitals would mean that the average size hospital with the average SSI population would have had about three stale records omitted from its calculation.

The MEDPAR public use extracts in the record also supports a finding that the stale records issue was not significant and that CMS consistent with the IPPS scheme, corrected the problem prospectively only. The data shown at Exhibit No. I-18, i.e., the Medicare fractions for the Provider for 1993 through 2000, shows that the Provider's Medicare fraction rose each year (with the exception of 1998-1999) by about the same percentage. If a significant number of stale records had been omitted by SSA, it is reasonable to conclude that there would be a noticeable Medicare fraction increase between 1994 and 1995, and then a steady rise from 1995 forward, but that is not the case. Instead, these figures show a more or less continuous, steady rise from one year to the next, including from 1994 to 1995. Moreover, also reflected in Exhibit No. I-18, the Medicare fractions for all hospitals in the country, for this time period, and the Medicare fractions for all Massachusetts hospitals, show a similar pattern. Thus, all indications are that the stale record issue was not significant.

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[89] See Tr. Sep. 22, 2004 at 2055.
[90] See Exhibit No. P-64 at 1529.

Further, the Provider argues and the Board appears to accept that the December 1996 version of the FY 1994 MEDPAR had 400 more SSI days and 2600 more covered days. The Provider's consultant concludes that 200 of the 400 days must be due to the effects of stale records and retroactive determinations.[91] However, the witness' extrapolation does not seem consistent with the national and state-wide observations of the effects of stale data in the Medicare fraction. The Administrator concludes that it was reasonable for CMS not to have retroactively recomputed the Provider's Medicare fractions so as to include any stale records for those years.

[91] Tr. 35-37, 874-77, 927-29.

6. Section 1619(b) beneficiaries

The Board determined that individuals addressed in §1619(b) of the Act ("§1619(b) beneficiaries) should be included in the numerator of the DSH computation, as set forth at 42 CFR 412.106(b)(2). Section 1619(b) reads, in relevant part, as follows:

> Blind or disabled individuals receiving supplemental security income benefits.
> (1)…[F]or purposes of title XIX [Medicaid.], any individual who was determined to be a blind or disabled individual eligible to receive a benefit under section 1611 [SSI] or any federally administered State supplementary payment for a month and who in a subsequent month is ineligible for benefits under this title (and for any federally administered State supplementary payments) because of his or her income shall, nevertheless, be considered to be receiving supplemental security income benefits for such subsequent month provided that …—[certain conditions are met]…. [Emphasis added.]

The relevant language of the DSH statute at Section 1886(d)(5)(F) refers to a fraction comprised of a numerator of which the number of paid days is made up of patients who were entitled to Medicare and "supplemental security income benefits under Title XVI." In addition, the relevant language of the regulation at §412.106(b) states that the days to be included 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.)

Further, the Board determined that, pursuant to application of the special SSI eligibility rule set forth at 20 CFR 416.264, individuals who are "considered" to be eligible for SSI but are ineligible because of their income, should be counted in the computation at 42 CFR 412.106(b)(2), above. In relevant part, 20 CFR 416.264 states that:

> The special SSI eligibility status applies for the purposes of establishing or maintaining your eligibility for Medicaid. For these purposes we 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. You must meet the eligibility requirements in §416.265 in order to qualify for the special SSI eligibility status. (Emphasis added.)

Applying the law to the facts of this case, the Administrator finds that the Intermediary properly excluded §1619(b) beneficiaries from the computation set forth in 42 CFR 42.106(b)(2). Section 1619(b) expressly states that "for purposes

of title IX [Medicaid]," certain individuals will be "considered" to be receiving SSI benefits during the month if certain conditions are met. Moreover, 20 CFR 416.264 states that the special SSI eligibility status referenced therein "applies for the purposes of establishing or maintaining your eligibility for Medicaid." Thus, all of the regulations relied upon by the Board in this case expressly state that they are applicable only for purposes of Medicaid eligibility. Section 1619(b) was written narrowly to limit its application to certain individuals in very specific situations, i.e., those who lost their eligibility for SSI, and, therefore, for Medicaid, because of income due to employment. The policy objective appears to be that of a work incentive, i.e., the continuation of Medicaid benefits even though the individual exceeds SSI income limits, and the elimination of the need to reapply for SSI cash benefits if the individual again becomes unable to work. Where the statutory conditions are met, §1619(b) beneficiaries will only be "considered" to be receiving SSI. Section 1619(b) does not reinstate their actual SSI cash payments.[92]

The Administrator finds the Board erroneously relied upon 20 CFR 416.264 to resolve the §1619(b) issue, for that regulation expressly states that individuals in the special SSI status "are in fact no longer receiving SSI benefits or special SSI cash benefits." Thus, §1619(b) beneficiaries are not "entitled to both Medicare Part A and SSI," as required by 42 CFR 412.106(b)(2), and, therefore, were correctly excluded from the regulatory computation.

[92] The Conference Report states that "when a disabled SSI recipient's earnings rise to the point that he no longer qualifies for the Federal SSI benefits, State Supplementary payments or the special benefit status [under section 1619(a)] he would nevertheless continue to retain eligibility for medicaid and social services as though he were an SSI recipient …" H.R. Conf. Rep. 99-944 at 49.

V. Credibility of Witnesses

The Board decision relies, in part, on the testimony of David Pfeil, president of Southwest Consultant Associates and Gerry Smith, Vice President of Southwest Consulting Associates.[93] While both individuals are identified as consultants, the Provider did not proffer either witness as experts.[94]

The record shows that both offered opinion testimony, similar to that which would be offered by an expert as to the effects of certain alleged CMS data flaws on the DSH patient percentage.[95] Jerry Johnson, employee of the Provider stated that the Provider had engaged Southwest Consulting Associates to work on the matter on behalf of the hospital on this appeal and that he had not personally done a lot of the data analysis and examination.[96] The record also shows that Southwest Consultant Associates has a 35 percent contingency fee arrangement and is paying all of the

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[93] See, e.g., Board decision at n. 137, referring to Smith testimony regarding additional 200 days as an unexplained discrepancy and something other than "new or additional Medicare covered days coming in the denominator." The Board than concluded that the "discrepancies" between the earlier calculation and the 1996 run alone (i.e., the additional days beyond the expected 200 days testified to by Smith) "illustrates that the original data was inaccurate with respect to the stale data."Id. at 25; Board decision at p. 24, referring to Pfiel's testimony that changes to the Medicare fraction would have a major impact
on hospitals that treat a large indigent population and Board ruling at p. 25; Board decision at p. 22 adopting Pfiel's opinion testimony with respect to the use of multiple alternative identifiers.

[94] A consultant is generally considered to be one "who gives expert advice." *The American Heritage Dictionary. Wilkipedia.* ("A consultant (from the Latin, concultus, meaning legal expert) is a professional who provides expert advice in a particular domain or area of expertise.")

[95] See Fed. Rules of Evidence, Rule 701 ("If the witness is not testifying as an expert, the witness testimony in the form of opinions or inferences is limited to those opinions or inferences which are (a) rationally based on the perceptions of the witness and (b) helpful to a clear understanding of the witnesses testimony or the determination of a fact in issue."); Fed. Rules of Evidence, Rule 702 ("If scientific, technical or other specialized knowledge will assist the trier of fact to understand
the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience training or education may testify thereto in the form of an opinion or otherwise." While the Board is not bound by the Federal Rules of Evidence (42 CFR 405.1855), such rules can provide helpful and practical guidance.

[96] Tr. 971.

legal and consulting fees and expenses in relation to these appeals.[97] Such agreements are generally found to be against public policy and void.[98] There is no indication that the consultants thought the agreement was void when they testified in this case. Therefore, the existence of the agreement must be taken into consideration when evaluating the witnesses' credibility in this case.[99]

Alan Schafer was another consultant engaged by the Provider's representative.[100] His compensation agreement was not discussed in the testimony, although it would have been correctly a subject of examination.[101] However, certain data that he

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[97] See Intermediary Exhibit I-10, Provider's Response to CMS Second Set of Interrogatories and Request for Production of Documents, p.11.

[98] See e.g. Reffett, et.al. v Commissioners of Internal Revenue, 39 T.C. 869, 878 (1963) "[I]t seems to be rather generally accepted rule that all agreements to pay witnesses extra compensation contingent on the success of the lawsuit are against public policy whether the agreement is with an ordinary witness, an expert witness or a witness who cannot be compelled to testify, because such agreements constitute a direct temptation to commit perjury." Alexander v. Watson, supra, Hough v State, 145 App. Div. 718, 130 N.Y. Supp. 407 (1911); Sherman v. Burton, 165 Mich. 293, 130 N.W. 667 (1911); Annot., 16 ALR 1457, 1460, 1464 (1922)''). See also Accured Fin. Service v. Prime Retail, 298 F. 3d 291, 300 (4th Cir. 2001) (addressing that supplying expert testimony for a contingent fee as against public policy. Id. at 299); New England Telephone & Telegraph Company v Board of Assessors of Boston, 392 Mass. 865, 872 (1984)("The majority rule in this country is that an expert witness may not collect compensation which by agreement was contingent on the outcome of a controversy.") Belfonte v. Miller, 243 A.2d 150. 152-153 (1968) (addressing that supplying expert testimony for a contingent fee as against public policy. Id at 152.)

[99] Further, where the method of compensation is altered, "the stake in the litigation would be eliminated thereby significantly meeting the policy concerns…. Of course, the witness would still be subject to impeachment on the grounds of bias with respect to evidence prepared and opinions formulated during the period in which the witness labored under the contingency fee agreement." Mushroom Transportation v Continental Bank, 70 B.R. 416, 418 (1987)

[100] Tr. 414-415.

[101] As the court noted in New England Telephone & Telegraph Company v. Board of Assessors of Boston., supra, 392 Mass. 865, 870, the expectation of future business cannot be a ground for disregarding testimony, however, ''an expert witness "financial interest in… a continuing business relationship including an expectation of more….. work 'may bear on his credibility, but does not warrant a blanket determination that the witness lacks credibility." Id. at 870. Mr. Schafer would have properly been examined, not only as to his compensation arrangement,

analyzed was selected through Gerry Smith,[102] while other of Schafer's testimony at times consisted of antidotal evidence without any independent corroborating evidence.

Numerous courts have addressed the problems of credibility when a witness is compensated on a contingency fee basis.[103] As the court noted in Creative Dimensions in Management v. Thomas Group, Inc., 1999 U.S. Dist. LEXIS 2757 (March 11, 1999), that:

> The testimony of an interested lay witness about historical facts generally does not pose a risk of the same proportion as that of an expert with a contingent financial interest. The concealment of a contingent financial relationship with a witness would be unconscionable. With the disclosure of such an arrangement, an opinion proffered by an expert would likely be so undermined as to be deprived of any substantial value. See Gediman v Sears, Roebuck & Co., 484 F. Supp. 1244, 1248 (D. Mass. 1980) ("an agreement to give an opinion on a contingent basis, particularly on an arithmetical scale, attacks the every core of expert testimony"). Jurors, however, routinely take and assess the testimony of parties and persons related to them who have a direct financial interest in the outcome of a case. "With many witnesses and of course parties, interest is unavoidable. An expert however, whose only relevance is his expertise, should not have that expertise flawed." (Emphasis added.) Id. n.4.

Further, the First Circuit Court of Appeals found in Crowe v. Bolduc, 334 F. 3d 124, 132 (1st Cir. 2003)

> The problem was exacerbated here because the witnesses, admittedly not called as experts, gave what amounted to opinion testimony as to the meaning of the contract language. The majority rule in this

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but also as to his expectation of future work especially in light of the allegation that there are in excess of one thousand cases pending on this issue.

[102] Tr. 420, 434. The court noted in Mushroom Transportation v Continental Bank, 70 B.R. 416 (1987) that any pre-trial assistance rendered to other witnesses by expert paid on contingency fee may be grounds for impeachment of that witness. Id. at .n.5

[103] See,e.g, Davey v. Chang, 286 B.R. 54 (2002)(distinguishing between rules of evidence and rules of ethics noting that in Universal Athletic Sales Co. v. American Sign, 546 F. 2d 530(3rd Cir. 1976) the court found nothing in the rules of evidence bars such testimony, but acknowledging that witness had incentive to shade testimony and was a consideration in assessing credibility, but not dispositive.)

> country is that an expert witness may not collect compensation which by agreement was contingent on the outcome of a controversy. The rule was adopted precisely to avoid even potential bias….[104]

The Administrator finds that the Board failed to weight the credibility of the consultants Pfiel[105] and Smith opinion testimony (and Schafer for related reasons) in light of the financial interest these consultants have in the outcome of the litigation.[106]

VI. Administrative burden

Finally, the Board's decision concludes that to redesign the computer program to recalculate the Medicare fraction to correct the claimed errors with updated data would not be an administrative burden for these cost years. The Board's decision chooses to look beyond this particular Provider's appeal in finding that this Provider need not show harm.[107] Yet, the Board's decision ignores the enormity of

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[104] The court in this case also pointed out that the problems inherent with the payment of a witness by contingent fee is addressed in many codes of professional responsibilities (such as the Maine bar Rule 3.7(g)(3)), by explicitly prohibiting the practice. See, e.g., Pa. Code of Professional Responsibility DR-109(C), Shore v. Parklane, 1978 U.S. Dist. LEXIS 14211 (1978) (referring to NY Judiciary Law, Disciplinary Rule, 7-109(c) and AICPA (Accounting) Ethics Ruling section 302).

[105] The Provider also submitted certain evidence through the consultant regarding the treatment of other hospitals with which CMS allegedly reached a settlement. To the extent such evidence is intended to show liability for the claim, it is not properly considered and part of the record. The court in Board of Trustees, supra, allowed in settlement evidence only where it was to show arbitrary and capricious action on the part of the agency, in that the Agency inconsistently applied its policy. The Court ultimately found that the evidence in the end did not support a finding of arbitrary and capricious action by the agency.

[106] In contrast, for example, the Board basically rejected all of the Intermediary arguments and inappropriately shifted the burden of proof to the Intermediary because of the data location and release problems. However in weighing evidence the record shows that the Intermediary's arguments were mostly based on independent statistics, the transparent mathematical analysis of those statistics and testimony of Federal employees with no financial interests in the outcome of the case.

[107] The Provider initially appealed issues that met the $10,000 amount in controversy, so the matter of the lack of financial harm does not affect this issue of jurisdiction. (See, e.g., Provider's Request for Hearing, dated March 19, 1999, FYE Sept 30, 1996) However, although not argued before the Board, it is difficult to reconcile the Provider's failure to show financial harm and the need for the

the Medicare Program in finding that the implementation of its order would be no administrative burden, despite its retrospective and wide reaching implications.[108]

The Administrator concludes that the Board erred in adopting the Provider's narrow view of the administrative burden which ignores the whole of CMS implementation scheme for IPPS. As the court in Methodist, supra, acknowledged, the provider's position in that case could "cause a significant if not debilitating disruption to the Secretary's administration of the already complex Medicare program." Methodist Hospital, 38 F. 3d at 1233. The Board failed to consider the wider implications of its decision in this case, despite the full knowledge of the cases presently pending before it on this issue and despite the fact that the Provider has not been able to demonstrate any financial harm to justify any such relief as the Board has ordered and may in fact experience a reduction in DSH payment.

In sum, the Board's standard applied in this case, which requires an errorless match in order to withstand the Board's scrutiny, is inconsistent with the IPPS and the efficient administration of the Medicare program. The Administrator finds that the Provider is not entitled to a recalculation of its Medicare fraction for the cost years involved in this case.

Provider to show "dissatisfaction" with the amount of its DSH payment as required under Section 1878(a) of the Act as an element of Board jurisdiction. Jurisdiction can never be waived, despite the Board's finding that the Provider did not have to show harm.

[108] The record shows that no CMS employee was questioned as to the administrative burden the proposed relief would have program wide. Therefore the Board erred in finding that statements of CMS' own employees support such a finding.

DECISION

The decision of the Board is modified in accordance with the foregoing opinion. The Administrator finds that the CMS' determination of the Provider's Medicare fraction is proper and is hereby affirmed.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 5/11/06

/s/
Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services