

CMS RULING 1498-R LITIGATION:

The Gallant Effort to Procure Additional Hospital
Medicare DSH Reimbursement in a Post – *Baystate* World

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Brief DSH Primer

- Under Medicare, a federally funded program that provides health insurance for the elderly and disabled, hospitals are not reimbursed for the **actual** cost of treating Medicare beneficiaries.
- Instead, the federal government, under Medicare Part E, reimburses hospitals for treating Medicare patients through a “prospective payment system” (PPS) based on predetermined rates for a given diagnosis (DRG), regardless of the cost of treatment. 42 U.S.C. § 1395ww(d).

Brief DSH Primer

- Those predetermined rates may be adjusted for specific hospitals.
42 U.S.C. § 1395ww(d)(5)
- One such hospital-specific adjustment is the Medicare Disproportionate Share Hospital (“DSH”) adjustment
- Under the Medicare DSH adjustment, the government pays a hospital more for treating Medicare patients if the hospital serves a “significantly disproportionate number of low-income patients.” 42 U.S.C. § 1395ww(d)(5)(F)(i)(I)
- The reason for this adjustment is Congress’s judgment that low-income Medicare patients generally are in poorer health and therefore are costlier to treat.

Brief DSH Primer

- One method of determining whether a hospital qualifies for a Medicare DSH adjustment and the amount of such adjustment is the hospital's disproportionate patient percentage (DPP), which serves as a proxy for the number of low-income patients treated by the hospital. A higher DPP means greater reimbursements because the hospital is serving more low-income patients. This figure is not the actual percentage of low-income patients served, rather, it is an indirect, proxy measure for low income.
- The disproportionate share (DSH) percentage is determined by a complicated statutory formula. 42 U.S.C. §1395ww(d)(5)(F)(iv) and (vii)-(xiii). The DSH percentage is the sum of two fractions which are commonly known as the "Medicare fraction" and the "Medicaid fraction."

Brief DSH Primer

- The Medicare fraction is defined as: 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 [Title XVIII] and were entitled to supplemental security income benefits (excluding any State supplementation) under [Title] XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under part A of [Title XVIII]...
- In layman's terms, the top of the Medicare fraction is based on the number of a hospital's patient days for individuals entitled to both Medicare Part A and SSI benefits, and the bottom of the fraction is based on the number of patient days for all patients under Part A.

Brief DSH Primer

- The Medicaid fraction is defined as: the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State [Medicaid] plan... but who were not entitled to benefits under [Medicare] Part A... and the denominator of which is the total number of the hospital's patient days for such period.
- Again, in layman's terms, the top of the Medicaid fraction is based on the number of a hospital's patient days for individuals who are eligible for Medicaid, but who are not entitled to benefits under Medicare Part A, and the bottom is the total number of all patient days for the hospital.

Brief DSH Primer

	Medicare fraction	Medicaid fraction
Numerator	Patient days for patients “entitled to benefits under part A” and “entitled to SSI benefits	Patient days for patients “eligible for [Medicaid] but not “entitled to benefits under part A”
Denominator	Patient days for patients “entitled to benefits under part A”	Total number of patient days

The Data Matching Process

- In determining the number of inpatient days for individuals entitled to both Medicare Part A and SSI as required for calculation of the numerator of the SSI fraction, CMS matches the Medicare records and SSI eligibility records for each hospital's patients during the Federal fiscal year (though a provider *may* elect to have its SSI fraction determined on the basis of the provider's cost reporting period)
- The data underlying the match process are drawn from:
 - The Medicare Provider Analysis and Review (MedPAR) data file, and;
 - SSI eligibility data provided by the Social Security Administration (SSA)

The Data Matching Process

- CMS had historically ‘matched’ Medicare and SSI eligibility records using Title II numbers (included in the SSI records) and Health Insurance Claim Account Numbers (HICANs)(contained in the MedPAR file).
- Providers became suspicious of the CMS matching process, concluding, among other factors, that the data calculated (and hence, used in the Medicare SSI fraction) was omitting critical aspects, in particular, not taking into consideration, for example identification of SSI patients’ through social security numbers, of forced (cash) payments, and furthermore, relying upon stale SSI records.

Enter *Baystate*

- In *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 220, as amended, 587 F. Supp 2d 37,44 (D.D.C. 2008) (“Baystate”), the U.S. District Court for the District of Columbia determined that the Secretary was in fact, not using the “best available data” to determine providers’ SSI fractions
 - The Court further found that the CMS Administrator’s refusal to afford the *Baystate* plaintiffs retrospective relief was arbitrary and capricious
 - The Court held that the miscalculations identified in *Baystate* had a negative effect on the reimbursement amounts of the Providers in that case.

Enter *Baystate*

- In order to correct the Secretary's errors, the Court specifically ordered the Secretary to:
 - Use patient social security numbers in the data matching process;
 - Use updated SSA records that become available before the time that the cost report at issue is settled;
 - Forced pay SSI records, and;
 - Inactive ("stale") SSI records
- The Court also ordered the Secretary to recalculate each plaintiff provider's SSI fractions and DSH adjustments, and pay the provider the additional monies due plus interest. The total payout to all plaintiff providers exceeded \$500,000,00

~~Enter~~ Exit *Baystate*

- The *Baystate* litigants were not the only parties challenging the Medicare SSI fraction of the DSH calculation; thousands of provider fiscal years were challenged. Regrettably, and despite the Court's order that CMS immediately apply that Court's criteria to correct its flawed matching process, the subsequent matching process remained deeply flawed.
- As a consequence, providers *post-Baystate* found themselves *once* again initiating appeals to the PRRB alleging recurring errors of the SSI calculation.
- Displaying her mastery of understatement, the Secretary noted that “[h]ospitals have filed numerous PRRB appeals” challenging the DSH calculation.
- To resolve these countless appeals, on April 28, 2010, the Secretary issued Ruling 1498-R.

CMS RULING 1498-R

- Ruling 1498-R applies to appeals in any of the three following categories:
 - Challenges to CMS' data matching process for matching Medicare and SSI eligibility data in determining the SSI Medicare fraction;
 - Challenges to the exclusion from the disproportionate patient percentage (DPP) of non-covered inpatient hospital days (e.g., Medicare secondary payer (MSP) days or exhausted benefit (EB) days; or
 - Challenges to the exclusion from the DPP of labor/delivery room (LDR) patient days
- Pursuant to Ruling 1498-R, any appeal involving any of the above three categories must be remanded by the Board to the MAC

CMS RULING 1498-R

- Ruling 1498-R further provides:
 - The MAC is to revise the SSI/Medicare fraction to include certain non-covered inpatient hospitals days (e.g., MSP and EB days) in the SSI/Medicare fraction;
 - The MAC is to re-compute the SSI fraction using the revised data matching process ordered by the District Court in *Baystate*;
 - That the Board “hereby lacks jurisdiction over each properly pending claim on the SSI/Medicare fraction data matching process issue,” and therefore, a remand back to the MAC is the appropriate procedural remedy

LAWSUITS FILED OBJECTING TO CMS RULING 1498-R

- Since the 2010 implementation of Ruling 1498-R, hundreds of lawsuits involving thousands of provider fiscal years have been filed objecting to this CMS Ruling
 - The gravamen of each complaint is the assertion that the Ruling's order of remand back to the MAC is arbitrary and capricious because –
 - It divests the Board of jurisdiction over timely filed appeals, and requires the MAC to recalculate their DSH eligibility and adjustments in violation of the Medicare Act
 - and despite the specific *Baystate* Court mandate concerning the specific methodology in which to re-compute the Medicare SSI fraction, there still exists numerous flaws in the manner in which CMS (and the MAC) calculates DSH payments

LAWSUITS FILED OBJECTING TO CMS RULING 1498-R

- One key allegation is that that CMS continues to undercount the number of Medicare patients entitled to Supplemental Security Income (SSI) – financial help for disabled poor people – in violation of *Baystate*
- While *Baystate* directed CMS to explain why patients shouldn't be identified using Social Security numbers, Ruling 1498-R impermissibly fails to do so. As a result, the Ruling fails to match Medicare and SSI records on the basis of, for example, Social Security numbers, often resulting in a deflated value of the Medicare SSI fraction
- In addition to its failure to use SSN in the matching process, the post-*Baystate* matching process fails to take into consideration SSI beneficiaries who are *entitled* to SSI, but whose payments are in suspense or other non-pay status.

LAWSUITS FILED OBJECTING TO CMS RULING 1498-R

- Under the terms of the Ruling, individuals are “entitled” to SSI only when they actually RECEIVE an SSI payment, whereas individuals are deemed “entitled” to Medicare even *if* they do not receive any payment from Medicare
 - Thus, there is a significant and illogical disparity in the manner in which the two components of the Medicare SSI fraction numerator – those entitled to Medicare Part A and those entitled to SSI - define and apply the very same term, “entitled”
- Moreover, individuals whose SSI benefits are retroactively awarded will be captured in the matching process only in the month in which retroactive payment is actually made, NOT in the prior months, which the retroactive payment was intended to cover

LAWSUITS FILED OBJECTING TO CMS RULING 1498-R

- Including certain Part A non-covered inpatient hospital days in the Medicare SSI fraction, including exhausted benefit (EB), secondary payer (SP) and HMO days is a contradiction because the law requires that patients have entitlement (i.e., payment) to Medicare Part A for treatment days to be included in the calculation of the provider's Medicare reimbursement. Since such days are often not covered (i.e., unpaid) under Part A, inclusion in the Medicare SSI fraction results in a diminished Medicare SSI ratio, and hence, a lower reimbursement calculation
 - The resulting lower DSH reimbursement is due to the fact that such inclusion increases the total pool of patients treated by a provider Under Part A (the denominator) while SSI recipients constitute a smaller percentage of the total pool (SSI payment *is* required and must be appropriately 'captured')
 - recall that the factor in the numerator requires entitlement to *both* Part A *and* SSI

BENEFITS TO LITIGATING OBJECTIONS TO RULING 1498-R

- A more timely resolution of alleged erroneous DSH calculations
 - A provider adhering to the mandate of Ruling 1498-R must subject its DSH appeal to remand back to the MAC for re-consideration and re-calculation
 - By taking that route, the provider risks the likelihood that the end result of that re-calculation will be unsatisfactory based upon the application of the 1498-R formulas and definitions just discussed
 - The remand process back to the MAC could delay the finalization of that re-calculation for months - quite possibly years
 - As noted, this long delay may nonetheless produce an unsatisfactory end result
- Lawsuits objecting to Ruling 1498-R commenced in 2010 just after issuance of that Ruling. Many of the cases filed in the District Court for the District of Columbia have been ordered by the court to proceed to mediation before federal Magistrates in an effort to address and resolve the issues in a satisfactory fashion, with the end goal of producing an appropriate DSH calculation and DSH reimbursement allocation to the provider
- The opportunity to recover litigation interest on the principal sum ultimately re-calculated