Beth Israel Medical Center v Department of Health of State of New York
2003 NY Slip Op 30094(U)
April 25, 2003
Supreme Court, New York County
Docket Number: 0120640/1998
Judge: Barbara Kapnick
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SUPREME COURT OF THE STATE OF NEW YORK — NEW YORK COUNTY

PRESENT: Hon. BARBARA R. KAPNICK PART 12
Justice

BETH ISRAEL MEDICAL CENTER et al.

INDEX NO. 120640/98

MOTION DATE

- v -

MOTION SEQ. NO. 003

THE DEPARTMENT OF HEALTH OF THE STATE OF New York et al.

MOTION CAL. NO.

The following papers, numbered 1 to ______ were read on this motion to/for ______

	PAPERS NUMBERED
Notice of Motion/ Order to Show Cause — Affidavits — Exhibits ...	
Answering Affidavits — Exhibits	
Replying Affidavits	

SCANNED
MAY 0 1 2003

Cross-Motion: ☒ Yes ☐ No

Upon the foregoing papers, it is ordered that this motion and cross-motions are decided in accordance with the accompanying memorandum decision.

MOTION/CASE IS RESPECTFULLY REFERRED TO JUSTICE
J.S.C.
DATED:

Dated: 4/25/03

J.S.C.
BARBARA R. KAPNICK

Check one: ☒ FINAL DISPOSITION ☐ NON-FINAL DISPOSITION

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK : IA PART 12

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BETH ISRAEL MEDICAL CENTER, et al.,

Petitioners,

- against -

THE DEPARTMENT OF HEALTH OF THE STATE OF NEW YORK, DENNIS WHALEN, as Acting Commissioner of the Department of Health of the State of New York, and ROBERT L. KING, as Director of the Budget **of** the State **of** New York,

Respondents,

-and-

EXCELLUS HEALTH PLAN, INC. (d/b/a BLUE CROSS AND BLUE SHIELD OF CENTRAL NEW YORK, BLUE CROSS AND BLUE SHIELD OF UTICA-WATERTOWN, and BLUE CROSS AND BLUE SHIELD OF THE ROCHESTER AREA); EMPIRE BLUE CROSS AND BLUE SHIELD, and NEW YORK STATE CONFERENCE **OF** BLUE CROSS AND BLUE SHIELD PLANS,

Intervenors-Respondents.

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DECISION/JUDGMENT
Index No. 120640/98
Motion Seq. No. 003

BARBARA R. KAPNICK, J.:

Petitioners, 116 acute care general hospitals located throughout New York State, seek in this action a judgment vacating and annulling determinations by the Department of Health ("DOH") denying their various administrative appeals challenging the Medicaid reimbursement rates established for the 1992, 1993, and 1994 rate years; declaring that certain calculations by respondents are arbitrary, irrational, illegal, capricious and in contravention of the Public Health Law or other relevant statutes and regulations and the Constitutions of New York State and the United States of

America; and directing that petitioners' Medicaid rates for the 1992, 1993, and 1994 rate years, and all relevant rate years thereafter, be appropriately and properly recalculated and that such recalculated rates be promptly certified, approved and paid by the respondents.[1]

Petitioners now move pursuant to CPLR §§ 3212 and 7806 for summary judgment.

Respondents the Department of Health of the State of New York, Dennis Whalen, as Acting Commissioner of DOH, and Robert L. King, as Director of the Budget of the State of New York, cross-move pursuant to CPLR §§ 3212 and 7806 for an order directing that judgment be entered in their favor and dismissing the Amended Complaint/Petition, and awarding the costs and disbursements of this action.

Intervenors-respondents Excellus Health Plan, Inc. (d/b/a Blue Cross and Blue Shield of Central New York, Blue Cross and Blue Shield of Utica-Watertown, and Blue Cross and Blue Shield of the Rochester Area), Empire Blue Cross and Blue Shield, and The New York State Conference of Blue Cross and Blue Shield Plans cross-

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[1] This action, which was commenced as a plenary action, was converted to an Article 78 proceeding by Order of this Court dated November 30, 1999, which deemed the pleadings in this action as if brought pursuant to Article 78 of the CPLR.

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move for summary judgment in their favor and dismissing petitioners' amended complaint/petition.[2]

Backsround

Prior to January 1, 1988, hospitals were reimbursed for acute inpatient care given to Medicaid clients on a per diem basis. Pursuant to the New York Prospective Hospital Reimbursement Methodology ("NYPHRM"), L.1988, ch.2, the per diem basis for rate-setting was replaced by a "per case" basis, as of January 1, 1988.

Under this system, each patient, upon discharge from a hospital, was classified into one of more than 600 diagnostic related groups ("DRGs") based on the patient's primary diagnosis and any secondary diagnosis and/or any surgery performed.[3] Each DRG has a corresponding service intensity weight ("SIW") "which reflects the relative general hospital resources used by all patients, other than beneficiaries of title XVIII **of** the federal social security act (medicare), with respect to discharges classified within that diagnosis-related group compared to

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[2] From the mid-1980's until 1997, the reimbursement rates for virtually all other payors **of** inpatient hospital care other than the Medicare program (Blue Cross, commercial insurance companies, workers' compensation and no-fault carriers) were derived from the Medicaid rate. Medicare, which is an exclusively Federal program, has independently set its own rates in the State since January **1,** 1986.

[3] For certain DRGs, other factors such as the patient's age or birth weight, can affect DRG assignment. The DRG classifications mirror those used in the Medicare program. See, Public Health Law § 2807-c(3)(a).

discharges classified within other diagnosis related groups." See, Health Law § 2807-c(3)(c).[4]

The relative mix of different DRGs at any particular hospital is known as that hospital's "case mix." The relative complexity of each facility's inpatient cases is expressed numerically as the facility's "case mix index." The more complex the average of DRGs at a hospital, the higher its case mix index would be.

Over time, it could be expected that the case mix indexes would rise as a result of advances in medical technology which have enabled relatively complex procedures to be performed on patients who would not have previously been admitted. Likewise, less complex procedures that were previously performed in hospitals could increasingly be performed on an out-patient basis.[5]

In addition, it was contemplated that as hospitals became more familiar with the DRG coding system, they would more frequently identify the higher weight DRG when more than one DRG was applicable to a particular case; i.e., when a combination of conditions had been diagnosed for a particular patient. The

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[4] For example, in 1992, a normal newborn infant delivered without complications would be assigned to DRG 629, which has an SIW of 0.2128, while a patient receiving a heart transplant would be assigned *to* DRG 103, which has an **SIW** of 31.9113.

[5] Out-patient cases are not included in the calculation of a hospital's case mix index.

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increase in case mix indexes, resulting from this practice is commonly known as "case mix creep."

"In order to allow for real increases in general hospital case mix while limiting the effect of potential case mix changes that are the result of changes in coding practices rather than real changes in case mix," (Public Health Law § 2807-c[11][f][i]) the Legislature established a cap on the growth of case mix. The reimbursable increase in Statewide aggregate case mix for the 1987-1988 period was 2% and the allowable increase thereafter was set at 1% per year, as compared to 1987.[6]

To measure the Statewide case mix each rate year, DOH is required to use data from medical records, as reported by the hospitals to DOH's Statewide Research and Planning Cooperative System ("SPARCS") data base. 10 NYCRR 86-1.75(a). To determine the case mix limit for each hospital, DOH first adjusts the SPARCS data from that hospital pursuant to a standard method known as "Hospital-Specific DRG Creep Methodology Edits" in order to exclude the effect *of* case mix creep. The adjusted Statewide case mix change from the preceding rate year is then compared to the statutory cap and, if the change exceeds the cap, a second adjustment is made to each hospital's rate to exclude so much of the increase as exceeds the cap. This second adjustment, which is

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[6] Thus, in 1989, the allowable limit was 3%, as compared to 1987; in 1990, it was 48, and so on.

known as the "Statewide Case Mix Limit Penalty," is applied to each hospital as an across-the-board percentage rate reduction whether or not that particular hospital's case mix index has increased or decreased. The adjusted Statewide growth in case mix, after removal of all hospital-specific DRG creep, has exceeded the statutory cap in every year since the present system was enacted.

The NYPHRM does not apply to the costs of providing inpatient services to Medicare patients (Public Health Law §§ 2807-c[1], 2807-c[1][g]), and the costs of providing such services are to be excluded from the setting of rates under the NYPHRM. Public Health Law § 2807-c(11)(g). In addition, the costs of providing inpatient services to Medicare patients, who are also covered by a secondary payor, are excluded. Public Health Law § 2807-c(11)(g)(ii).

Also exempted from the per case system are certain hospitals and units of hospitals that provide specialized services, including the treatment of AIDS. See, Public Health Law §§ 2807-c(4)(e), (4)(g), (6)(b). Finally, case mix changes that are due to AIDS, epidemics, "or other catastrophes resulting in extraordinary hospital utilization" are not subject **to** the cap and, therefore, are not included in the calculation of the Statewide case mix. See, Public Health Law § 2807-c(11)(f)(i); 10 NYCRR 86-1.75(a)

Petitioners contend that respondents failed to exclude data pertaining to Medicare patients from the calculation of the

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Statewide case mix, that they failed to exclude all exempt units, and that they failed to exclude all AIDS-related costs.[7]

Petitioners further contend that Medicare-related costs were improperly included in the calculation of the Statewide case mix in the following two ways.

First, Medicare patients who were enrolled in HMOs were included in the data reported to SPARCS for the 1992 rate year as "generic" HMO patients, rather than as Medicare patients, because SPARCS did not provide a separate classification for Medicare HMO cases. In the 1993 and 1994 rate years, miscoding occurred because DOH changed the reporting format to include a designation as "Medicare HMO," but instructed hospitals to use the Expected Primary Reimbursement Code for "Other HMO" if it was not clear at the time of discharge that the patient was in a Medicare HMO. The change in format was reported by DOH only to hospital personnel who were responsible for gathering and disseminating the SPARCS data, as opposed to the hospitals' financial officers who would have been more conversant with the financial implications of a Medicare HMO category.

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[7] It is undisputed that Medicare-related costs, like AIDS-related costs, are higher than average. Thus, including these costs in the case mix raises the case mix and results in a higher penalty.

Second, patients who were eligible for both Medicaid and Medicare were included in the data reported to SPARCS because DOH directed that the hospitals identify the payor expected to contribute the majority of dollars in a given case in the Expected Primary Reimbursement field. Thus, Medicaid was identified as the expected primary reimburser if it was expected to pay the largest amount in a given case (i.e. more than Medicare) even though (i) pursuant to Public Health Law § 2807-c(11)(g)(ii), "[c]osts and statistics related to inpatient services provided to beneficiaries of title XVIII of the federal social security act (medicare) and covered by a secondary payor shall be excluded ...," and (ii) Ralph Bielefeldt, Assistant Director of the Bureau of Health Economics of DOH's Division of Health Care Financing acknowledged at his deposition that Medicaid, as the payor of last resort will pay for a patient's care only after all other potential sources of payment have been exhausted.

With regard to exempt units, 18 NYCRR 530.1(a) provides that:

> [f]or admissions on or after January 1, 1988 ... designated acquired immune deficiency syndrome (AIDS) units and alcohol rehabilitation units are also exempt [from the case payment system], as described in 10 NYCRR 86-1.57, and will be paid on a per diem basis.

As discussed above, Public Health Law § 2807-c(11)(f)(i) provides that case mix changes at general hospitals that are due to AIDS are not subject to the Statewide cap. Petitioners contend, however, that only those exempt unit cases where the primary

diagnosis was within one of the specified AIDS DRGs were excluded. Similarly, respondents contend that only those cases where AIDS was the primary diagnosis or where AIDS was 'secondary to an AIDS Related Condition were excluded from data relating to AIDS patients in non-exempt units.

According to plaintiffs' expert, Stephen MacCormack, a principal with IMR Global - Orion Consulting, certain diagnoses are designated as Major Complications and Co-Morbidities ("Major CCs"), when they occur as a secondary diagnosis. Cases where AIDS is a secondary diagnosis and the principal diagnosis is not an AIDS Related Condition are generally assigned to MCC DRGs. Petitioners contend that although the SIWs for both AIDS DRGs and MCC DRGs are significantly higher than the average case mix for non-AIDS patients, DOH did not exclude those AIDS cases that were designated as another Major CC DRG.

In addition to claiming that DOH's failure to exclude all AIDS cases from the Statewide aggregate case mix violates the Public Health Law, petitioners argue that DOH's policy not to exclude AIDS cases where AIDS is assigned to an MCC DRG diagnosis amounts to the adoption of a rule without the rulemaking procedures required by the State Administrative Protection Act.

Prior to 1994, DOH measured the hospital-specific DRG creep adjustment and the Statewide Case Mix Limit Penalty directly from

the 1987 base year to each respective rate year. Starting in 1994, however, DOH measured case mix growth in two stages, from 1987 to 1992, and from 1992 to the rate year. Petitioners contend that if a particular hospital was determined to have a negative hospital-specific DRG creep in either of those periods, the creep adjustment was set at zero. Thus, petitioners contend that if a hospital had positive creep in one of the periods and negative creep in the other period, the hospital was denied the offsetting benefit of the negative creep.

Petitioners contend that the cumulative effect of these acts is that the Statewide Case Mix Limit Penalty, as calculated for the three years at issue, is substantially overstated, causing the petitioner hospitals to forfeit millions of dollars annually through a series of invalid Statewide Case Mix Limit Penalty assessments.

Discussion

Petitioners move for an order pursuant to CPLR §§ 3212 and 7806 granting judgment in their favor, annulling respondents' actions and determinations; directing respondent DOH and its officials to recalculate the Statewide Case Mix Limit Penalty in accordance with the relevant common law and statutory principles; directing respondents to certify a proper and lawful reimbursement rate; directing the respondent Division of the Budget to approve that rate; directing respondents and intervenor-respondents to pay

to pay the petitioners in accordance with that rate and directing respondents and intervenor-respondents to reimburse petitioner hospitals for the collateral costs and losses incurred as a result of respondents' allegedly unlawful actions.

Respondents cross-move to dismiss the petition on the grounds that some or all of the causes of action are barred by the applicable statute of limitations, the doctrines of estoppel, failure to exhaust, and/or waiver, and that all of petitioners' claims fail to state a cause of action.

The intervenors-respondents cross-move to dismiss the proceeding against them on the ground that it is barred by the doctrine of primary jurisdiction because they were not served with copies of most of petitioners' administrative appeals and because the petition makes no claims as against them.

1. Timeliness

Respondents argue that this action is barred by the applicable four month Statute of Limitations (see, CPLR § 217). There is no dispute that petitioners brought this action more than one year after the last adverse determination was made.

Respondents argue that petitioners' time was not tolled by the pendency of petitioners' administrative appeals because the matters

that are raised here were not administratively appealable. Petitioners, on the other hand, contend that this proceeding is timely because the issues raised were appealable.

However, 10 NYCRR 86-1.61 limits the matters as to which a hospital may appeal relating to the determination of its allowable cumulative case mix increase to:

> (a) Mathematical or clerical errors in the cost and/or statistical data originally submitted by the medical facility ... or mathematical or clerical errors made by the Department of Health...[8]

Similarly, 10 NYCRR 86-1.17, limits appeals, insofar as is relevant here, to " [elrrors, whether mathematical or clerical or otherwise, in data submitted by a medical facility,..." 10 NYCRR 86-1.17(a) (2).[9]

It has been repeatedly held that where a petition "does not allege a computational error but, rather, addresses the methodology employed to calculate the rate", the proceeding must be commenced within four months or is time barred. Evergreen Alley Nursing Home

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[8] Administrative appeals pursuant to that subdivision "must be submitted within 120 days of receipt of the applicable title XIX and/or article 43 corporation initial rate computation sheet." 10 NYCRR 86-1.61 (a).

[9] Applications to the State Commissioner of Health for prospective revisions based on this paragraph "must be submitted within 120 days of the receipt of the applicable title XVIII, title XIX and/or article 43 corporation program initial rate computation sheet." 10 NYCRR 86-1.17(a)(2).

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v. DeBuono, 277 A.D.2d 569, 570 (3rd Dep't 2000); see also, Lyden Nursing Home v. DeBuono, 287 A.D.2d 490 (2nd Dep't 2001), lv. to app. denied, 98 N.Y.2d 602 (2002); Matter of Sylcox v. Chassin, 227 A.D.2d 834 (3rd Dep't 1996); Charles P. Sitrin Nursing Home Co. v. McBarnette, 198 A.D.2d 579 (3rd Dep't 1993), lv. to app. denied, 83 N.Y.2d 752 (1994).

In the instant case, petitioners claim that negative creep should have been allowed to offset positive creep in the period between 1987 and 1994; that AIDS-related cases should have been excluded from the case mix when AIDS was secondary to a non-AIDS-Related Condition; and that cases where the patient was eligible for both Medicare and Medicaid should have been excluded from the case mix.

Although petitioners contend that their administrative appeals did not raise methodological issues and characterize the nature of the challenges (which involved claims that the calculations erroneously included bad data) as computational - i.e. costs and statistics not permitted under the legislative scheme - this Court finds that the administrative appeals did not involve either computational or clerical errors; rather, they challenged DOH policies on the ground that they violate the Public Health Law and applicable regulations - in other words, the methodology used. Therefore, this Court finds that the pendency of the administrative

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appeals did not toll the statute of limitations and that these claims are time barred.[10]

Likewise, petitioners' claim that DOH failed to exclude certain Medicare cases because petitioners and other hospitals in the State failed to code those cases as Medicare cases alleges neither computational nor clerical errors. Rather, it alleges that the DOH form on which data for the 1992 rate year was to be reported to SPARCS was improper and that DOH failed to notify petitioners' financial officers when DOH changed the form. Therefore, this claim also challenges the agency's methodology and is time-barred.

Petitioners argue, in the alternative, that DOH should be estopped from raising the Statute of Limitations as a defense, because DOH appeared to accept the administrative appeals since they were under consideration for over two years,[11] and because DOH failed to notify petitioners that these claims raised questions of

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[10] To the extent that petitioners also claim that DOH should have adjusted the SPARCS data submitted by the hospitals on the basis of information available from other sources, including third-party auditors such as Island Peer Review Organization ("IPRO") and Blue Cross, such claim challenges DOH's methodology and is similarly time-barred.

[11] There is no dispute that the rate appeals were assigned an appeal number and forwarded to a rate analyst for a review as to whether or not the appeal contained an appealable item, and that no letter was sent to the hospitals informing them that the challenges were non-appealable. Respondents, however, contend that a number was assigned for tracking purposes only and said assignment did not constitute a formal determination as to whether or not the challenges were administratively appealable.

law and were thus not administratively appealable until several years after petitioners had filed them. Moreover, **DOH** failed to issue a decision until after petitioners had filed a mandamus proceeding pursuant to Article 78 of the CPLR in 1998 to compel DOH to determine the pending administrative appeals.

However, estoppel does not lie against the State, or its political subdivisions, "in all but the rarest cases". Matter of Parkview Assocs. v. City of New York, 71 N.Y.2d 274, 282, cert. denied 488 U.S. 801 (1988); see also, New York State Medical Transporters Assn. v. Perales, 77 N.Y.2d 126 (1990).

In addition, the administrative appeals concerned a multiplicity of issues; i.e. hybrid questions involving both data issues and methodological challenges. Petitioners have failed to point to any statute or regulation which imposes upon DOH a duty, prior to its final determinations, to place petitioners on notice as to which of those issues, if any, were appealable and which of those issues were not appealable.

This Court further notes that judicial estoppel only "'precludes **a** party who assumed a certain position in a prior legal proceeding and who secured a judgment in his or her favor from assuming a contrary position in another action simply because his or her interests have changed' (citation omitted)." All Terrain Props. Inc. v Hov, 265 A.D.2d 87, 93 (1st Dep't 2000).

Since the earlier Article 78 proceeding was settled prior to the issuance of a final judgment, respondents are not judicially estopped by virtue of their silence as to the administrative appealability of the instant matters at the time that petitioners filed the earlier Article 78 proceeding.

2. The Merits

A. The AIDS Issues

Moreover, even were these claims timely brought, petitioners would prevail on only one of them.

Specifically, this Court finds that it was not unreasonable for DOH to limit the exclusion of case mix changes due to AIDS (Public Health Law § 2807-c[11][f][1]), to patients who were hospitalized because of AIDS or an AIDS-Related Condition, and not to extend it to instances when an AIDS-diagnosed patient was admitted because of an entirely different condition.

Although respondents contend that the treatment of certain non-AIDS related cases will be more costly if the patient has AIDS than if the patient does not, there is no evidence in the record that the cost of treatment is increased more often, or by a greater amount, where AIDS is secondary to a non-AIDS related condition than when the secondary diagnosis is an MCC DRG other than AIDS. Accordingly, petitioners have failed to show that in excluding only those cases where AIDS is the primary diagnosis or is secondary to

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an AIDS-Related Condition (i.e., only those cases where the patient was admitted because of AIDS), DOH failed to exclude case mix changes "due to [AIDS], tuberculosis, epidemics or other catastrophes resulting in extraordinary hospital utilization," as required by Public Health Law § 2807-c(11)(f)(i)(F).

However, with regard to the exclusion of exempt units (18 NYCRR 530.1[a]), DOH exempted only those patients who were designated as being in one of the AIDS DRGs until 1994, when DOH added a coding marker for exempt units. Thus, in both 1992 and 1993, DOH failed to exclude from the case mix patients in exempt units whose primary diagnosis was not AIDS. However, this issue affected no more than approximately 5,700 out of the approximately 2.5 million discharges that were reported to SPARCS in each of those years, i.e., less than 0.3%. This minuscule effect on the Statewide case mix would not warrant granting petitioners the relief that they seek.[12]

B. The Creep Issue

In 1994, the Legislature amended Public Health law § 2807-c(11)(f)(i) to provide that the base year from which increases in

[12] Although petitioners claim that this problem did not end in 1994, DOH cannot be held responsible for any failure on the part of an exempt unit to correctly code itself.

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case mix would be measured was 1992, rather than 1987. L.1994, ch.170, § 442. Under this amendment, the maximum allowable increase in the Statewide aggregate case mix was set at 2% from 1992 to 1994, with an additional **1%** in each succeeding year. The cap for the years 1987 to 1992 remained unchanged. Accordingly, DOH measured the change in hospital-specific case mix, first from 1988 to 1992 using 1987 as the base year, and then from 1992 to 1994 using 1992 as the base year.

Ralph Bielefeldt, the Assistant Director of the Bureau of Health Economics of DOH's Division of Health Care Financing, claims that nothing in the analysis of case mix change would show that a facility's coding practices had deteriorated and that "negative creep" simply measures the amount by which a facility's case mix increase falls short of the allowable Statewide increase.

As discussed above, DOH assigned a value of zero to any "negative" creep. However, nothing in the 1994 amendment of Public Health Law § 2807-c(11)(f)(i) authorizes DOH **to** net the degree by which a facility's increase in case mix fell short **of** the maximum allowed in one period against an increase that exceeded the cap in the other period. To the contrary, by requiring separate measurements of case mix increase for each of the two periods, and by setting different caps for the two periods, the Legislature clearly indicated that the overall change over the two periods was

not to be averaged. Thus, **DOH's** refusal to provide a credit for "negative creep" was fully consistent with the 1994 amendment.

C. The Medicare Issues

Petitioners have presented no evidence that **DOH** included in its calculation of the Statewide case mix any case in which Medicare was coded on the data form. Rather, petitioners claim that a large number of Medicare cases were counted because they were not coded as Medicare cases.

Petitioners have amply demonstrated that a number **of** Medicare cases were likely included in the Statewide case mix in the 1992, 1993, and 1994 rate years. Moreover, it appears that petitioners' expert, Stephen MacCormack, repeatedly informed DOH that various data sources showed that the SPARCS information included Medicare cases that had been reported in non-Medicare categories. However, 10 NYCRR 86-1.75(a) requires DOH to determine case mix based upon "those non-Medicare discharges for which the hospital has submitted Discharge Data Abstracts (DDAs)" to SPARCS. Thus, **DOH** is required to base its case mix calculations on the SPARCS data, and it is not authorized to use alternative data sources, much less data sources that are provided by third parties.

Even were DOH free to base its case mix calculation upon other data, petitioners have failed to show that the universe of

individual hospital discharges is adequately captured by any other set of data. Petitioners point to various third-party audits of their billings (e.g. institutional cost reports) which could have been used to determine whether additional Medicare and **AIDS** exempt cases should be excluded. However, there has been no showing that any of the third parties audit all of the hospitals' billings or that such data could be used to correct individual patient discharge records.

In addition, petitioners have not shown that any of the audits are random. Thus, the information contained in such reports could not be used as a sample from which the proportion of incorrectly coded Medicare patients in the entire universe of discharges, or even in the universe of discharges designated as "HMO" or "other HMO," could be extrapolated.

Petitioners themselves acknowledge that the alternative data could not be used directly by **DOH,** but contend that once the extrinsic data demonstrated that a number **of** Medicare cases had likely been coded as non-Medicare in the **SPARCS** data, **DOH** should have taken steps to have the **SPARCS** data corrected before using it in the Statewide calculations.

However, the responsibility for such miscoding rests upon the hospitals. It is undisputed that hospitals may correct the data that they provide to **SPARCS** an unlimited number of times, and that

they have two years or more to do so with regard to data from any given rate year. Indeed, there is no dispute that a group of petitioner hospitals did correct their data and that the overall Statewide reported case mix decreased significantly, resulting in a decrease in the residual penalty.

Petitioners point out that every hospital in the State is hostage to those hospitals that fail to provide accurate information to SPARCS and that no hospital can require another to correct the data that the latter has submitted. However, that constraint is inherent in the provisions of. the NYPHRM and petitioners have made no showing that the Legislature ever intended to impose upon DOH an independent obligation to audit the 2.5 million discharges per year across New York State.

Petitioners have thus "failed to establish that, to the extent that DOH was required as a practical matter to rely upon some data that was erroneous or unaudited, such data will produce an unreasonable reallocation or that the entire process is so fundamentally flawed as to be arbitrary and capricious.(citations omitted)." St. Joseph's Hospital Health Center v. Department of Health **of** State of New York, 247 A.D.2d 136, 153 (4th Dep't 1998).

Moreover, "[i]t is not for this Court or DOH to legislate by supplying an omission that would effectively broaden the scope and

application of the statute (citations omitted)." St. Joseph's Hospital Health Center, supra at 155.

With regard to petitioner's specific objections to DOH's forms and practices, although there was no specific category (or "field") in the 1992 rate year to identify a case as a Medicare HMO case, it is undisputed that there was a category for Medicare. According to Ralph Bielefeldt, those Medicare patients who were in an HMO should have been designated as Medicare, rather than HMO, cases. However, there is also no dispute that DOH notified the hospital personnel responsible for filing the SPARCS data of the addition of a Medicare HMO category for the 1993 and 1994 rate years. Petitioners have failed to cite any statute or regulation in support of their contention that DOH should have also notified the hospitals' financial officers of this change.

D. The Medicare/Medicaid Issue

There is no dispute that DOH did not fully exclude individuals who are eligible for both Medicare and Medicaid from the Statewide Case Mix Penalty Calculation. Medicaid is always considered the "payor of last resort" since it pays only if there is no other payor. Thus, petitioners argue that Medicaid can never be "primary" to Medicare and contend that DOH's failure to remove these cases overstates the Statewide Case Mix Limit penalty by approximately 0.25% in both 1992 and 1993 and by 0.43% in 1994.

Respondents, however, contend that the cases where Medicare was reported as secondary to Medicaid may well have been reported correctly.

According to Ralph Bielefeldt,

> [h]ospitals are required to report to SPARCS the expected payor, with the primary payor the entity that is expected to pay the greatest portion of the cost of care. This group of cases may reflect cases where hospitals did not expect to receive reimbursement from Medicare because of coverage and/or eligibility issues or other reasons and expected that ultimately Medicaid would be the primary payor.

Bielfeldt concludes that "[w]ithout more, it is impossible to say this reporting was erroneous."

Likewise, this Court finds that petitioners have failed to meet their burden of demonstrating that it was unreasonable for DOH to require hospitals to list Medicaid as the primary payor if it was expected to pay all or the largest part of the bill in a given case.

Conclusion and Judgment

Accordingly, based on all the papers submitted and the oral argument held on the record on July 30, 2001, the cross-motions by

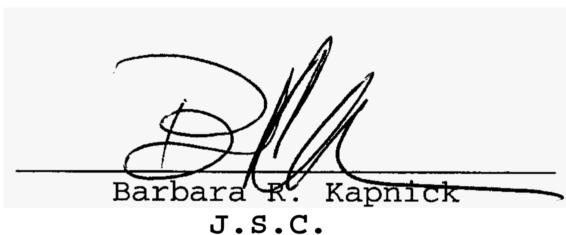
the respondents and the intervenor-respondents are granted and the motion by petitioner is denied.

It is hereby

ORDERED and ADJUDGED that the petition is denied and the proceeding is dismissed with prejudice and without costs or disbursements.

This constitutes the decision and judgment **of** the court.

Dated: April 25, 2003



Barbara R. Kapnick
J.S.C.

BARBARA R. KAPNICK
J.S.C.