PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

98-D91

PROVIDER -
Memorial Hospital of Gardena
Los Angeles, CA

Provider No. 05-0468

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Blue Cross of California

DATE OF HEARING-
January 21, 1998

Cost Reporting Period Ended -
June 30, 1992

CASE NO. 95-1921

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ISSUE:

Should the Provider's Medicaid patient days in its "subacute unit" be included in calculating the disproportionate share hospital ("DSH") adjustment?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Memorial Hospital of Gardena ("Provider") is an urban acute care hospital located in Los Angeles, California. During the fiscal year ended ("FYE") June 30 1992, the Provider had an 18-bed subacute unit The sub-acute beds are licensed by the California Department of Health Services as SNF beds, but they are certified by HCFA, for Medicare purposes, as part of the general acute care hospital. The Provider included 9216 subacute care unit bed days[1] in both the numerator and denominator of the DHS calculation. Blue Cross of California ("Intermediary") excluded all Medicaid patient days associated with care provided in the subacute unit in the numerator portion of the DSH calculation. It left the Medicaid days in the denominator portion of the DHS calculation. The Provider filed a timely appeal with the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841 and has met the jurisdictional requirements of those regulations. The Medicare reimbursement effect is approximately $1,585,000.

Under the prospective payment system ("PPS"), Congress provided extra reimbursement to providers who treated a disproportionate number of low income patients. These patients are often in poorer health and are more expensive to treat. The amount of extra reimbursement is determined by a formula with two parts - one that counts the number of days associated with treating Medicare patients eligible for supplemental security income, divided by the provider's total Medicare patient days, and the other that counts a provider's Medicaid eligible patient days divided by total patient days ("the Medicaid proxy") days. See 42 U.S.C. § 1395ww(d)(5)(F)(vi). The instant case concerns the Medicaid proxy.

The Provider has an 18 bed subacute unit which treats principally Medicaid patients. Since the total number of Medicaid patient days recognized effects the calculation of the Medicaid proxy, the Provider disputes the Intermediary's adjustments removing the Medicaid patient days associated with the subacute unit from the DSH calculation.

The Provider was represented by Laurence Getzoff, Esquire, of Hooper, Lundy and Bookman. The Intermediary was represented by James R. Grimes, Esquire, of the Blue Cross and Blue Shield Association.

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[1] Provider Exhibit No. 6.

PROVIDER'S CONTENTIONS:

The Provider contends that its position that the sub-acute days should be counted in calculating the DSH adjustment is based on several grounds. The principal argument is that the governing statute indicates that they should be included. The relevant statutory provision at 42 U.S.C. § 1395ww(d)(5)(F)(vi) provides that:

> [i]n this subparagraph, the term "disproportionate patient percentage" means, with respect to a cost reporting period of a hospital, the sum of -
>
> > (I) the fraction . . . [the SSI percentage] . . .
> >
> > (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 subchapter XIX of this chapter, but who were not entitled to benefits under Part A of this subchapter, and the denominator of which is the total number of the hospital's patient days for such period.

Id.

According to the Provider, the Medicaid patient days in the subacute unit are hospital days for acutely ill individuals. The language of the governing statute includes no restriction concerning which Medicaid days, or what level of care is provided, for purposes of including those days in the DSH calculation. The statute provides that all of a provider's Title XIX days are to be divided by total patient days. There is no reason to exclude subacute days from the numerator as the Intermediary has done.

The Provider also notes that the regulation at 42 C.F.R. § 412.106, supports its position that the subacute days should be included. The regulation in pertinent part provides that:

> (a) General Considerations. (1) The factors considered in determining whether a hospital qualifies of a payment adjustment include the number of beds, the number of patient days, and the hospital's location . . .
>
> (ii) the number of patient days includes only those days attributed to areas of the hospital subject to the prospective payment system and excludes all others.

42 C.F.R. § 412.106(a).

The Provider indicates that it is only appropriate to exclude Medicaid patient days from the DSH calculation when such patients are treated in an area of the hospital that is exempt from PPS. The subacute unit is not certified by Medicare as a SNF, nor is it exempt from PPS, only the SNF unit is certified as such and is exempt. The 18 beds that make up the subacute unit, although licensed by the State of California as a SNF, are beds that have been specifically and repeatedly certified by Medicare as being subject to PPS, and must therefore be counted for purposes of the DSH adjustment.

The Provider contends that the inclusion of the subacute days in the DSH calculation is consistent with HCFA manual provisions. The Provider points out that in HCFA's State Operations Manual (HCFA Pub. 7) § 2110.F states, in pertinent part, that:

> [a] distinct part of an institution may, at the provider's election, participate as a SNF under Title XVIII, Title XIX or both. The participating area does not have to include all parts of the institution rendering SNF service. For example, an institution consisting of SNF wings A and B plus hospital wing C may elect to have only wing A participate as a distinct part SNF. Furthermore, it may elect to have wing A participate as a Title XVIII SNF and wing B participate as a Title XIX SNF. Although the establishment of common health and safety standards for Titles XVIII and XIX would appear to remove any reason for separate participation, an institution may make this choice on the basis of a presumed reimbursement advantage . . .

HCFA Pub. 7 § 2110.F (emphasis added).

The Provider indicates that it was following this Medicare rule in electing not to have its subacute unit certified as a Medicare SNF, exempt for PPS.

The Provider also contends that HCFA has expressly indicated to similarly situated providers that inclusion of Medicaid subacute days in the DSH calculation is appropriate, and thus the Intermediary's position in this case is contrary to expressed HCFA policy statements. The Provider refers to a December 17, 1992 letter from the Chief of the Audit Review Section of the Division of Medicare of Region IX of HCFA.[2] This letter states in pertinent part that:

> [i]n summary, a provider's disproportionate patient percentage is the sum of the following ratios:
>
> - [The SSI percentage]

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[2] Provider Exhibit No. 23.

- The number of patient days during the hospital's cost reporting period of those patients who are entitled to Medicaid but not to Medicare Part A, divided by the total number of patient days in that same period. [The Medicaid percentage].

Per 42 C.F.R. § 412.106(a)(1)(ii), for the purpose of computing the above ratios, patient days are determined by counting those days attributed only to areas of the hospital subject to the prospective payment system (PPS). Patient days attributed to areas or units of the hospital excluded from the PPS are not included in the count of patient days. In the case of Tustin Community Hospital, where there is a subacute unit with 18 subacute beds and six swing beds, the days associated with the subacute beds (which are not excluded from PPS) will be included as patient days for disproportionate patient percentage computation. As for the days associated with the swing beds (where either subacute or skilled nursing services are furnished), the Provider needs to include the patient days associated with subacute services . . . .

HCFA Regional Office Letter of December 17,1992 (emphasis added).

The Provider contends that the Intermediary should follow HCFA's expressed policy which states that subacute days are included in the DSH calculation.

The Provider indicates that HCFA has included Medicaid days associated with other types of units which are similar to subacute units in the DSH calculation. The Provider notes that subacute is more than SNF care. In the State of California regulation on subacute units it indicates that it is appropriate only for patients who require "more intensive licensed skilled nursing care than is provided to the majority of patients in a skilled nursing facility." 22 C.C.R. § 51124.5(a). Subacute is also defined by the American Health Care Association and the Joint Commission on Hospital Accreditation of Healthcare Organizations as "comprehensive inpatient care designed for someone who has an acute illness, injury, or exacerbation of a disease process. . . . Subacute is generally more intensive than traditional nursing facility care and less than acute care." Medicare and Medicaid Guide (CCH) ¶ 42,645. Based on these definitions, the Provider contends that subacute services are clearly more intensive than SNF services and require a richer skill mix of nursing services because of the patients treated. The Provider points out that the level of nursing care required for subacute care is higher by California regulation. See 22 C.C.R. § 41215.5(e). The Provider indicates that the nursing hours per day staffing requirement for subacute care was as high as 6.0 versus the 3.0 for SNF care. The Provider also indicates that the subacute staffing levels match those of transitional inpatient care ("TIP"), See 22 C.C.R. § 51215.4(e), which is classified as inpatient care for the DSH adjustment under the California state Medicaid plan. The Provider argues that the similarities between TIC units and subacute units support the inclusion of those days in the DSH adjustment as well.

The Provider contends that patients in subacute units are acutely ill hospital patients and those days should be considered closer to hospital days than to skilled nursing care days. The Provider indicates that the issue in this case resembles the cases previously heard by the Board in determining the reimbursement level of definitive observation units ("DOUs"). In these cases, the providers argued that DOUs should be treated as Intensive Care Units and reimbursed under the cost reimbursement system. In Desert Samaritan Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Arizona, PRRB Case No. 84-D145, July 12, 1984, Medicare and Medicaid Guide (CCH) ¶ 34,166, rev'd in part and aff'd in part (DOU issue) HCFA Administrator, August 13, 1984, unreported, aff'd (DOU issue), Civil Action No. 84-2840 (D.D.C. 1985) Medicare and Medicaid Guide (CCH) ¶ 34,923 and Good Samaritan Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Arizona, PRRB Case No. 84-D146, July 12, 1984, Medicare and Medicaid Guide (CCH) ¶ 34,167, decl. rev. HCFA Administrator, August 13, 1984, the Board found that DOUs would not be considered special care units because their nurse to patient ratios were substantially less than those of other specialty care and ICU units. In the instant case, the Provider argues that the subacute patients have substantially higher nurse to patient ratios, even with those of medical surgical units as opposed to the SNF level. In addition, the admission criteria for patients resemble those of medical/surgical units as opposed to SNF.

In Hollywood Presbyterian Medical Center v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Case No. 81-D36, January 20, 1982, Medicare and Medicaid Guide (CCH) ¶ 31,831, aff'd in part (DOU issue) and mod. in part HCFA Administrator, March 19, 1982, Medicare and Medicaid Guide (CCH) ¶ 31,907, the Board held that the DOU did not equate to a special care unit because staff floated between units, and special life saving equipment in the DOU was not unique to special care units. In the instant case, the subacute unit has specially trained nurses who do not float between it and the SNF, and the subacute unit has life saving equipment found only in that unit and the ICU.

In Fountain Valley Community Hospital v. Blue Cross and Blue Shield Association/Blue Cross of Southern California, PRRB Cased No. 81-D18R, January 15, 1982, Medicare and Medicaid Guide (CCH) ¶ 31,832, decl. rev. HCFA Administrator, March 21, 1982, the Board held that one had to establish the similar number of nursing hours per day to qualify a DOU as an special care unit. In the instant case the Provider has shown that nursing hours in the subacute unit more closely resemble the medical surgical units than the SNF.

Additionally, in Mission Bay Hospital v. Office of Direct Reimbursement, HCFA, PRRB Case No. 82-D56, February 17, 1982, Medicare and Medicaid Guide (CCH) ¶ 31,870, decl. rev. HCFA Administrator, March 18, 1982, the Board held that the degree of care in a DOU must be shown to be comparable to special care units. The Provider again notes that it has made this showing with nurse to patient ratios that exceed those in acute units. The Provider also presented

testimony that patients in the subacute units are different and sicker than those in the SNF, the staffing ratios higher, and nurse skills levels are vastly different.[3]

The Provider indicates that the Intermediary failed to indicate a valid basis for its adjustments. In particular, the Intermediary admitted that if a specialty care unit was under PPS their Medicaid patient days would be used in the DSH calculation.[4] Since their is no indication that the subacute unit was excluded from PPS, those days should be included in the DSH calculation.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the subacute units were not in areas of the hospital subject to the PPS. It argues that the evidence supported the fact that the subacute units were skilled nursing beds. The Intermediary states that the proper Medicaid days were determined pursuant to the Medicaid finalized cost report. The Intermediary reconciled the Medicaid acute care inpatient days to the Medicaid cost report. The state Medicaid agency had adjusted the patient days to remove the subacute days.[5] The subacute beds were licensed by the State of California as skilled nursing beds.[6] The contract with the State of California requires that the subacute unit be licensed as a skilled nursing unit.[7] While the Provider's witness testified the labeling of the subacute unit as a skilled nursing unit was merely for convenience, it was admitted there was no written documentation to support that claim.[8]

The Intermediary continues to believe the nature of the care given in the subacute unit essentially was the same as in a skilled nursing facility. Patients were being maintained, and the plan of treatment was already determined with nursing staff monitoring patients and equipment.[9] In addition, the average length of stay at the Provider's subacute unit was 113 days.[10] This length of stay is more typical of a skilled nursing facility than an acute care hospital.

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3 Transcript ("Tr.") at 92-93.

4 Tr. at 200-201.

5 Tr. at 166.

6 Tr. at 63.

7 Id.

8 Tr. at 65.

9 Tr. at 172.

10 Tr. at 170.

As the subacute unit was not in the hospital, the federal rate used for reimbursement under PPS was unaffected by the Medicaid days in the subacute unit. Therefore, the days should not be added to the numerator of the DSH adjustment.

The Intermediary indicates that the applicable regulations define inpatient days for purposes of calculating the DSH adjustment as only including those days associated with the treatment of patients in the hospital subject to PPS. 42 C.F.R. § 412.106(a)(1)(ii). The evidence establishes that the subacute units were not a part of the acute care areas of the hospital but were licensed as non-certified skilled nursing beds. The state regulation defining the nature of subacute care clearly states that subacute care means a level of care needed by a patient who does not require hospital acute care. 22 C.C.R. § 51124.5(a). The State of California reinforces that definition of subacute care by continually designating the unit as a skilled nursing area. It should be noted that the state Medicaid agency itself dropped the patient days out of the count of general acute care patient days in the finalized state Medicaid cost report for the Provider. Further, the nature of the care, the physician coverage requirements, and the length of stay in the subacute unit all point to a level of care similar to skilled nursing. The Intermediary argues that the subacute unit was properly designated as skilled nursing beds for purposes of the DSH adjustment, and it was correct to remove these days from the Medicaid patient days calculation of the DSH adjustment.

CITATIONS OF LAWS, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Laws - 42 U.S.C.:

§ 1395x(v)(1)(A)	-	Reasonable Cost
§ 1395ww(d)(5)(F)(vi)	-	Exceptions and Adjustments to PPS

2. Regulations - 42 C.F.R.:

§ 412.106	-	Special Treatment: Hospitals that Serve a Disproportionate Share of Low-Income Patients
§ 413.9	-	Cost Related to Patient Care

3. Program Instructions State Operations Manual, HCFA Pub No. 7:

§ 2110.F	-	Distinct Part SNF

4. Cases:

Desert Samaritan Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Arizona, PRRB Case No. 84-D145, July 12, 1984, Medicare and Medicaid Guide (CCH) ¶ 34,166, rev'd in part and aff'd in part (DOU issue) HCFA Administrator, August 13, 1984, unreported, aff'd (DOU issue), Civil Action No. 84-2840 (D.D.C. 1985) Medicare and Medicaid Guide (CCH) ¶ 34,923.

Fountain Valley Community Hospital v. Blue Cross and Blue Shield Association/Blue Cross of Southern California, PRRB Cased No. 81-D18R, January 15, 1982, Medicare and Medicaid Guide (CCH) ¶ 31,832, decl. rev. HCFA Administrator, March 21, 1982.

Good Samaritan Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Arizona, PRRB Case No. 84-D146, July 12, 1984, Medicare and Medicaid Guide (CCH) ¶ 34,167, decl. rev. HCFA Administrator, August 13, 1984.

Hollywood Presbyterian Medical Center v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Case No. 81-D36, January 20, 1982, Medicare and Medicaid Guide (CCH) ¶ 31,831, aff'd in part (DOU issue) and mod. in part HCFA Administrator, March 19, 1982, Medicare and Medicaid Guide (CCH) ¶ 31,907.

Mission Bay Hospital v. Office of Direct Reimbursement, HCFA, PRRB Case No. 82-D56, February 17, 1982, Medicare and Medicaid Guide (CCH) ¶ 31,870, decl. rev. HCFA Administrator, March 18, 1982.

5. Other:

22 C.C.R. § 51124 - Skilled Nursing Facility Level of Care

22 C.C.R. § 51124.5 - Subacute Level of Care

22 C.C.R. § 51215.4 - Transitional Inpatient Unit

American Health Care Association and Joint Commission on Hospital Accreditation of Health Care Organization Definition of Subacute Care, Medicare and Medicaid Guide (CCH) ¶ 42,645.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, evidence presented, testimony elicited at the hearing, and post hearing briefs, finds and concludes as follows:

The Board finds that the subacute unit was not a part of the Provider's distinct part Medicare SNF and remained part of the Provider's hospital subject to PPS. The Board further finds that the State of California licensure of a subacute unit and special payment arrangement for those days does not affect how those days are classified for Medicare and whether they should be included in the DSH calculation. The Board finds that the statute, regulation, manual provisions and HCFA policy letters, support the Provider's contention that care rendered in areas of the hospital that are not exempt from PPS should be included in the DSH adjustment. The Board agrees with the Provider's contention that the care rendered in the subacute unit is well above routine SNF care, and that subacute patients are not SNF patients as claimed by the Intermediary.

The Board finds that the Provider established an 18 bed subacute unit separately from its existing distinct-part SNF unit. The 18 bed subacute unit, while licensed as a SNF under California law, is not certified by Medicare as a SNF, appears to be staffed and equipped as a separate unit, and treats considerably more acutely ill patients than does the Provider's Medicare-certified distinct part SNF.

The Board finds that the state licensure does not determine Medicare certification. SNFs that are certified for Medicare participation are excluded from PPS. For this to occur the SNF must enter into a provider agreement with the Secretary. No such SNF provider agreement exists between the Provider's subacute unit and the Secretary. Therefore, the subacute unit remained part of the inpatient hospital for Medicare purposes and is one of the "areas of the hospital that are subject to [PPS]" 42 C.F.R. § 412.106(a)(ii). The Provider in this case chose not to have its California licensed subacute unit participate as a Medicare SNF; therefore, the subacute unit is not an SNF for Medicare purposes.

Under the statute, 42 U.S.C. § 1395ww(d)(F), the ratio of a hospital's Medicaid patient days over its number of total of patient days is to be taken into account for purposes of calculating the hospital's DSH adjustment. The statute does not indicate that subacute patient days should be excluded from those counted as part of the Medicaid percentage. The statute indicates that the entire number of a hospital's patient days are to be included in this calculation. The Board finds that the Intermediary's exclusion of subacute Medicaid patient days from the ratio runs contrary to the statute, and its adjustment should be modified so that the Provider's subacute unit Medicaid patient days are included in the Medicaid percentage calculation.

The Board also points to a HCFA Regional Office letter which states that subacute unit days should be included in the calculation of a provider's DSH adjustment.[11] The HCFA letter indicates that Tustin Community Hospital had a subacute unit, licensed as a skilled nursing facility by the State of California, with 18 subacute beds, which beds were not Medicare certified as SNF beds, and as such, remained within areas of the hospital subject to PPS. HCFA stated unambiguously that Medicaid patient days associated with these beds "will be

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[11] Provider Exhibit 4.

included as patient days for disproportionate patient percentage computation." Id. In addition, with respect to six additional swing beds, where either subacute or skilled nursing services could be furnished, the provider was instructed to include those patient days associated with subacute services (but not SNF services) for purposes of disproportionate patient percentage computation. The Intermediary's adjustment in this case appears to be contrary to HCFA's own policy statement on the subject. HCFA's policy statement, dated December 1992, coincides with the Provider's fiscal year at issue in this case.

The Board also notes that HCFA has approved a California Medicaid state plan amendment that would include TIC days in the count of Medicaid inpatients for purposes of the DSH adjustment. Just like subacute units, TIC units are licensed by the California Department of Health Services as SNF units. 22 C.C.R. § 51215.4(a). HCFA recently recognized that in the case of TIC units, the services provided in a TIC unit, like those provided in a subacute unit, involve a significantly greater level of care than services required in a SNF. Thus, HCFA agreed that days of care in a TIC unit are appropriately counted as inpatient Medicaid days. Likewise, subacute units, which have very similar nurse staffing requirements to TIC units, should also be included in the count of Medicaid inpatient days for the DSH adjustment.

The Board finds that the care rendered in the Provider's subacute unit was closer to inpatient acute care than to SNF care. The Board notes that the State of California recognizes subacute care as a level of care quite different than the SNF level of care.[12] In addition to being required to meet all minimum requirements for SNF beds, California regulations mandate that subacute units employ almost twice the nursing staff and from to two to four times the licensed nursing staff, than the levels SNFs are required to utilize; such nurses are further required to have vastly more experience prior to hire when working in a subacute unit, than when working in a SNF; ongoing educational requirements are greater for subacute units; physician visits are more frequent in subacute units than in SNFs; and the subacute level of care is defined, in pertinent part, as a level of care needed by a patient. . . "who requires more intensive licensed skilled nursing care than is provided to the majority of patients in a skilled nursing facility." 22 C.C.R. §§ 51215.5, 51124, and 51124.5.

The Board further notes that the State of California Medi-Cal regulations subacute services clearly are more intensive than SNF services and require a richer skill mix of nursing services because of the higher acuity of the patients treated. 22 C.C.R. § 15524.5(a), 22 C.C.R. § 51215.5(e). These subacute staff requirements, at least 6.0 mixed nursing hours per patient day, or 4.8 minimum licensed nursing hours per patient day, are in fact, quite close to and actually exceed those of TIC units, another level of care in California hospitals. TIC units must have nurse staffing which in no case falls below 4.5 actual unduplicated average nursing hours per patient day. 22 C.C.R. § 51215.4(e).

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[12] Tr. at 33 - 35.

The Board finds that the Provider has submitted extensive evidence demonstrating the high acuity of the patients treated, high intensity of services delivered, and complexity of staffing required, in its subacute unit. There was evidence that the subacute unit was staffed by a registered nurse at all times, at least three per nursing patient day; whereas, the SNF unit need only have one registered nurse for the entire day.[13] There was testimony that in all probability the hospital could not put a subacute patient in a skilled nursing unit because, the subacute level would be too high a level, high acuity for skilled nursing.[14] The Provider stated that the subacute and SNF units, respectively, at the Provider operate under totally separate protocols and procedures, in addition to having separate nursing staffs.[15] The Provider pointed out that subacute patient often required maximum assistance in "activities of daily living."[16] The Board also notes that many of the Provider's subacute patients were on ventilators, which required even more specialized care. The State of California Medi-Cal program had entirely different admission criteria for SNF and subacute admission, and that the services required to be provided for subacute patients were far more complex, indicating a far greater patient acuity.[17] The Provider also pointed out that physician visits for subacute patients greatly exceeded those for SNF level of care.[18] For these reasons, the Board believes that these subacute days should be classified more akin to acute hospital days and should be considered in calculating the Provider's DSH adjustment.

Based on the foregoing analysis, the Board concludes that the Provider's subacute unit was subject to PPS, and the care rendered was closer to inpatient acute care. Therefore, the Provider's subacute days should be included in the calculation of the DSH adjustment.

DECISION AND ORDER:

The Intermediary's calculation of the DSH adjustment was improper. The Intermediary's adjustment is modified to include Medicaid days in the numerator of the DSH adjustment.

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13 Tr. at 93.

14 Tr. at 96.

15 Id.

16 Tr. at 96-97.

17 Tr. at 98-100.

18 Id.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire
Martin W. Hoover, Jr., Esquire

Date of Decision: September 11, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman