PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2009-D11

PROVIDER -
Quality Reimbursement Services (QRS)
Catholic Healthcare West (CHW)
DSH Labor Room Days Groups

Provider Nos.: See attached Schedules of Providers in the Group

vs.

INTERMEDIARY -
Blue Cross Blue Shield Association/
United Government Services, LLC – CA

DATE OF HEARING -
February 12, 2008

Cost Reporting Years Ended –
1998, 1999, 2000 and 2001

CASE NOs.: 05-1360G, 05-1362G,
05-1363G, 05-1527G

INDEX

ISSUE:

Whether the Intermediary improperly disallowed from the calculation of the Providers' Disproportionate Share Hospital (DSH) payments, patient days associated with Medicaid patients who were admitted to the hospital prior to the day of giving birth and that were characterized by the Intermediary as "labor days."

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20 and 413.24.

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

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the Prospective Payment System (PPS). See 42 U.S.C. §1395ww(d). The PPS statute contains a number of provisions that adjust reimbursement based in hospital-specific factors. See 42 U.S.C §1395ww(d)(5). This case involves the hospital-specific disproportionate share adjustment. The "disproportionate share hospital," or "DSH" adjustment requires the Secretary to provide increased PPS reimbursement to hospitals that serve a "significantly disproportionate number of low-income patients." 42 U.S.C. §1395ww(d)(5)(F)(i)(I). Whether a hospital qualifies for the DSH adjustment, and how much of an adjustment it receives, depends on the hospital's "disproportionate patient percentage." See 42 U.S.C. §1395ww(d)(5)(F)(v). The disproportionate patient percentage" is the sum of two fractions, the "Medicare and Medicaid fractions," expressed as percentages. 42 U.S.C. §1395ww(d)(5)(F)(vi).

Although the disproportionate patient percentage measures low-income utilization as a percentage of "patient days," the statute does not define that term. The regulation at 42 C.F.R. §412.106(a)(1)(ii), states that "[t]he number of patient days includes only those

days attributable to areas of the hospital that are subject to the prospective payment system and excludes all others."

Prior to 1991, CMS policy required an inpatient day to be counted for an admitted maternity patient in the labor/delivery room at the census taking hour, consistent with Medicare policy for counting days for admitted patients in any other ancillary department at the census taking hour. See CMS Pub. 15-2, §2345, Accounting for Labor and Delivery Room Days. This policy was challenged and not upheld in a number of Federal courts of appeal, including the United States Court of Appeals for the District of Columbia Circuit. HCFA accepted the court's position in HCFA Ruling 87-3, April 27, 1987. HCFA subsequently changed its policy with Transmittal No. 365, December 1, 1991 which implemented CMS Pub. 15-1 §2205.2, Counting Patient Days for Maternity Patients. The new policy states as follows.

> A maternity patient in the labor/delivery room ancillary area at midnight is included in the census of the inpatient routine (general or intensive) care area only if the patient has occupied an inpatient routine bed at some time since admission. No days of inpatient routine care are counted for a maternity inpatient who is discharged (or dies) without ever occupying an inpatient routine bed. However, once a maternity patient has occupied an inpatient routine bed, at each subsequent census the patient is included in the census of the inpatient routine care area to which assigned even if the patient is located in an ancillary area (labor/delivery room or another ancillary area) at midnight. In some cases, a maternity patient may occupy an inpatient bed only on the day of discharge, where the day of discharge differs from the day of admission. For purposes of apportioning the cost of inpatient routine care, this single day of routine care is counted as the day of admission (to routine care) and discharge and, therefore, is counted as one day of inpatient routine care.

CMS Pub. 15-1 §2205.2.

Until 2003, there were no Medicare rules that explicitly addressed the treatment of labor and delivery days for purposes of the DSH calculation. In 2003, CMS amended the DSH regulation to "clarify" that a patient day should not be counted for a patient who is in a labor and delivery room at census-taking hour unless the patient previously occupied a routine bed at some point since admission. See 68 Fed. Reg. 45346, 45419-20 (August 1, 2003, (adding 42 C.F.R. §412.106(a)(1)(ii)(B)).

The preamble to the final rule, in pertinent part, states the following:

> 5. Labor, Delivery, and Postpartum Beds and Days
>
> . . . Increasingly, hospitals are redesigning their maternity areas from separate labor and delivery rooms, and postpartum rooms, to single multipurpose labor, delivery, and postpartum (LDP) rooms. In order to

appropriately track the days and costs associated with LDP rooms, it is necessary to apportion them between the labor and delivery cost center, which is an ancillary cost center, and the routine adults and pediatrics cost center. This is done under our policy by determining the proportion of the patient's stay in the LDP room that the patient was receiving ancillary services (labor and delivery) as opposed to routine adult and pediatric services (postpartum).

* * * * *

Comment: Some commenters stated that the LDP days that patients spend in routine inpatient wards of hospitals prior to the day those patients give birth are in areas of the hospital where routine inpatient beds are located, and they are not excluded from the IPPS. Therefore, the commenters asserted that these days should be counted in the patient days and available bed days counts. Commenters also pointed out the LDP days are in licensed beds, and argued that these days should be counted in their entirety.

* * * * *

One commenter suggested that it is not necessary for our policy applicable to counting patient days for purposes of the DSH computation to comply with other Medicare cost reporting policies, such as the need to separately allocate the ancillary costs associated with LDP rooms. The commenter cited prior PRRB appeals in which CMS took this position.

Response: As we previously stated above and in the proposed rule, initially, Medicare's policy did count an inpatient day for an admitted maternity patient even if the patient was in the labor/delivery room at the census-taking hour. However, based on adverse court decisions, the policy was revised to state that the patient must first occupy an inpatient routine bed before being counted as an inpatient. With the development of LDP rooms, we found it necessary to apply this policy consistently in those settings, in order to appropriately apportion the costs between labor and delivery ancillary services and routine inpatient care.

Although we have not previously formally specified in guidance or regulations the methodology for applying this policy to LDP rooms, this is not a new policy. However, as suggested by the commenters, we believe this policy may not have been applied consistently. Therefore, we believe it is important to clarify the policy as part of our discussion of our policies pertaining to counting patient bed days.

> We continue to believe the LDP apportionment described above is an appropriate policy and does not, in fact, impose a significant additional burden because hospitals are already required to allocate cost on the cost report between ancillary and routine costs. In addition, this allocation is already required to be consistent with our treatment of costs, days, and beds and is consistent with our other patient bed day policies. Therefore, this policy will be applied to all currently open and future cost reports. However, it is not necessary to reopen previously settled cost reports to apply this policy.

Id.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The Providers in these group cases are owned by Catholic HealthCare West (CHW). The appeals cover all hospitals owned by CHW that are appealing this common issue for their fisca1 years ended (FYEs) 1998, 1999, 2000 and 2001. On their cost reports, the Providers claimed Medicaid eligible maternity days in both the numerator of the Medicaid fraction and the denominator of the Medicaid fraction. United Government Services (the Intermediary) removed all Medicaid eligible maternity days claimed. The Providers timely appealed from their original NPRs and subsequently established these group appeals.

The parties have reached the following stipulations in this case.[1]

1. The Fiscal Intermediary agrees that are no jurisdictional impediments to the final list of appeals in this group appeal, which are set forth on the jurisdictional schedules attached hereto as Exhibit 1. In regard to St. Elizabeth Community Hospital, Provider No. 05-0042, FYE 6/30/2001, for which no labor days adjustment has yet to be made as the Provider has not yet qualified for disproportionate share ("DSH") payments, the Intermediary agrees that, should the Providers prevail in this case, it will not make a labor days adjustment if St. Elizabeth eventually qualifies for DSH payments.

2. The Parties stipulate and agree that, if the Providers prevails (sic) in this appeal, the Intermediary will add back the Medi-Cal labor days and Total labor days removed by the Intermediary when determining the final disproportionate share adjustment for each Provider. For purposes of determining the number of days that were removed and that are to be added back, the parties agree to the number of days on the schedules attached hereto collectively as Exhibit 2. For those cost reports included in these group appeals, but not to the attached schedules, the Parties agree to the number of days that are included in the Intermediary's workpapers, which will be identified by the Intermediary if there is a final favorable decision in these appeals.

[1] See, Stipulations of Parties, February 12, 2008.

3. The Parties stipulate and agree that Medi- Cal, California Medicaid program, has treated the excluded days as covered inpatient days. For those Providers that have a Medi-Cal contract negotiated with the California Medical Assistance Commission ("CMAC"), Medi-Cal pays for the excluded labor days at the Medicaid contracted per diem (or per discharge) rate for inpatient services. For those Providers that do not have a CMAC contract, Medi-Cal reimburses the Providers for the costs of providing services and counts the labor days as inpatient days when determining Medi-Cal's percentage of costs. There is no difference between what Medi-Cal pays the Providers for a labor and delivery day and what Medi-Cal pays for a postpartum day.

4. The Parties stipulate and agree that, for any Medicare patients who deliver babies at the Providers' facilities, the Medicare program treated the excluded labor days as inpatient days for purposes of Medicare Prospective Payment Systems (sic) payments. Consistent with Medicare Hospital Manual Section 216.1, these days were counted against a maternity patient's Medicare coverage for inpatient services.

5. The Parties stipulate and agree that the women whose "labor days" were removed from the DSH calculation by the adjustments at issue in the following hospitals were admitted to Labor, Delivery, Recovery (LDR) or Labor, Delivery, Recovery, Postpartum (LDRP) rooms that had licensed inpatient beds, all of which were located in areas of the hospitals subject to the Medicare Prospective Payment System.

The Provider was represented by Byron J. Gross, Esquire, of Hooper, Lundy & Bookman, Inc. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS**:**

The Providers assert that the Intermediary's exclusion of LDRP days from the Medicaid fraction is improper for the following reasons:

First, the Intermediary's determination is inconsistent with the plain meaning of the DSH regulation in effect during the period at issue. The DSH regulation stated that the DSH calculation includes patient days in areas of the hospital subject to PPS, and PPS applies to all operating costs of inpatient hospital services. Under this definition, the Providers' LDRP rooms are clearly in areas of the hospital subject to PPS. Accordingly, these days should be counted in the DSH calculation. The Providers assert that the 9th Circuit Court of Appeals decision in Alhambra Hospital v. Thompson, 259 F.3d 1071, 1075 (9th Cir. 2001) (Alhambra) supports its position and controls the law of this case. The Court found that if the patient days are in areas of a hospital subject to PPS, they should be counted, regardless of whether the services offered to the patients in those beds were subject to PPS. Exhibit P-4. The Court found that the language of the regulation was not ambiguous and that the Secretary clearly designated which days should be included in the

DSH calculation solely on the basis of the area of the hospital in which they were located, not based on the type of care given on those days. The Court also noted that the Medicare regulatory scheme establishes a default rule that all areas of a hospital are subject to PPS unless an area meets the strict requirements for exemption from PPS. Since the sub-acute unit was never established as exempt, it was subject to PPS. Id. at 1074-1075. The Court also rejected the argument that only areas of a hospital that provide Medicare covered services need to be specifically exempted from PPS. Id.

The Providers also indicate that the CMS Administrator has confirmed that the Alhambra decision must be applied in the Ninth Circuit when those days are in areas of a hospital not excluded by PPS. See BBL 94-98 Observation Bed Day Group Center [sic] v. Blue Cross Blue Shield Association/Premera Blue Cross, CMS Administrator Decision, May 21, 2002, Medicare & Medicaid Guide (CCH) ¶80,864 (BBL 94-98), Exhibit P-5. In that case, the Administrator noted that the Court made a distinction by geographic area within a hospital when analyzing what types of days should be excluded from the DSH calculation and that since the observation days were provided in areas of the hospital not excluded from PPS, they could not be excluded from the DSH calculation.

Second, the Providers believe the Intermediary may be relying on language added to the DSH regulation in August 2003 as part of the fiscal year 2004 Inpatient PPS update. See 68 Fed. Reg. 45346, 45419-45420 (Aug. 1, 2003), Exhibit P-6. The revised version of 42 C.F.R. §412.106, which became effective October 1, 2003, provides that for purposes of the DSH calculation, the number of patient days "excludes patient days associated with . . . [b]eds otherwise countable under this section used for . . . ancillary labor/delivery services." 42 C.F.R. §412.106(a)(1)(ii)(B)(2003), Exhibit P-7. Because the amended version did not become effective until 2003 and cannot be applied retroactively it does not apply to any of the cost report years at issue in this appeal. The Providers disagree with any assertion that the policy is a clarification of previously existing CMS policy and that the Alhambra interpretation of the previous language makes it clear that any days in a PPS area cannot be excluded.

Third, the amended regulation at 42 C.F.R. §412.106 appears to be based on cost allocation or cost finding rules that should have no application to the DSH calculation. See, 68 Fed Reg. 45419 (citing CMS Pub. 15-1 §2205.2), Exhibit P-6. These rules relate to apportioning routine care service costs and do not directly apply to the DSH calculation which is intended to capture how many low income patients a particular hospital treats including patients the Medicare program does not cover. Thus, the justification for excluding certain days from the cost apportionment process simply does not extend to the DSH context.

Fourth, the Provider asserts that the amended regulation is inconsistent with the DSH statute. In preamble language to the 2003 rule, CMS made clear that that the purpose of the revision was to ensure that only beds and bed days related to services covered under PPS should be counted in the Medicaid Proxy for DSH purposes. See, 68 Fed. Reg. at 45415-45416. The DSH statute does not link the determination of a hospital's Medicaid Proxy to Medicare coverage and payment, however. The purpose of the DSH percentage

is to provide an approximation of the utilization of the hospital by all low income patients, not just Medicare patients See, 42 U.S.C. §1395ww(d)(5)(F)(vi)(II). The Medicaid proxy component of the DSH calculation expressly excludes days for patients who are entitled to Medicare benefits. Id. Therefore, it is inconsistent with the language of the DSH statute for CMS to take the position that certain days, such as the days at issue, cannot be included in the Medicaid Proxy because Medicare generally does not pay for the type of care those patients received on the days in question. Again, the Alhambra court rejected CMS's attempt to link the DSH patient day count to Medicare coverage and payment for services. In response to CMS's argument that subacute days at issue should not factor into the DSH adjustment because Medicare does not pay for subacute care, the Court opined that Medicare coverage "is entirely beside the point in the context of DSH reimbursement." Id. at 1075. It further stated that:

> By definition, the DSH reimbursement is calculated on the basis of services that not only are not covered by Medicare, but are actually *prohibited* from reimbursement through Medicare. The statute explicitly states that the Medicaid proxy includes those patient days for which the patient was eligible for Medicaid, *"but who were not entitled to benefits under part A of this subchapter."* 42 U.S.C. §1395ww(d)(5)(F)(vi)(II) (emphasis added). Therefore, no patient days included in the Medicare proxy are *ever* payable under PPS . . . Whether the subacute units provide Medi*care* services to inpatients is wholly irrelevant for determining what counts as a Medi*caid* patient day. (Emphasis in original).

Fifth, the Provider asserts that the amended DSH regulation is not a clarification but a new rule and cannot be retroactively applied to any cost report years at issue in this case. And finally, the Providers assert that the facts in this are similar to Sharp Chula Vista Medical Center v. Blue Cross Blue Shield Association/United Government Services LLC-CA,[2] (Sharp Chula Vista), in which the Board found that, under either the current regulations or the 1991 policy on counting days for maternity patients, the LDRP beds days should be counted for DSH purposes because the patients received services in licensed inpatient beds. The Providers further assert that the CMS Administrator's decision did not successfully distinguish the case from the decision in Alhambra. Tr. at 22-35.

The Intermediary responds that CMS' policy before 1991 was to include a day if the maternity patient was located in the labor and delivery room department at the census taking hour. As a result of court decisions noted above, CMS changed the policy concerning when to count days for maternity patients in CMS Pub. 15-1 §2205.2. Under the new policy, a patient day was counted only if a maternity patient in the labor/delivery room at the census taking hour had occupied an inpatient routine bed at some time since admission. The Intermediary asserts that the intent of the policy is to not allow days for maternity patients unless the patient first occupies a routine inpatient bed and received inpatient services before she received labor and delivery services. An example of an

[2] PRRB Dec. No. 2007-D34, May 10, 2007, Medicare & Medicaid Guide (CCH) ¶81,708, rev'd, CMS Administrator Decision, July 2, 2007, Medicare & Medicaid Guide (CCH) ¶81,753.

allowable day would be a maternity patient who is admitted for a respiratory infection and then goes into labor.

The Intermediary explains that there have been problems applying the new policy because some hospitals have changed from "traditional" or separate labor and delivery rooms (in an ancillary department) and postpartum rooms (in an inpatient routine area) to single multi-use rooms that use licensed beds to deliver a combination of labor and deliver services and postpartum services. In the traditional LDR setting, hospitals would have a separate LDR area in which patients would be assigned to non-licensed beds in an ancillary department until after delivery and then moved into a postpartum (or Obstetrics) room to occupy a licensed inpatient bed. In hospitals that use a single multi-purpose area for labor and delivery (L&D) and postpartum services, the beds used for L&D are licensed inpatient beds. Use of multi-purpose rooms led to hospital claims that because the patients were "occupying" inpatient beds, all Medicaid days should be included in the Medicaid fraction of the DSH calculation, even while these patients were receiving ancillary services.

The Intermediary explains that the issues created with the advent of these multi-purpose rooms led CMS to clarify its policy in its Final Rule in the Federal Register on August 1, 2003. See 68 Fed. Reg. 45346, 45419-45420 (Aug. 1, 2003), Exhibit P-6. CMS indicated that providers need to determine the percentage of ancillary time (labor and delivery) versus inpatient time (postpartum). Once the percentage is developed, the figure is applied to the costs, days and beds. The final rule clarifies that the labor and delivery room days must be broken out so only that portion of the patient's stay attributable to postpartum care that represents routine inpatient days is counted in the Medicaid days or the total days of the DSH calculation.

The Intermediary notes that the preamble to the final rule states that the policy is not new even though CMS had not previously formally specified in guidance or regulations the methodology for applying the policy, Id. at 45420, and it has long made this adjustment and applied this policy as clarified.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The facts and arguments in this case are similar to those presented in Sharp Chula Vista, supra, and therefore, the Board reaches similar findings and conclusions.[3] Under either the current regulations or the 1991 policy on counting days for maternity patients, the LDRP days should be counted for DSH purposes because the patients received services in licensed inpatient beds.

[3] Despite the CMS Administrator's reversal of the Board's decision, the Board maintains it addressed the CMS administrator's arguments in its decision and that its reasoning is supported by the decision in Alhambra, supra.

CMS' new guidelines issued to respond to adverse court decisions changed the way it counted labor and delivery days for IPPS purposes. The new guidelines implemented in CMS Pub. 15-1, §2205.2, effective December 1991, did not specifically address how these days would be counted for DSH purposes, however, nor did CMS make any modifications to the regulations or other guidelines that would change the treatment of these days for DSH purposes. To the contrary the regulation continued to require that "the number of patient days includes only those days attributable to areas of the hospital that are subject to the prospective payment system and excludes all others." 42 C.F.R. §412.106(a)(1)(ii). Courts have consistently found this language to require all beds and bed days be included in the DSH calculation if the area in the hospital is subject to PPS, even when the services themselves are not covered by PPS. See, Alhambra, supra, BBL 94-98, supra, and Clark Regional Medical Center v. Shalala, 136 F.Supp.2d 667 (E.D. Ky. 2001) (dealing with swing-beds). In the present case, the Board finds that the Providers' LDRP units were located in an area subject to PPS; therefore, all beds days must be counted.

The Board acknowledges that many providers have changed the setting in which they deliver services to maternity patients from "traditional" or separate labor and delivery rooms in an ancillary department and separate postpartum rooms in an inpatient routine area to single multi-purpose rooms that use licensed beds to deliver a combination of labor and delivery services and postpartum services. According to the Intermediary, although maternity patients may be in licensed inpatient beds, they receive ancillary services while in labor and delivery and do not receive inpatient care services until postpartum. Therefore, the time associated with labor and delivery should not count as inpatient days as CMS clarified in its 2003 final rule. The Providers assert that it uses licensed, routine, inpatient beds in LDRP multi-purpose units for maternity patients that are admitted as inpatients. The Providers further argue that under the existing policy once a maternity patient has occupied a licensed inpatient routine bed, the patient is included in the census of the inpatient routine care area to which she was assigned even if the patient is located in an ancillary area. The Intermediary did not dispute that the Providers used licensed inpatient beds to deliver maternity care. See, Stipulation 5. Considering these facts, the Board finds that because all of the Providers' LDRP rooms contain licensed, routine beds, all labor and delivery days necessarily relate to patients who occupied inpatient routine beds from the time of admission. Accordingly, they must be included for DSH purposes.

Finally, the Board finds that even though the preamble to the 2003 final rule proposes that providers divide days between labor and delivery and postpartum care, the language of the regulation does not require any such proration of days. The new regulation at 42 C.F.R. §412.106(a)(1)(ii)(2003) states that "the number of patient days in a hospital includes only those days attributable to units or wards of the hospital providing acute care services generally payable under the prospective payment system . . ." The Board observes that patients admitted to LDRP multi-purpose rooms that contain licensed routine inpatient beds are, by definition, receiving acute care services, even though they

may also be receiving ancillary services. As a result, only days in unlicensed ancillary labor and deliver beds would be excluded.

The Medicaid program's treatment of these days further supports the Board's decision that days should not be apportioned. The parties agree that, for purposes of payment by Medicaid, both labor and delivery and postpartum days are covered inpatient days and paid at the same Medicaid contracted per diem rate for inpatient hospital services. Stipulation 3. Since these days are eligible and paid for by Medicaid as covered inpatient days, the Board finds that they should be included in the DSH Medicaid fraction. The Board notes that the apportionment of LDRP days between ancillary and routine cost centers was done for cost reimbursement purposes to properly reflect costs between ancillary and routine cost centers and is not required for DSH purposes. DSH is a measure of the amount of care to low-income patients by an institution, and both the DSH statute and the regulation require that the Medicaid fraction include all days of inpatient care furnished to patients who are eligible for medical assistance under a State Medicaid plan.

DECISION AND ORDER:

The Board finds that the Intermediary's exclusion of labor and delivery days (or labor days) from the DSH calculation was improper. The Intermediary is directed to add back the number of labor and delivery days as agreed to by the parties at stipulation 2.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Yvette C. Hayes
Keith E. Braganza, C.P.A. (inactive)

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairman

DATE: February 27, 2009