

PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2007-D34

PROVIDER -
Sharp Chula Vista Medical Center
San Diego, California

Provider No.: 05-0222

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
United Government Services, LLC-CA
(n/k/a National Government Services,
LLC-CA)

DATE OF HEARING -
January 20, 2006

Cost Reporting Period Ended -
September 30, 1997

CASE NO.: 06-0456

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ISSUE:

Whether the Intermediary improperly excluded from the Disproportionate Share Hospital (DSH) Medicaid fraction days attributable to the labor and delivery portion of stays of maternity patients who occupied licensed inpatient beds located in Labor, Delivery, Recovery and Postpartum (LDRP) rooms.

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(b) and 413.24(b).

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 service 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. 15-12, §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. See Exhibit P-14. 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. See Exhibit P-5. 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:

Sharp Chula Vista Medical Center (the Provider) is an acute care hospital located in San Diego, California. On its fiscal year ending (FYE) September 30, 1997 cost report, the Provider included 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 1,670 Medicaid eligible maternity days claimed. The Provider timely appealed from the original NPR for FYE 9/30/1997 and that appeal was assigned PRRB Case No. 01-2515.¹

By letter dated June 30, 2004, the Provider transferred the DSH Labor and Delivery (L&D) days issue to a group appeal, the Sharp Health Care 1997 DSH L&D Days Group Appeal, and assigned PRRB Case No. 03-1394G. The other participant in the group appeal was Sharp Grossmont Hospital (Grossmont).² While the Provider's cost report reflected the removal of Medicaid eligible maternity days, an adjustment to remove such days from Grossmont's fiscal year 1997 cost report had been proposed but not yet implemented. The absence of an adjustment for Grossmont raised a potential jurisdiction problem for the group appeal.

Subsequently, the Provider's individual appeal was administratively resolved. The administrative resolution provided that the Intermediary had incorrectly removed all maternity days from the Medicaid fraction and that this error would be corrected in a revised NPR. The parties agreed that the Provider had 332 Medicaid eligible labor and delivery days and 558 total labor and delivery days. On August 25, 2005, the Intermediary issued a revised NPR that excluded 332 labor and delivery days from the numerator of the Medicaid fraction and 558 labor and delivery days from the denominator of the Medicaid fraction. The Provider timely appealed the revised NPR on December 22, 2005 and was assigned PRRB Case No. 06-0456. Initially, the Provider requested that this issue be heard concurrently with the issue in the group appeal at the scheduled hearing on January 20, 2006.³ The parties subsequently agreed that the

¹ See, Provider's final position paper at 1.

² See, Intermediary's supplemental position paper (PRRB Case No. 03-1394G). Exhibit I-2.

³ See, Provider's final position paper 2-3.

Provider would dismiss the group appeal and proceed with the issue from the revised NPR.

The parties have stipulated that if the Provider prevails in this appeal, the Intermediary will add 329 labor and delivery days to the numerator of the Medicaid fraction and add 551 labor and delivery days to the denominator of the Medicaid fraction.⁴ The parties have also stipulated that Medi-Cal, the state of California Medicaid program, has treated the excluded days as covered inpatient days and pays for them at the Medicaid contracted per diem rate for inpatient hospital services. There is no difference between the Medicaid per diem rate for a labor and delivery day and the per diem rate for a postpartum day.⁵ The parties have also stipulated that in the Provider's detailed PS&R, Medicare treated the excluded LDRP days as inpatient days for purposes of Medicare PPS payment. Consistent with Medicare Hospital Manual 216.1, these days are counted against a maternity patient's Medicare coverage for inpatient services.⁶

The Provider was represented by Stephanie A. Webster, Esquire, and Christopher L. Keough, Esquire, of Vinson & Elkins LLP. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Provider asserts that the Intermediary's exclusion of LDRP days from the Medicaid fraction is improper for the following four 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 Provider's LDRP rooms are clearly in areas of the hospital subject to PPS. Accordingly, these days should be counted in the DSH calculation. See, Alhambra Hospital v. Thompson, 259 F.3d 1071, 1075 (9th Cir. 2001) (Alhambra) (ruling that the DSH regulation requires the inclusion of all days attributable to areas of a hospital subject to PPS, regardless of whether particular services or patients are subject to PPS). Exhibit P-15. Alhambra deals with the exclusion of days spent by Medicaid patients in a sub-acute care unit of the hospital. The court found that this "area" of the hospital was subject to PPS even though the "services" were not covered by PPS. A similar decision was reached in Clark Regional Medical Center v. Shalala, 136 F.Supp.2d 667 (E.D. Ky. 2001) (Clark) (dealing with swing-beds).

Second, the Intermediary's determination is inconsistent with CMS' "clarified" policy enunciated in 2003. In the preamble of the 2003 rule, CMS indicated that its policy, based on CMS Pub. 15-1 §2205.2, states that a patient in the Labor/Delivery room at midnight "is included in the census of the inpatient routine (general or intensive) care

⁴ See Stipulation #2.

⁵ See Stipulation #3.

⁶ See Stipulation #4.

area only if the patient has occupied an inpatient routine bed at some time since admission.” In this case, all of the Provider’s LDRP rooms contain licensed, routine beds; therefore, all of the labor and delivery days at issue necessarily relate to patients who occupied inpatient routine beds from the time of admission. Moreover, other relevant sections of the manual were not amended by CMS Pub. 15-1 §2205.2. They state that if a maternity patient has occupied a routine bed at some point since admission, even if the patient was located in an ancillary area at the census taking hour, the patient’s days were considered “inpatient days.” See MHM §§210, 230.6.B; CMS Pub. 15-1 §2202.1; MHM §§ 216, 216.1; MIM §3103.1.

Third, the Provider asserts that CMS’ change in policy with the issuance of CMS Pub. 15-1 §2205.2 is procedurally invalid because CMS did not follow the Administrative Procedure Act’s (APA’s) notice and comment rulemaking procedure when it revised an established interpretation of a substantive rule like the DSH regulation. See, *Monmouth Medical Center v. Thompson*, 257 F.3d 807, 814 (D.C. Cir. 2001). Nothing prior to 1991 purports to exclude labor and delivery days from the number of patient days included in the DSH calculation. Thus, if the language in CMS Pub. 15-1 §2205.2 was intended to mean what CMS now says it meant for the DSH calculation, then this construction would be invalid for failure to follow the notice and comment rulemaking process mandated by the APA.

Finally, the Provider asserts that the application of the current CMS policy is arbitrary and capricious for the following reasons: (1) Medicare guidelines allow days attributable to maternity patients in labor and delivery rooms at the census taking hour to be counted against a beneficiary’s coverage for inpatient services. MHM §§216, 216.1; MIM §3103.1. If CMS is going to count labor and delivery days against a patient’s Part A benefits for inpatient hospital services, it necessarily follows that these days must be counted as inpatient hospital days in the Medicare DSH calculation; (2) The policy provides dissimilar treatment for time spent by maternity patients in labor and delivery rooms based upon whether or not the patient has been admitted to and occupied an inpatient routine bed. This factor has no bearing on the patient’s indigence, and, therefore, should not impact the calculation of the Medicaid fraction. Further, the Provider notes that the overarching purpose of the Medicaid fraction is to establish a proxy measure for utilization by low-income patients.

The Intermediary indicates 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 only counted if a maternity patient in the labor/delivery room at the census taking hour had occupied an inpatient bed at some time since admission. The Intermediary asserts that the intent of the policy is to not allow days unless the patient was receiving inpatient services before she received labor and delivery services. An example of an allowable day would be a maternity patient who is admitted for a respiratory infection and then goes into labor.

The Intermediary notes that there have been problems with 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 labor and delivery room (LDR) setting, hospitals would have a separate LDR area in which patients would be assign to unlicensed 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 and postpartum services, the beds used for L&D are licensed inpatient beds. The hospital claims that because the patients are “occupying” inpatient beds, all Medicaid days should be included in the Medicaid fraction of the DSH calculation, even while these patients are receiving ancillary services.

The Intermediary states 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. 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 specified in guidance and regulations the methodology for applying the policy. Fed. Reg. at 45420. The Intermediary indicates that 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 Board finds that 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. The Board questions whether, even under the clarification to the DSH regulations, patients admitted to licensed inpatient beds in multi-purpose LDP units should have any time excluded from the DSH calculation.

The Board notes that as a result of adverse court decisions CMS 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, 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 Board notes that 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). The Board notes that in determining whether patient days should be counted for DSH purposes, the courts have found that the plain language of the regulation requires that 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 and Clark, supra. In the present case, the Board finds that the Provider’s LDRP unit was 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 are receiving ancillary services while in labor and delivery and are not receiving 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 Provider asserts that it uses licensed, routine, inpatient beds in LDRP multi-purpose units for maternity patients that are admitted as inpatients. The Provider further argues 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 Board notes that the Intermediary acknowledged that the Provider used licensed inpatient beds to deliver maternity care. See, Tr. at 77. Considering these facts, the Board finds that because all of the Provider’s 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 should 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) states that “the number of patient days in a hospital includes only those days attributable to units and 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. In addition, the Board notes that maternity care is paid for under the PPS system, and for Medicare coverage purposes, these days count against the patient’s inpatient days. See, Medicare Hospital Manual 216.1. As a result, only days in unlicensed ancillary labor and deliver beds would be excluded.

In addition, the Board notes that the regulation provides the following with regard to counting patient days in the Medicaid portion of the DSH calculation:

The fiscal intermediary determines . . . the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. . . .

- (i) A patient is deemed eligible for Medicaid on a given day if the patient is eligible for medical assistance under an approved State Medicaid plan on such day, regardless of whether particular items or services were covered or paid under the State plan.

42 C.F.R. §412.106(b)(4).

The Board notes that the parties have stipulated that for purposes of payment by Medicaid both labor and delivery and postpartum days are paid at the same Medicaid contracted per diem rate for inpatient hospital services. 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 PPS 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 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 from the DSH calculation was improper. The Intermediary is directed to add 329 labor and delivery days to the numerator of the Medicaid fraction and 551 labor and delivery days to the denominator of the Medicaid fraction.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary Blodgett, D.D.S.
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West
Yvette C. Hayes

Date: May 10, 2007

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairman