CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of: **QRS CHW DSH Labor Room Days Groups** **Providers** **vs.** **Blue Cross Blue Shield Association/United Government Services LLC-CA** **Intermediary**	**Claim for:** **Reimbursement Determination for Cost Year(s) Ending: 1998, 1999, 2000 and 2001** **Review of:** **PRRB Dec. No. 2009-D11** **Dated: February 27, 2009**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in § 1878(f)(1) of the Social Security Act (Act), as amended (42 USC 1395oo(f)). The parties were notified of the Administrator's intention to review the Board's decision. Comments were submitted by the Center for Medicare Management (CMM) and the Provider. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue before the Board was 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."

The Board held that the numerator and the denominator of the Medicaid fraction should be revised to include Labor, Delivery, Recovery and Postpartum (LDRP) days. The Board noted that the guidelines set forth at § 2205.2 of the Provider Reimbursement Manual (PRM), effective December 1991, did not specifically

address how these days would be counted for DSH purposes, nor did CMS make any modification to the regulations, nor other guidelines that would change the treatment of these days for DSH purposes. 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" of the hospital is subject to inpatient patient payment system (IPPS), even when the services are not covered by IPPS. In this case, it is undisputed that the LDRP rooms are located in areas subject to inpatient prospective payment system, or IPPS, therefore, the days at issue must be counted.

SUMMARY OF COMMENTS

The Providers submitted comments requesting that the Administrator affirm the decision of the Board. The Providers argued that there was no support in the Medicare statute or regulations that were operative during the fiscal periods at issue for excluding LDRP days from the DSH calculation. The Providers contended that, since the LDRP days in question were spent in general inpatient areas of the providers, which were not specifically excluded from IPPS, these days must be included in the DSH payment calculation. The Providers relied on *Alhambra Hospital v. Thompson*, 259 F. 3d 1071 (9th Cir. 2001) to support their position.

CMM submitted comments stating that to the extent that the Board's decision did not include LDRP days for non Medicaid-eligible patients in the Medicaid fraction of the Providers' DSH calculation, such days should be only be included in the denominator (i.e., "total inpatient days.").

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

The Social Security Amendments of 1965,[1] established Title XVIII of the Social Security Act, which authorized the establishment of the Medicare program to pay part of the costs of the health care services furnished to entitled beneficiaries. The Medicare program primarily provides medical services to aged and disabled persons and consists of two Parts: Part A, which provides reimbursement for inpatient hospital and related post-hospital, home health, and hospice care, and Part B, which is supplemental voluntary insurance program for hospital outpatient services, physician services and other services not covered under Part A. At its inception in

[1] Pub. Law No. 89-97.

1965, Medicare paid for the reasonable cost of furnishing covered services to beneficiaries.

From the beginning of the program, under reasonable cost hospital inpatient reimbursement, the average cost per day for reimbursement purposes was calculated by dividing the total costs in the inpatient routine cost center by the "total number of inpatient days."[2] Generally, Medicare reimbursement for routine inpatient services was based on an average cost per day as reflected in the inpatient routine cost center multiplied by the total number of Medicare inpatient days.[3] Consequently, the inclusion or exclusion of a bed day in the per diem calculation would impact the Medicare per diem payment.

However, concerned with increasing costs, Congress enacted Title VI of the Social Security Amendments of 1983.[4] This provision added §1886(d) to the Act and established the inpatient prospective payment system, or IPPS, for reimbursement of inpatient hospital operating costs for all items and services provided to Medicare beneficiaries, other than physician's services, associated with each discharge. The purpose of IPPS was to reform the financial incentives hospitals face, promoting efficiency by rewarding cost effective hospital practices.[5]

These amendments changed the method of payment for inpatient hospital services for most hospitals under Medicare. Under IPPS, hospitals and other health care providers are reimbursed their inpatient operating costs on the basis of prospectively determined national and regional rates for each discharge rather than reasonable operating costs. Thus, hospitals are paid based on a predetermined amount depending on the patient's diagnosis at the time of discharge. Hospitals are paid a fixed amount for each patient based a diagnosis-related group (DRG) subject to certain payment adjustments. Notably, while IPPS was implemented to replace the reasonable cost method of reimbursing hospitals for the operating costs of inpatient hospital services, it continues to require cost reporting consistent with that required under the reasonable cost methodology including the principles guiding the inpatient routine per diem methodology.

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[2] *See e.g.* 42 CFR 413.53(b); 42 CFR 413.53(e)(1) ("Departmental Method: Cost reporting periods beginning on or after October 1, 1982.")

[3] *Id. See also* Section 2815 PRM-Part II, "Worksheet D-1 Computation of Inpatient Operating costs" sets forth definitions to apply to days used on Worksheet D-1 which ahs been in place since 1975. 60 Fed. Reg. 45778, 45810 (1995).

[4] Pub. L. No. 98-21.

[5] H.R. Rep. No. 25, 98th Cong., 1st Sess. 132 (1983).

Concerned with possible payment inequities for IPPS hospitals that treat a disproportionate share of low-income patients, pursuant to § 1886(d)(5)(F)(i) of the Act, Congress directed the Secretary to provide, for discharges occurring after May 1, 1986, an additional payment per patient discharge, "for hospitals serving a significantly disproportionate number of low-income patients…."[6] The legislative history of Consolidated Omnibus Budget Reconciliation Act (COBRA) 1985 shows that, with respect to hospitals that serve a disproportionate share of low-income patients, Congress found that these hospitals have "a higher Medicare cost per case."[7]

To be eligible for the additional payment, a hospital must meet certain criteria, concerning, inter alia, its disproportionate patient percentage. Generally, the location and bed size of a hospital determines the threshold patient percentage amount to qualify for a DSH payment. For the cost year at issue, under § 1886(d)(5)(F)(v) of the Act, a hospital that is located in an urban area and has 100 or more beds is eligible for the additional DSH payment, if its disproportionate patient percentage is 15 percent. Moreover, the amount of the add–on DSH payment will be based on the hospital's disproportionate patient percentage.

Consistent with the statute, the governing regulation at 42 C.F.R. § 412.106 (1998), which addresses the DSH adjustment, states that:

> (a) *General considerations.* (1) The factors considered in determining whether a hospital qualifies for a payment adjustment include the number of beds, the number of patient days, and the hospital's location.
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> (i) The number of beds in a hospital is determined in accordance with § 412.105(b).
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> (ii) 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.

The Secretary explained in the preamble promulgating the regulation that:

> [W] e believe that, based on a reading of the language in section 1886(d)(5)(F) of the Act, which implements the disproportionate share provision, we are in fact required to consider only those inpatient days

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[6] Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. Law No. 99-272). *See also* 51 Fed. Reg. 16772, 16773-16776 (1986).

[7] H.R. Report No. 99-241 at 16 (1986); *reprinted* in 1896 U.C.C.A.N. 594

> to which the prospective payment system applies in determining a prospective payment hospital's eligibility for a disproportionate share adjustment. Congress clearly intended that a disproportionate share hospital be defined in terms of subsection (d) hospital, which is the only type of hospital subject to the prospective payment system….
>
> Moreover, this reading of section 1886(d)(5)(F) of the Act produces the most consistent application of the disproportionate share adjustment, since only data from prospective payment hospitals or from hospital units subject to the prospective payment system are used in determining both the qualifications for and the amount of additional payment to hospitals that are eligible for a disproportionate share adjustment.[8] (Emphasis added.)

Similarly, the Secretary stated in discussing the counting of bed days used to determine the related DSH bed size issue at 42 C.F.R. § 412.105, that:

> Our current position regarding the treatment of these beds is unchanged from the time when cost limits established under section 1861(v)(1)(A) of the Act were in effect and is consistent with the way we treat beds in other hospital areas. *That is, if the bed days are allowable in the calculation of Medicare's share of inpatient costs, the beds within the unit are included as well*.[9] (Emphasis added.)

The general policy for counting bed days for purposes of inpatient services has remained unchanged from prior to the establishment of inpatient prospective payment system (IPPS), except to account for adverse case law. From the beginning of the program, under reasonable cost hospital inpatient reimbursement, the average cost per day for reimbursement purposes is calculated by dividing the total costs in the inpatient routine cost center by the "total number of inpatient days." Early in the program, an inpatient day was defined as a day of care rendered to any inpatient except a newborn. Medicare reimbursement for routine services was based on an average cost per day as reflected in the inpatient routine cost center multiplied by the total number of Medicare inpatient days. Consequently, a bed day included in either

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[8] 53 Fed. Reg. 38480 (Sept. 30, 1988); *See also* 53 Fed. Reg. 9337 (March 22, 1988).

[9] 59 Fed. Reg. 45330, 45373 (1994). *See also* Id. at 45374 (with respect to the inclusion of neonatal beds in the count: "We disagree with the position that neonatal intensive care beds should be excluded based on the degree of Medicare utilization. Rather, we believe it is appropriate to include these beds because the costs and the days of these beds are recognized in the determination of Medicare costs (nursery costs and days, on the other hand, are excluded from this determination)…."

the total number of Medicare days (for example, if for a Medicare hospital inpatient) or the total number of inpatient days (including both Medicare and non-Medicare hospital inpatients) would impact the Medicare per diem payment. Notably, IPPS was implemented to replace the reasonable cost method of reimbursing hospitals for the operating costs of inpatient hospital services, but continues to require cost reporting consistent with that required under the reasonable cost methodology. Moreover, certain payments for IPPS hospitals continued to be made under a pass-through reasonable cost methodology.

With respect to adverse case law affecting the counting of bed days, Medicare's policy on counting days for maternity patients was to count an inpatient day for an admitted maternity patient in the LDR at the census taking hour prior to December 1991. Generally, § 2205 of the PRM provides that:

> Only a full patient day must be used to apportion inpatient routine care services … to the Medicare program. A day begins at midnight and ends 24 hours later. The midnight-to-midnight method must be used even if you use a different definition of patient day for your statistic or other purposes.
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> An inpatient at midnight is included in the census of your inpatient *routine (general or intensive) care area regardless of the patient's location at midnight (whether in a routine bed, an ancillary area, etc.*) including a patient who has yet occupied a routine care bed since admission (see exception in section 2205.2 regarding maternity patients.). (Emphasis added.)[10]

This is consistent with Medicare policy for counting days for admitted patients in any other ancillary department at the census-taking hour. However, based on decisions adverse to the government regarding this policy in a number of Federal courts of appeal, including the United States Court of Appeals for the District of Columbia Circuit, the policy regarding the counting of inpatient days for maternity patients was revised to reflect our current policy.

Reflecting that adverse case, the Secretary's current policy regarding the treatment of labor and delivery bed days is described in § 2205.2 of the PRM. Section 2205.2 provides that:

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[10] Adopted by Tans. No. 155 (June 1976), amended Trans. No. 293 (July 1983), Trans. No. 317 (Dec. 1984, effective for cost reporting periods beginning after September 1983 for hospitals under IPPS) and by Trans. No. 365 (December 1991).

> *A maternity inpatient in the labor/delivery room at midnight is included in the census of inpatient routine (general or intensive) care area if the patient has occupied an inpatient routine bed at some time since admission*. No days of inpatient routine care are counted for 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 routine care area to which it is 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 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.

Therefore, for purposes of the DSH calculation, if a Medicaid patient is in the labor room at the census and has not yet occupied a routine inpatient bed, the bed day is not counted as a routine bed day of care in Medicaid or total days and, therefore, is not included in the counts under the regulation at 42 C.F.R. § 412.106(a)(1)(ii). If the patient is in the labor room at the census but had first occupied a routine bed, a routine inpatient bed day is counted, in Medicaid and total days, for DSH purposes and for apportioning the cost of routine care on the cost report consistent with the Secretary's longstanding policy to treat days, cost, and beds similarly.

In addition, as a result of changes in the delivery of health care, hospitals have been redesigning their maternity areas from the separate purpose rooms, to single multipurpose LDRP rooms. The Secretary noted that, as a result of these changes in the provision of health care, further clarification of the policy was required. The Secretary stated that:

> 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). 68 Fed. Reg. 45346, 45419-45420 (Aug 1, 2003).[11]

[11] 68 Fed. Reg. 45346, 45419-45420 (Aug 1, 2003). The Secretary further explained that: "An example of this would be if 25 percent of the patient's time in the LDP

In response to comments concerning the counting of labor/delivery bed days, the Secretary stated that:

> As we previously stated above and in the proposed rule, initially, Medicare's policy did count and 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.
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> Although we have not previously formally specified in guidance or regulations the methodology for applying this policy the LDP rooms, this is not a new policy…[W]e 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.
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> 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.[12]

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room was for labor/delivery services and 75 percent for routine care, over the course of a 4-day stay in the LDP room. In that case, 75 percent of the time the patient spent in the LDP room is applied to the routine inpatient bed days and costs (resulting in 3 routine adults and pediatrics bed days for this patient, 75 percent of 4 total days)…… Alternatively, the hospital could calculate an average percentage of time patients receive ancillary services, as opposed to routine inpatient care in the LDP room(s) during a typical month, and apply that percentage through the rest of the year." Id.

[12] 68 Fed. Reg. 45346, 45419-45420(Aug 1, 2003).

The Secretary also recognized adverse case law in the Ninth Circuit Court of Appeals reflected in *Alhambra v. Thompson*.[13] The court ruled that days attributable to groups of beds that are not separately certified as distinct part non-acute care beds and the care is provided at a level below the level of routine inpatient acute care, but are adjacent to or in an acute care "area" are included in the areas of the hospital that are subject to the prospective payment system and should be counted in calculating the Medicare DSH patient percentage. The Secretary stated that:

> In particular, we proposed to revise our regulations to clarify that the beds and patient days attributable to a nonacute care unit or ward should not be included in the calculations at .. § 412.106(a)(1)(ii), even if the unit is not separately certified by Medicare as a distinct-part unit and even if the unit or ward is within the same general location of the hospital as areas that are subject to the IPPS (that is, a unit that provides an IPPS level of care is on the same floor of the hospital as a subacute care unit that does not provide an IPPS level of care).
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> Exceptions to this policy to use the level of care generally provided in a unit or ward as proxy for the level of care provided to a particular patient on a particular day are outpatient observation bed days and swing-bed days, which are excluded from the count of available bed days even if the care is provided in an acute care unit. Our policies pertaining to these beds and days are discussed further below.
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> We also proposed to revise the DSH regulations at § 412.106(a)(1)(ii) to clarify that the number of patient days includes only those attributable to patients that receive care in units or wards that generally furnish a level of care that would generally be payable under the IPPS.
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> We note the proposed revision were clarifications of our regulations to reflect our longstanding interpretation of the statutory intent, especially relating to the calculation of the Medicare DSH patient percentage.[14]

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[13] 259 F.3d 1071, 2001 U.S. App. for the Ninth Circuit No. 99-57009, Aug. 7, 2001, (CCH) ¶300,785

[14] 68 Fed. Reg., at 45417-45418.

Pursuant to the FFY 2004 rates, the Secretary revised the regulation to clarify, consistent with longstanding policy, the rule with respect to the days for non-acute and non-routine care provided in the hospital to state that:

> § 412.106 -- Special treatment: Hospitals that serve a disproportionate share of low-income patients.
> (a) General considerations. (1) * * *
> (ii) For purposes of this section, 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 and excludes patient days associated with-*
> (A) Beds in excluded distinct part hospital units;
> (B) Beds otherwise countable under this section used for outpatient observation services, skilled nursing swing-bed services, or *ancillary labor/delivery services*; and
> (C) Beds in any other units or wards where the level of care provided would not be payable under the acute care hospital inpatient prospective payment system.
> * * * * *[15] (Emphasis added.)

The Administrator recognizes that, under the statute, the DSH adjustment is intended to be an additional payment to account for a "higher Medicare payment per case" for IPPS hospitals that serve a disproportionate number of low-income patients. The Administrator finds that the policy to only include bed days that are recognized as part of hospital's inpatient operating costs is consistent with that overarching statutory intent.

Applying the relevant law and program policy to the foregoing facts, the Administrator finds that the CMS policy requires that the bed days relating to patients in labor who had not yet occupied a routine inpatient bed are not recognized under IPPS as part of the inpatient operating costs of a hospital and must be excluded from the inpatient day count for purposes of the DSH adjustment. As established by the above law and manual instructions, generally, CMS has excluded from the bed day count those bed days not paid as part of the inpatient operating cost of the hospital, that is, days not recognized as an inpatient operating cost under IPPS. When implementing IPPS, CMS has reasonably required the application of the same fundamental cost reporting and statistical methods and principles for identifying inpatient operating costs as applied under the prior reasonable cost methodology.

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[15] 68 Fed. Reg. 45346 at 45470 (Aug 1, 2003).

Further, section 2205.2 of the PRM is consistent with the regulation at 42 C.F.R. § 412.106(a)(iii) and the further clarifications set forth at 42 C.F.R. § 412.106(a)(iii)(B) and (C). Like the regulation, the § 2205.2 of the PRM uses the specific term "area" in discussing the counting of patient days. While the regulation generally refers to patient days in "areas" of the hospitals that are subject to IPPS, § 2205.2 of the PRM specifically explains that a maternity patient in a labor delivery room bed at midnight is not to be included in census of "the inpatient routine [i.e., IPPS] care area" of the hospital if the patient has not occupied an inpatient routine bed at some time since admission. Similarly, the program guidance set forth in the PRM states that: "An inpatient at midnight is included in the census of your inpatient *routine* (general or intensive) *care area* regardless of the patient's *location* at midnight (whether in a routine bed, an ancillary area, etc.) including a patient who has yet occupied a routine care bed since admission." [16]

The Administrator finds that regardless of whether the term "area" is referring to a "physical or geographical space" or whether it is referring to a "sphere or scope of operation or action"[17], the PRM instructions specify when days for admitted patients are, or are not, to be included in the routine patient "area" for purposes of counting inpatient days under the Medicare program.[18] Under the PRM interpretative guidelines, routine inpatients, even if "located" in the ancillary area of the hospital at

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[16] Section 2205 of the PRM.

[17] The Administrator continues to maintain that, the term "area" is referring to a "sphere or scope of operation or action."

[18] See also the analysis of the term "area" as geographical in *District Memorial Hospital v. Thompson* , 364 F.3d 513, 519-520 (4th Cir. 2004)("Even if one were to insist that the word "area," as used in regulation § 412.106, be read to carry its geographical connotation, the Secretary's interpretation would remain a reasonable construction of the regulatory language. The word "area" would then refer to the location of any bed used to provide *acute care* when such services were being provided, and the disproportionate share adjustment would apply to that location at such times. Similarly, the word "area" would not refer to the location of a bed when *skilled nursing services* were being provided at that bed because such services were not "subject to the prospective payment system." Under this interpretation, the word "areas" in a geographical sense would be referring to the locations of individual beds, as opposed to wings or units of the hospital. Use of this meaning would result in the same interpretation advanced by the Secretary, who counted "patient days" when beds were actually being used for acute care. Although the reimbursement status of each swing bed might thus change daily, as the use of the bed shifted between acute care and skilled nursing care, such a daily reassessment would be consistent with the regulatory language, which refers to "*days* attributable to areas of the hospital that are subject to the prospective payment system." 42 C.F.R. § 412.106(a)(1)(ii) (1988).")

census time, are to be counted in the routine "area". The exception is set out for the labor delivery patients who are not to be counted in the routine "area" before the birth of their babies if they have not yet occupied a routine bed.

However, the Administrator recognizes that, under § 1878(f)(1) of the Act, the Providers, as a group, can file in a judicial District located in the Ninth Circuit. The Administrator finds that the type of bed and the controlling regulation is distinguishable from that presented in *Alhambra.* However, the court's definition of the term "areas" within the context of "geographical" boundaries of the hospital for DSH purposes, as opposed to a definition within the context of cost reporting requirements, is similarly problematic in this case.

Hence, as the *Alhambra* case is binding in the circuit in which the Providers are entitled to seek judicial review, the Administrator hereby affirms the Board's decision and reverses the Intermediary's adjustment with respect to LDRP days. The Board's decision is affirmed only on the limited grounds that there is binding law in the Ninth Circuit ruling that the term "area" is defined within the context of the geographical location of the bed. The decision does not affect the Secretary's ability to continue to defend this issue in other circuits or future cost years, or further clarify his definition of bed size and available beds consistent with his longstanding policy.

DECISION

The Board's decision is affirmed, but only on the limited grounds that in the circuit in which the Providers can file suit as a group there is adverse case law relevant to the pertinent facts and law of this case. This decision is limited to the facts and circumstances of this case and the cost years at issue.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: **4/13/2009** **/s/**

Michelle Snyder
Acting Deputy Administrator
Centers for Medicare & Medicaid Services