PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON THE RECORD
2004-D37

PROVIDER –
Clark Regional Medical Center

Provider No. 18-0092

vs.

INTERMEDIARY –
Blue Cross Blue Shield Association/
AdminaStar Federal-Kentucky

DATE OF HEARING –
June 3, 2004

Cost Reporting Period Ended –
June 30, 1993

CASE NO. 96-0720

INDEX

ISSUE:

Whether non-acute care swing-bed days should be included in the Medicaid proxy for the disproportionate share calculation ("DSH").

STATEMENT OF THE CASE AND APPLICABLE LAW:

This dispute arises out of the Intermediary's failure to reimburse Clark Regional Medical Center ("Provider") the amount it claims is due under the Medicare program.

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")[1] is the operating component of the Department of Health and Human Services charged with administering the Medicare program.

The Secretary's payment and review functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under the Medicare statutes, regulations and interpretative guidelines published by CMS. *Id*.

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 what portion of those costs are 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 informs the provider in 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 NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

In 1983, Congress created the Prospective Payment System ("PPS") to reimburse hospitals for services to Medicare patients. Under PPS, inpatient operating costs are reimbursed based on a prospectively determined formula that takes into account national and regional operating costs.

In establishing this system, however, Congress recognized that low-income patients generally have poorer health and are costlier to treat than higher-income patients.[2] Congress, therefore, authorized additional Medicare funds for certain hospitals that treat a disproportionate share ("DSH") of low-income patients.

A hospital is entitled to a DSH adjustment if its "disproportionate patient percentage" equals a specified percentage, depending on the size of the hospital. *Id.* §1395ww(d)(5)(F)(v).

[1] Formerly known as Health Care Financing Administration ("HCFA")

[2] H.R. Rep. No. 98-25(I), at 141-42 (1983), *reprinted in* 1983 U.S.C.C.A.N. 219, 360-61; *see also Cabell Huntington*, 101 F.3d at 985.

Thus, if a hospital is located in an urban area and has 100 or more beds, its disproportionate patient percentage must equal or exceed fifteen percent (15%) for discharges prior to April 2001 in order for it to be entitled to a DSH adjustment, while a hospital located in rural area that has less than 100 beds must have a disproportionate patient percentage of forty five-percent (45%) for discharges prior to April 2001. *Id.* Congress then defined "disproportionate patient percentage" to be the sum of two fractions. Both fractions are designed to count the number of patients served by a hospital, but each fraction counts a different group of those patients. The first fraction, called the "Medicare proxy," counts Medicare recipients who are entitled to supplemental security income, a federal low-income supplement. The second fraction is called the "Medicaid proxy" and counts patients who are not entitled to Medicare benefits but who qualify for Medicaid. Specifically, the Medicaid proxy, codified at 42 U.S.C. §1395ww(d)(5)(F)(vi)(II), is defined as:

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under [the Medicaid program], but who were not entitled to benefits under part A of [the Medicare program], and the denominator of which is the total number of the hospital's patient days for such period. (emphasis added)

The number of a hospital's "patient days" and the percentage of those patient days representing Medicaid-eligible patients is central to a hospital's eligibility for a DSH adjustment. It is the Secretary's interpretation of the regulation implementing and construing the term, "patient days," that is in dispute.

The Provider is a voluntary, non-profit, general short-term hospital located in Westchester, Kentucky. In its cost report for fiscal year ended June 30, 1993, the Provider included its swing-bed utilization as "patient days" for purposes of calculating its DSH patient percentage. A "swing-bed" hospital is one which may, when necessary, use acute care beds to provide post-hospital skilled nursing facility ("SNF")[3] care on a temporary basis. See 42 U.S.C. §1395tt(a)(1). Thus, a swing-bed hospital may permit acute beds to "swing" temporarily to SNF care and then "swing" back to acute care when the SNF care is complete or the acute care bed is needed. 42 U.S.C. §1395tt(d). AdminaStar Federal – Kentucky ("Intermediary") excluded days of service rendered to patients who occupied swing-beds when computing the Provider's disproportionate patient percentage. As a result, the Provider's DSH payment was significantly reduced. The Provider appealed the Intermediary's determination to the Board pursuant to 42 C.F.R. §§405.1835-.1841 and met the jurisdictional requirements of those regulations. The amount of Medicare reimbursement in controversy is approximately $205,685.

[3] SNF care is not reimbursed by Medicare under the PPS system but is reimbursed under another mechanism.

The Provider was represented by Keith D. Barber, Esquire, of Hall, Render, Killian, Heath & Lyman, P.S.C. The Intermediary was represented by Bernard M. Talbert, Esquire, Associate General Counsel, Blue Cross Blue Shield Association.

PARTIES CONTENTIONS:

Specifically, the issue is whether the Intermediary properly concluded that swing-bed utilization days do not count as "patient days" for purposes of the Medicaid proxy. It is undisputed that nothing in the statutory language of the Medicaid proxy defines "patient days" to either include or exclude swing-bed utilization days. The regulation limits "patient days" to "those days attributable to areas of the hospital that are subject to PPS and excludes all others." 42 C. F.R. §412.106(a)(I)(ii).

The Provider argues that the plain language of this regulation permits the exclusion of patient days only if those days are attributable to geographic areas of the hospital that are excluded from PPS. The Intermediary maintains, however, that the "area" is "subject to PPS" when the patient receives hospital services in the areas that are subject to PPS, but is not subject to PPS when a patient receives SNF-type services in the area. According to the Intermediary, since SNF care is not reimbursed under PPS, the number of bed days utilized for SNF care do not count toward "patient days."

The Intermediary notes that the term "hospital" as used in 42 U.S.C. §1395ww(d) is a defined term, meaning any hospital that is not a psychiatric hospital, a rehabilitation hospital, a children's hospital, a long-term care facility, or a hospital involved extensively in treatment for, or research on, cancer. 42 U.S.C. §1395ww(d)(1)(B). The Intermediary argues that an interpretation of 42 C.F.R. §412.106 that permits the inclusion of swing-bed utilization days in the DSH calculation undermines the purpose of the DSH adjustment in that Congress intended for the DSH adjustment to lessen the financial impact on hospitals that serve a disproportionate share of low-income patients. Therefore, the Intermediary maintains that it would not make sense to include in the eligibility calculation the days of non-hospital SNF care that are reimbursed on a "reasonable cost" basis and are in no way affected by PPS.

The Provider asserts that the example of how to count beds provided at CMS Pub. 15-1 §2405.3G supports its position as beds used for long-term care but not certified as such are included in the bed count. Specifically, the manual states: "[a]lthough 35 beds are used for long-term care, they are considered to be acute care beds unless otherwise certified." Id. The example provided in the manual is directly on point. Beds used for another purpose (e.g., long-term care) but licensed or certified for acute care are counted as acute care beds. Swing-beds are simply temporarily used for long-term type services but are still certified for acute care services. The use of these beds for long-term care is irrelevant. As the example

[4] In order to obtain approval from CMS to operate swing beds, a hospital must, *inter alia*, have fewer than 100 beds and be located in a rural area. 42 C.F.R. §482.66(a).

plainly demonstrates, the beds are included in the count for DSH purposes based upon their certification as acute care beds.

The Provider asserts that its position is supported by prior Board and Court cases. In *Clark Regional Medical Center, et. al., v. United States Department of Health and Human Services*, 314F.3d 241 (6th Cir. 2001), the Court ruled that non-acute swing-bed days and observation days should not be removed from available bed days in computing available beds. The Court's finding allowed the Provider to receive DSH payments as a hospital with at least 100 beds. The Intermediary counters that Clark is not controlling in that it does not address the number of patient days that should be included in the Medicaid proxy; it only addresses the number of beds.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of the controlling law and manual guidelines, parties' contentions, and evidence presented, the Board finds and concludes that the Intermediary's exclusion of swing-bed days from the DSH calculation was not proper.

The relevant statute requires counting "hospital's patient days." 42 U.S.C. §1395ww(d)(5)(F)(vi)(II). The regulation, 42 C.F.R. §412.106(a)(ii) defines the statutory phrase:

> The number of patient days includes only those days attributable to areas of the hospital the are subject to the prospective payment system and excludes all others.

The Board concludes that the plain language of the regulation requires that the swing bed patient days be counted for the DSH calculation because they are from an "area" of the hospital "subject to [PPS]."

The Board's position has been upheld in other analogous cases. In Alhambra Hospital v. Tommy Thompson,[5] the 9th Circuit repudiated the alleged connection between PPS and DSH, stating that "DSH payments are in addition to, and separate from, the ordinary PPS payments" and that "by definition, the DSH reimbursement is calculated on the basis of services that not only are not covered by Medicare but are prohibited from reimbursement through Medicare." Describing the methodology established by CMS regulations for counting patient days as "geographic," the Court emphasized that the sole issue is whether the "patient days are 'attributable to *areas* of the hospital' that are subject to PPS." The 9th Circuit concluded that "[o]bviously, an area of a hospital is either subject to PPS or it is not." In short, the Court of Appeals endorsed the notion that the CMS regulatory structure focuses on areas or departments under PPS, and rejected the CMS Administrator's assertion that a patient day in a bed in an area under PPS is not counted when the service furnished was not reimbursed under PPS.

[5] 2001 WESTLAW 880831 decided on August 7, 2001.

In *District Memorial Hospital of Southwestern North Carolina*,[6] the court held that so long as the beds involved are in the "geographic area" of the hospital used for acute care, it does not matter if they are sometimes used for swing-bed services.

The Board's conclusion is also supported by other cases that involve counting beds for the DSH calculation, including a case involving this provider.[7] Although the bed count is a different criteria, it is directly related in that the DSH patient days count arises from services provided in the beds included in the DSH calculation. The Intermediary's position on both criteria is that, to be counted, the beds and the patient days must derive from services reimbursed under the PPS system. Both the Board and the federal courts have soundly rejected that position.

With respect to determining the number of beds for DSH status, the regulation at 42 C.F.R. §412.106 (a)(1)(i) requires this determination to be made in accordance with 42 C.F.R. §412.105(b), which also governs additional payments to hospitals for indirect medical education programs and states:

> Determination of number of beds. For purposes of this section, the number of beds in a hospital is determined by counting the number of available beds during the cost reporting period, not including beds or bassinets in the healthy newborn nursery, custodial care beds, or beds in excluded distinct part hospital units, and dividing that number by the number of days in the cost reporting period.

The Board found that this regulation requires that all beds and all bed days be included in the calculation unless they are specifically excluded under the categories listed in the regulation. Id.

The Board relied in large part on CMS Pub. 15-1 §2405.3.G. In part, the manual states:

> G. Bed Size.-- A bed is defined for this purpose as an adult or pediatric bed (exclusive of beds assigned to newborns which are not in intensive care areas, custodial beds, and beds in excluded units) maintained for lodging inpatients, including beds in intensive care units, coronary care units, neonatal intensive care units, and other special care inpatient hospital units. Beds in the following locations are excluded from the definition: hospital-based skilled nursing facilities or in any inpatient area(s) of the facility not certified as an acute care hospital, labor rooms, PPS excluded units such as psychiatric or rehabilitation units, post-anesthesia or postoperative recovery rooms, outpatient areas,

[6] CCH Medicare & Medicaid Guide, ¶301,314 (W.D.N.C. – Feb. 3, 2003):
[7] Commonwealth of Kentucky Group Appeal, Decision No. 99-D66.

> emergency rooms, ancillary departments, nurses' and other staff residences, and other such areas as are regularly maintained and utilized for only a portion of the stay of patients or for purposes other than inpatient lodging.
>
> To be considered an available bed, a bed must be permanently maintained for lodging inpatients. It must be available for use and housed in patient rooms or wards (i.e., not in corridors or temporary beds). Thus, beds in a completely or partially closed wing of the facility are considered available only if the hospital puts the beds into use when they are needed. The term "available beds" as used for the purpose of counting beds is not intended to capture the day-to-day fluctuations in patient rooms and wards being used. Rather, the count is intended to capture changes in the size of a facility as beds are added to or taken out of service.

CMS Pub. 15-1 §2405.3.G (emphasis added).

Given the degree of specificity with which the manual addresses this issue and the fact that the enabling regulation has been modified on at least two occasions to clarify the type of beds excluded from the count, the Board found that these comprehensive rules are meant to provide an all-inclusive listing of the excluded beds. The Board rejected the Intermediary's argument that since the purpose of DSH is to adjust PPS amounts, only beds reimbursed under PPS should be included in the count of available bed days. The Board reasoned that, if the Intermediary's argument were valid, Congress would simply have said that in the enabling statute, and a regulation could have easily been promulgated to accommodate a category for PPS-excluded beds. Instead, the controlling regulation and manual guidelines have been written in a manner which provides great specificity regarding beds that are included and excluded from the count.

The Board found further support in CMS Pub. 15-1 §2405.3.G(2), which provides an example for determining bed size. In this example, a hospital has 185 acute care beds, including 35 beds that were used to provide long-term care. CMS explains that all 185 beds are used to determine the provider's total available bed days since the 35 beds are certified for acute care. In part, CMS states:

> [a]lthough 35 beds are used for long-term care, they are considered to be acute care beds unless otherwise certified.

CMS Pub. 15-1 §2405.3.G(2) (emphasis added).

Thus, acute care beds that are temporarily or occasionally used for another type of patient care, but not certified as such, identical to the swing-beds at issue in this case, were found to be included in the bed count.

The Administrator reversed the Board's decision, relying on the same argument, made in this case: to be included for DSH, the beds must have been used to provide services paid for under the PPS system. (See Provider Exhibit P-4). The District Court upheld the Board's decision. Clark Regional Medical Center, et al. v. Shalala, 2001 U.S. Dist LEXIS 4658 (E.D. Ky. 2001), described the Secretary's position as one that "tortures the plain language of the regulation," and stated that "a plain and common sense reading of the regulation requires that all beds and all bed days be included in the calculation unless they are in one of the specifically enumerated categories of excluded beds." The District Court further noted that "none of the beds at issue are located in a hospital-based SNF . . . therefore, the fact that they temporarily may perform similar functions is irrelevant." The Sixth Circuit affirmed the District Court's decision. Clark Regional Medical Center et. al., v. U.S. Dep't HHS, 314F.3d 241 (6th Cir. 2002)

The Provider points out that SNF beds in dispute for the bed count in Clark Regional are the same beds that are in dispute in this case for the patient days count.

The rationale applicable to the SNF beds in Clark Regional is equally applicable here. The regulation and manual provisions indicate that the location of the beds where services are rendered in a geographic area of the hospital subject to PPS is the determining factor and the method of payment for those services is irrelevant to the determination.

In conclusion, the Board finds that the patient days associated with swing-bed services are to be included in the patient days count when calculating the Provider's DSH payment

DECISION AND ORDER:

The Intermediary's adjustment excluding swing-bed days from the Provider's count of patient days used in the Medicaid proxy for DSH payment was improper and is reversed.

BOARD MEMBERS PARTICIPATING:

Gary Blodgett, D.D.S.

Suzanne Cochran, Esquire
Martin W. Hoover, Jr., Esquire
Elaine Crews Powell, CPA

DATE: September 2, 2004

FOR THE BOARD:

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Chairman