PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2008-D37

PROVIDER –
Beverly Hospital
Beverly, Massachusetts

Provider No.: 22-0033

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
Associated Hospital Services

DATE OF HEARING –
September 6, 2006

Cost Reporting Periods Ended -
September 30, 1999; September 30, 2000;
September 30, 2001 and September 30, 2002

CASE NOs.: 04-1083; 04-1091; 04-1093
and 04-1950

INDEX

ISSUES:

1) Whether the Intermediary improperly computed the numerator of the Medicaid fractions that were used to calculate the Provider's disproportionate share hospital (DSH) payments for fiscal years (FYs) 1999, 2000, 2001, and 2002 by excluding inpatient days attributable to individuals who were both eligible for medical assistance under an approved Medicaid State plan and enrolled in a Medicare +Choice (M+C) plan for such days.

2) Whether the Intermediary improperly computed the numerators of the Medicaid fractions that were used to calculate the Provider's DSH payments for FYs 1999, 2000, 2001 and 2002 by excluding inpatient days attributable to individuals who allegedly received assistance under the Massachusetts Uncompensated Care Pool for such days.

3) Whether the Intermediary improperly computed the Medicaid fraction that was used to calculate the Provider's DSH payment for fiscal year 2002 by i) excluding from the numerator inpatient days attributable to individuals who were in a labor and delivery room at the census-taking hour and who had not previously occupied a routine bed and ii) including such days in the denominator.

4) Whether the Medicare/Supplemental Security Income (SSI) fraction that was used to calculate the Provider's DSH payment for FY 1999 should be recalculated, or, in the alternative, whether the Medicare SSI fraction should be revised.

MEDICARE STATUTORY AND REGULATORY GENERAL BACKGROUND/DSH STATUTE:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

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 the 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 portion 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 on hospital-specific factors. See, 42 U.S.C. §1395ww(d)(5). This case involves the hospital-specific DSH adjustment, which 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 large an adjustment it receives, depends on the hospital's "disproportionate patient percentage (DPP)." See, 42 U.S.C. § 1395ww(d)(5)(F)(v). The DPP is the sum of two fractions, the "Medicare and Medicaid fractions," for a hospital's fiscal period. 42 U.S.C. §1395ww(d)(5)(F)(vi). The Medicare fraction's numerator is the number of a hospital patient days for such period which were made up of patients who (for such days) were entitled to both Medicare Part A and SSI, excluding patients receiving state supplementation only, and the denominator is the number of patient days for patients entitled to Medicare Part A. See also, 42 C.F.R §412.106(b)(2). The Medicaid fraction's numerator is the number of hospital patient days for patients who (for such days) were eligible for medical assistance under a State Plan approved under Title XIX for such period but not entitled to benefits under Medicare Part A, and the denominator is the total number of the hospital's patient days for such period. See also, 42 C.F.R. §412.106(b)(4). A provider whose DSH percentage meets certain thresholds receives an adjustment which results in increased PPS payment for inpatient hospital services. 42 U.S.C. §1395ww(d)(5)(F)(ii).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY

Beverly Hospital (the Provider) is a Medicare participating, general, acute care hospital located in Beverly, Massachusetts. The Intermediary is Associated Hospital Services. The cost reporting periods at issue are the Provider's fiscal years ended September 30, 1999, 2000, 2001, and 2002. The parties filed stipulations specifically identifying the disallowances and adjustments at issue.[1]

The Provider was represented by Christopher L. Keough, Esquire, of Vinson and Elkins, LLP. The Intermediary was represented by Arthur E. Peabody, Jr., Esq. of Blue Cross Blue Shield Association.

ISSUE 1: BACKGROUND/FACTS

The Intermediary excluded from the numerator of the Medicaid fraction the days attributable to patients who were eligible for Medicaid and enrolled in a M+C plan during

[1] See, Provider Exhibit P-25.

their inpatient hospital stays. Additionally, the Intermediary allowed virtually none of these days in the Medicare/SSI fraction.[2]

ISSUE 1: PARTIES' CONTENTIONS

The Intermediary contends that CMS policy has consistently dictated that M+C days be included in the Medicare fraction. Although CMS had considered including these days in the Medicaid fraction, following debate, CMS determined that the Medicare fraction should remain the proper placement for such days.

The Provider contends that the Intermediary's exclusion of the M+C days from the Medicaid fraction's numerator was improper for four reasons. First, because these M+C patients were eligible for Medicaid and were not entitled to benefits under Medicare Part A during the period of their enrollment in a M+C plan, the patient days at issue should be counted in the Medicaid fraction's numerator. Second, when Congress established the M+C program in the Balanced Budget Act of 1997, it manifested its intent that M+C patient days should not be considered to be days with respect to which payment may be made under Medicare Part A as evidenced by its provisions for graduate medical education (GME) payment. Third, effective October 1, 2004, CMS adopted and revised the DSH regulation to begin to count M+C days in the Medicare/SSI fraction. The policy and practice shows that prior to the 2004 amendments to the DSH regulation, CMS did not consider M+C patients to be entitled to payment under Part A. The fact that CMS did not count M+C days in the Medicare/SSI fraction (except by mistake), is evidence that, at least prior to the 2004 amendments, M+C enrollees should not be considered to be entitled to Medicare Part A benefits. Fourth, it would be arbitrary and capricious for CMS to treat M+C days as Medicare Part A days for DSH purposes but for no other payment purposes, such as GME, for the periods at issue.

ISSUE 1: FINDINGS OF FACT, CONCLUSION OF LAW AND DISCUSSION:

After consideration of the Medicare law and guidelines, the parties' contentions and evidence presented, the Board finds and concludes that for the fiscal years at issue, the M+C days should be counted in the Medicare fraction. Although the Medicare statute does not expressly address the treatment of M+C days, in reading the statute along with the DSH and M+C regulations, it is clear that the M+C days can only be counted in the Medicare fraction as they are specifically precluded from being included in the Medicaid fraction.

---

[2] For the time periods in question, 43 (out of a total 2,711) Medicaid eligible M+C days were included in the routine use data produced by CMS in support of the calculation of the Medicare/SSI fraction. These days were originally mistakenly billed for payment under Medicare Part A and a CMS programming fault did not eliminate the denials from the routine use data. See, Provider's Post Hearing Brief at 16 and 17, Provider Ex. 26, Item 5; Tr. at 65-68, 76, 109-112.

Pursuant to 42 U.S.C. §1395ww(d)(5)(F)(vi), a hospital's DPP is the sum of the Medicare and Medicaid fraction. The Medicare fraction's numerator is the number of a hospital patient days for such period which were made up of patients who (for such days) were entitled to both Medicare Part A and SSI, excluding patients receiving state supplementation only, and the denominator is the number of patient days for patients entitled to Medicare Part A. See also, 42 C.F.R §412.106(b)(2). The Medicaid fraction's numerator is the number of hospital patient days for patients who (for such days) were eligible for medical assistance under a State Plan approved under Title XIX for such period *but not entitled to benefits under Medicare Part A*, and the denominator is the total number of the hospital's patient days for such period. (emphasis added) See also, 42 C.F.R. §412.106(b)(4).

The term "entitled" as it is used in the definition of the Medicare fraction found in 42 U.S.C. 1395ww(d)(5)(F), has been interpreted through case law. In *Jewish Hospital, Inc. v. Secretary of Health and Human Services*, 19 F.3d 270, 274-75 (6th Cir. 1994), the term "entitled" was defined as, "To be *entitled* to some benefit means that one possesses the *right* or *title* to that benefit. Thus the Medicare proxy *fixes* the calculation upon the absolute right to receive an independent and readily defined payment." In support of the definition utilized by the court in *Jewish Hospital*, the U.S. District Court, Southern District of West Virginia[3] further defines "entitled":

> Looking at the dictionary definitions of the root words "eligible" and "entitle," it is seen that "eligible" and "entitle" are both defined as being synonymous with "qualified" The American Heritage Dictionary of the English Language 423 (eligible), 437 (entitle) (new college ed. 1976). However, "entitle" has the additional meaning of "[t]o give (one) a right to do or have something; allow." Id. at 437. "Qualified" means, in turn, simply "having met the requirements," id. at 1067, while "allow" includes the concepts of letting happen, permitting one to have, granting, or providing, id. at 35. The word "entitled" thus encompasses more than being eligible or qualified by meeting certain requirements. In the context of the Medicare proxy, it means, in addition, that one has a right to have Medicare benefits provided.

The statute implementing payments to HMOs and CMPs is found at 42 U.S.C.1395mm. The statute strictly identifies at 42 U.S.C.1395mm (a)(5), that payments will be made to eligible organizations under this section for ". . . individuals enrolled under this section with the organization and **entitled to benefits under part A** of this subchapter and enrolled under part B of this subchapter shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund." (emphasis added) Therefore, pursuant to the statute, a beneficiary who enrolled in the M+C program must first be entitled to benefits under Medicare Part A.

---

[3] Cabell Huntington Hospital, et al. v. Shalala, et al., U.S. District Court, Southern District of West Virginia, C.A. No. 2:94-0345

After reading the DSH statute and implementing regulations along with the M+C statute, the Board concludes that a beneficiary can only be eligible for part C if "entitled to benefits" under part A. Once so entitled, under the DSH statute, the individual would be excluded from being counted in the Medicaid percentage by the explicit language of DSH statute "eligible for medical assistance under state plan approved under XIX and not entitled to benefits under part A."

The Board recognizes that the language regarding the treatment of M+C days for GME purposes is confusing and appears to conflict with CMS' policy to include M+C days as a Medicare day in the DSH calculation. The Board also recognizes that CMS' own policy on this issue has wavered over time, and has at times reversed completely. However, the clear language of the statute cannot be overridden by commentary made by CMS in the preamble to a GME final rule[4] or in its policy shifts. The Board finds that the language in the preamble is unclear and it cannot be determined if it is meant for GME apportionment purposes only or for all areas in "respect to whom payment may be made under part A."

ISSUE 2: BACKGROUND/FACTS

The State of Massachusetts (State) established an uncompensated care pool (UCP) as a financing mechanism to distribute more equitably the burden of uncompensated care.[5] The State received Medicaid DSH payments; that is, Federal financial participation (FFP or matching funds), for its expenditures on the assistance through the UCP.[6]

The Intermediary excluded from the numerator of the Medicaid fraction inpatient days attributable to individuals who received assistance from the UCP. None of the patients that the Provider seeks to count were determined eligible for Medicaid by the relevant state agency.[7]

ISSUE 2: PARTIES' CONTENTIONS

The Intermediary contends that the UCP days may not be included in the numerator of the Medicaid fraction as the Provider failed to demonstrate that each of the individuals it wished to count was determined eligible for Medicaid by the relevant state agency. Massachusetts' UCP program specifically excludes those individuals participating in the Medicaid program and patients receiving assistance from the UCP are not necessarily eligible for Medicaid. Moreover, CMS policy as described in Program Memorandum

---

[4] See, 53 Fed. Reg. 36589, 36600 "As in the case with other apportionment issues, hospital inpatient days of Medicare beneficiaries whose hospital stays are paid by risk basis health maintenance organizations are recorded as non-Medicare days." See also, 42 U.S.C. 1395ww(h)(3)(D).

[5] Intermediary Post Hearing Brief (PHB) at 14, Provider PHB at 41.

[6] Provider PHB at 44. See Mass Health MA DSH Expenditures Chart, Provider Ex 7; 114.6 Mass. Code Regs. § 11.04(1)(a), Provider Ex. 8 at 4; Provider Exhibit 9 at 2.

[7] Intermediary PHB at 14, Transcript (Tr.) at 161-62.

A-99-62, which permits inclusion of days not otherwise covered in some limited circumstances, provides no relief to the Provider, but, rather, is consistent with the Intermediary's position.

The Provider contends that the UCP days should be counted in the numerator of the Medicaid fraction because the UCP is part of the Medicaid DSH payment described in the CMS approved Medicaid State plan. Because CMS paid FFP (Medicaid DSH) for UCP expenditures, and because CMS has the authority to pay matching funds only for State expenditures on medical assistance under the State plan, the UCP qualifies as "medical assistance under the State Plan" in accordance with the 42 U.S.C. §1395ww(d)(5)(F)(vi)(II) computation at issue. Likewise, the recipients of UCP assistance are "eligible" for this medical assistance under the State plan, as they were the direct beneficiaries of the assistance.[8]

The Provider further asserts that reimbursement from the UCP is based on a hospital's cost of inpatient hospital services furnished to individuals who qualified for assistance through the UCP. A hospital is entitled to payment from the pool based on the ratio of the hospital's free care costs in proportion to the total of all hospitals' free care costs and an allocated shortfall amount (the difference between total free care costs and funds available in the pool). The payment levels do not vary based on the volume or value of services furnished to other Medicaid recipients. As a result, UCP recipients are receiving a federally-funded benefit under the State plan that is indistinguishable in any material way from the benefit received by other Medicaid recipients under the State plan. Therefore, the days of inpatient care furnished to UCP recipients should be included in the Medicaid fraction.[9]

ISSUE 2: FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of the Medicare law and guidelines, the parties' contentions and evidence presented, the Board finds and concludes as follows: The UCP days at issue should be included in the numerator of the Medicaid fraction for DSH.

The statute at 42 U.S.C. §1395ww(d)(5)(F)(vi)(II) is controlling on this issue. Under this provision, the Medicaid proxy of the DSH calculation includes all "patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under Title XIX of this chapter, but who were not entitled to benefits under Part A of this subchapter. . ."

The Intermediary asserts that the Medicare statute, when read in conjunction with its implementing regulation, limits "medical assistance" to Medicaid. The Intermediary argues that "eligible for medical assistance under a State Plan approved under Title XIX" is the statute's description of Medicaid as used in the regulation, and the terms "medical

[8] See, Provider PHB at 47.
[9] Id. at 44 and 46

assistance" and "Medicaid" are interchangeable in the context of this appeal. The Board disagrees.

The purpose of the DSH statute is to compensate hospitals for the additional costs associated with treating low-income patients. The plain language of the statute, which is the controlling authority, requires all days relating to patients eligible for medical assistance under a State Plan approved under Title XIX to be included in the Medicaid proxy. The clear and unambiguous statute does not contain the limitation that the Intermediary suggests. The Board finds no rationale to limit the term "eligible for medical assistance under a State Plan approved under Title XIX" to the Intermediary's narrow definition.

In this case, it is undisputed that assistance provided via the UCP is allowed in the approved State plan as a Medicaid DSH payment and that CMS provided FFP through this payment. Because the State made Medicaid DSH payments to hospitals to cover the costs of services furnished to individuals who qualified for assistance through the UCP, those individuals were eligible for, and received "medical assistance under a State plan"[10] for such days. Accordingly, the UCP days at issue should be included in the numerator of the Medicaid fraction for DSH.

ISSUE 3: BACKGROUND/FACTS

Prior to 1991, CMS policy required an inpatient day to be counted for an admitted maternity patient in the labor/delivery room (LDR) 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. Based on decisions adverse to CMS regarding this policy in a number of Federal courts of appeals including the United States Court of Appeals for the District of Columbia Circuit, CMS subsequently changed its policy in Transmittal No. 365, December 1, 1991 which implemented CMS Pub. 15-1 §2205.2, Counting Patient Days for Maternity Patients. That section states:

> 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

[10] 42 U.S.C. §1396(b) [Payment to States]. 42 C.F.R. §433 et. seq.

> 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.

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/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:

> 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.

In its as-filed cost report for FY 2002, the Provider identified and under protest, self-disallowed 169 Medicaid-eligible LDR days, from the numerator of the Medicaid fraction. As part of this protest, the Provider also requested that if LDR days are excluded from the numerator of the Medicaid fraction then they should also be removed from the denominator of that fraction. The Provider has specifically identified 543 LDR days in its total number of inpatient days. In the settled cost report, the Intermediary excluded the 169 LDR days at issue from the numerator of the Medicaid fraction, but included the 543 total LDR days in the denominator of that fraction.

ISSUE 3: PARTIES' CONTENTIONS

The Intermediary argues that labor and delivery room days cannot be included in the Medicaid fraction. CMS Pub. 15-1, §2205.2 and PRRB case law hold that a maternity patient in the labor/delivery room at midnight is included in the census of the inpatient routine care area only if the patient has occupied an inpatient routine bed at some time since admission. Generally, when a maternity patient is admitted to the hospital for delivery, she does not occupy a hospital inpatient bed until after delivery and, therefore,

has not used any routine inpatient services. Labor and delivery room "services" have traditionally been viewed as ancillary services. Thus, if the patient is in the labor/delivery room when the census is taken, the patient neither occupied a hospital bed nor incurred traditional inpatient care services. Moreover, the Provider's witness conceded that its data is inadequate to determine whether the patients at issue were in the labor/delivery room or a routine bed at the census-taking hour.[11]

The Provider contends that the LDR days should be included in both the numerator and the denominator of the Medicaid fraction. Alternatively, the Provider contends that if the days are excluded from the numerator, they should likewise be excluded from the denominator. The Provider cites four principal reasons LDR days should be included in the Medicaid fraction:

First, the exclusion of LDR days from the Medicaid fraction is inconsistent with the plain language of the DSH regulation at 42 C.F.R. §412.106(a)(1)(ii) (2002) which included all days in the PPS areas of a hospital and drew no distinction between those patients who were in a routine service area and those who were in an ancillary area at the census-taking hour.[12]

Second, the exclusion of LDR days from the Medicaid fraction is inconsistent with CMS' statements of intent when it adopted the Manual provision that CMS' new DSH rule purports to be based upon. Accordingly, the application of the new DSH rule to the prior period at issue is invalid. It is clear that CMS Pub. 15-1 §2205.2 was not originally intended to carve out LDR or days from the number of inpatient days included on the cost report either generally or in the DSH calculation specifically. Section 2205.2 was created for the express, limited purpose of conforming CMS' policy for the computation of a hospital's inpatient average routine cost per diem, for cost apportionment purposes, to the prior decisions of several federal courts that had invalidated CMS' former policy of including LDR days in the computation. Accordingly, when CMS added §2205.2, it did not amend other existing program guidance more generally defining what counts as an inpatient day with respect to maternity patients in particular or other patients. The controlling authority draws no distinction between admitted inpatients who are in a routine service area of a hospital and those who are in an ancillary service area at the census-taking hour.

Third, even if CMS intended to alter its interpretation of the DSH regulation as it relates to the CMS Pub. 15-1 §2202.5 inpatient days that are included in the DSH calculation through the addition of CMS Pub. 15-1 §2202, such change would be procedurally invalid as the agency did not follow the Administrative Procedure Act's notice and comment rulemaking procedure.[13]

---

[11] Tr. at 218.

[12] The Provider cites Alhambra Hosp. v. Thompson, 259 F.3d 1071, 1075 (9th Cir. 2001) in support of its position.

[13] See, Monmouth Medical Center v. Thompson, 257 F. 3d 807 (D.C. Cir. 2001).

Fourth, the exclusion of LDR days from the Medicaid fraction is arbitrary and capricious because it is inconsistent with CMS' treatment of other days attributable to patients in other ancillary service areas at the census-taking hour. Also, since CMS counts LDR days against a patient's Part A benefit for inpatient hospital services, such days should be counted as inpatient hospital days in the Medicare DSH calculation. Moreover, because whether a patient is sent directly to a LDR upon arrival or assigned to routine bed has no bearing on the patient's indigence. Finally, CMS' position is inconsistent with its treatment of LDR days as inpatient days for purposes of computing Medicare/SSI fraction.

ISSUE 3: FINDINGS OF FACT, CONCLUSION OF LAW AND DISCUSSION

After consideration of the Medicare law and guidelines, the parties' contentions, and evidence presented, the Board finds and concludes that the disputed LDR days should be counted in both the numerator and the denominator of the Medicaid fraction.
As a result of adverse court decisions, CMS changed the way it counted LDR 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 DSH 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). 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.[14] It is undisputed that the LDR units at issue, and LDR units in general, are located in an area subject to PPS; therefore, the days at issue must be counted.[15]

The Board acknowledges that many providers have changed the setting in which they deliver services to maternity patients from "traditional" or separate LDRs in an ancillary department and separate post partum 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. The Board observes that patients admitted to such 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 IPPS system, and for Medicare coverage purposes, these days are therefore counted against the patient's inpatient days. See, Medicare Hospital Manual 216.1.

---

[14] See, footnote 15, supra.

[15] The Board also notes that the Intermediary made no allegation that such beds were unlicensed.

ISSUE 4: BACKGROUND AND FACTS

The Supplemental Security Income (SSI) program is administered by the Social Security Administration (SSA); therefore, identifying patients who were entitled to SSI during their hospitalization requires access to SSA's SSI data.

To implement the DSH legislation, the number of patient days of those patients entitled to both Medicare Part A and SSI is determined by matching data from the Medicare Provider Analysis and Review (MEDPAR) file, Medicare's database of hospital inpatients, with a file created for CMS by SSA to identify SSI eligible individuals. Although the intermediary calculates and reviews the disproportionate patient percentage (DPP), it is CMS that develops the SSI fraction.

In this case, the Medicare/SSI percentage computed by CMS for the Provider's fiscal year 1999 was 7.40 percent. It is undisputed that the data furnished by CMS to the Provider supports a ratio of 9.21%.

ISSUE 4: PARTIES' CONTENTIONS

The Intermediary contends that pursuant to the Administrator's decision in Baystate Medical Center v. Mutual of Omaha Ins. Co.,[16] the SSI fraction that was computed by CMS (7.40%) should not be recalculated or revised.

The Provider contends that consistent with the Board's findings in Baystate, the Board should remand the calculation of the SSI ratio for 1999 to CMS because its computations of the Medicare/SSI fractions systematically understated the SSI ratio. Similarly, the Provider contends that the Medicare/SSI percentage that was applied to determine the DSH payment is unsupported and is otherwise invalid. Accordingly, the 9.21% should be utilized as it is supported by CMS' own data.

ISSUE 4: FINDING OF FACT, CONCLUSION OF LAW AND DISCUSSION

After consideration of the Medicare law and guidelines, the parties' contentions, and evidence presented, the Board finds and concludes that the SSI ratio for 1999 should be revised to 9.21%. No legal authority precludes CMS from recalculating a provider's DSH adjustment. Further, the Board finds, consistent with its previous decision in Baystate Medical Center, that an approximation of the DSH percentage is not permitted by statue or regulation. The Medicare law requires the calculation to be accurate. In this case, as the best available data was furnished by CMS itself, the 9.21% figure should be used.

[16] Admr. Dec. 2006-D-20 (May 11, 2006).

DECISION AND ORDER

ISSUE 1: The Board finds that the M+C days are properly included in the Medicare fraction.

ISSUE 2: The Board finds that the numerator of the Medicaid fraction should be revised to include the UCP days.

ISSUE 3: The Board finds that the numerator and denominator of the Medicaid fraction should be revised to include the LDRP days.

ISSUE 4: The Board finds that the SSI ratio for 1999 should be revised to 9.21%.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Elaine Crews Powell, C.P.A.
Yvette C. Hayes

FOR THE BOARD:

Suzanne Cochran, Esq.
Chairperson

DATE: September 23, 2008