CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Clark Regional Medical Center **Provider** **vs.** **Blue Cross and Blue Shield Assn.** **AdminaStar Federal - Kentucky** **Intermediary**	**Medicare Reimbursement for Cost Year Ending: 06/30/93** **Review of:** **PRRB Dec. No. 2004-D37** **Dated: September 2, 2004**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the Provider Reimbursement Review Board (Board) decision. The review is during the sixty-day period mandated in §1878(f)(1) of the Social Security Act (Act) [42 USC 1395oo(f)(1)], as amended. Comments were received from the Provider. Accordingly, the Board decision is now before the Administrator for final administrative review.

ISSUE AND BOARD DECISION

The issue was whether the Provider's non-acute care swing-bed days should be included in the total of Medicaid patient days used in the calculation of the disproportionate share (DSH) hospital payment.

The Board found that the Intermediary's exclusion of the swing-bed days from the DSH calculation was improper. The Board stated that the governing statute at §1886(d)(5)(F)(vi)(II) sets forth a calculation for determining a hospital's DSH patient percentage, which requires the counting of patient days. The implementing regulation, at §412.106(a)(ii), defines the "number of patient days" as "only those days attributable to areas of the hospital that are subject to the prospective payment system [PPS] and excludes all others." Based upon the plain language of the regulation, the Board concluded that the swing-bed days must be counted for the DSH patient percentage

calculation because they were from an area of the hospital subject to PPS. The Board cited as support for its position, *Alhambra Hospital v. Thompson*[1] and *District Memorial Hospital of Southwestern North Carolina v. Thompson,*[2] as well as decisions involving the bed count for the DSH calculation, including a case involving the instant Provider in *Clark Regional Medical Center v. Shalala.*[3] The Board noted that, although the bed count issue involves a different criteria than that in the present case, it is directly related to the DSH patient days count, which arises from services provided in the beds included in the DSH calculation. Although the Intermediary's position on both the DSH bed count and the DSH patient days is that, to be counted, the beds and the patient days must derive from services reimbursed under PPS, the Board maintained that the Intermediary's position has been rejected by the courts.

The Board stated that the regulations require the number of beds in a hospital to be established in accordance with §412.105(b), which, in turn, requires that all beds and all bed days be included in the DSH calculation unless they are specifically excluded in the regulation. The Board found that the regulations, along with §2405.3.G of the Provider Reimbursement Manual (PRM), establish an "all-inclusive listing of the excluded beds." The Board added that an example in §2405.3.G.2 supported its position that acute care beds which are temporarily used for another type of patient care are to be included in the bed count.

Based upon the above reasoning, the Board found that the patient days associated with swing-bed services are to be included in the patient days count for the DSH calculation, and reversed the Intermediary.

SUMMARY OF COMMENTS

The Provider requested affirmance of the Board's decision because it properly applied the legal standard and facts already resolved in favor of this Provider by the Sixth Circuit. The Provider noted that CMS did not appeal that decision, and argued that the doctrines of *res judicata* and *collateral estoppel* prevent CMS from successfully re-litigating this question, which would also be a frivolous action risking the imposition of sanctions.

The Provider claimed that the Intermediary has admitted that the relevant issue in this case is whether the subject patient days are attributable to areas of the Provider which are subject to the prospective payment system. The Provider also maintained that some

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[1] 259 F.3d 1071 (9TH Cir. 2001).
[2] 261 F.Supp. 2d 378 (W.D. N.C. 2003), *rev'd* 364 F.3d 513 (4th Cir. 2004).
[3] 314 F.3d 241 (6th Cir. 2002). The Board cited to *Commonwealth of Kentucky Group Appeal,* PRRB Dec. No. 99-D66, *rev'd* Admr. Nov. 8, 1999, *rev'd Clark Regional Medical Center, et al., v. Shalala,* 136 F. Supp.2d 667 (E.D. KY. 2001), *aff'd* 314 F.3d 241 (6th Cir. 2002).

courts have rejected the argument that whether a bed is in an "area" reimbursed by PPS depends on the type of services the patient is receiving. In addition to the Sixth Circuit case involving itself, the Provider cited to the Ninth Circuit case of *Alhambra* for support. The Provider also noted that particular courts have suggested the Administrator may be hostile to the concept of the DSH adjustment.

DISCUSSION

The entire record furnished by the Board has been examined, including all correspondence, position papers, exhibits, and subsequent submissions. All comments timely received have been considered and included in the record.

Title VI of the Social Security Amendments of 1983,[4] adding §1886(d) to the Act, established the prospective payment system or "PPS" for reimbursement of inpatient hospital operating costs for all items and services provided to Medicare beneficiaries other than physicians' services associated with each discharge. These amendments changed the method of payment for inpatient hospital services for most hospitals under Medicare. Under PPS, 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. The purpose of PPS was to reform the financial incentives hospitals face, promoting efficiency by rewarding cost-effective hospital practices.[5]

Pursuant to §1886(d)(5)(F)(i), Congress directed the Secretary to provide, for discharges occurring after May 1, 1986, "for an additional payment amount for each subsection (d) hospital" serving "a significantly disproportionate number of low-income patients…."[6] To be eligible for the additional DSH payment, a hospital must meet certain criteria concerning, *inter alia*, its bed size and its disproportionate patient percentage. Relevant to the facts of the instant case, under §1886(d)(5)(F)(v) of the Act, when a hospital is located in an urban area and has 100 or more beds, it must have a disproportionate patient percentage which equals or exceeds 15 percent to be eligible for the DSH adjustment.[7]

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

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

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

[7] *See also* 42 CFR 412.106(c). The Administrator's Decision in *Commonwealth of Kentucky 92-96 DSH Group*, PRRB Dec. No. 99-D66, explained that, at the time the Provider was approved for *the use of swing beds*, the Provider was located in a rural area. That area has since been designated an urban area.

Consequently, the two factors in determining a hospital's DSH eligibility is its number of beds and its disproportionate patient percentage payments.

The latter factor in the DSH payment calculation is explained at §1886(d)(5)(F)(vi) of the Act, which states that the "disproportionate patient percentage" means, with respect to a cost reporting period of a hospital:

> (I) the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A of this title and were entitled to supplementary security income benefits (excluding any State supplementation) under title XVI of this Act, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under part A of this title, and
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> (II) 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 title XIX, but who were not entitled to benefits under part A of this title, and the denominator of which is the total number of the hospital's patient days for such period.

Consistent with the Act, the regulation at 42 CFR 412.106 further explains the DSH calculation:

> *(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).[8]
>
> (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.

[8] The regulation at 42 CFR 412.105(b) reads as follows: "For purposes of this section, the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period, not including beds assigned to newborns, custodial care, and excluded distinct part hospital units, and dividing that number by the number of days in the cost reporting period."

The regulation at 42 CFR 412.106(b) sets out the first and second computation used to determine the hospital's disproportionate patient percentage, as follows:

> *(1) General rule.* A hospital's disproportionate patient percentage is determined by adding the results of two computations and expressing that sum as a percentage.
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> *(2) First computation : Federal fiscal year.* For each month of the Federal fiscal year in which the hospital's cost reporting period begins, [CMS]—
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> (i) Determines the number of covered patient days that—
>
> (A) Are associated with discharges occurring during each month; and
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> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation;
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> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of patient days that—
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A.

Further, paragraph (b)(4) states:

> *Second computation.* The fiscal intermediary determines, for the hospital's cost reporting period, the number of patient days furnished to patients entitled to Medicaid but not to Medicare part A, and divides that number by the total number of patient days in that same period.

With respect to the conditions for payments, §1815(a) of the Act states that Medicare payments will not be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider for the particular cost period at issue. The Secretary has implemented this provision in the regulations at §§413.20 and 413.24, which require providers to maintain financial and statistical records sufficient for an accurate determination of program costs. Specific to the DSH payment, CMS explained, with respect to the determination of the patient

percentage, that "Medicaid data submitted by the hospital, whether on the cost report or furnished subsequently, are subject to intermediary audit to ensure their accuracy."[9]

The Provider in this case is approved for the use of swing beds. Congress recognized the need for "swing bed" hospitals in 1980. Pursuant to §904 of the Omnibus Reconciliation Act (OBRA) of 1980,[10] Congress allowed certain small, rural hospitals with fewer than 50 beds[11] to use their inpatient facilities to furnish skilled nursing facility (SNF) services to Medicare and Medicaid beneficiaries and intermediate care facility services (ICF) to Medicaid patients under the newly added §1833 of the Act. Pursuant to §4005 of OBRA of 1987,[12] §1833 of the Act was amended to expand the swing bed program to include rural hospitals with 50 to 99 beds.[13] In explaining the rationale behind swing bed hospitals, the Secretary stated that:

> Hospitals participating in Medicare and Medicaid, in addition to providing an inpatient hospital level of care, may also provide skilled nursing facility (SNF) or nursing facility (NF) level of care through the establishment of a separately participating "distinct part" unit. (The term nursing facility replaces the term "skilled nursing facility" and "intermediate care facility" in the Medicaid program.) Among other requirements, a distinct part SNF or NF must be an entirely separately identifiable unit consisting of all the beds within the unit (such as a separate building, floor, wing or corridor). A distinct part SNF or NF unit is paid as an entity separate from the rest of the institution.
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> Small rural hospitals had difficulty in establishing these identifiable units for SNF or NF level of care because of the limitations of their physical plant and accounting capabilities. These hospitals often had an excess of hospital beds, while their communities had a scarcity of SNF beds in Medicare and Medicaid participating facilities. To alleviate this problem, Congress enacted section 904 (the swing bed provision) of the Omnizbus Reconciliation Act of 1980.[14]

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[9] *See* 51 Fed. Reg. At 16777.
[10] Pub. L. No. 96-499. See 4/7 Fed. Reg. 31518 (1980).
[11] For purposes of the swing bed hospital approval, the bed count is calculated by excluding, *inter alia*, beds that, because of their special nature, such as newborn and intensive care beds, would not be available for swing bed use. Also excluded are beds in distinct part units.
[12] Pub. L. No. 100-203.
[13] 56 Fed. Reg. 54539 (1991).
[14] *Id.*

Section 1833(f) of the Act specifically provides that Medicare-SNF type services in swing bed hospitals are subject to the same requirements applicable to services when furnished by a SNF, "except those requirements the Secretary determines are appropriate." In response to this Congressional directive, the Secretary stated that:

> We believe that there is clear statutory intent to treat swing bed hospitals similarly to SNFs in order to assure adequate quality of care for long term care patients in swing bed hospitals and clear congressional intent to utilize excess capacity and increase the supply of long term beds in rural areas. We are attempting to strike this balae by requiring that Medicare SNF type services in swing-bed hospitals be subject to the same eligibility and coverage requirements as services furnished in a particular SNF except for those conditions that (1) duplicate existing hospital requirements, (2) require a facility to make extensive structural modifications or changes, or (3) are unnecessary in what is primarily a general routine hospital setting.[15]

In this case, the record reflects that the Provider argued that the plain language of §412.106(a)(1)(ii) permits the exclusion of patient days from the DSH adjustment calculation only if those days are attributable to geographic areas of the hospital that are excluded from PPS. Moreover, the Provider contended that §2405.3.G. of the PRM is the relevant guideline in the determination of whether the swing bed patient days should be excluded in the DSH calculation. The Provider also maintained that a bed day is counted if it is merely available for inpatient care. The Provider further pointed out that the decision of the Sixth Circuit Court of appeals in *Clark Regional*, *supra*, required the inclusion of the swing beds in the DSH bed count for purposes of determining DSH eligibility. This decision is equally applicable to the calculation of the disproportionate patient percentage, and, under the doctrines of *collateral estoppel* and *res judicata*, bars the Secretary from relitigating the issue and facts in this case.

The record shows that the Provider filed a "Hospital and Hospital Health Care Complex Cost Report" and that the hospital and hospital health care complex worksheet S-2 identifies the hospital and hospital-based components with individual provider numbers that included a swing bed SNF and swing bed NF.[16] The swing beds were recorded under the "swing-bed NF" and "swing-bed SNF" component. The settlement of the reimbursement due the Provider for the swing-bed NF and swing-bed SNF was similarly separately identified and settled on the health care complex cost report as a subcomponent.

The Administrator finds that the reason for this treatment on the cost report is clear. The swing-bed hospital provisions set forth at 42 CFR 413.114 and 42 CFR 482.66 reflect that

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[15] 47 Fed. Reg. 31518 (1982).
[16] *See* Provider's Cost Report for FYE 06/30/93.

these days are not recognized, nor paid, as inpatient bed days. The regulation at §413.114(a) explains that, "[p]ayments to these hospitals for posthospital SNF care furnished in general routine inpatient beds are based on the reasonable cost of posthospital SNF care…." Section 2230.2 of the PRM further explains that:

> Under the swing bed reimbursement method, a patient may be admitted to a swing-bed hospital as an inpatient requiring a hospital level of care and subsequently, require a reduced level of care at the SNF or NF level…. *When a patient's level of care is reduced, the situation is treated as a discharge from the hospital and an admission to a SNF, ICF (or NF) bed even though the change in level of care may not involve a physical move of the patient.* The day on which a patient begins to receive a lower level of care is considered to be the day of discharge from the hospital and the day of admission to a SNF or ICF (or NF) bed. [Emphasis added.]

As noted at §421 of the Hospital Manual, the "swing-bed SNF bill has a unique hospital provider number in lieu of a provider number in the usual SNF provider number series." This treatment of the swing bed SNF/NF, similar to that of a distinct part SNF/NF, is also reflected at §415.B of the Hospital Manual. This provision explains that hospitals and distinct part hospital units excluded from PPS are paid on a reasonable cost or other basis *including* routine SNF-level services furnished in swing beds. Thus, the swing bed days at issue were not recognized under PPS as inpatient days and the swing-bed SNF/NF days were treated similarly to other distinct part units excluded under PPS. The Administrator finds that such treatment is reasonable given that the purpose of the swing bed provision is to allow small providers that could not meet the physical and accounting criteria for a SNF distinct part unit to have, in essence, a proxy for the SNF distinct part unit.

The DSH provisions are set forth within that part of the statute addressing payment to "PPS hospitals," which is a term of art. These SNF and NF swing bed days are not inpatient hospital bed days. As the Secretary explained:

> [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 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 a *subsection (d) hospital*, which is the only type of hospital subject to the prospective payment system. Section 1886(d)(1)(B) of the Act defines a subsection (d) hospital as a " *hospital* located in one of the fifty States or the District of Columbia *** and does not include a psychiatric or rehabilitation unit of a hospital which is a distinct part of the hospital." In providing for the disproportionate share adjustment, section

> 1886(d)(5)(F) of the Act specifically refers to a subsection (d) hospital. Thus, section 1886(d)(5)(F) of the Act refers only to "an additional payment amount for each subsection (d) hospital ***." Other references in Section 1886(d)(5)(F) of the Act are to "hospital" and "such hospital." However, since 1886(d)(5)(F) of the Act incorporates the definition of "hospital" by reference to "subsection (d)," all further references in that subparagraph, unless stated otherwise, are taken to mean a subsection (d) hospital….
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> 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.[17] [Emphasis added.]

Thus, to be included in the Medicare DSH calculation, the bed day must be an inpatient subsection (d) "hospital" bed day. Although the SNF/NF beds at issue are not distinct part SNF/NF bed days, the bed days, for similar reasons, cannot be counted as an inpatient PPS hospital bed day. Just as the distinct part SNF/NF bed days are excluded, inter alia, because they are not inpatient hospital bed days, and, thus, are not subject to inpatient hospital PPS, similarly, the beds at issue here are not inpatient hospital bed days and are not subject to inpatient hospital PPS. Rather, Congress specifically allowed for the creation of swing bed hospitals in lieu of a distinct part SNF/NF unit. Therefore, the Administrator finds that the Board's literal reading of the language of 42 CFR 412.106(a)(1)(ii) to require the beds to be physically located in an "area" of the hospital excluded from PPS, i.e., a SNF distinct part unit, is incorrect and ignores the intent and purpose of the swing bed provisions. The DSH provision is meant to grant additional payment for the higher inpatient hospital costs incurred by hospitals because of services to a disproportionate number of low-income patients.

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[17] 53 Fed. Reg. 38476, 38480 (Sep. 30, 1988); see also 53 Fed. Reg. 9337 (Mar. 22, 1988).

Further, the parties and the Board discussed at length the statutory, regulatory and PRM provisions controlling the determination of a provider's *bed size* under the IME and DSH adjustments. The Administrator finds that those provisions are not controlling in relation to the instant issue. However, the Administrator notes that the agency has been consistent in the exclusion of the SNF/NF swing bed days in determining a provider's number of beds under both 42 CFR 412.105(b) and 42 CFR 412.106(a)(1)(ii).[18] Moreover, contrary to the Board's conclusion, courts have rejected earlier attempts by providers to argue that 42 CFR 412.105(b) is an "all-inclusive" list.[19] Thus, the Administrator disagrees with the Board's conclusion that, because swing beds are not specifically listed as beds to be excluded under this provision, these beds must be included in the bed day count for both provisions.

Thus, based upon the above review of the law and application to the facts of this case, as well as CMS' long-standing policy concerning the counting of bed days for the DSH patient percentage, the Administrator finds that the swing bed days are properly excluded from the DSH calculation. CMS has consistently excluded from the bed day count, those

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[18] The Administrator recognizes the Provider and Board's reliance on the criteria for determining bed size and especially their reliance on the example set forth in §2405.3.G.2 of the PRM. The Administrator finds that a review of that language, and the original source for that language at §2510.5.A of the PRM (now obsolete), suggests that the reference to long-term beds not otherwise certified is an anachronism of the routine cost limits (RCLs) reimbursement. Under the RCLs, a provider could have a long-term care certified unit with its own subprovider number and, similar to the swing-bed hospital SNF/NF beds here, was reimbursed under a separate cost report as part of a multiple-facility hospital. In that respect, the bed days at issue in this case are more like the certified long-term beds under RCL reimbursement. However, a "long-term care certified bed" is not a term used under PPS and, therefore, has an anomalous use here. Instead, PPS refers to SNF distinct-part unit beds and, as noted above, the swing-bed SNF is a proxy for the SNF distinct-part unit under PPS, whose beds are not counted under 42 CFR 412.105(b) and §2405.3.G. of the PRM.

[19] The Secretary was faced with similar arguments concerning neonatal intensive care beds and was successful in arguing that the regulation did not clearly exclude all beds assigned to newborns, but could reasonably be interpreted to apply only to newborns receiving routine care. Contrary to the Board's narrow reading of 42 CFR 412.105(b) as an "all-inclusive" list, courts have found that they are not confined to the literal terms of §412.105(b) in assessing its meaning. *See, e.g., AMISUB d/b/a St. Joseph's Hospital v. Shalala*, No. 94-1883 (D.D.C. 1995); *Grant Medical Center v. Shalala*, 905 F. Supp. 460 (S.D. Oh. 1995); *Sioux Valley Hospital v. Shalala*, 29 F.3d 628 (8th Cir. 1994).

bed days not paid as part of the inpatient operating cost of the hospital, i.e., not recognized under PPS as an inpatient operating cost.[20]

However, the Administrator recognizes that the Provider cites to *Clark Regional, supra*, for support that swing bed days should be included in the Provider's DSH adjustment. The Court of Appeals for the Sixth Circuit in *Clark Regional* ruled in favor of this Provider on the related issue of whether swing bed days may be included in the calculation of available bed days for purposes of the DSH adjustment.

This related-issue decision in *Clark Regional* is binding in the circuit in which the Provider is entitled to seek judicial review. The Administrator hereby affirms the Board's decision and reverses the Intermediary's adjustment with respect to swing bed days. The Board's decision is affirmed only on the limited grounds that there is related binding law in the Sixth Circuit that swing bed days should be included in the DSH available bed day calculation, when the hospital provides swing bed services in beds that are located within areas/units or wards that are generally used to provide inpatient acute care services. This Administrator's decision is limited to the facts, circumstances, and cost year presented in this specific case. The decision does not affect the Secretary's ability to continue to defend this issue in other circuits, or further clarify his definition of bed size and available beds consistent with his longstanding policy.

[20] The Provider has also frequently cited to the Ninth Circuit case of Alhambra and the U.S. District Court case of *District Memorial Hospital of Southwestern North Carolina*. However, the Administrator notes that the Provider is located outside of the Ninth Circuit and Fourth Circuit Moreover, the *District Memorial Hospital* case was reversed in favor of the Administrator by the Fourth Circuit.

DECISION

The Board's decision is affirmed, but only on the limited grounds that in the circuit in which the Provider may file suit, there is adverse case law relevant to the pertinent facts and law of this case. The decision is limited to the facts and circumstances of this case and to the cost year at issue.

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

Date: 10/27/04

/s/
Leslie V. Norwalk, Esq.
Deputy Administrator
Centers for Medicare & Medicaid Services