PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
00-D13

PROVIDER -
Hackensack Medical Center
Hackensack, New Jersey

Provider No. 31-0001

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of New Jersey

DATE OF HEARING-
October 5, 1999

Cost Reporting Period Ended -
December 31, 1991

CASE NO. 94-0718

INDEX

ISSUES:

1. Did the Intermediary err by including the Provider's fourteen neonatal intensive care unit ("NICU") beds when calculating the Medicare reimbursement for costs relating to indirect medical education ("IME")?

2. Did the Intermediary err by including NICU days when calculating the Provider's Medicare reimbursement for graduate medical education ("GME") costs?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY

Hackensack Medical Center ("Provider") is a not-for-profit, general acute care hospital located in Hackensack, New Jersey that also operates the Community Nursing Service ("CNS"), a hospital-based home health agency. The Provider submitted its FY 1991 cost report (which included costs related to CNS) on April 30, 1992.[1] Blue Cross and Blue Shield of New Jersey, the Provider's fiscal intermediary audited the cost report and issued Notices of Program Reimbursement ("NPRs") for the Medical Center[2] and CNS[3] on June 30, 1993, with the audited cost report.[4]

In a letter dated December 27, 1993, the Provider appealed the FY 1991 NPRs to the PRRB.[5] The Provider has met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841.

The List of Issues agreed upon by the Provider and the Intermediary included a total of eleven numbered issues, nine of which related to the Medical Center and two of which related to CNS.[6] In a letter to the Board dated December 1, 1998, the Provider added a challenge to the amount that the Intermediary paid the Medical Center for its outlier cases. However, that issue was subsequently transferred to a group appeal.

As a result of the process of exchanging position papers, several issues were either withdrawn by the Provider or resolved with the Intermediary. In addition, on February 24, 1999, the Intermediary and the Provider entered into a settlement agreement, which resolved administratively most of the remaining

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[1] Exhibit 1 of Provider's Final Position Paper.

[2] Exhibit 2 of Provider's Final Position Paper.

[3] Exhibit 3 of Provider's Final Position Paper.

[4] Exhibit 4 of Provider's Final Position Paper.

[5] Exhibit 5 of Provider's Final Position Paper.

[6] Exhibit 6 of Provider's Final Position Paper.

issues. Accordingly, as a result of the exchange of position papers and the administrative resolution, only the issues relating to the NICU beds and NICU days remain.

In accordance with the process approved by the Board, the two remaining issues in this appeal will be decided pursuant to an "on the record" hearing. Each party was afforded the opportunity to update its position paper and to respond to the opposing party's update. The Provider was represented by Robert L. Roth, Esquire, of Michaels, Wisher & Bonner, P.C. The Intermediary was represented by Eileen Bradley, Esquire, of the Blue Cross and Blue Shield Association.

Issue No. 1 - Inclusion of NICU Beds
Medicare Regulatory Background

On September 3, 1985, the Health Care Financing Administration ("HCFA") published a final rule specifying how the number of beds is to be determined for purposes of the IME adjustment. That regulation provided:

> [D]etermination of number of beds. 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.

42 C.F.R. § 412.118(b) (1985).

In adopting the regulation, HCFA stated that "available beds" are generally defined as adult or pediatric beds (exclusive of newborn bassinets, beds in excluded units, and custodial beds that are clearly identifiable) maintained for lodging inpatients. The language of the regulation remained in effect throughout the periods at issue, although it was reclassified to 42 C.F.R. § 412.105(b) in August of 1991.

Until 1988, there was nothing in the Provider Reimbursement Manual, (HCFA Pub. 15-1) which indicated that the term "newborn beds" in 42 C.F.R. § 412.118 (b) should be interpreted to exclude newborn intensive care beds in the IME calculation. In 1988, HCFA imposed a qualification on the regulation, by defining beds as follows:

> [A] bed is defined [for purposes of the IME calculation] 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.

HCFA Pub. 15-1 § 2405.3G. This manual provision was effective August 25, 1988. On September 1, 1994, HCFA amended the text of 42 C.F.R. § 412.105(b) to provide:

> [f]or 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 nursery beds assigned to newborns that are not in intensive care areas, custodial care beds, and beds in excluded distinct part hospital units, and dividing that number by the number of days in the cost reporting period.

Id.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's position lacks a legal basis in that the 1985 version of 42 C.F.R. §412.118(b) makes it clear that NICU beds must be excluded from the IME calculation and the Intermediary may not rely on regulations adopted in 1994 and 1995, or on a manual provision to alter the clear meaning of the 1985 regulation.

The 1985 regulation clearly states: beds "assigned to newborns" are excluded from the IME calculation. The regulation does not distinguish between beds located in the Provider's nursery or the NICU. Therefore, regardless of location, "beds assigned to newborns" are excluded. In addition, the preambles to the proposed and final rules promulgating this regulation did not limit the application of this term.

The Board has considered whether NICU beds must be excluded when calculating IME payments on several previous occasions. Before a number of recent decisions reaching a contrary holding, the Board had consistently held that these beds must be excluded."[7]

As the Board stated in Kern:

> this regulation clearly instructs the Intermediary to exclude all beds assigned to newborns whether the newborn beds are located in a routine or intensive care unit. Since the existing regulation contains specific instructions which relate directly to the computation of the IME

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[7] See Kern Medical Center v. Blue Cross & Blue Shield Assn./Blue Cross of California, PRRB Dec. No. 95-D42, June 13, 1995, Medicare and Medicaid Guide (CCH) ¶ 43,467, rev'd HCFA Administrator, July 30, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,682. See also the decisions in Presbyterian Intercommunity Hospital, and Humana Hospital.

> cost adjustment factor, the Board views the Intermediary's determination as an improper and arbitrary action which totally ignores the governing regulatory rule.

Kern at ¶43,467.

Where, as in the instant case, a regulation is clear, both HCFA and the Intermediary must follow it. In Kern, the Board addressed Sioux Valley Hospital v. Shalala 29 F. 3d 628 (8th Cir. 1994). In that case, the Court found that the IME regulation was ambiguous and upheld the Secretary's policy as a "plausible" interpretation of an ambiguous regulation. In Kern, the PRRB stated that it was cognizant of the Court's decision in Sioux Valley, but:

> contrary to the Eighth Circuit's finding that the language of the regulation is ambiguous, the Board finds the language of the regulation clear in the instruction and application. The Intermediary should not be permitted to substitute a different interpretation . . .

Id.

The Provider asserts that the Board correctly decided in Kern that the regulation at issue was clear and required the exclusion of NICU beds when determining a PPS hospital's IME adjustment.

The Provider also contends that the Secretary sought to avoid the effect of the 1985 regulation by substantively changing 42 C.F.R. §412.118(b) in 1994 and 1995, and then claiming that the changes were mere "clarifications' to the 1985 regulation. The 1994 change, which excluded from the IME calculation "nursery beds assigned to newborns that are not in intensive care areas," actually supports the Provider's position because the 1994 change recognized that "newborn beds in intensive care areas" are properly considered to be "nursery beds." Contending that the 1994 change had only added to the confusion, the Secretary revised the regulation again in 1995 to state that "beds or bassinets in the healthy newborn nursery" are excluded from the IME calculation.

The 1994 and 1995 regulations are both substantively different from the 1985 regulation in that they can be read to require that NICU beds be included when making the IME calculation. In that the United States Supreme Court has held that substantive changes to regulations, such as these, can only be applied prospectively, the Provider contends that the Intermediary cannot apply the 1994 and 1995 regulatory revisions retroactively to the Provider's FYE 1991 IME calculation.[8]

The Provider disagrees with the Intermediary's argument that the Secretary and Medicare's intermediaries have consistently interpreted the 1985 regulation to require inclusion of NICU beds when computing IME payments. In support of this argument, the Intermediary refers to (1) a manual

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[8] See Georgetown University Hospital v. Bowen, 488 U.S. 204 (1988).

provision published in 1988, and (2) statements published by the Secretary in the Federal Register on September 1, 1995.[9] Rather than support the Intermediary's assertion that there has been a consistent policy, the Secretary conceded in the Federal Register pages cited by the Intermediary that the IME regulation has been applied inconsistently, despite the manual provision.

In support of its assertion that the Secretary had a consistent policy to include NICU beds in the IME calculation, the Intermediary quotes the following statement that the Secretary published in the Federal Register on September 1, 1995:

> [O]ur policy is and has been that only beds in a healthy, or regular, baby nursery are excluded from the count. All other beds available for occupancy by a newborn are to be counted.

Id.

The Intermediary also argues that HCFA Pub. 15-1 § 2405.3G, published in 1988, makes it "quite clear" that NICU beds are included in the IME calculation:

> [A] bed is defined for {purposes of the IME adjustment} 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). . . .

Id.

While the Intermediary argues that these statements taken together allegedly show that HCFA had a consistent policy on paper, at least since 1988, the Secretary herself has conceded that her policy was anything but consistent. On the same Federal Register page cited by the Intermediary to support its assertion that the Secretary's NICU policy has been consistent the Secretary conceded:

> W]e recognize that there have been inconsistencies in the application of this policy.

Id.

From this concession, it is clear that there was no "longstanding" or "consistent" policy to include NICU beds when making the IME calculation. This policy was not made clear and "consistent" until the 1994 and 1995 regulatory change which, as argued above, cannot legally be applied retroactively to the Provider's 1991 IME payment.

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[9] See 60 Fed. Reg. 45777 (September 1, 1995) in Provider exhibit 12.

As shown above, the Secretary has conceded that her NICU policy has been applied inconsistently. Despite this concession, the Intermediary argues that it 'is quite clear" from HCFA Pub. 15-1 §2405.3G, that NICU beds must be included in the Medical Center's FY 1991 IME calculation. The Provider argues that the Intermediary cannot rely on this manual provision as authority for including the NICU because it conflicts with, and makes a substantive change to, the language of 42 C.F.R. §412.118(b), which was in place in FY 1991 and which required all "beds assigned to newborns" to be excluded when computing the IME payment.

The Provider contends it is a bedrock principle of administrative law that a manual provision, which is published without having gone through the rigors of notice and comment rulemaking, cannot overcome a regulation that was adopted through that process and cannot change the clear meaning of a regulation. See Shalala v.Guernsey Memorial Hospital, 115 S.Ct. 1232, 1239 (1995). Notice and comment rules, such as 42 C.F.R §412.118(b) have the force and effect of law. However, manual provisions do not. Where, as in the instant case, a manual provision conflicts with a clear regulation, the regulation must prevail.

The Provider further asserts that even if one were to assume that the IME regulation was ambiguous and could be read to allow the Intermediary to include the Provider's NICU beds, the Board must refuse to permit this action by the Intermediary because the Secretary has been arbitrary and capricious in the application of this regulation in violation of the Administrative Procedures Act ("APA"). Under the APA, a reviewing court must set aside agency action if it is found to be "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." See 5 U.S.C. §706(2)(A). Here, the Secretary has conceded that the application of the IME regulation relating to inclusion of NICU beds has been inconsistent. Thus, the Provider argues that the application of the policy should not be recognized by the Board.

Finally, the Provider contends that the Intermediary, in its supplemental/updated position paper, has raised a new argument which should not be accepted by the Board. Specifically, on page 5 of its supplemental position paper, the Intermediary argues that HCFA Pub. 15-1 § 2405.3G does not represent a change in policy because that provision merely "amplified" HCFA's longstanding policy to include NICU beds when calculating IME costs. The Provider contends that the Intermediary is now attempting to argue that the above cited manual provision is a valid interpretation of the applicable IME regulation.

The Provider acknowledges that recent Board decisions have held that NICU beds are properly included in IME purposes for fiscal years beginning after August 25, 1988, the date that HCFA Pub. 15-1 § 2405.3G was published. See, e.g., University of Chicago Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Illinois, PRRB Dec. No. 99-D-14, December 4, 1998, Medicare and Medicaid Guide (CCH) ¶80,149, dec'd. rev. HCFA Administrator, February 1, 1999. The Board's position was based on the conclusion that HCFA Pub. 15-1 § 2405.3G was consistent with the regulatory authority in place at the time the manual provision was published. The Provider contends that it has now demonstrated that HCFA Pub. 15-1 § 2405.3G is invalid due to its

inconsistency with the existing, governing regulation. As such, the Provider argues that the manual provision did not become valid until the IME regulation was revised in accordance with the notice and comment provisions of the APA in 1994 and 1995. According, the Provider requests that the Board reconsider its position in light of the arguments cited above.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that inclusion of the Provider's 14 NICU beds in its calculation of the IME payment was proper and consistent with 42 CFR § 412.118(b)[10] and HCFA Pub. 15-1 § 2405.3G. The threshold issue in this case centers on how to interpret and apply a particular phrase in the regulation on how to determine the number of beds for insertion in the equation. The regulation provides- (b) "[T]he number of beds in a hospital is determined by counting the number of available days during the cost reporting period, not including beds assigned to newborns...." 42 CFR § 412.118(b) (emphasis added.)

The Secretary had clarified the meaning of "beds assigned to newborns" in an August 1988 revision to HCFA Pub. 15-1 which stated:

> G. Bed size. -- A bed is defined for [the purpose of the IME calculation] as an adult or pediatric bed (exclusive of beds assigned to newborns which are not in intensive care areas...

HCFA Pub. 15-1 § 2405.3G (Aug. 1988) (Emphasis added). Thus, under 42 C.F.R. § 412-118(b), as amplified by this interpretive rule, a proper calculation of the IME payment requires the Intermediary to include NICU beds because they are the type of pediatric bed expressly denied exclusion from the payment determination.

The rule reflects the longstanding HCFA policy governing implementation of § 1886(d)(5)(B) of the Social Security Act, 42 U.S.C. §l395ww(d)(5)(B), which authorizes the Secretary to make an additional payment for the indirect costs of medical education to those hospitals subject to the prospective payment system. In the Preamble to the September 3, 1985 final rule that revised § 412.118 by adding a definition of available beds, the Secretary responded to a commenter seeking a more precise definition of the phrase "available bed days" as follows:

> For purposes of the prospective payment system, available beds' are generally defined as adult or pediatric beds (exclusive of newborn bassinets... maintained for lodging inpatients.

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[10] 42 C.F.R. § 412.118 was redesignated effective October 1, 1991 to 42 C.F.R. § 412.105 as per 56 Fed. Reg. 43241 (August 30, 1991).

50 Fed. Reg. 35646, 35683 (Sept. 3, 1985) (emphasis added.)

Following her May 24, 1994 proposed rule, the Secretary published a final rule on September 1, 1994, revising § 412.105(b), to expressly exclude only beds assigned to newborns in the nursery from the determination of beds for IME payment purposes. See 56 Fed. Reg. 27708 (May 27, 1994),[11] and 56 Fed. Reg. 45330, (Sept. 1, 1994).[12] The Secretary made clear that this change was a clarification, not a change in policy, and recounted the long history associated with her policy of including NICU beds in the number of beds to determine the IME payment adjustment. The Secretary also made clear that the September 3, 1985 revisions to § 412.118 effected no change to the longstanding definition of available beds or the policy of including NICU beds in the bed count for the IME payment adjustment calculation. As the Preamble notes, the definition hails from as far back as 1975, and the policy on treatment NICU beds, from at least as early as the inception of the cost limits. Id.

In further support of these observations, the Preamble to the September 1, 1994 rule, traces the relevant PRM transmittals issued over the years preceding adoption of § 412.118, whose terms were consistent with requiring the exclusion of newborn beds. It notes further that the term newborn has historically been used synonymously with nursery. Finally, as pointed out above, the Manual was modified in August 1998 to expressly exclude beds assigned to newborns that are not in intensive care areas.

The Intermediary does not agree with the Provider's position that the HCFA manual provision, which emerged after the September 1983 revisions to § 413.118, conflicted with the regulations and constituted a substantive modification to the regulation, without benefit of the rulemaking process required by the APA. Another parallel argument has been made that the regulation is ambiguous and that a better reading of the rule's language would be to embrace any bed occupied by any newborn inpatient. The Intermediary asserts that the Provider is now trying to advance precisely these types of claims in this case. The Intermediary contends that the Secretary has consistently maintained that the September 3, 1985 revisions to § 412.118 did not change prior, longstanding policy. If it had been her intent to do so, she would have announced it. Therefore, "newborn beds" mean what they always have meant; that is, they do not include NICU beds. In addition, the HCFA Pub. 15-1 clarification was a legitimate exercise of the Secretary's authority to issue interpretative clarifications of her regulations. See 56 Fed. Reg. 45330, 45, 37-74 (Sept. 1, 1994).

Moreover, two United States Courts of Appeal that have visited the questions found no APA violation, and deferred to the Secretary's interpretation of her regulation contained in the Manual. See Sioux Valley v. Shalala, 29 F. 3d 628, (8th Cir., July 20, 1994); and Hahnemann University Hospital v. Shalala, C.A. No. 94-2457 (JHG) (D.D.C 1996) aff'd. per. curiam. No. 96-5191 (D.C. Cir. 1997).

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[11] Intermediary Exhibit 36.

[12] Intermediary Exhibit 37.

The Intermediary also points out that for cost reports filed after 1988, the Board no longer follows the rule of Kern Medical Center, cited by the Provider to support its opposition to the Intermediary's audit adjustment. Beginning with its decision in Riverside Methodist Hospital v. Blue Cross and Blue Shield Association/Community Mutual Blue Cross and Blue Shield, PRRB Dec. No. 97-D31, February 12, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,081, decl'd. rev. HCFA Admin. March 17, 1997,[13] the Board has found that HCFA Pub. 15-1 § 2405.3G is not an impermissible clarification of 42 CFR § 412.118. Citing the Supreme Court's decision in Shalala v. Guernsey, the Board concluded that the interpretive rule is valid and should be applied because it did not establish a new policy inconsistent with any of the Secretary's regulations, and therefore, did not need to be issued under the notice and comment rulemaking procedures. Because the Manual revision was issued in August 1988, the Board held in Riverside that it should apply to cost reporting years after 1988.

The Board followed Riverside with a similar decision on the same issue in Grant Medical Center v. Blue Cross & Blue Shield Association/Community Mutual Insurance Company, PRRB Dec. No. 98-D67, June 18, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,453, decl'd. rev. HCFA Admin. July 30, 1997.[14] There the Board again held that NICU beds must be included in the IME payment adjustment calculation following the reasoning it had enunciated in Riverside.

The Intermediary also points to the decision in the Sacred Heart Medical Center v. Blue Cross and Blue Shield Association/Blue Cross of Washington and Alaska, PRRB Dec. No. 99-D2, October 16, 1998, Medicare and Medicaid Guide (CCH) ¶ 80,085, aff'd. HCFA Admin. December 21, 1998, Medicare and Medicaid Guide (CCH), ¶ 80,154, wherein the Board took judicial notice of the two U.S. Circuit Court decisions cited above, and deferred to their decisions in upholding the Secretary's interpretation of her regulation requiring inclusion of NICU beds in the IME payment adjustment calculation.

The Intermediary also notes that the Board expressly abandoned its original position in Kern, opposing inclusion of NICU beds in the IME adjustment calculation as having been based on a literal interpretation of § 412.118. See Sacred Heart Medical Center v. Blue Cross and Blue Shield Associated Blue Cross of Washington and California, PRRb Dec. No. 99-D2, October 16, 1998, Medicare and Meidcaid Guide (CCH) ¶80,085, aff'd HCFA Admin. December 21, 1998, Medicare and Medicaid Guide (CCH) ¶80,154. See also University of Chicago Hospital v. Blue Cross and Blue Shield Association/ Blue Cross and Blue Shield of Ilinois, PRRB Dec. No. 99-D14, December 4, 1998, Medicare and Medicaid Guide (CCH) ¶ 80,149, decl'd. rev. HCFA Admin. February 1, 1999.[15] The Intermediary contends it is clear that the Board, the HCFA Administrator/Secretary, and several U.S. circuit and district courts have uniformly concluded that under 42 CFR § 412.118 and the

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[13] Intermediary Exhibit 38.

[14] Intermediary Exhibit 41.

[15] Intermediary Exhibit 40.

accompanying interpretive rule at HCFA Pub. 15-1 § 2405.3G, NICU beds must be included in the calculation of the IME payment adjustment.

Issue 2 - Inclusion of NICU Bed Days
Facts:

The Graduate Medical Education ("GME") payment is apportioned to Medicare utilizing a patient load based upon a ratio of Medicare days to total days. Consequently, the lower the total patient days, the greater the Medicare reimbursement. When computing the Provider's FY 1991 GME payment, the Intermediary used 182,581 total inpatient days, which included 4,777 NICU days.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary erred by refusing to exclude NICU bed days when computing the Provider's FY 1991 GME payment. Under 42 C.F.R. § 413.86(b),[16] the Intermediary is explicitly required to exclude "nursery days" from the GME computation. Under this regulation, NICU bed days must be excluded because they come within the ambit of "nursery days." This language inherently recognizes that beds assigned to newbornes in intensive care areas are properly considered to be "nursery beds." Unlike the 1994 IME regulation, the GME regulation does not limit the exclusion of "nursery days." The Provider asserts that by failing to limit the reference to "nursery days" in the GME regulation only to "healthy newborns," it is clear that the regulation is intended to encompass, and thereby exclude, all nursery days and, therefore, all NICU days.

The Provider also contends that the two documents cited by the Intermediary to buttress its position were not presented by the Intermediary in its original position paper. Accordingly, the Provider argues that the Board should not recognize these documents, since the process allows only for an "update" to the previous position paper. However, should the Board consider these documents the Provider contends they do not refute the Provider's position.

The first document is an excerpt from a Final Rule that was published by HCFA on September 29, 1989, which generally addresses GME payments. See 54 Fed.Reg. 40286 (September 29, 1989)[17]. However, the language from this Final Rule quoted by the Intermediary on page 10 of its Supplement is inapplicable to this appeal because it addresses "nursery room days" without mentioning NICU days. The issue in this appeal is not "nursery room days," which even the Intermediary concedes must be excluded, but whether NICU bed days must be included because they are encompassed within "nursery bed days." By not addressing NICU days, the Final Rule cited by the Intermediary does not refute the Provider's position.

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[16] Intermediary Exhibit 13.

[17] Intermediary Exhibit 45.

The Intermediary also cited a letter dated November 8, 1990 from the Chief of the Financial Management Branch of HCFA's Region III Medicare Division to Independence Blue Cross (IBC), a fiscal intermediary.[18] Accompanying this letter apparently was a series of questions and answers to GME payments.

The Provider challenges this document and the excerpt quoted by the Intermediary on three grounds. First, the Provider objects to the Board's consideration of this document because only part of the attachment to the letter was included in the record. The Intermediary has included only two of at least twenty-four questions and answers that were attached to it even though it is possible that the rest of the letter could contain other relevant or clarifying information.[19]
The Provider also objects to the Board's consideration of this letter on the basis of relevance. This letter was issued from HCFA's Region III office. However, the Provider is located in HCFA Region II. and IBC is not the Provider's intermediary.

Finally, the Provider points out that the mere existence of this letter contradicts the Intermediary's assertion that the GME regulation is "quite clear" in its alleged requirement that NICU days are included in the GME calculation. The Provider contends that if the regulation were so "clear," the letter from the HCFA regional office would never have been sent.
The Provider also contends that the GME regulation is properly interpreted to exclude NICU days when its language is compared to the text of the IME regulation. Had HCFA intended to exclude NICU days for GME purposes, it could have adopted language to do so. Its failure to do so before FY 1991, and its failure to do so afterwards when changing the IME regulation, supports the Provider's position that NICU days are excluded from the GME calculation.

INTERMEDIARY'S CONTENTIONS:

The Intermediary states that the regulation at 42 C.F.R. § 413.86 defines inpatient days to be used in the Medicare patient load ratio as:

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[18] Intermediary Exhibit 46.

[19] See Weinstein's Evidence, (1993), § 1003 at 1003-13.. "Exclusion under Federal Rules of Evidence is authorized where only a part of the original writing may have been reproduced and the remainder could either qualify the duplicated portion or disclose relevant information". Even if the Board were to consider the letter, Fed. R. Evid. 106 would require the introduction of the complete letter. "When writing or recorded statement or any other part thereof is introduced. . . An adverse party may require the introduction at that time of any other part or any other writing or recorded statement which ought in fairness . . . be considered contemporaneously with it."

> [i]npatient days in any distinct part of the hospital furnishing a hospital level of care are included and nursery days are excluded.

The Intermediary contends that the neonatal intensive care unit is not part of the routine nursing unit. Therefore, the days associated with the unit should not be excluded from the patient load ratio.

In the supplement to its original position paper, the Intermediary offered two additional source documents to show that "nursery days" do not include NICU bed days. First, on September 29, 1989 , the Secretary published final rule making changes in Medicare policy relative to GME costs.[20]

The Preamble to that rule noted that several commenters sought clarification about whether nursery room days are counted in the formula for determining Medicare patient load. HCFA's response indicated:

> [I]t has been the standard practice to exclude nursery room days in all Medicare computations that involve inpatient days since the Medicare program does not incur any liabilities for nursery room costs. . . [C]onsistent with this treatment of nursery room days, no GME costs that are allocated to the nursery room cost center in the GME base period will be included in the GME base-period per resident amount.[21]

Secondly, the Intermediary points to a series of questions and answers to the fiscal intermediaries to guide their application of the new regulations. One question inquired as to how intermediaries were to treat boarder babies in determining the percentage of Medicare Part A days. The response was as follows:

> [N]ursery days are explicitly excluded from the determination of the "Medicare Patient load " under 42 C.F.R. § 413.86(b). Thus, an infant born in and remaining in the hospital, and occupying a newborn bed in the nursery after the mother is discharged, is counted as a nursery day and excluded from the "Medicare Patient load" determination. However, an infant occupying a bed in other than the newborn nursery, is included in inpatient days used in the "Medicare Patient load" determination.[22]

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[20] 54 Fed. Reg. 40286 (September 29, 1989)

[21] Intermediary Exhibit 45

[22] Intermediary Exhibit 46.

The Board has also held that under 42 C.F.R. §412.86(b), NICU days are not the "nursery days" that must be excluded from the Medicare patient load for purposes of calculating the GME payment. See Riverside Methodist Hospital v. Blue Cross and Blue Shield Association/Community Mutual Blue Cross and Blue Shield, PRRB Dec. No. 97-D31, February 12, 1997, Medicare & Medicaid Guide (CCH) ¶45,081, decl'd. Rev. HCFA Admin. March 17, 1997, and Grant Medical Center v. Community Mutual Blue Cross and Blue Shield, PRRB Dec. No. 98-D67, June 18, 1997, Medicare & Medicaid Guide (CCH) ¶45,453. decl'd. rev. HCFA Admin. July 30, 1997. The Intermediary contends that the Board should uphold its adjustment in that it was consistent with the applicable regulation, and the Secretary's interpretation of that regulation.

CITATION OF LAW REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - Title XVIII of the Social Security Act:

§ 1886(d)(5)(B)	-	PPS transition period; DRG classification system; exceptions and adjustments to PPS

2. Law - 5 U.S.C.:

§ 706(2)(A)	-	Administrative Procedures Act

3. Law - 42 U.S.C.:

§ 1395ww(d)(5)(B)	-	PPS transition period; DRG classification system; exceptions and adjustments to PPS

4. Regulations - 42 C.F.R.:

§§ 405.1835-1841	-	Board Jurisdiction
§ 412.105(b)	-	Determination of number of beds
§ 412.118(b) (Redesignated 412.105(b) et seq	-	Determination of Indirect Medical Education Costs
§ 413.86 et. seq.	-	Direct graduate medical education payments.

5. Program Instructions- Provider Reimbursement Manual (HCFA Pub. 15-1):

§ 2405.3G - Bed Size

6. Case Law:

Kern Medical Center v. Blue Cross and Blue Shield Assoc./Blue Cross of California, PRRB Dec. No. 95-D42, June 13,1995, Medicare & Medicaid Guide (CCH) ¶ 43,467, rev'd HCFA Administrator, July 30, 1995, Medicare & Medicaid Guide (CHH) ¶ 43,682.

Sioux Valley Hospital v. Shalala, 29 F. 3d 628 (8th Cir. July 20, 1994)

Presbyterian Intercommunity Hospital v. Aetna Life Insurance Company, PRRB Dec. No. 95-D40, May 31, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,481, rev'd. HCFA Administrator July 18, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,530.

Humana Hospital University v. Blue Cross and Blue Shield Association/Blue Cross of Kentucky, PRRB Dec. No. 95-D15, January 4, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,021, rev'd. HCFA Administrator, February 21, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,140.

Georgetown University Hospital v. Bowen, 488 U.S. 204 (1988).

Shalala v. Guernsey Memorial Hospital, 115 S Ct. 1232 (1995).

University of Chicago v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Illinois, PRRB Dec. No. 99-D14, December 4, 1998, Medicare & Medicaid Guide (CCH) ¶ 80,149, dec'd. rev. HCFA Administrator, February 1, 1999.

Hahnemann University Hospital v. Shalala, C.A. No. 94-2457 (JHG) (D.D.C. 1996) aff'd. per. curiam, No. 96-5191 (D.C. Cir. 1997).

Riverside Methodist Hospital v. Blue Cross and Blue Shield Association/Community Mutual Blue Cross and Blue Shield, PRRB Dec. No. 97-D31, February 12, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,081, decl'd. rev. HCFA Administrator March 17, 1997.

Grant Medical Center v. Community Mutual Blue Cross and Blue Shield, PRRB Dec. No. 98-D67, June 18, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,453, decl'd. rev. HCFA Admin. July 30, 1997.

Sacred Heart Medical Center v. Blue Cross and Blue Shield Association/Blue Cross of Washington and California, PRRB Dec. No. 99-D2, October 16, 1998, Medicare & Medicaid

Guide (CCH) ¶ 80,085, aff'd. HCFA Admin. December 21, 1998, Medicare & Medicaid Guide (CCH) ¶ 80,154.

Little Company of Mary Hospital and Health Care Centers v. Blue Cross and Blue Shield of Illinois, PRRB Dec. No. 98-D1, (October 21, 1997). Medicare & Medicaid Guide (CCH) ¶ 45,739, rev'd in part, HCFA Admin. Dec. (December 22, 1997), Medicare & Medicaid Guide (CCH) ¶ 46,053.

Little Company of Mary Hospital and Health Care Centers v. Shalala, No. 97-C-4107 (DND.IL. 1998).

7. Other:

50 Fed. Reg. 35646 & 35683 (September 3, 1985)
54 Fed. Reg. 40286 (September 29, 1989)
56 Fed. Reg. 27708 (May 27, 1994)
56 Fed. Reg. 43241 (August 30, 1991)
56 Fed. Reg. 45330 (September 1, 1994)
60 Fed. Reg. 45777 (September 1, 1995)
Weinstein's Evidence, (1993)

Letter dated November 8, 1990 from Chief of the Financial Management Branch, HCFA Region III to Independence Blue Cross.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, and evidence presented, finds and concludes as follows:

Issue 1 - Inclusion of NICU Beds:

The Board notes that this issue has been brought before it many times in the past. The Board finds that its original position opposing the inclusion of NICU beds in the IME calculation was predicated on the Board's liberal interpretation of 42 C.F.R. § 412.118(b). This subsection states in part:

> [d]etermination of number of beds. 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.

42 C.F.R. § 412.118(b). (emphasis added).

The Board further notes that the Board majority modified the above position for cases with fiscal years beginning after the manual revision to HCFA Pub. 15-1 § 2405.3G on August 25, 1988. See Grant Medical Center v. Community Mutual Insurance Company/BCBSA. HCFA Pub. 15-1 § 2405.3G defines beds as follows:

> [a] bed is defined [for purposes of the IME calculation] 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.

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

Most recently, the Board reaffirmed its position on the inclusion of NICU beds in the IME calculation. See University of Chicago v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Illinois. The Board also recognizes the HCFA Administrator's position requiring inclusion of the NICU beds. See Little Company of Mary Hospital and Health Care Centers v Blue Cross and Blue Shield of Illinois, PRRB Dec. No. 98-D1, (October 21, 1997), Medicare & Medicaid Guide (CCH) ¶ 45,739 rev'd in part, HCFA Admin. Dec. (December 22, 1997), Medicare & Medicaid Guide (CCH) ¶ 46,053.

The Board was not persuaded by the Provider's argument that HCFA Pub. 15-1 § 2405.3G was invalid in that it was inconsistent with the governing regulation at 42 C.F.R. § 412.118(b). The Board finds that HCFA Pub 15-1 § 2405.3G is interpretative of the above cited regulation. As such, the Board notes that the Supreme Court found that interpretive rules do not require notice and comment, as long as they were not a new position inconsistent with any of the Secretary's existing regulations. See Shalala v. Guernsey Memorial Hospital, 115 S Ct. 1232, 1239 (1995).

The Board also finds that the Provider's argument with respect to a violation of the Administrative Procedures Act (APA) is without merit. The Board takes judicial notice of two United States Court of Appeals decisions on the same issue as presented in the instant case. The Court found no APA violation, and deferred to the Secretary's interpretation of her regulation.
See Sioux Valley Hospital v. Shalala, 29 F. 3d 628 (8th Cir. July 20, 1994), and Hahnemann University Hospital v Shalala, No. 94-2457, (D.D.C. 1996), aff'd. per curiam, No. 96-5191 (D.C. Cir.1997).

Issue 2 - Inclusion of NICU Bed Days:

The Board notes that the language in the Graduate Medical Education (GME) regulation provides that "inpatient days in any distinct part of the hospital furnishing a hospital level of care are included and nursery days are excluded". See 42 C.F.R. 413.86(b). The Board has consistently interpreted nursery days as to not include NICU days.

The Board finds that its prior decisions in Riverside Methodist Hospital and Grant Medical Center are relevant to, and consistent with the facts applicable to the case at hand. Specifically, the same level of care is not provided in the general nursery setting as is provided for infants in the NICU. Thus, only care for infants in the general nursery should be excluded from the Medicare patient load determination used to calculate the Provider's allowable GME costs.

The Board also notes the Secretary's consistency in the handling of NICU beds and NICU bed days. The applicable rules surrounding each result in the inclusion of NICU beds in the IME calculation, and the inclusion of NICU bed days in the GME calculation. This was reaffirmed in Little Company of Mary Hospital and Health Care Centers v. Shalala wherein the court stated: "As stated earlier in this opinion, long before hospital submitted its 1988 cost report Secretary had adopted and adhered to the view that a reference to "nursery beds" in the IME regulation meant beds assigned to infants in a healthy newborn nursery, not to those in a neonatal intensive care unit. And it is surely reasonable for Secretary to give the comparable words the same meaning for GME purposes that has been ascribed to them in the IME adjustment context." Id.

DECISION AND ORDER:

Issue 1 - Inclusion of NICU Beds:

The inclusion of the NICU beds in the IME calculation is proper. No additional Intermediary action is required.

Issue 2 - Inclusion of NICU Bed Days:

The inclusion of the NICU bed days in the GME calculation is proper. No additional Intermediary action is required.

BOARD MEMBERS PARTICIPATING

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire
Martin W. Hoover, Jr., Esquire
Charles R. Barker

Date of Decision: December 16, 1999

For The Board

Irvin W. Kues
Chairman