PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2002-D2

PROVIDER –
Central Texas Medical Center
San Marcos, Texas

Provider No. 45-0272

vs.

INTERMEDIARY – Blue Cross and Blue Shield Association/Trailblazer Health Enterprises, LLC

DATE OF HEARING -
November 28, 2001

Cost Reporting Period Ended
December 31, 1991

CASE NO. 99-3300

INDEX

ISSUE:

Whether the Intermediary's disallowance of disproportionate share (DSH) payments to the Provider on the grounds that it did not have 100 or more available beds was proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

In 1983, the Congress of the United States created the Prospective Payment System (PPS) to pay hospitals for services to Medicare patients. Under PPS, inpatient-operating costs are reimbursed based on a prospectively determined formula taking into account national and regional operating costs. Congress also provided for adjustments to the PPS rates for certain hospitals that meet specific criteria with respect to their inpatient population. Pursuant to 42 U.S.C. § 1395ww(a)(2)(B), the Secretary was directed to provide for appropriate adjustments to the limitation on payments that may be made under PPS to take into account:

> (B) the special needs of psychiatric hospitals and of public or other hospitals that serve a significantly disproportionate share of patients who have low income or are entitled to benefits under Part A of this title.

42 U.S.C. § 1395ww(a)(2)(B).

The statutory provision at 42 U.S.C. § 1395ww(d)(5)(F)(i) further directs the Secretary to provide "for an additional payment amount for each subsection (d) hospital" serving "a significant disproportionate number of low-income patients." To be eligible for the additional payment, a hospital must meet certain criteria concerning its disproportionate patient percentage. Under the exception relevant to this case, 42 U.S.C. § 1395ww(d)(5)(F)(v), a hospital that is located in an urban area and has 100 or more beds is eligible for the additional DSH payment if its disproportionate patient percentage is 15 percent. This case involves the method by which the number of beds is determined.

Adventist Health Systems/Sunbelt, Inc. d/b/a Central Texas Medical Center (Provider) is an acute care hospital located in San Marcos, Texas. It was opened in 1983 as a newly constructed hospital which replaced Hays County Memorial Hospital. It was designed with a bed capacity of 109 beds because there had been considerable overcrowding at the Hays County facility, and rapid growth was expected in the Provider's service area. On May 15, 1991, the Provider responded to a community need by converting nine beds to skilled nursing facility beds and formed a distinct part skilled nursing unit. That left the Provider with exactly 100 licensed beds used for acute care hospital patients.

Although the Provider was originally licensed for 109 beds,[1] in actuality it had 119 places for

1 See Provider Exhibit 15.

beds that met licensure requirements.[2] The facility had 119 places where there is a headwall for the bed to go, where there is oxygen, suction, nurse call system, ceiling rails for privacy curtains, bathroom facilities and adequate square footage. All of these spaces comply with the Texas law on licensure for a bed. Under Texas licensure, a provider's beds are not licensed by room or by individual, actual beds. Rather, a facility's overall bed capacity is licensed by the State. As long as a provider operates within its licensed bed capacity, the provider could move licensed beds from one room to another if the room had adequate square footage, contained a window, had medical gas hookups and was served by a nursing station.[3] This does not mean that the Provider could have legally operated 119 beds during 1991. What it does mean is that the Provider could have as many as ten beds out of service and still have operated at its full licensed capacity.

The Provider had qualified for DHS payments for several years, including 1991-1997, based on having 100 licensed and available beds. All filed and audited cost reports have reported on Worksheet S-3 these licensed beds as available.[4] Trailblazer Health Enterprises, LLC (Intermediary), which acts as CMS'[5] contractor, audited the Provider's cost reports and accepted that the Provider had 100 beds. Accordingly, the Provider claimed and has received DSH payments from the Intermediary. Prior to the audit of the Provider's 1994 cost report, the Intermediary had never made an adjustment to the Provider's count of available bed days.

The Provider has a DSH percentage in excess of 15 percent but less than 40 percent, and is located in an urban area. Upon auditing the December 31, 1994 cost report, the Intermediary determined that the Provider had only 97 beds available and disallowed all DSH payments. In addition, the Intermediary issued Notices of Reopening for all prior years starting with December 31, 1991 to December 31, 1993, believing that the Provider had less than 100 available beds in all years.

The Notice of Program Reimbursement (NPR)[6] issued in conjunction with the reopening for December 31, 1991 indicates a decrease in reimbursement of $667,151, which corresponds to the Intermediary's decreased bed count of 89.98 beds.[7] The Intermediary's audit adjustments for 1991 excluded maternity beds (8 beds), observation beds (1.95 beds), swing beds (1.25 beds), and beds in rooms used for alternative purposes (39 beds).

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2 See Provider Exhibit 38

3 See Provider Exhibit 17.

4 See Provider Exhibit 12.

5 The Health Care Financing Administration (HCFA) has been renamed Centers for Medicare and Medicaid Services (CMS).

6 See Provider Exhibit 1.

7 See Intermediary Exhibit 3.

Upon receipt of the NPR, the Provider filed a timely hearing request with the Provider Reimbursement Review Board (Board). The Provider's filing meets the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841. The Provider is represented by Dennis M. Barry, Esquire, of Vinson and Elkins, LLP. The Intermediary is represented by James R. Grimes, Esquire, of Blue Cross and Blue Shield Association (BCBSA).

PROVIDER'S CONTENTIONS:

The Provider contends that the central issue to be determined in the instant case is the number of available beds in the facility for purposes of 42 U.S.C. § 1395ww(d)(F)(5)(v). As the Administrator of CMS has held in several cases, actual use of the available beds is not the determinative factor.[8] In 1991, the Provider's facility existed as a four-floor hospital with 109 licensed beds (100 acute care beds and 9 skilled nursing facility beds). From January 1, 1991, through May 14, 1991, the Provider had 109 licensed acute care beds. On May 15, 1991, for purposes of Medicare certification, nine beds were converted to skilled nursing facility beds. While the Provider was licensed for 109 beds, it had 119 available bed spaces, distributed among the hospital's floors as follows:

First Floor	10 Intensive Care Unit Beds
Second Floor	27 Available Medical/Surgical Beds
Third Floor	43 Available Medical/Surgical Beds
Fourth Floor	39 Available Medical/Surgical Beds
Total All Floors:	119 Beds

The Provider acknowledges that it did not actually use all of its 100 licensed acute care beds for inpatient care. Although some patient rooms were used for other purposes, the Provider contends that the rooms were capable of being used and staffed within twelve hours to accommodate acute care beds up to the full complement of 100 licensed beds.[9]

The Provider notes that according to the Intermediary's audit adjustments, the controversy in this appeal revolves around four categories of beds: maternity beds, observation beds, swing beds and beds in rooms used for alternative purposes as explained below.

Maternity Beds

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[8] Transcript (Tr) at 22.

[9] Tr at 93.

The Provider had maternity beds in rooms on the second floor, which are licensed inpatient beds according to the State of Texas.[10] In its audit adjustments, the Intermediary characterized these eight beds as "labor room" beds that should be excluded from the bed count. The Provider counters that they are maintained for inpatient lodging of patients. These rooms, used for maternity patients, are equipped the same as other routine inpatient rooms.[11] The services furnished in the maternity rooms were routine services as defined in 42 C.F.R. § 413.53.[12] The maternity beds are not located in a designated labor area but are in the general inpatient area. The Intermediary conceded at the hearing that these eight[13] maternity beds should not be excluded as labor room beds but should be included in the bed count.[14]

Observation Beds

The Provider comments that if a patient of the Provider requires observation services, that patient may be placed in any of the Provider's acute care beds to receive observation services. The Provider has no beds dedicated exclusively to observation.[15] Rather, beds used for observation services are permanently maintained inpatient beds which may, on occasion, be used for observation patients.[16] The reason the Provider does not have an area dedicated to furnishing observation services is that the varying demand and insufficient volume do not justify creating a distinct observation unit. Instead, the Provider assigns observation patients to open inpatient routine beds. Thus, the Provider does not dedicate any resources to observation services which are not equally available to admitted inpatients. Nurses and other personnel who furnish services to observation patients are the same staff who serve routine patients, and the services furnished to observation patients are indistinguishable from the services furnished to inpatients.[17] Indeed, when a decision is made to admit an observation patient, most patients remain in the same bed. Similarly, a bed used one day for an observation patient may very well be used the next day for an admitted inpatient. The Provider's practice of using "scattered" observation beds is very common, perhaps even more common than the use of a distinct observation area. The Provider has used inpatient beds for observation services since at least 1991. During that entire period, it

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10 Tr at 61.

11 Tr at 62.

12 Tr at 63.

13 See Intermediary Exhibit 3.

14 Tr at 34 and 144.

15 Tr at 58.

16 Tr at 59.

17 Id.

has accounted for the costs of those "scattered" observation bed days by using the cost reporting methodology of adding the observation hours billed as outpatient services and dividing by 24. The Provider understood CMS's policy to be that its available bed day count was not affected by the intermittent use of scattered routine beds for observation services. The Provider had clearly reported the existence of observation services on its cost report in accordance with HCFA instructions in 1991.

With respect to the reduction for observation bed days, the Provider observes that the Intermediary retroactively applied a 1997 HCFA policy to the 1991 time period. On February 27, 1997, HCFA issued a Memorandum, the subject of which was "Counting Beds and Days for Purposes of the Medicare Hospital Inpatient Disproportionate Share and Indirect Medical Education Adjustments" (HCFA Memorandum).[18] The HCFA Memorandum included the following instructions:

> [i]f a hospital provides observation services in beds that are generally used to provide hospital inpatient services, the equivalent days that those beds are used for observation services should be excluded from the count of available bed days for purposes of the IME [Indirect Medical Education] and DSH adjustments. If a patient in an observation bed is later admitted, then the equivalent days before the admission are also excluded. Thus, all observation bed days are excluded from the available bed day count.

Although the Provider did not have a dedicated observation area during the cost reporting periods at issue, the Intermediary used "scattered observation bed days" to calculate 1.95 "observation beds," which it deducted from the 100 available beds initially determined to arrive at its final total of 89.98 available beds.[19] The Provider testified that all of the "observation bed days" used by the Intermediary involved the intermittent use of licensed inpatient beds scattered throughout the facility that were only capable of immediate use as inpatient beds.[20]

The Provider contends that this proposed HCFA policy should not be applied because it substantively changes the regulations regarding DSH and IME bed counting. While the proposed policy may provide a basis for the Intermediary's exclusion of observation beds, it does not serve as a basis for excluding any of the other beds at issue. The Provider insists that the proposed policy is clearly inconsistent with HCFA's prior policies,[21] and effectively attempts

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[18] See Intermediary Exhibit 5.

[19] Tr at 58-59.

[20] Tr at 163-169.

[21] See Intermediary Exhibit 3.

to substantially modify the DSH and IME bed counting regulations. Accordingly, if the proposed HCFA policy is implemented, it would clearly violate the rule making requirements of the Administrative Procedures Act, 5 U.S.C. § 553 et seq. and violate the Provider's right to due process.

The Provider contends that observation days are not in any of the areas excluded by the terms set forth in 42 C.F.R. § 412.105(b) i.e., healthy newborn nursery, custodial care beds, or beds in excluded hospital units. Thus, beds used for observation services must be counted if they fit within the definition of an "available bed day." The scattered observation beds used by the Intermediary to determine the reduction in the Provider's DSH bed count are those routine beds which are universally interpreted as being within a hospital's bed count; i.e., the beds are licensed and certified. Pursuant to 42 C.F.R. § 413.20, the Medicare program has adopted standardized definitions commonly used by hospitals. A hospital's temporary use of a licensed and certified inpatient routine bed to furnish observation services does not reduce a hospital's bed size under standard and accepted definitions of bed size.

The Provider argues that, when HCFA Pub. 15-1 § 2405.3.G is read in conjunction with the regulation at 42 C.F.R. § 412.105(b), it is clear that the manual's reference to beds in "outpatient" departments is limited to unlicensed beds. The excluded beds listed in the regulation do not include ancillary or outpatient beds because such beds are not within accepted industry definitions and would not be counted in the first instance. Accordingly, the manual's exclusion of unlicensed beds is consistent with the regulation. Since the manual cannot contradict or go beyond an acceptable interpretation of a regulation, the reference to ancillary or outpatient beds in HCFA Pub. 15-1 § 2405.3.G must be read as a reference to unlicensed beds.

The Provider also refers to the available bed calculation example cited in HCFA Pub. 15-1 § 2405.3.G(2), which included the following notation: "[a]lthough 35 beds are used for long-term care, they are considered to be acute care beds unless otherwise certified." The Provider argues that the use of licensed and certified inpatient beds for observation services does not make the beds any less available for inpatient routine services than beds used for long-term care. Moreover, the case of scattered observation beds that are only intermittently used for furnishing services to persons other than admitted acute care hospital patients is stronger than the use of beds that are dedicated to long-term care.

The Provider further argues that the proposed HCFA policy is unsupported on logical grounds. The proposed HCFA policy set forth in the HCFA Memorandum not only requires the exclusion of observation days billed as outpatient services, but also requires the exclusion of observation days billed as inpatient days. The Provider contends that the "DRG payment window" set forth in 42 U.S.C. § 1395ww(a)(4) clearly requires that all outpatient services furnished within three days of the date of admission must be billed as inpatient services. Since observation services for a Medicare patient who is admitted must be billed as inpatient services, there is no conceivable basis for excluding the bed day from the count of bed days used to calculate a hospital's bed count. The Provider points out that a patient in a "scattered" observation bed is in an inpatient bed, receives the same services as inpatients, and is billed as an inpatient. However, HCFA's

new policy states that the bed is not an available inpatient bed.

The Provider argues that the exclusion of observation bed days in scattered beds which are billed as inpatient services is impractical as well as unsupportable on logical grounds. The cost report calculation of observation days for admitted inpatients and the revenue codes on claims forms do not identify those services. Accordingly, the Provider concludes that the lack of a mechanism for identifying such days is evidence, by itself, that it was never HCFA's policy to exclude such days from the count of available bed days.

Swing Beds

The Provider observes that, in addition to providing an inpatient hospital level of care, it also provides a skilled (SNF) level of care through a distinct part. While the Provider has such a unit, it also from time to time uses a small number of beds (swing beds) interchangeably as either hospital or SNF beds, with reimbursement based on the specific type of care provided. These beds are licensed for inpatient services. The Intermediary's adjustment for swing beds decreased the bed count by 1.25 beds.[22]

Beds in Rooms Used for Alternative Purposes

The Provider contends that since the Provider had a lower census than had been expected when the facility was designed and a certificate of need was granted,[23] it used several of its rooms with beds licensed for routine inpatient care on the fourth floor for other purposes. However, there were no structural changes made at any time through 1991 that would have prevented the Provider from having 39 available beds on the fourth floor. The Provider's records show that it did admit patients to the fourth floor hospital beds in 1991.[24] Rooms 406 and 407, which could house beds licensed for inpatient routine services, were used for physical therapy services.[25] The Provider does not have the records that tie the square footage reported as statistics on Worksheet B-1 of the Medicare cost report to specific space. However, the Provider believes that the square footage for Rooms 406 and 407 was reported in the ancillary physical therapy cost center. The Intermediary did not rely upon the manner in which square footage was reported in making its adjustment. The Provider believes that the availability of a bed for IME and DSH purposes and the reporting of the square footage for the room in which a bed could be placed are separate and unrelated. Square footage should follow the principal function. The cases where the CMS Administrator held that inpatient rooms used as physician sleeping rooms or as offices for patient

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22 Tr at 103-104.

23 See Provider Exhibit 41; Tr at 93-94.

24 Tr at 15, 81 and 84; See Provider Exhibit 18.

25 Id.

accounting services were silent on how the square footage for that space was reported. The omission of a fact from a decision indicates that the decision maker treats that fact as irrelevant. There is nothing inconsistent with a bed being available to house an inpatient on 24-48 hours notice, the standard applied by Blue Cross and Blue Shield Association (BCBSA), and reporting the square footage of the room housing that bed for the department or function for which the space is used most often.[26]

The Provider further notes that rooms 410, 412 and 413 which were licensed for inpatient beds were used for storage. Rooms 409 and 414 served as temporary office space, but still retained their status as rooms licensed for routine inpatient services.[27] In addition, recreational therapy services could have been rendered in a patient waiting area, in a visitors' waiting area or in the activity room such as Rooms 417 or 418.[28] The integrity of all of the rooms used for alternative purposes was maintained. The call system, the bathroom, the rails and everything else needed to support the rendering of routine inpatient services remained in these rooms.[29] None of these rooms were modified in any material respect. They all met the state of Texas licensure standards for inpatient beds and could readily have been made available for routine inpatient services.

In addition, the Provider states that it had a written contingency plan for putting beds in rooms used for alternative purposes into service to assure that the facility could always provide services to 109 patients (and after May, 1991, 100 hospital inpatients and 9 SNF patients).[30] In the event that rooms 406 and 407, which were used for physical therapy services, were needed for inpatient care, a large first floor classroom could have been used for physical therapy. In addition, half of the front lobby of the hospital, which was already divided in half, could have been used for physical therapy.[31] Under the contingency plan, all of the rooms on the fourth floor which had alternative uses could have been converted to daily inpatient use within twelve hours.[32] In fact, these contingency plans to convert rooms to inpatient use were implemented on at least two occasions by the physical movement of beds into the rooms.[33] The Provider in 1991 had a total of 125 bed frames and mattresses either on the hospital campus or in adjacent storage,

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26 Tr at 77.

27 Tr at 121-123.

28 Tr at 77-78.

29 Tr at 86, 103.

30 Tr at 86-87.

31 Tr at 93.

32 See Provider Exhibit 20.

33 Tr at 52-55.

approximately one mile from the hospital.[34] These beds could readily have been moved into any of the rooms used for alternative purposes as part of the contingency plan.

The Provider contends that the Intermediary used the wrong standard in determining the number of available beds at the facility. The Intermediary states its standard was the number of beds permanently maintained for inpatient care for which inpatient services were reimbursed under PPS.[35] The use of this standard to calculate available beds contravenes the applicable statutes, regulations, program instructions and CMS Administrator decisions regarding the appropriate counting of available beds.

Regarding the statutory and regulatory authority relating to the counting of beds for DSH purposes, the Provider observes that the statutory provisions at 42 U.S.C. § 1395ww(d) et seq. provide for additional payments for certain hospitals which serve "a significantly disproportionate number of low-income patients," which is defined as having "a disproportionate patient percentage.., which equals or exceeds 15 percent, if the hospital is located in an urban area and has 100 or more beds." The DSH regulation at 42 C.F.R. § 412.106 states that the bed-counting methodology for determining the number of beds for DSH status, shall be the same as the IME bed count rules.

In the September 3, 1985 Federal Register, HCFA provided a clarification in responding to a commenter's request for a more precise definition of "available bed days" by stating:

> For purposes of the prospective payment system, "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. Beds used for purposes other than inpatient lodging, beds certified as long-term, and temporary beds are not counted. If some of the hospital's wings or rooms on a floor are temporarily unoccupied, the beds in these areas are counted if they can be immediately opened and occupied.

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

The Provider further notes that BCBSA issued Administrative Bulletin #1841, 88.01 on November 18, 1988, to clarify certain points concerning the definition of available bed days.[36] This Bulletin advised that beds are considered "available" and must be counted "even though it

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[34] Tr at 28 and 31-33.

[35] See Provider Exhibit 2.

[36] Tr at 31.

may take 24-48 hours to get nurses on duty from the registry." Beds in use for treating inpatients are counted as "available" despite the fact that they are occupied. As the regulation at 42 C.F.R. § 412.105(b) indicates, "available bed days" are simply the product of multiplying the number of beds by the number of days in a cost reporting period. There is no regulatory requirement that a bed be used to be considered available. Contrary to the Intermediary's determination, it is clear from HCFA's policy as well as the CMS Administrator's decisions that beds do not have to be set up or staffed to be counted as available beds so long as they are capable of being staffed in 24-48 hours.

The Provider contends that the Provider Reimbursement Manual, Part 1 (HCFA Pub. 15-1) provides further clarification of the available beds determination process set forth in the regulations and includes and expands upon the definition contained in the preamble to the final rule. HCFA Pub. 15-1 § 2405.3.G states the following:

> A bed is defined for this purpose as an adult or pediatric bed (exclusive of beds assigned to newborns which are not in intensive care areas, custodial beds, and beds in excluded units) maintained for lodging inpatients, including beds in intensive care units, coronary care units, neonatal intensive care units, and other special care inpatient hospital units. Beds in the following locations are excluded from the definition: hospital-based skilled nursing facilities or in any inpatient area(s) of the facility not certified as an acute care hospital, labor rooms, PPS excluded units such as psychiatric or rehabilitation units, post-anesthesia or postoperative recovery rooms, outpatient areas, emergency rooms, ancillary departments, nurses' and other staff residences, and other such areas as are regularly maintained and utilized for only a portion of the stay of patients or for purposes other than inpatient lodging.
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> To be considered an available bed, a bed must be permanently maintained for lodging inpatients. It must be available for use and housed in patient rooms or wards (i.e., not in corridors or temporary beds). Thus, beds in a completely or partially closed wing of the facility are considered available only if the hospital put the beds into use when they are needed. The term "available beds" as used for the purpose of counting beds is not intended to capture the day to day fluctuations in patient rooms and wards being used. Rather, the count is intended to capture changes in the size of a facility as beds are added to or taken out of service.
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> In the absence of evidence to the contrary, beds available at any time during the cost reporting period are presumed to be available during the entire cost reporting period. The hospital bears the burden of proof to exclude beds from the count.

HCFA Pub. 15-1 § 2405.3.G.

The Provider argues that the manual provisions clearly state that "available bed days" include all routine beds, and there is no reference that bed size be determined solely on beds that are "set up and staffed." Further, the manual clarifies that the available bed count is designed to capture changes in the "size of a facility as beds are added to or taken out of service." The Provider asserts that the beds on the fourth floor of its facility were not taken out of service, and the size of its facility remained constant during the relevant time period. The hospital facility remained licensed and capable of operating 100 beds, and there were no structural changes in the size of the facility that would have limited the use of the beds on the Provider's fourth floor.

The Provider further argues that the Intermediary's interpretation of HCFA Pub. 15-1 § 2405.3.G is without merit. The Intermediary emphasizes a single sentence of § 2405.3.G to establish a basis for its bed count noting that, "[t]o be considered an available bed, a bed must be permanently maintained for lodging inpatients."[37] The Provider contends that the Intermediary's reliance on this one sentence ignores other portions of the manual provision, which state that, for a bed to be permanently maintained, it must be available for use, and housed in patient rooms or wards.

The Provider argues that the floor plans furnished to the Intermediary, as well as the testimony of the Provider's witness, provide ample evidence that the fourth floor had spaces for 39 beds in patient rooms which were available for use as inpatient beds within 24-48 hours. The Intermediary's focus on the actual alternative uses of the fourth floor beds caused it to inappropriately ignore the availability of the beds in accordance with the manual provisions. The Provider notes HCFA's example presented in HCFA Pub. 15-1 § 2405.3.G(2) wherein a bed licensed as a hospital acute care bed must be included in the hospital's available bed count even if the bed is actually used for long-term care. For the same reason, the Provider asserts that its fourth floor beds that were used for alternative purposes must be counted because they remained licensed as acute care beds throughout the relevant time period.

The Provider argues that existing case law supports the inclusion of the beds at issue. The Provider points out that HCFA has clearly stated that beds are presumed available and counted unless the provider presents affirmative evidence to exclude the beds. In support of this contention, the Provider cites various Board/HCFA Administrator decisions. In Natividad Medical Center v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 91-D58, August 9, 1991, Medicare and Medicaid Guide (CCH) ¶ 39,573, rev'd HCFA Administrator, October 6, 1991, Medicare and Medicaid Guide (CCH) ¶ 39,611 (Natividad),[38] the Administrator held that the provider was required to count all of its licensed beds as

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[37] See Provider Exhibit 29.

[38] See Provider Exhibit 30.

available, concluding that there is a presumption that all licensed beds are available. The provider in Natividad furnished the intermediary with the number of available beds it had reported to the State of California Office of Statewide Health Planning and Development. The annual survey used in Natividad carried no weight as evidence of the number of available beds at the facility, and the HCFA Administrator ruled that the intermediary's use of the licensed bed count was appropriate.

The Provider also cites the HCFA Administrator's decision in Pacific Hospital of Long Beach v. Aetna Life Insurance Company, PRRB Dec. No. 93-D5, December 12, 1992, Medicare and Medicaid Guide (CCH) ¶ 40,987, rev'd in part, HCFA Administrator, February 2, 1993, Medicare and Medicaid Guide (CCH) ¶ 41,355 (Pacific).[39] In Pacific, the provider attempted, for IME purposes, to exclude beds on two of its units by demonstrating that one unit was used as office space and that construction was in process on the second unit. The HCFA Administrator ruled that the provider failed to meet the burden of proof to exclude the beds. According to the Administrator, "[t]he [p]rovider's census records alone [do] not provide the basis for determining whether beds are available; rather it merely shows that they were not put in service." Id. If the beds, although temporarily withheld from service, were immediately occupiable" ; i.e., if they could be placed in service within 24-48 hours, the provider and the intermediary were required to include them in the bed count. The Provider insists that the situation on its fourth floor for the periods in controversy was identical to the Pacific case. The Provider contends that all of the beds on the fourth floor which were used for alternative purposes were capable of conversion into inpatient beds ready for immediate occupancy, even though some of the beds were being temporarily used for other purposes. If the beds are required to be counted for IME purposes, the DSH regulation requires the Intermediary to count them as available beds for DSH determinations.

The Provider notes that the CMS Administrator addressed the issue of available bed days in Santa Clara Valley Medical Center v. Blue Cross and Blue Shield Association, HCFA Adm. Dec., March 28, 1997, Medicaid and Medicare Guide (CCH) ¶ 45,230, rev'g in part PRRB Dec. Nos. 97-D25 and 97-D26, January 29, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,064.[40] In that case, the provider claimed that 18 beds were unavailable and were not included in the IME bed count because they were utilized for physician sleeping quarters. The Administrator held that the beds were deemed "available for inpatient lodging" as described in HCFA Pub.15-1 § 2405.3.G, despite the fact that they were temporarily occupied by physicians. Therefore, if actual use of a bed as a physician sleeping bed, which requires no nurse staffing, does not render the bed unavailable, then the use of a bed for a few hours by an observation patient or for alternative purposes also should not render the bed unavailable.

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[39] PRRB Dec. No. 97-D-26 is not published since it is identical to PRRB Dec. 97-D25.

[40] See Provider Exhibit 35.

The Provider further notes that the Board has upheld the broad definition of "available beds" that has been promulgated by the CMS Administrator in the past. In United Hospitals Medical Center v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of New Jersey, PRRB Dec. No. 2000-D23, March 2, 2000, Medicare and Medicaid Guide (CCH) ¶ 80,399,[41] the Board agreed with the intermediary that the beds in question would have to be included in the available bed count if the provider made no adjustment to remove the depreciation for these beds as required by Administrative Bulletin #1841, 88.01. In this DSH appeal, the provider did not remove its fourth floor beds from its depreciable assets on the cost report. The Provider notes that the Board's reliance upon HCFA Administrative Bulletins is consistent with previous HCFA Administrator decisions, and reflects the importance of these bulletins in establishing HCFAs available bed policy.

In summary, the Provider argues that the Intermediary has completely ignored prior decisions by the HCFA Administrator and the Board in establishing the IME bed counting requirements, which must also be utilized to determine the number of beds for purposes of DSH status. The law requires that the IME bed counting rules be used for DSH purposes, and the Intermediary is bound by these rules.

The Provider further contends that the CMS Administrator's rationale for the proposed CMS policy is not reasonable. The Intermediary cites the CMS Administrator's decision in Commonwealth of Kentucky 92-96 DSH Group v. Blue Cross and Blue Shield Association/AdminaStar Federal, PRRB Dec. No. 99-D66, September 2, 1999, Medicare and Medicaid Guide (CCII) ¶ 80,332, rev'd HCFA Administrator, November 8, 1999, Medicare and Medicaid Guide (CCH) ¶ 80,389 (Commonwealth of Kentucky), as its authority for relying on the proposed HCFA policy to exclude the Provider's scattered observation beds from the available bed count. While the Administrator's decision in Commonwealth of Kentucky supports the proposed HCFA policy, the Provider contends that its rationale is unsupportable by previous HCFA regulations, manual provisions, policy pronouncements and other Administrator decisions. The Administrator's decision indicates that it has always been HCFA's policy to count as available bed days "only inpatient days to which the prospective payment system applies" and, therefore observation bed days are not counted in the available bed day count, even if the bed is an inpatient bed. The Provider points out that this decision focuses directly on the use of a bed rather than its availability, and is contrary to the law and previous policy promulgated for years by HCFA. According to the Commonwealth of Kentucky decision, bed days not reimbursed under the Medicare PPS System are not counted because the "day was not recognized under PPS as an inpatient operating cost." The Provider counters that one need only look to the bed counting example in HCFA Pub. 15-1 § 2405.3.G(2) to see that this is incorrect. Further, a number of observation bed days are actually paid under PPS because of the effect of the "DRG payment window." The Provider asserts that its observation beds were clearly within its inpatient units and should have been counted as part of the unit in which they were located in

[41] See Provider Exhibit 1-4

accordance with HCFA's longstanding policy.

The District Court for the Eastern District of Kentucky has determined in Clark Regional Medical Center et al. v. Shalala, 136 F. Supp. 2d 667 (E.D. Ky 2001) (Clark), that the Administrator's decision in Commonwealth of Kentucky was arbitrary and capricious and not supported by the applicable regulations in Provider Reimbursement Manual (PRM) guidelines. The Court found the Administrator's construction of the applicable regulations and guidelines relating to the exclusion of scattered observation and swing beds from the DSH available bed count could not be seen as rational in light of the plain language of the regulations and the PRM. The District Court decision supports the Provider's position and reverses the Commonwealth of Kentucky decision relied upon by the Intermediary to support the argument.

The Provider notes that while the Sixth Circuit has not yet scheduled a hearing on the appeal of the District Court decision in Clark , the Ninth Circuit has already held that swing beds should be included in the bed-size calculation used to determine DSH adjustments. Alhambra Hospital & Memorial Hospital of Gardena v. Thompson, 259 F. 3d 1071 (9th Cir. 2001). The Court stressed that § 42 C.F.R. § 412.106 is plain on its face and requires the inclusion of subacute patient days as part of the DSH reimbursement. The swing beds met all the necessary requirements as available beds and were not specifically identified as beds excluded from the DSH calculation. Finally, the Board has most recently reiterated that observation beds are to be included in the calculation of the 100-available bed threshold requirement for the calculation of the DSH payment adjustment in Presbyterian Hospital of Greenville v. Blue Cross and Blue Shield Association/Trailblazer Health Enterprises, LLC, PRRB Dec. No.2002-D1, November 21, 2001, Medicare and Medicaid Guide (CCH) ¶ 80,788.

INTERMEDIARY'S CONTENTIONS

The Intermediary contends that its use of available PPS beds to determine the DSH payment adjustment factor complied with the governing provisions of 42 C.F.R. §§ 412.105 and 412.106, and HCFA Pub. 15-1 § 2405.3.G. Pursuant to these controlling provisions, an available bed must be permanently maintained. The conversion of rooms to uses other than inpatient routine care, such as office space, physical therapy, recreational therapy and storage, would eliminate those rooms from being "permanently maintained" as routine inpatient beds. Consequently, the use of the fourth floor beds for alternative uses would also be excluded since the beds are no longer permanently maintained for lodging inpatients.

The Intermediary contends that the PRM instructions at HCFA Pub 15-1 § 2405.3.G specifically indicate that beds used for ancillary, outpatient areas, and other areas regularly maintained and utilized for only a portion of the stay by patients are not considered available beds for lodging inpatients. Further support for the exclusion of bed days related to observation services can be found in the Hospital Manual (HCFA Pub. 10), which addresses the definitions of "covered inpatient hospital services" and the "counting of inpatient days" as follows:

An inpatient is a person who has been admitted to a hospital for

> bed occupancy for purposes of receiving inpatient hospital services.
>
> The number of days of care charged to a beneficiary for inpatient hospital services is always in units of full days.

Hospital Manual § 210 and § 216.1, respectively.

Pursuant to the Hospital Manual, a patient day would only be counted where a patient was admitted for inpatient services. In the case of outpatient observation services, the patient is not admitted as an inpatient. The Hospital Manual offers further guidance by defining "outpatient observation services" as follows:

> A. Outpatient Observation Services Defined. - Observation services are those services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient.
>
> B. Coverage of Outpatient Observation Services. - Generally, a person is considered a hospital inpatient if formally admitted as an inpatient with the expectation that he or she will remain at least overnight. (See § 210 regarding coverage of inpatient admissions.) When a hospital places a patient under observation, but has not formally admitted him or her as an inpatient, the patient initially is treated as an outpatient. The purpose of observation is to determine the need for further treatment or for inpatient admission. Thus, a patient in observation may improve and be released, or be admitted as an inpatient.

Hospital Manual § 230.6.

The Intermediary cites HCFA Memorandum, dated February 27, 1997, which "clarified" the treatment of observation beds in the count of available bed days for the purpose of the IME and DSH adjustments. The Intermediary also cites the HCFA Administrator's decision in Commonwealth of Kentucky, supra , which directly addresses the count of available beds for the determination of the DSH payment. In that decision, the Board found that the intermediary's adjustment improperly disallowed swing bed days and observation bed days from the count of available days used to determine bed size. However, the HCFA Administrator reversed the Board's decision stating that HCFA had a long-standing policy of only considering bed days in the bed count if the costs of such days were allowable in the determination of Medicare inpatient costs. While the Administrator's decision in Commonwealth of Kentucky only addresses observation and swing beds, the Intermediary argues that the analysis and final decision are

equally applicable to the other beds at issue claimed by the Provider; i.e., fourth floor beds being used for office space, storage, and physical therapy services. The Intermediary insists that none of these additional "available" beds claimed by the Provider were included in the hospital's PPS inpatient operating costs.

Based on the floor by floor, room by room review of the Provider's facility, the Intermediary notes that it excluded 10 beds from the Provider's count of 119 beds[42] prior to May 15, 1991, and excluded 24 beds from the Provider's count of 108 beds[43] effective May 15, 1991 through December 31, 1991. Since the SNF sub-provider was certified during the fiscal year, the Intermediary calculated the total bed days available for the period January 1, 1991 through May 14, 1991 and May 15, 1991 – December 31, 1991 and divided the total bed days for the entire period by 365 days. The calculation reflected the Provider had 93.18 available beds for the cost reporting period 1/1/91 - 12/31/91.[44]

The Intermediary also determined that the Provider had rendered observation services and skilled nursing care services (swing beds) in routine beds. Consistent with instructions from CMS, the Intermediary determined the actual observation services and skilled nursing care services (swing beds) use of routine beds amounted to 1.95 and 1.25 beds, respectively, being used for non-routine, non-PPS patient care services. Therefore, the 93.18 total beds available was reduced by 3.2 beds for the use of routine beds in rendering outpatient ancillary services (observation) and skilled nursing services (swing-beds), which are not subject to PPS. After all adjustments to the Provider's beds were accounted for, the Intermediary determined the Provider had only 89.98 available beds.[45]

The Intermediary observes that the Provider relied on the Board's decision in Commonwealth of Kentucky 92-96 DSH Group v. Blue Cross and Blue Shield Association /Administar Federal, supra, to support its position that the reduction of total available beds by beds used for observation and swing-bed services was improper. However, the Intermediary notes that the Board's decision was reversed by the HCFA Administrator on November 8, 1999. In reversing the Board, the Administrator determined the HCFA had a long-standing policy of only considering bed days in the bed count if the costs of such days were allowable in the determination of Medicare inpatient costs. In discussing the issue of observation and swing-bed services, the Administrator noted this interpretation of available beds is also consistent with that aspect of DSH eligibility concerning the determination of the patient percentage calculation under 42 C.F.R. § 412.106(a)(1)(ii). The Administrator continued the analysis and the

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[42] See Intermediary Exhibit 1-3

[43] See Intermediary Exhibit 3.

[44] See Intermediary Exhibit 1-3.

[45] See Intermediary Exhibit 1-3.

application to 42 C.F.R. § 412.105(b) and stated that HCFA's requirement that a bed day under 42 C.F.R. § 412.105(b) only be included in the DSH bed count calculation when the costs of the day are reimbursed as an inpatient service cost. It must also be consistent with the inclusion of only "inpatient days to which the prospective payment system applies" in determining a PPS hospital's eligibility for a DSH adjustment. The Administrator found that, contrary to the Board's contention, the DSH adjustment is intended to be an additional payment to account for a higher Medicare payment per case for PPS hospitals that serve a disproportionate number of low-income patients. Accordingly, it is proper to determine a PPS hospital's eligibility for this additional payment based on beds which are recognized as part of the PPS hospital's inpatient operating costs.

The Intermediary notes that HCFA Pub. 15-1 § 2405.3.G specifically indicates that beds used by ancillary, outpatient areas, and other areas regularly maintained and utilized for only a portion of the stay of patients are not considered as available beds for lodging inpatients. Therefore, beds used for observation services, delivery/labor room, and physical therapy, ancillary services, and areas treated as part of the certified SNF should not be included in the determination of available beds.

The Intermediary further notes that on February 27, 1997, HCFA issued Memorandum F.A.-31 clarifying the treatment of Observation Beds in the count of available bed days for the purposes of the IME and DSH adjustments. HCFA's Memorandum stated:

> Observation Beds
>
> If a hospital provides observation services in beds that are generally used to provide hospital inpatient services, the equivalent days that those beds are used for observation services should be excluded from the count of available bed days for purposes of the IME and DSH adjustments. If a patient in an observation bed is later admitted, then the equivalent days before the admission are also excluded. Thus, all observation bed days are excluded from the available bed day count.

The last paragraph of HCFA's memorandum required intermediaries to review any cost report that was still within the three-year reopening period to ensure that the policies addressed in the Memorandum were applied. Pursuant to these instructions, the Intermediary reviewed the Provider's 1991 cost report and determined the Provider did not have 100 or more beds.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law-42 U.S.C.

§1395ww et seq.	-	Payment to Hospitals for Inpatient Hospital Services

2. Law – 5 U.S.C.

§ 533	-	Administrative Procedure Act

3. Regulations - 42 C.F.R.

§§ 405.1835-.1841	-	Board Jurisdiction
§ 412.20 (a)	-	Hospital Services Subject to the Prospective Payment System
§ 412.105 et seq.	-	Special Treatment: Hospitals That Incur Indirect Costs for Graduate Medical Education Programs
§ 412.106 et seq.	-	Special Treatment: Hospitals that Serve a Disproportionate Share of Low - Income Patients
§ 413.20	-	Financial Data and Reports
§ 413.53	-	Determination of Cost of Services to Beneficiaries

4. Program Instructions - Provider Reimbursement Manual, Part I (HCFA Pub. 15-1):

§ 2405.3.G et seq.	-	Adjustment for the Indirect Cost of Medical Education - Bed Size

5. Program Instructions - Hospital Manual(HCFA Pub. 10):

§210 et seq.	-	Covered Inpatient Hospital Services
§216 et seq.	-	Inpatient Hospital Benefit Days
§230 et seq.	-	Outpatient Hospital Services

6. Other:

HCFA Memorandum, February 27, 1997.	-	Counting Beds and Days for Purposes of the Medicare Inpatient DSH and IME Adjustments
BCBSA Administrative Bulletin #1841, 88.01.	-	Definition of Available Days

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

7. Case Law:

Clark Regional Medical Center, et al. v. Shalala, 136 F. Supp. 2d 667 (E.D. Ky 2001)

Alhambra Hospital & Memorial Hospital of Gardena v. Thompson, 259 F. 3d 1071 (9th Cir. 2001).

Natividad Medical Center v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 91-D58, August 9, 1991, Medicare and Medicaid Guide (CCH) ¶ 39,573, rev'd HCFA Administrator, October 6, 1991, Medicare and Medicaid Guide (CCH) ¶ 39,611.

Pacific Hospital of Long Beach v. Aetna Life Insurance Company, PRRB Dec. No. 93-D5, December 12, 1992, Medicare and Medicaid Guide (CCII) ¶ 40,987, rev'd in part, HCFA Administrator, February 2, 1993, Medicare and Medicaid Guide (CCH) ¶ 41,355.

Santa Clara Valley Medical Center. v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. Nos. 97-D25 and 97-D26, January 29, 1997, Medicare and Medicaid Guide (CCHI) ¶ 45,064, rev'd in part, HCFA Administrator, March 28, 1997, Medicare and Medicaid Guide (CHH) ¶ 45,230.

United Hospital Medical Center v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of New Jersey, PRRB Dec. No. 2000-D23, March 2, 2000, Medicare and Medicaid Guide (CCH) ¶ 80,399.

Commonwealth of Kentucky 92-96 DSH Group v. Blue Cross and Blue Shield Association/AdminaStar Federal, PRRB Dec. No. No. 99-D66, September 2, 1999, Medicare and Medicaid Guide (CCH) ¶ 80,322, rev'd HCFA Administrator, November 8, 1999, Medicare and Medicaid Guide (CCH) ¶ 80,389.

Presbyterian Hospital of Greenville v. Blue Cross and Blue Shield Association/ Trailblazer Health Enterprises, LLC, PRRB Dec. No. 2002-D1, November 21, 2001, Medicare and Medicaid Guide (CCH) ¶ 80,788.

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND DISCUSSION:

The Board, after considering the Medicare law, regulations, program instructions, facts, parties' contentions, evidence submitted and post-hearing briefs, finds and concludes that the Provider meets the requirement for 100 beds available. Therefore, the Provider is eligible to receive additional reimbursement for DSH of Provider services. The statute at 42 U.S.C. § 1395ww(d)(5)(F) provides for a DSH adjustment to hospitals that serve a significant disproportionate number of low-income patients. Under the statute, a hospital that is located in an urban area and has 100 or more beds qualifies for the DSH adjustment if 15 percent of its patients are low-income patients. The Board finds that this authorizing statute considers three factors in determining a hospital's qualification for a DSH adjustment. These factors include a provider's location (rural or urban), its patient days and its number of beds, which is the factor at issue for the Provider. The Board notes that the statute does not expound upon the meaning of "bed" with respect to DSH eligibility.

The regulation at 42 C.F.R. § 412.106 implements the statutory provisions and establishes the factors to be considered in determining whether a hospital qualifies for a DSH adjustment. With respect to determining the number of beds for DSH status, the regulation at 42 C.F.R. § 412.106(a)(1)(i) requires this determination to be made in accordance with 42 C.F.R. § 412.105(b)[46] which states:

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

42 C.F.R. § 412.105(b).

The Board finds that the controlling regulation at 42 C.F.R. § 412.105 establishes the fundamental methodology for determining a hospital's bed size for purposes of DSH eligibility. This regulation requires that all beds and all bed days be included in the calculation unless they are specifically excluded under the categories listed in the regulation.

The Board finds that the word "bed" is specifically defined at HCFA Pub. 15-1 § 2405.3.G for the purpose of calculating the adjustment for indirect medical education and DSH eligibility. In part, the manual states:

> G. Bed Size. - A bed is defined for this purpose as an adult or

[46] 42 C.F.R. § 412.105 provides for additional payments for IME. One of the factors determining the IME payment is the bed count.

> pediatric bed (exclusive of beds assigned to newborns which are not in intensive care areas, custodial beds, and beds in excluded units) maintained for lodging inpatients, including beds in intensive care units, coronary care units, neonatal intensive care units, and other special care inpatient hospital units. Beds in the following locations are excluded from the definition: hospital-based skilled nursing facilities or in any inpatient area(s) of the facility not certified as an acute care hospital, labor rooms, PPS excluded units such as psychiatric or rehabilitation units, post-anesthesia or postoperative recovery rooms, outpatient areas, emergency rooms, ancillary departments, nurses' and other staff residences, and other such areas as are regularly maintained and utilized for only a portion of the stay of patients or for purposes other than inpatient lodging.
>
> To be considered an available bed, a bed must be permanently maintained for lodging inpatients. It must be available for use and housed in patient rooms or wards (i.e., not in corridors or temporary beds). Thus, beds in a completely or partially closed wing of the facility are considered available only if the hospital puts the beds into use when they are needed. The term "available beds" as used for the purpose of counting beds is not intended to capture the day-to-day fluctuations in patient rooms and wards being used. Rather, the count is intended to capture changes in the size of a facility as beds are added to or taken out of service.

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

Four categories of beds are in dispute: maternity beds, observation beds, swing beds and beds used for alternative purposes. The Board notes that the exhibits offered by both parties appear to have conflicting numbers of beds in issue, particularly with regard to the alternative bed category. It is undisputed, however, that the Provider will meet the 100 bed requirement if all the disputed categories are resolved in the Provider's favor.[47] In light of the Board's decision that the Intermediary's adjustment to the bed count was improper in all categories, it is unnecessary to resolve any conflict.

Maternity beds

[47] The Provider argues that even though it was only licensed for 100 acute care beds, it had 109 rooms set up and available for treating patients, so that, even if the Intermediary properly excluded 9 beds from the count, it would still meet the 100 bed requirement.

The Intermediary conceded at the hearing that the eight beds which it had excluded as labor/delivery room beds were in fact maternity routine care beds and should have been included in the available bed count.[48] The Board finds that these beds should be added back to the count of available beds.

Observation and Swing Beds

The Board notes that the parties addressed these categories jointly. The Board will address them accordingly. Based on the above-cited authorities, the Board concludes that the criteria applied by the Intermediary for the exclusion of observation beds cannot be supported based on the correct and clear interpretation of the language set forth in the regulations and manual guidelines.
The Board finds that all of the observation and swing beds at issue were licensed acute care beds located in the acute care area of the Provider's hospital facility. It further finds that these beds were permanently maintained and available for lodging inpatients and were fully staffed for the provision of inpatient services during the cost reporting periods in contention.

The Board's determination also relies upon the fact that the enabling regulation and manual instructions identify the specific beds excluded from the bed count and neither of these authorities provide for the exclusion of observation or swing beds. Given the degree of specificity with which the manual addresses this issue and the fact that the enabling regulation has been modified on at least two occasions to clarify the type of beds excluded from the count, the Board finds that these comprehensive rules are meant to provide an all-inclusive listing of the excluded beds. The Board rejects the Intermediary's argument that only beds reimbursed under PPS should be included in the count of available bed days since the purpose of DSH is to adjust PPS amounts. If this argument were valid, Congress would simply have said that in the enabling statute and a regulation could have been easily promulgated to accommodate a category for PPS-excluded beds. Instead, the controlling regulation and manual guidelines have been written in a manner which provide great specificity regarding beds that are included and excluded from the count.

The Board notes that the Secretary has stated in various decisions reversing the Board in its interpretation of available beds, that its use of PPS days for determining DSH reimbursement has been its consistent and long-standing policy. The Board finds this statement inconsistent with the Program Instruction at HCFA Pub.15-1 § 2404.5 (G). That section specifically allows available beds to be determined based on changes in size of a facility as beds are added to or taken out of service. These beds do not necessarily have to be "PPS beds." The example in HCFA Pub-15-1 § 2405.3 G. 2 specifically allows treatment of beds as available for beds set up and used as long term care beds. The latter beds are not covered by PPS yet are allowed in the available bed count for DSH reimbursement purposes. In this section's example, a hospital has 185 acute care beds, including 35 beds that were used to provide long-term care beds. CMS

[48] Tr 34 and 144.

explains that all 185 beds are used to determine the provider's total available bed days since the 35 beds are certified for acute care. In part, CMS states:

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

HCFA Pub. 15-1 § 2405.3.G.2 (Emphasis added).

The Board finds the informal instructions set forth in the CMS Memorandum dated March 11, 1997, which served as the basis for the Intermediary's exclusion of observation beds, are wholly inconsistent with the controlling Medicare regulations, manual instructions and prior CMS policy regarding the counting of available beds. Moreover, since the Provider's cost report at issue was for the 1991 reporting period, the Board finds that such instructions cannot be retroactively applied even if otherwise proper.

Finally, the Board observes that the district court's decision in Clark, supra, recently upheld the decision rendered by the Board in Commonwealth of Kentucky 92-96 DSH Group, supra, wherein the Board found that observation bed days met all of the Medicare program's requirements to be included in the bed size calculation used to determine DSH eligibility. The court found that, under the plain meaning of the regulation at 42 C.F.R. § 412.105(b), the observation bed days should not have been excluded from the count for determining DSH eligibility. The court further stated that HCFA's proposed construction "tortures the plain language of the regulation," and that "the regulation does not say 'not including non-PPS beds' or 'not including bed days that are not allowable in the determination of Medicare inpatient costs.' " With respect to the manual guidelines, the court found the instructions in HCFA Pub. 15-1 § 2405.3.G also support the inclusion of observation bed days because the beds were permanently maintained and staffed for acute care inpatient lodging, and that their temporary use for other purposes did not change this fact.

The court concluded that the HCFA Administrator's decision in Commonwealth of Kentucky 92-96 DSH Group was arbitrary and capricious and not supported by the applicable regulations and PRM guidelines. Therefore, it was a clear error of judgment for the CMS Administrator to ignore the language of the regulations and guidelines and instead construe eligibility based solely upon its own statement of intent hidden in the Federal Register.

Alternative Use

As to the Intermediary's exclusion of several medical/surgical beds located on the Provider's fourth floor from the available bed count used to determine DSH eligibility, the Board finds that the Intermediary applied an erroneous standard in making this determination. The beds were being used for alternative purposes: office space, storage and therapy services. Rather than applying the standard of "maintained and available beds" as set forth under the controlling regulatory and manual provisions, the Intermediary used a "set up and staffed beds" standard. The use of the "set up and staffed beds" standard is unsupportable under Medicare policy and

ignores the long-standing Medicare definition of "available beds" which is intended to capture changes in the size of a facility rather than day to day fluctuations in patient room and wards.

The evidence presented demonstrated that beds on the Provider's fourth floor were licensed inpatient beds in routine areas that were maintained to provide inpatient services even though some were used for other purposes. The Board finds the Provider's license to be a more accurate measure of the number of available beds at the Provider's facility than the number of "set up and staffed beds" identified by the Intermediary. The record shows that the Provider's fourth floor inpatient beds including those used for storage, office, and physical therapy were: (1) reasonably ready for immediate inpatient use within 24-48 hours; (2) maintained as depreciable plant assets on the Medicare cost reports; and (3) capable of being adequately covered by the Provider's nursing staff or nurses from a nurse registry if the need arose. It is the Board's conclusion that the inclusion of fourth floor beds in the available bed count for purposes of the DSH eligibility determination reflects a more accurate application of Medicare policy than the standard devised by the Intermediary.

In summary, the Board finds that maternity, observation, and swing beds and beds on the fourth floor that were being used for storage, office and therapy should have been included in the Provider's bed count and results in the Provider's having at least 100 beds required for an additional disproportionate share payment.

DECISION AND ORDER:

The Provider meets the requirement for 100 available beds and is eligible for the resulting DSH payment. The Intermediary's adjustment is reversed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Henry C. Wessman, Esquire
Stanley J. Sokolove
Gary B. Blodgett, D.D.S

DATE OF DECISION: October 16, 2002

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairman