PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2005-D57

PROVIDER -
Central Texas Medical Center
San Marcos, Texas

Provider No.: 45-0272

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
TrailBlazer Health Enterprises, LLC

DATE OF HEARING -
August 30, 2004

Cost Reporting Period Ended -
December 31, 1993

CASE NO.: 99-3096

INDEX

ISSUE:

Whether observation days and swing bed days should reduce the number of available beds for the purpose of calculating the Provider's eligibility for disproportionate share (DSH) payments.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This case arises from a dispute over the amount of Medicare payments due a Provider.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration (HCFA)) is the agency of the Department of Health and Human Services (DHHS) responsible with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395(h), 42 C.F.R. §§413.20(b) and 413.24(b).

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the proportion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

Hospitals are paid for services to Medicare patients under a Prospective Payment System (PPS). 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 additional payments for certain hospitals that met specific criteria with respect to their inpatient population. The statutory provision at 42 U.S.C. §1395ww(d)(5)(F)(i) requires that the Secretary provide an additional payment for hospitals that serve "a significant disproportionate number of low-income patients." To be eligible to receive this additional DSH payment, a hospital located in an urban area must have a minimum of 100 beds and a disproportionate patient percentage of at least 15 %. The dispute in this case concerns the method by which the number of beds is determined.

Medicare regulations provide that the number of beds for purposes of DSH payment must be determined in accordance with the indirect medical education (IME) bed count rules set forth in 42 C.F.R. §412.105(b). See, 42 C.F.R. §412.106(a)(1)(i). Under the IME regulation:

> 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 or bassinets in the healthy newborn nursery, custodial care beds, or beds in excluded units, and dividing that number by the number of days in the cost reporting period.

42 C.F.R. §412.105(b) (emphasis added). The Provider Reimbursement Manual (PRM) (CMS Pub. 15-1) §2405.3G further explains that, to be available, a bed must be permanently maintained for lodging inpatients, available for use, and housed in patient rooms or wards. The term "available beds" is not intended to capture the day-to-day fluctuations in patient rooms being used, but rather, the count is intended to capture changes in the size of a facility as beds are added to or taken out of service. In the absence of evidence to the contrary, beds available during any time during the cost reporting period are presumed to be available during the entire cost reporting period.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Central Texas Medical Center (Provider) is an acute care hospital located in San Marcos, Texas with a certificate of need for 109 beds. On May 14, 1991, the Provider opened a nine-bed distinct part skilled nursing facility, thereby reducing the number of acute care hospital beds to 100. Under Texas licensure, a provider's beds are not licensed by room or by individual, actual beds. Rather, a provider's overall bed capacity is licensed by the state. Accordingly, a provider could have a licensed bed capacity of 120 beds and have 140 beds that meet the licensure requirements but it could only use 120 beds at one time.

In 1993, the Provider's cost report was settled allowing for DSH payments based on having 101 licensed and available qualifying beds.[1] This was the number of beds reported on Worksheet S-3 on the as-filed and audited cost reports. The Provider qualified for DSH reimbursement because it had a DSH percentage in excess of 15 percent and was located in an urban area. 42 U.S.C. §1395ww(d)(5)(F)(v).

When auditing the FYE 1994 cost report, the Intermediary determined that the Provider had only 97 available beds and disallowed all of the DSH payments. In addition, the Intermediary issued a Notice of Reopening for FYE 1993 because it believed that the Provider had less than 100 beds in this year as well. The revised NPR that was issued reflected the disallowance of the DSH payments as the result of disallowing observation beds and swing-beds from the count of available beds.[2] The reimbursement effect for fiscal year 1993 is approximately $827,000. [3]

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[1] Provider Position Paper Ex. 93-5.

[2] Provider Position Paper Ex. 93-5, see also 42 U.S.C. § 1395tt(d) regarding the definition of swing beds.

[3] Provider Position Paper at 1.

The parties have stipulated to the following facts with regard to the observation bed days and swing bed days issue:

> . . .before observation bed days and swing bed days were removed the Provider had 101 available beds. The parties agree that there were 3.71 observation bed days and 0.48 swing bed days in 1993. The observation bed day services were furnished in routine beds and not in a distinct observation unit.
>
> . . .that adoption of the Intermediary's position would result in 96.81 available beds. The parties agree that adoption of the Provider's position would result in 101 available beds.

The Board has previously issued a decision for this Provider for fiscal year 1991[4] on the question of whether observation bed days and swing bed days should have been included in the available beds. Those same arguments are once again before the Board in the appeal of this fiscal year. The appeal of FYE 1993 meets the jurisdictional requirements of 42 U.S.C. §1395oo(a) and 42 C.F.R. §§405.1835-405.1841.

The Provider was represented by Dennis Barry, Esq., of Vinson and Elkins, LLP, Washington, D.C. The Intermediary was represented by Bernard Talbert, Esq., of Blue Cross Blue Shield Association, Chicago, Illinois.

PARTIES CONTENTIONS:

The Provider asserts that observation beds were not in a distinct unit. Rather, observation patients were assigned to open inpatient routine beds and utilized the same staff and services as inpatients. In addition, although the Provider had a distinct-part skilled nursing facility (SNF), from time to time it used a small number of beds (the swing-beds) interchangeably as either hospital or SNF beds with reimbursement based on the type of care provided. Swing-beds, licensed for hospital inpatient services, are permitted by Medicare.

The Provider argues that since DSH payments are calculated using the IME bed count rules set forth in 42 C.F.R. §412.105, the number of beds is based on the number of available beds, excluding those identified in the regulation, such as bassinets in the newborn nursery. Since observation beds and swing-beds are not excluded by the terms of the regulation, they should be included in the count of available beds. Further, PRM §2405.3G excludes beds such as labor room and recovery room beds under a standard and accepted definition of a hospital's bed count. The use of licensed and certified inpatient routine beds to provide observation and swing bed services does not reduce a hospital's bed size under the definitions found in either the regulation or manual.

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4 Central Texas Medical Center v. Trailblazer Health Enterprises/Blue Cross Blue Shield Association, PRRB Decision 2003-D2, Medicare and Medicaid Guide (CCH) ¶ 80,911, aff'd in part/rev'd in part, HCFA Adm. Dec. (December 19, 2002), Medicare & Medicaid Guide (CCH), ¶ 80,962.

The Intermediary contends that the definition of available beds in PRM §2405.3.G requires that a bed be permanently maintained for lodging inpatients. As a result, providers would be required to keep beds in their existing usable state as inpatient routine care beds indefinitely in order to be available. Further, this manual provision specifically indicates that beds used in ancillary outpatient areas and other areas regularly maintained and utilized for only a portion of a patient stay are not considered available beds for lodging inpatients. Observation services are an ancillary service. Therefore, beds used for observation services should not be included in the determination of available beds.

With regard to swing-beds, the Intermediary excluded the equivalent bed days related to the rendering of swing-bed skilled nursing services in the inpatient routine care beds, because the Provider was certified for SNF services and the costs and use of the beds were not subject to payment under PPS. The Intermediary distinguishes the example of swing-beds in PRM §2405.3.G, in which the beds were included in the count of available beds, because the example involves a facility that was not certified for SNF care. In this case, the Provider has a distinct-part SNF and was certified to render skilled nursing care in swing-beds. Because the Provider used inpatient routine beds for certified swing-bed skilled nursing care, the use of those beds is outside the scope of and excluded from PPS, and the equivalent bed days would be excluded from the determination of available days.

The Provider reasons that once beds qualify as available beds under the definition set forth in PRM §2405.3.G, they should be counted for purposes of DHS reimbursement. The beds are in an open area of the hospital which is maintained for lodging inpatients and not in an excluded unit or outpatient area of the hospital. The swing-beds and observation beds are scattered throughout the routine inpatient area and are not in dedicated outpatient areas for either type of care. The count of available beds does not capture day-to-day fluctuation in the use of the beds. The Provider billed the beds used as either an observation bed or swing-bed in compliance with the cost reporting instructions and contends that a bed used temporarily as an observation bed or swing-bed should be included in the count of available beds.

The Intermediary also relies on a February 27, 1997, HCFA Memorandum F.A.-31[5] clarifying the treatment of observation beds in the count of available beds for purposes of IME and the DSH calculation. In that memorandum, HCFA stated that where a hospital furnishes observation services in beds generally used to provide inpatient hospital services, those beds used for observation services should be excluded from the count of available beds for purposes of IME and DSH adjustments. Also, if a patient in an observation bed is later admitted, then the days prior to admission are also excluded. HCFA, thus, concluded that all observation bed days are excluded from the available bed count.

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5 Provider Ex. P-5.

The Intermediary points out that in the Commonwealth of Kentucky 92-96 DSH Group Appeal v. Blue Cross Blue Shield Association [6] (Kentucky DSH Group appeal) the HCFA Administrator reversed the Board's decision which found that observation bed days and swing-bed days met the program requirements to be included in the bed count used to determine DSH eligibility. In the Kentucky DSH Group appeal, as in this case, all the beds were permanent, licensed, acute care beds located in inpatient routine use areas of the hospital and sometimes used as either observation beds or swing-beds. The Administrator determined that HCFA's requirement that a bed day under 42 C.F.R. §412.105(b) be included in the DSH calculation only when the costs are reimbursed as inpatient service costs was consistent with the inclusion of only "inpatient days to which the PPS applies. Therefore, it was proper to determine a PPS hospital's eligibility for this additional payment based on beds that are part of the PPS hospital inpatient operating costs. After reviewing the law and HCFA's policy, the Administrator concluded it was appropriate for the intermediary to exclude observation bed days and swing-bed days from the bed count for purposes of the DSH calculation. The Intermediary maintains that its determination complied with the requirements of the regulation, 42 C.F.R. §412.105(c) and (d), the manual instructions and HCFA's February 27, 1997 memorandum.

In addition to excluding observation bed days from the available bed day count, the February 1997 memorandum required the intermediaries to apply the policy to any open cost report or any cost report subject to reopening. Because it was characterized as a policy clarification, HCFA maintained that it could be applied retroactively. The Provider contends that HCFA should not be allowed to apply the policy retroactively and notes that in other areas where a policy was unclear, the Administrator has concluded that retroactive application was impermissible.[7]

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND DISCUSSION:

The Board, after considering the Medicare law, and guidelines, the parties' contentions and evidence submitted finds that the observation bed days and swing-bed days should be considered available beds to be used in determining the Provider's eligibility for DSH reimbursement, and that the total number of available beds to be used in the DSH calculation for this fiscal year is 101.

The statute, 42 U.S.C. §1395ww(d)(5)(F), considers three factors in determining a hospital's qualification for a DSH adjustment: (1) the provider's location (urban or

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6 Commonwealth of Kentucky 92-96 DSH Group Appeal v. Blue Cross Blue Shield Association PRRB Dec. No. 99-D66, Medicare and Medicaid Guide (CCH) ¶ 80,332; rev'd Administrator's Dec. (November 8, 1999), Medicare and Medicaid Guide (CCH) ¶ 80.389; rev'd sub nom Clark Regional Medical Center v. Shalala, 136 F. Supp. 2d 667, (E.D. KY 2001); aff'd sub nom Clark Regional Medical Center v. Thompson, 314 F. 3d 241 (6th Cir. 2002).

7 Provider Position Paper at 27.

rural);[8] (2) the number of patient days;[9] and (3) the number of beds.[10] In this case, it is undisputed that the Provider is located in an urban area and that the only criterion under dispute is the number of beds. The statute does not expound upon the meaning of "bed" with respect to DSH eligibility. However, the regulation, 42 C.F.R. §412.106, implements the statutory provisions and establishes factors to be considered in determining whether a hospital qualifies for a DSH adjustment. Section 412.106(a)(1)(i) requires that the number of beds be determined in accordance with 42 C.F.R. §412.105(b).[11] This regulation 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 bed days during the cost reporting period, not including beds assigned to newborns, custodial care, and excluded in 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) (1992).

The Board finds that the controlling regulation, 42 C.F.R. §405.105(b), establishes the fundamental methodology for determining a hospital's bed size for purposes of DSH eligibility. This regulation requires that all beds be included in the calculation unless they are specifically excluded under the categories listed in the regulation.

Further, the Board finds that the word "bed" is specifically defined in PRM §2405.3.G for the purpose of calculating the adjustment for IME and DSH eligibility. In part, the PRM states that:

> G. Bed Size- A bed is defined for this purpose as an adult or pediatric bed (exclusive of beds assigned to newborns which are not in intensive care areas, custodial beds, and beds in excluded units) maintained for lodging inpatients, including beds in intensive care areas, 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 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

[8] 42 U.S.C. §1395ww(d)(5)(F)(i)(II)

[9] 42 U.S.C. §1395ww(d)(5)(F)(vi)

[10] 42 U.S.C. §1395ww(d)(5)(F)(v)(I)

[11] 42 C.F.R. §412.105 provides for additional payments for IME costs of graduate medical education.

> 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 a 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 using used. Rather, the count is intended to capture changes in the size of a facility as beds are added or taken out of service.

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

Based on the above-cited authorities, the Board concludes that the criteria applied by the Intermediary for the exclusion of observation beds and swing-beds cannot be supported by the correct and clear interpretation of the language set forth in the regulation 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. The Board further finds that these beds were permanently maintained and available for the lodging of inpatients and were fully staffed to provide inpatient services during the cost reporting period under appeal.

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 types of beds excluded from the count, the Board finds these comprehensive rules are meant to provide an all-inclusive listing of the excluded beds.

The Board rejects the Intermediary's contention that only beds reimbursed under PPS should be included in the count of available beds, since the purpose of DSH is to adjust PPS payment amounts. If this argument were valid, Congress would simply have said so in the enabling statute, and regulations could have been promulgated to accommodate a category for PPS-excluded beds. Instead, the controlling regulation and manual guidelines were written in a manner that provides great specificity regarding beds that are to be included and those that are to be excluded from the count.

The Board notes that the Secretary has stated in various decisions reversing the Board's interpretation of available beds, that the CMS has had a long-standing policy of using PPS days to determine the number of available bed days for DSH reimbursement.

However, the Board finds this statement inconsistent with the program instructions at PRM §2404.5.G. According to the example in manual provision, a hospital that has 185 acute care beds, of which 35 beds are used to provide long-term care beds, would include all 185 beds to determine the available bed days, since the 35 beds are certified for acute care.

The Board finds that the informal instructions set forth in the HCFA Program Memorandum dated March 11, 1997, which serves as the basis for the Intermediary's exclusion of observation beds, are wholly inconsistent with the controlling Medicare regulations, manual instructions and prior HCFA policy regarding counting available beds. Moreover, since the Provider's cost report at issue was for the 1992 reporting period, the Board finds that such instructions cannot be retroactively applied even if otherwise proper.

Finally, the Board observes that the Sixth Circuit decision in Clark Regional Medical Center,[12] upheld the Board's decision in the Kentucky DSH Group appeal, supra, wherein the Board found that observation and swing-bed days meet the Medicare program's requirements to be included in the bed size calculation used to determine DSH eligibility. The Court found that HCFA's application of its own regulations and the PRM could not be squared with the plain meaning of the definition of "available beds." Because the regulation specifically listed certain types of beds that were excluded from the calculation but did not list swing-beds or observation beds, the plain meaning of the regulation suggested that it is permissible to count swing beds and observation beds in the calculation of available beds. Further, the Court found that the PRM was conclusive proof that both types of beds are intended to be counted in the tally of "available bed days" in the DSH calculation. PRM §2405.3.G. states that "to be considered an available bed, a bed must be permanently maintained for lodging inpatients." The beds in question were always staffed and available for acute care inpatients. The PRM explains that "the term 'available bed' is not intended to capture the day-to-day fluctuations in patient rooms and wards being used." Therefore, the Court concluded that this was precisely the type of day-to-day fluctuation that should not be captured when counting beds under 42 C.F.R. §105(b). Clark at 247-249.

The Court affirmed the lower Court's finding that the HCFA Administrator's decision in the Kentucky DSH Group appeal was arbitrary and capricious and not supported by the applicable regulations and PRM guidelines. The Court noted that implicit in the Administrator's interpretation was that the counting of beds under 42 C.F.R. §412.105(b) for purposes of the DSH adjustment was an interpretation that was construed so as to offer the least advantage to the hospital. Id. at 249.

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.

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12 314 Fed. 3d 241 (6th Cir.. 2002)

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