PROVIDER REIMBURSEMENT REVIEW BOARD HEARING DECISION

99-D66

PROVIDER -Commonwealth of Kentucky
92-96 DSH Group

Provider Nos. Various

vs.

INTERMEDIARY - Blue Cross and Blue Shield Association/AdminaStar Federal

DATE OF HEARING-
April 28, 1999

Cost Reporting Periods Ended - Various

CASE NO. 98-0211GE

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ISSUE:

Did the Intermediary properly determine that the Providers had less than 100 "beds" for the fiscal years in question?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

This appeal is brought by Clark Regional Medical Center, located in Clark County, Kentucky, and Pattie A. Clay Hospital, located in Madison County, Kentucky ("Providers").[1] For the various cost reporting periods at issue, AdminaStar Federal ("Intermediary ") determined the number of beds at each facility. The Intermediary's determinations included adjustments that removed observation bed days and swing-bed days from the available bed days calculation. As a result, the number of beds claimed by the Providers was reduced, and the Providers either became ineligible for a disproportionate share hospital adjustment ("DSH") or the amount of their DSH was significantly reduced.[2]

For each of the cost reporting periods at issue, the Providers appealed the Intermediary's determination to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841, and met the jurisdictional requirements of those regulations. The amount of Medicare reimbursement in controversy is approximately $5,092,000.[3]

The Providers were represented by Keith D. Barber, Esq., and Sharon K. Hager, Esq., of Hall, Render, Killian, Heath & Lyman, P.S.C. The Intermediary was represented by James R. Grimes, Esq., Associate Counsel, Blue Cross and Blue Shield Association. .

PROVIDERS' CONTENTIONS:

The Providers contend that the Intermediary's adjustments are improper. The Providers assert that when Congress established DSH it chose to distinguish large hospitals from small hospitals by setting a 100 bed threshold. Congress clearly envisioned a simple count of beds for this purpose. The Intermediary, however, seeks to exclude beds licensed and staffed for acute care because they were used for either skilled nursing or observation on a temporary basis. In all, the bed count intended by Congress was just a proxy for the size of a hospital, and was not designed to reflect a detailed calculation of hospital reimbursement.[4]

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[1] Providers' Position Paper at 1. Transcript ("Tr.") at 19 and 35.

[2] Intermediary's Position Paper at 2.

[3] Intermediary's Position Paper at 1. Exhibit P-1.

[4] Tr. at 6.

The Providers contend that the Intermediary's adjustments are improper since no Medicare laws, regulations or manual instructions require observation bed days and swing-bed days to be excluded from the determination of "available bed days" for purposes of determining DSH eligibility.[5] In particular, 42 C.F.R. § 412.105, which is the rule for counting beds for both indirect medical education and DSH, excludes many specific types of beds from the count. However, it does not address observation or swing-bed utilization. The regulation is specific about excluding healthy newborn beds, and beds in excluded distinct part hospital units from the count. Yet, in all this specificity, there is no suggestion that swing-beds or observation beds are excluded. In fact, the explicit language in the regulation stating that "beds in excluded distinct part hospital units" are removed from the count suggests that beds in non-distinct units are included. Id.

The Provider Reimbursement Manual, Part I ("HCFA Pub. 15-1") § 2405.3.G seems to provide a list of the specific beds that are excluded from the count, and it also does not address swing beds or observation beds. This guideline suggests that only the beds on the list are excluded by stating: "[b]eds in the following locations are excluded from the definition" preceding the listing. HCFA Pub. 15-1 § 2405.3.G. The guideline provides no hint of any other beds that might be excluded, nor does it use standard language (e.g., "such as", or the list of excluded beds "includes") that might suggest that beds other than those on the list can be excluded. Notably, under the legal principle of *ejusdem generis*, the listing of specific items in this manner restricts the class to those items listed.

The manual does, however, state that acute care beds used for long-term care should be considered "available beds" unless they are otherwise certified. Accordingly, the manual instructions clearly indicate that beds generally available for inpatient care during the year are to be counted despite occasional use for other purposes.

The Providers assert that prior cases interpreting HCFA Pub. 15-1 § 2405.3.G and 42 C.F.R. § 412.105 also indicate that bed counts should not be reduced because beds generally available for acute inpatient care are occasionally used for observation or swing-bed purposes. Virtually all of these cases pertain to the adjustment for indirect medical education where hospitals benefit from a lower bed count. In each of these cases the Administrator of the Health Care Financing Administration ("HCFA") reversed the Board's decisions and maintained that all of a hospital's licensed beds are to be counted except those beds expressly excluded from the count by 42 C.F.R. § 412.105, i.e., certain nursery, custodial and distinct part unit beds, unless the provider proves that the beds were not available as required by the regulation and manual instructions.[6] See Pacific Hospital of Long Beach v. Aetna Life Insurance Company, PRRB Dec. No. 93-D5, December 16, 1992, Medicare & Medicaid Guide (CCH) ¶ 40, 987, rev'd. HCFA Administrator, February 11, 1993, Medicare & Medicaid Guide (CCH) ¶ 41,355 ("Pacific Hospital"); St. Joseph Hospital (Omaha, Neb.) v. Mutual of Omaha, PRRB

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[5] Providers' Position Paper at 8. Providers' Post Hearing Brief at 12.

[6] See also Providers' Post Hearing Brief at 13.

Dec. No. 94-D29, April 20, 1994, Medicare & Medicaid Guide (CCH) ¶ 42,253, rev'd. HCFA Administrator, June 20, 1994, Medicare & Medicaid Guide (CCH) ¶ 42,559; Rochester Methodist Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Minnesota, PRRB Dec. No. 94-D70, August 9, 1994, Medicare & Medicaid Guide (CCH) ¶ 42,603, rev'd. HCFA Administrator, October 11,1994, Medicare & Medicaid Guide (CCH) ¶ 42,792.

Moreover, the Providers note that in Pacific Hospital, and again in Natividad Medical Center v. Blue Cross of California, PRRB Dec. No. 91-D58, August 9, 1991, Medicare & Medicaid Guide (CCH) ¶ 39,573, rev'd. HCFA Administrator, October 6, 1991, Medicare & Medicaid Guide (CCH) ¶ 39,611, the HCFA Administrator clearly asserts a presumption that a hospital's licensed beds are to be counted absent substantial evidence of unavailability for occupancy. The Providers submit that if bed counts should not be reduced for the circumstances set forth in these cases, they should not be reduced for this case because beds generally used for acute inpatient care are occasionally used for observation or swing-bed purposes.

The Providers maintain, therefore, that given the prevalence with which acute care beds are utilized for observation and swing purposes, it is inconceivable that such utilization was overlooked in drafting the relevant statutes, regulations and manual instructions. The Providers believe that excluding observation and swing-bed days from the bed count formula represents an improper expansion of program instructions.

The Providers contend that the Intermediary's adjustments also reflect policy that is contrary to the plain language of the law.[7] Provisions at 42 U.S.C. § 1395ww(d)(5)(F)(v) describe varying thresholds for DSH eligibility depending upon a hospital's number of beds. Court decisions addressing DSH issues explain the Congressional purpose for DSH is to allow for additional payments to hospitals that serve a significant number of low-income patients, as defined by statute. Congress believes that such payment is necessary because of additional costs associated with the care of such individuals. See Jewish Hospital, Inc. v. Secretary, 19 F.3d 270 (1994) ("Jewish"). Accordingly, given the Congressional intent behind DSH, it is logical to conclude that Congress intended the DSH bed count thresholds to simply encompass licensed acute care beds.

Additionally, absent clear language to the contrary, the rules of statutory construction require the term "bed" to be interpreted to have its plain and common meaning. There is nothing in the statute to suggest that Congress intended to allow HCFA to engineer a formula that would have the effect of not allowing a hospital to include its full complement of inpatient beds for purposes of DSH eligibility. When a statute is not ambiguous, HCFA's interpretation of the statute is owed no deference. See Jewish; see also Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc., et al., 467 U.S. 837 (1984).

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[7] Providers' Position Paper at 11. Providers' Post Hearing Brief at 25.

In all, based upon the plain language of the statute, the Providers assert that Congress intended the word "bed" to have its common meaning and encompass licensed beds. Significantly, the Providers' licensed acute care beds were permanently maintained for lodging inpatients, and their occasional use for observation or skilled nursing does not change their character. Nothing in the DSH statute suggests, much less mandates, a diminution of the Providers' bed counts if beds are occasionally used for observation and swing-bed purposes -- uses which certainly were known to Congress when it promulgated the DSH legislation.

The Providers add that the courts which have considered HCFA's bed count methodology for indirect medical education purposes appear to have confirmed its validity. See AMISUB d/b/a St. Joseph's Hospital v. Shalala, Medicare & Medicaid Guide (CCH) ¶ 43,974; Grant Medical Center v. Shalala, 905 F. Supp. 460 (So. Dist. of Ohio, 1995); Sioux Valley Hospital v. Shalala, 29 F.3d 628 (8th Cir. 1994). However, in all of these cases the courts were affirming HCFA's determination that the provider had a higher bed count than urged by the provider. The Providers herein submit that HCFA cannot waffle on interpretation of its regulatory scheme to avoid spending program dollars. Although use of the indirect medical education bed count methodology may financially benefit HCFA in implementing the DSH mandate, indirect medical education and DSH were enacted for two different purposes. Use of the indirect medical education regulatory methodology should not be used to thwart Congressional purposes for DSH. It is axiomatic that Congress did not intend to count all beds of any character a hospital might house in its facility. The manual, HCFA Pub. 15-1 § 2405.3.G, appears to include beds whose general character during the course of the fiscal year is "inpatient lodging," which is licensed acute care beds.

The Providers also contend that the Intermediary's arguments are not supported by statute, regulations or manual provisions. As previously noted, the words "swing" and "observation" do not appear in the DSH statute, pertinent regulations or manual instructions.[8]

Program instructions at HCFA Pub. 15-1 § 2405.3.G clearly state that, "the bed count is intended to capture changes in the size of a facility as beds are added to or taken out of service." Id. The manual states further, "[a] bed is defined . . . as an adult or pediatric bed . . .. maintained for lodging inpatients . . . ." Id. Respectively, the Providers assert that all of their beds were "maintained for lodging inpatients" and none were "added to or taken out of service" during the fiscal years at issue. The manual instruction does not state that beds should be deemed to have been "taken out of service" in proportion to swing and observation utilization.

Also, it is of no consequence that some of the licensed acute care beds are certified under the swing-bed program. All of these beds are licensed as acute care, and are permanently maintained for lodging inpatients. Beds licensed and certified as long-term care (i.e., nursing facility) are different from beds certified as swing-beds, i.e., such beds are not licensed as acute and are not subject to the limitations of

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[8] Providers' Position Paper at 13.

the swing-bed program. Beds licensed and certified as long-term care are in an inpatient area of the facility not certified as an acute care hospital and should be excluded per the manual instruction.

The Providers maintain that in the absence of evidence to the contrary, it must be concluded that Congress intended the term "bed" in 42 U.S.C. § 1395ww(d)(5)(F)(v) to mean licensed acute care beds. Taking the Intermediary's position to its conclusion creates a situation that Congress clearly did not intend. For example, Clark Regional Medical Center ("Clark") has 100 licensed beds. According to the Intermediary, Clark would be ineligible for DSH if it used a single bed for a single day of observation or swing use. Observation is a common, historical and clinically appropriate use of acute care beds. Congress did not intend to disqualify 100 bed hospitals from DSH eligibility because of observation utilization. Congress also did not intend to discourage hospitals from participating in the swing-bed program, particularly given the purpose of that program, by disqualifying them from DSH if their beds are used for swing purposes.

The Providers contend that the means by which HCFA instructed the Intermediary to exclude observation and swing-bed days from the bed count calculation constitutes improper substantive rule making.[9] The Intermediary relied upon Administrative Bulletin # 1841 and two HCFA letters in its determination of the Providers' DSH eligibility (Exhibits P-3, P-4 and P-5). These "rules," which address the treatment of observation and swing-bed days, were never promulgated in accordance with the Administrative Procedure Act ("APA") and are therefore invalid. 5 U.S.C. 551. Notably, observation and swing utilization was not discussed in the narrative that accompanied the passage of either 42 C.F.R. § 412.106 or 42 C.F.R. § 412.105, and there is nothing in HCFA Pub. 15-1 § 2405.3.G that suggests that observation and swing-bed days should be excluded from the bed count determination.

Rules of a substantive nature must be promulgated in accord with the APA, which requires a process of public notice and comment. Exceptions to the notice and comment requirements under the APA are to be narrowly interpreted, and one reason for this narrow approach is to ensure "fairness to the affected parties." American Hospital Assn. v. Bowen, 834 F.2d 1037 (D.C. Cir. 1987). An agency policy "must be published if it is of such a nature that knowledge of it is needed to keep the parties informed of the agency's requirement as a guide for their conduct." Id. Under established government policy and numerous court decisions, proposed interpretive rules or statements of broad policy that may have such a "substantial impact on private rights and obligations" must use the notice and comment procedures set forth in the APA. See ,e.g. National Retired Teacher Association v. United States Postal Service, 430 F.Supp. 141, 147 (D.C. 1977).

Respectively, the facts in this case establish that the method of counting beds for DSH eligibility and the policy as to which beds will be excluded or included from the count, have a substantial impact on providers. In addition, it is difficult to imagine a process more unfair to hospitals than this one. For

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[9] Providers' Position Paper at 15. Providers' Post Hearing Brief at 20.

example, the Providers reasonably relied on years of DSH payments from the Intermediary where the Intermediary counted the observation and swing-beds it now suddenly seeks to exclude. No regulation or guideline contradicted the Intermediary's favorable treatment until the circumstances that created this case. It should be noted that where there is a "manifest lack of guidance" on an issue, then repeated conduct by HCFA or its Intermediary on payments, "a pattern of reliance" is established for providers to follow. Mercy Hospital v. Shalala, Medicare and Medicaid Guide (CCH) 41,735, (D.C.--1993). Also, where such "a pattern of reliance" has been established, then should HCFA desire to break the pattern "the proper course is for HCFA to pronounce a clear policy ... by invoking the proper rulemaking procedures under the APA." Id. It should also be noted that the March 7, 1997 letter relating to counting observation beds was issued after the cost reporting periods at issue. Accordingly, this letter constitutes retroactive rule making and should not be considered by the Board in this case.

The Providers reject the Intermediary's argument that only beds reimbursed under Medicare's prospective payment system ("PPS") should be included in the bed count since the purpose of DSH is to adjust PPS amounts.[10] The Providers argue that if the Intermediary were correct regarding this point, then the DSH calculation would be based upon inpatient days or PPS reimbursed days rather than beds. However, that is not what Congress did.

Moreover, there is no support for the Intermediary's position in the pertinent regulations or manual instructions. Both 42 C.F.R. § 412.105 and HCFA Pub. 15-1 § 2405.3.G address the bed count at issue. However, neither of these authorities can be read in a manner suggesting that only beds reimbursed under PPS are included in the count. Rather, these authorities are clear that a bed is counted so long as it is merely available for inpatient care, which is an undisputed fact regarding the beds at issue. The very nature of swing-beds is that they can "swing" immediately back to acute care services. Similarly, a bed temporarily used to observe a patient was immediately available for that patient should he or she require inpatient admission.

The Intermediary's position also does not reconcile with HCFA's statement in the September 1, 1995 Federal Register responding to how a bed in a healthy baby nursery would be counted if it were temporarily used for less healthy infant care.[11] HCFA claimed:

> policies have consistently followed the general principle that we do not attribute costs or days to individual beds, but rather to units or departments. Therefore, individual beds that are occasionally used to treat less healthy infants, but that are located within a regular, healthy baby nursery, continue to be treated as part of the unit in which they are

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[10] Tr. at 91. Providers' Post Hearing Brief at 23.

[11] Providers' Post Hearing Brief at 16.

> located, that is part of the healthy baby nursery ... one must consider the cost center concept [of PRM § 2302].

60 Fed. Reg. 45778 (September 1, 1995).

With respect to this policy, it is undisputed that all of the beds at issue in this case were located in the acute care portion of the Providers' facilities; there were no observation departments or swing-bed units. Just as in the example above, where healthy baby beds might be used for less healthy babies, acute care beds in the Providers' facilities were used for observation and swing-bed services at various times.

The Providers also reject the Intermediary's argument that swing-beds and beds used for observation do not meet the manual's requirement of being "permanently maintained for lodging inpatients."[12] HCFA Pub. 15-1 § 2405.3.G. If this Intermediary argument were valid, then a bed used even once as a swing-bed or for observation would never be counted. However, that is not the methodology established by HCFA. Also, this argument is in direct opposition to the manual statement that: "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." Id.[13]

Respectively, the Providers maintain that the temporary use of a licensed and staffed acute care bed for swing utilization or observation does not change the size of a facility. Factually, all of the beds at issue are permanently maintained for inpatient care.

The Providers also reject the Intermediary's position regarding the manual's requirement which states: "[t]he hospital bears the burden of proof to exclude beds from the count."[14] Specifically, the Intermediary says that this requirement only applies to indirect medical education where placing the burden on the hospital makes sense; however, it does not apply to DSH because placing the burden on the hospital works to the hospital's benefit. However, 42 C.F.R. § 412.106 clearly establishes the rules for counting beds for DSH, and those rules say that the methodology to be used for DSH is exactly the same as that used for indirect medical education. Accordingly, the Intermediary's failure to rely upon the Providers to exclude beds is inconsistent with the enabling regulation.

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[12] Tr. at 96. Providers' Position Paper at 13.

[13] See also Providers' Post Hearing Brief at 16.

[14] Tr. at 98. Providers' Post Hearing Brief at 13.

The Providers assert that the example of counting beds contained in HCFA Pub. 15-1 § 2405.3.G, and presented in the Intermediary's position paper, supports its case.[15] First, the example shows where beds are removed from the count because of a renovation which lasted 6 months. The Providers maintain that the renovation, which required a wing of the hospital to be closed, clearly represents a change in the size of the facility as opposed to day-to-day fluctuations in bed utilization. Significantly, however, the example also shows that 35 beds used for long-term care are included in the count because they are considered acute care beds. The manual 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. The Providers contend that this is precisely the issue at hand. All of the beds used for swing utilization or observation are certified and staffed for acute care. As in the example, acute care beds were temporarily used for another purpose but were not certified as such.

The Providers disagree with the Intermediary's argument that swing-beds are "otherwise certified."[16] The Providers maintain that hospitals are certified as swing-bed providers and that no specific beds or even a specific number of beds are actually certified for swing utilization as explained in HCFA Pub. 15-1 § 2230.

The Providers also disagree with the Intermediary's argument that the subject beds were used more frequently for skilled nursing care and observation than the term "occasionally" would imply.[17] The Intermediary presents an exhibit which shows that approximately 10 percent of the Providers' total bed days were swing-bed days and observation bed days. In response, the Providers argue that this percentage of utilization is exactly the kind of day-to-day fluctuations that HCFA Pub. 15-1 § 2405.3.G says should be included in the count. Moreover, the Providers maintain that the Intermediary's argument regarding this utilization percentage is irrelevant. That is, since each of the beds at issue was licensed, certified, and staffed for acute care, and was generally available for lodging acute care patients throughout the cost reporting periods at issue.

Finally, the Providers assert that the letters explaining that swing-bed days and observation bed days should be excluded from the bed count, and which serve as the basis for the Intermediary's adjustments, are inconsistent with the enabling regulations and manual instructions.[18] See Exhibits I-2 and I-3. The enabling regulations and manual instructions specify the beds that are to be excluded from the count and they do not exclude swing-beds and beds used for observation. The letters do not reflect the manual's requirement that bed counts are not to be effected by day-to-day fluctuations but only for actual changes in a hospital's size. Also, the letters are not consistent with the program's rule that the

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[15] Tr. at 100. Providers' Post Hearing Brief at 17.

[16] Tr. at 103.

[17] Tr. at 107.

[18] Tr. at 109. Providers' Post Hearing Brief at 18.

hospital has the burden to exclude beds from the count, or the manual's example where beds used for long-term care but not certified as such were included in the count. And, the letters are not consistent with the September 1, 1995 Federal Register which explains that bed days are not counted based upon how a bed is used, but rather on the department in which a bed is located.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its adjustments removing observation bed days and swing-bed days from the calculation of the Providers' number of beds are proper. The Intermediary asserts that the determination of the number of beds must be viewed in the same context as the purpose of DSH. [19] Specifically, short term acute care hospitals are reimbursed under PPS where inpatient hospital services are paid pursuant to a set Federal rate per discharge.[20] In general, this rate reflects a national average which, under usual circumstances, is not adjusted to account for particular hospital costs. Congress, recognizing that some hospitals which provide services to a significant number of low income patients incur costs that are not reflected in the Federal rate, implemented DSH. Therefore, DSH should only be applied to inpatient hospital service payments under PPS. This would exclude swing-bed services since they are reimbursed on the basis of reasonable cost, and observation bed day costs since they are an outpatient service. Therefore, it is proper to remove bed days associated with these services from the number of beds determination so all that is left are the beds within the PPS area.

The Intermediary contends that the pertinent regulations and manual instructions define "beds" for purposes of DSH and indirect medical education as beds that are within the area of the hospital that is subject to PPS.[21] The Intermediary asserts that the regulation governing DSH, 42 C.F.R. § 412.106, explains that the number of beds is determined in accordance with 42 C.F.R. § 412.105(b), which states:[22]

> (b) 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).

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[19] Tr. at 16.

[20] Tr. at 12.

[21] Tr. at 13.

[22] Intermediary's Position Paper at 2.

Moreover, manual instructions at HCFA Pub. 15-1 § 2405.3.G provide the following guidance on available beds:

> 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 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, postanesthesia 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 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. 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 Intermediary asserts that days attributable to observation and swing-bed patients must be removed from available bed days pursuant to these rules and instructions. One requirement outlined in HCFA Pub. 15-1 § 2405.3.G is that a bed must be permanently maintained for lodging hospital inpatients. This cannot be the case for beds the Providers know are going to be occupied at times by hospital outpatients (observation) and at times by patients requiring skilled nursing care (swing-beds).

The Intermediary rejects the Providers' reliance on the portion of the manual instructions which explain that hospitals bear the burden of proof to exclude beds from the count, and that beds available at any time during the period are presumed to be available during the entire period unless there is evidence to

the contrary.[23] This instruction was written for indirect medical education where it is to a provider's advantage to remove beds from the count, so naturally it should be the provider's burden to submit proof. However, in this case, it is to a provider's detriment to remove beds from the count. Therefore, an intermediary must remove beds from the count if there is evidence that beds are not available, even if that evidence is not submitted by the provider. Moreover, in this case there is irrefutable evidence that the beds are not available on certain days for hospital inpatients since there are other patients already occupying them.

The Intermediary also contends that the manual instructions provide for counting beds on some days and not counting them on others. For example, beds located in a wing under renovation are not counted during the renovation because the beds are not immediately available. The same would be true on days beds are occupied by swing-bed and observation patients. The beds are not immediately available if they are already occupied.

The Intermediary also rejects the Providers' reliance on the portion of HCFA Pub. 15-1 § 2405.3.G which explains that acute care beds used for long-term care should be considered available beds unless they are otherwise certified.[24] That is, because swing-beds are "otherwise certified." They are separate providers with separate provider numbers whose cost is reclassified from the adult and pediatric cost center. The example in the manual is that of an area whose cost would stay in the adult and pediatric cost center. Clearly, the manual indicates days that beds are used for long-term care and are certified as such should not be considered available bed days. This would encompass swing-bed days.

The Intermediary also disagrees with the Providers' statement that observation and swing-bed utilization represents "occasional usage."[25] Although available beds are computed on an average basis for the year, the Intermediary believes there was no individual day during any year under appeal where Clark had 100 beds available for hospital inpatients, and probably very few days where Pattie A. Clay Hospital had 100 beds available for hospital inpatients. For example, Exhibit I-1 shows the actual number of skilled nursing bed days and observation bed days incurred by each facility for the fiscal years ended in 1993 through 1995. Clark, which has 100 licensed beds, had averages of 9.5, 9.1 and 9.3 beds being occupied by such patients, respectively. Similarly, Pattie A. Clay Hospital, which has 105 licensed beds, had averages of 10.1, 11.4, and 10.2 bed days utilized for swing patients or observation during these periods. The Intermediary asserts that it seems clear that the Providers' planned to use several of their licensed beds each year for patients other than hospital inpatients.

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[23] Intermediary's Position Paper at 3.

[24] Id.

[25] Id.

The Intermediary contends that correspondence from the Blue Cross and Blue Shield Association ("BCBSA") and from HCFA directly addresses the exclusion of swing-bed days and observation bed days from the available bed days calculation.[26] BCBSA Administrative Bulletin # 1841 (Exhibit I-2) relayed a clarification from HCFA on HCFA Pub. 15-1 § 2405.3.G. In part, the bulletin states:

> [d]ays in which swing beds are available for use for acute care inpatients should be counted for purposes of the indirect medical education adjustment. Available bed days are to be determined by using total swing bed days available less bed days utilized as skilled nursing beds.

BCBSA Administrative Bulletin # 1841.

In a HCFA letter dated March 7, 1997 (Exhibit I-3), the following statement is made:

> Observation Beds - If a hospital provides hospital 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 the 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.

HCFA Letter, March 7, 1997.

Finally, the Intermediary contends that HCFA's letter was meant as a clarification of existing policy since it says to ensure that the policies set forth in it are applied to all cost reports subject to the 3-year reopening rule.[27]

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§ 1395ww(d) et seq.	-	PPS Transition Period; DRG Classification System; Exceptions and Adjustments to PPS

[26] Intermediary's Position Paper at 4.

[27] Id.

	Law - 5 U.S.C. et. seq.	-	Administrative Procedure Act

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

§§ 405.1835-.1841	-	Board Jurisdiction
§ 412.105	-	Special Treatment: Hospitals that Incur Indirect Costs for Graduate Medical Education Programs
§ 412.105(b)	-	Determination of Number of Beds
§ 412.106	-	Special Treatment: Hospitals that Serve a Disproportionate Share of Low Income Patients

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

§ 2230 et seq.	-	Swing-bed Reimbursement for Qualifying Small, Rural Hospitals
§ 2405.3.G et seq.	-	Adjustment for the Indirect Cost of Medical Education-Bed Size

4. Case Law:

Pacific Hospital of Long Beach v. Aetna Life Insurance Company, PRRB Dec. No. 93-D5, December 16, 1992, Medicare & Medicaid Guide (CCH) ¶ 40,987, rev'd. HCFA Administrator, February 11, 1993, Medicare & Medicaid Guide (CCH) ¶ 41,355.

St. Joseph Hospital (Omaha, Neb.) v. Mutual of Omaha, PRRB Dec. No. 94-D29, April 20, 1994, Medicare & Medicaid Guide (CCH) ¶ 42,253, rev'd. HCFA Administrator, June 20, 1994, Medicare & Medicaid Guide (CCH) ¶ 42,559.

Rochester Methodist Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Minnesota, PRRB Dec. No. 94-D70, August 9, 1994, Medicare & Medicaid Guide (CCH) ¶ 42,603, rev'd. HCFA Administrator, October 11,1994, Medicare & Medicaid Guide (CCH) ¶ 42,792.

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

Jewish Hospital, Inc. v. Secretary, 19 F.3d 270 (1994).

Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc., et al., 467 U.S. 837 (1984).

AMISUB d/b/a St. Joseph's Hospital v. Shalala, Medicare & Medicaid Guide (CCH) ¶ 43,974.

Grant Medical Center v. Shalala, 905 F. Supp. 460 (So. Dist. of Ohio, 1995).

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

American Hospital Assn. v. Bowen, 834 F.2d 1037 (D.C. Cir. 1987).

National Retired Teacher Association v. United States Postal Service, 430 F.Supp. 141, 147 (D.C.--1977).

Mercy Hospital v. Shalala, Medicare and Medicaid Guide (CCH) 41,735, (D.C.--1993).

5. Other:

BCBSA Administrative Bulletin # 1841.

HCFA Letter, May 31, 1996.

HCFA Letter, March 7, 1997.

60 Fed. Reg. 45778 (September 1, 1995).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, evidence presented, testimony elicited at the hearing, and Providers' post hearing brief, finds and concludes as follows:

The Intermediary excluded observation bed days and swing-bed days from the calculation of "total beds" used to determine the Providers' eligibility for a DSH adjustment. In general, the Intermediary argues that only beds reimbursed under PPS should be included in the total bed count since the purpose of DSH is to adjust PPS payment amounts. In this regard, the Intermediary asserts that

observation bed days and swing-bed days must be excluded from the count since swing-beds are reimbursed on the basis of reasonable cost, while observation bed days are an outpatient service.

In association with its general argument, the Intermediary asserts that observation beds and swing-beds do not meet the program's rules which define "bed size" for the purpose of DSH eligibility. That is, observation beds and swing-beds, by their very nature, are not permanently maintained and available for lodging inpatients, and swing-beds are not acute care beds since they are separately certified and their costs are reclassified out of the adult and pediatric cost center. 42 C.F.R. § 412.105 and HCFA Pub. 15-1 § 2405.3.G.1 and 2.

The Provider raises several arguments in opposition to the Intermediary's decision. In part, the Provider argues that Congress never intended the bed count for DSH to employ a complicated formula as that used for indirect medical education, which is the methodology elected by HCFA to determine DSH eligibility. Moreover, the Provider argues that swing-beds and observation beds clearly meet the program's rules for counting beds, while the Intermediary's position has no authoritative basis and is actually inconsistent with the rules.

The Board finds that the enabling statute, 42 U.S.C. § 1395ww(d)(5)(F), considers three factors in determining whether or not a hospital qualifies 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 in this case. The Board notes that the statute refers only to the singular word "bed," and does not expound upon its meaning with respect to DSH eligibility.

The Board finds that the controlling regulation, 42 C.F.R. § 412.105, requires a hospital's bed size to be determined by dividing its "available bed days" by the number of days in the cost reporting period. Moreover, the regulation excludes nursery beds assigned to newborns that are not in intensive care areas from the determination of available bed days, as well as custodial care beds and beds in excluded units.

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 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, postanesthesia 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 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.

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

Based upon these authorities, the Board finds that the Providers' observation bed days and swing-bed days meet all of the program's requirements to be included in the bed size calculation used to determine DSH eligibility. In particular, all of the beds at issue in this case are licensed acute care beds located in the acute care area of the Providers' facilities. These beds are also permanently maintained and available for lodging inpatients. As established by the Provider, each of the beds was fully staffed to furnish inpatient services throughout the subject cost reporting periods. And, as discussed below, the fact that the beds were sometimes occupied by observation patients or patients requiring skilled nursing care does not affect their availability.

The Board's decision also relies upon the fact that the enabling regulation and manual instructions identify the specific beds excluded from the bed count, and that neither of these authorities exclude observation beds and swing-beds. The Board also finds that these rules are meant to provide an all inclusive listing of the excluded beds. That is, considering the great 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 beds excluded from the count, while never being modified to address observation bed days or swing bed-days. The Board also agrees with the Provider regarding this matter, in that, a listing of specific items in the manner employed by the regulations and manual instructions restricts the class to the items listed under the principle of *ejusdem generis*.

In addition, the Board finds support for its decision in the example provided by HCFA for determining bed size at HCFA Pub. 15-1 § 2405.3.G.2. In this example, a hospital has 185 acute care beds including 35 beds that were used to provide long-term care. HCFA 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, HCFA 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 this example directly on point. Acute care beds that are temporarily or occasionally used for another type of patient care but not certified as such, identically to the observation beds and swing-beds at issue in this case, are included in the count.

The Board notes the Intermediary's argument that swing-beds carry their own certification, i.e., as swing-beds, and should therefore be excluded from the count since they are in fact "otherwise certified." However, the Board finds that beds are not actually certified at all with respect to swing utilization, but rather, hospitals are approved to use acute care beds to provide skilled nursing service. Program instructions at HCFA Pub. 15-1 § 2230 state:

> [a] swing-bed hospital is a small, rural hospital that has been approved by the Health Care Financing Administration to use its beds interchangeably to furnish either acute care services or skilled nursing facility (SNF)-type services to Medicare beneficiaries.

HCFA Pub. 15-1 § 2230 (Emphasis added).

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. The Board finds that if this argument were true, Congress would simply have said that in the enabling statute. And, even with the statute written as it is, if only days reimbursed under PPS were to be included in the bed count, there would be no reason for the controlling regulation and manual guidelines to be written in the manner that they are, i.e., with great specificity regarding beds that are included and excluded from the count.

The Board also agrees with the Providers' argument regarding this matter, meaning that the bed count for DSH eligibility is essentially intended to distinguish small and large hospitals, and that the temporary use of acute care beds for swing utilization or observation does not change the size of a facility as stipulated in HCFA Pub. 15-1 § 2405.3.G. As illustrated by the Providers, a hospital with 100 acute care beds could arguably loose its DSH eligibility if it used 1 bed for just 1 day for observation, based upon the Intermediary's interpretation of the rules. The Board does not believe this was the intent of Congress.

Finally, the Board finds that the instructions serving as the basis of the Intermediary's adjustments are uncertain. With respect to the disallowance of swing-beds from the Providers' bed count, the Intermediary relied upon an administrative bulletin ("AB #1841") issued by BCBSA. With respect to the disallowance of observation bed days from the count, the Intermediary relied upon an identical letter issued by a HCFA regional office. Initially, the Board finds that neither document is consistent with the pertinent regulation and manual guidelines that are specific with respect to the beds that are excluded from the count, yet do not exclude either swing-bed days or observation bed days.

Moreover, since AB #1841was issued by BCBSA, and is not supported by a HCFA issuance, there is no assurance that all intermediaries treat swing-beds the same way or in the manner suggested by the Intermediary. Similarly, the identical letter placed into evidence regarding observation bed days reflects instructions for only one HCFA region, and not the country as a whole. And notably, there is an apparent discrepancy between the identical letter and a HCFA Central Office letter dated May 31, 1996. Specifically, the May 31, 1996 letter explains that where a patient is placed in a bed for observation and is then admitted to the hospital the observation bed days are included in the available bed days count. In contrast, the identical letter issued by the regional office explains that where a patient is in an observation bed and is later admitted, then the days before the admission are excluded from the count.[28]

DECISION AND ORDER:

The Intermediary did not properly determine that the Providers had less than 100 beds for the fiscal years in question. The Intermediary's adjustments disallowing swing-bed days and observation bed days from the Providers' count of available days used to determine bed size, as well as DSH eligibility, are improper and are reversed.

Board Members Participating:

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

Date of Decision: September 2, 1999

FOR THE BOARD:

Irvin W. Kues
Chairman

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[28] Exhibits I-2 and 3, and P-3, 4, and 5.