PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON THE RECORD
2002-D13

PROVIDER -
BBL 94-98 Observation Bed Days Group

Provider No. 50-0023; 44-0131 and
45-0059

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Premera Blue Cross/ Riverbend
Government Benefits Administrator/
Trailblazer Health Enterprises, LLC

DATE OF HEARING-
February 5, 2002

Cost Reporting Periods Ended -
Various

CASE NO. 01-3205G

INDEX

ISSUE:

Whether the Intermediary improperly determined the Provider's DSH adjustments by excluding observation bed days from the DSH bed day calculation in violation of the applicable regulation and manual provisions.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

On March 8, 2002, the Board consolidated case number 01-3826GE into case number 01-3205G, therefore it will be included in this decision. The following Providers have joined together to file a group appeal relating to the removal of observation bed days by the servicing Intermediaries from the hospitals' bed days available calculation: Our Lady of Lourdes Health Center, a 100 bed facility located in Pasco, Washington; Baptist Memorial Hospital – Tipton, a 100 bed facility located in Covington, Tennessee; and McKenna Memorial Hospital, a 116 bed facility located in New Braunfels, Texas. The three fiscal intermediaries involved in this group appeal – Premera Blue Cross, Riverbend Government Benefits Administrator, and Trailblazer Health Care Enterprises – are referred to collectively as the "Intermediary."[1]

The Providers in the group included in its available bed count, beds used for observation services in its determination of Disproportionate Share Hospital ("DSH") on the as-filed cost reports. At audit, the servicing Intermediaries removed observation bed days from the bed days calculation, which reduced the number of beds used in the calculation of DSH payments. The audit adjustments to bed days available caused the Providers' bed counts to fall below 100 beds. Thus, the Providers either did not qualify for DSH payments or the hospitals' DSH payments were reduced, based on the Intermediary's determination.[2]

For each of the cost reporting periods at issue, each the Provider appealed the Intermediary's determination to the Provider Reimbursement Review Board ("Board") and has met the jurisdictional requirements set forth in 42 C.F.R. §§ 405.1835-.1841. The amount of Medicare reimbursement in controversy exceeds $6,000,000.[3]

The Providers were represented by Sanford E. Pitler, Esquire, of Bennett Bigelow & Leedom, P.S. The Intermediary was represented by Bernard M. Talbert, Esquire, Associate Counsel, Blue Cross and Blue Shield Association.

[1] See Providers' position paper at 1.
[2] See Intermediary's position paper at 2.
[3] See Providers' position paper at 3.

PROVIDERS' CONTENTIONS:

The Provider group requests the Board to apply its 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 (CCH) ¶ 80,322, rev'd, CMS Adminstrator, November 8, 1999, Medicare and Medicaid Guide (CCH) ¶ 80,389 ("Commonwealth of Kentucky 92-96 DSH Group") to this case.[4] In that case, the Board decided in favor of the providers on the legal issue raised in this case. In both that case and the instant case, the providers asked the Board to consider whether the regulation and manual provisions permit the fiscal intermediary to exclude observation days from the DSH bed day calculation. Id. The providers in Commonwealth of Kentucky 92-96 DSH Group argued, as do the providers here, that the DSH regulation and manual provisions do not permit the intermediary to exclude observation bed days from the DSH bed day count.

The Providers contend that the issue at hand is the proper interpretation of the governing regulation 42 C.F.R. § 412.105. The providers in Commonwealth of Kentucky 92-96 DSH Group pointed out that the regulation excludes many specific types of beds from the count but does not mention observation beds. Id. The exclusionary language suggests that the beds omitted from the list are to be included in the count. Id. Likewise, HCFA Pub.15-1, § 2405.3.G provides a list of the specific beds that are excluded, and it does not address observation beds. The language of the above-referenced instruction suggests that only the listed beds be excluded. Id. The manual specifically references an example where beds certified as acute care beds are still counted, even though they may be temporarily and occasionally used for long-term care. Id. The providers point out that CMS' own example in the manual instructs intermediaries to count beds licensed and certified as acute care beds, even though the beds are used temporarily for another purpose. Id. Further, the providers argue that CMS acknowledges in a federal register document a policy not to "attribute costs or days to individual beds, but rather to units or departments."[5]

The Providers note that in Commonwealth of Kentucky 92-96 DSH Group, the providers identified numerous PRRB cases and CMS decisions that interpret the regulation and manual provisions to require the inclusion of beds used temporarily for something other than inpatient care. *Id.* Specifically, in that case the providers cited to Pacific Hospital of Long Beach v. Aetna Insurance Company, PRRB Dec. No. 93-D5, December 16, 1992, Medicare and Medicaid Guide (CCH) & 40,987, rev'd, CMS Administrator, February 11, 1993, Medicare and Medicaid Guide (CCH) & 41,355; St. Joseph Hospital (Omaha, Neb.) v. Mutual of Omaha, PRRB Dec No. 94-D29, April 20, 1994, Medicare and Medicaid Guide (CCH) & 42,253; rev'd, CMS Administrator, June 20, 1994, Medicare and 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 and Medicaid Guide (CCH) & 42,603, rev'd, CMS Administrator, October

[4] See Providers' position paper at 4 and Exhibit P-1.
[5] See Providers' position paper at 6.

11, 1994, Medicare and Medicaid Guide (CCH) & 42,792; and Natividad Medical Center v. Blue Cross of California, PRRB Dec No. 91-D58, August 9, 1991, Medicare and Medicaid Guide (CCH) & 39,573, rev'd, CMS Administrator, October 6, 1991, Medicare and Medicaid Guide (CCH) & 39,611. Id.[6]

To further support its contentions the Providers reference Clark Regional Medical Center et al. v. Shalala 136 F. Supp.2d 667 (E.D. Kentucky March 30, 2001) ("Clark Regional").[7]

The Providers comment that following a hearing, the Board held in Commonwealth of Kentucky 92-96 DSH Group that the fiscal intermediary improperly disallowed observation beds (and swing beds) from the providers' count of available days used to determine bed size. The Board's decision relied primarily on the DSH regulation and manual provisions discussed above. According to the Board, the regulation governing the DSH payment calculation and the pertinent manual instructions do not allow observation bed days to be excluded from the available days calculation. Under the Board's analysis, 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.[8] The regulation specifically excludes certain beds from the count, and does not exclude observation beds. Id. The only beds excluded are nursery beds assigned to "newborns that are not in intensive care areas," "custodial care" beds and beds in "excluded distinct part hospital units." Id.

The Board also found dispositive the manual issued by CMS, which specifically defines the "bed" for purposes of the DSH bed count. The manual, which lists the beds excluded from the definition, states:

> [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

[6] See Providers' position paper at 6.
[7] See Providers' position paper Exhibit P-2.
[8] See Providers' position paper at 7.

> 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.

HCFA Pub.15-1 § 2405.3.G.[9] The manual further clarifies that the concept of "available bed" is intended to capture the size of the facility, not fluctuations in the number of patient rooms being used:

> 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 § 2405.3G.

The Board in Commonwealth of Kentucky 92-96 DSH Group found the above authorities dispositive, holding that:

> [b]ased upon these authorities the Board finds that the Providers' observation bed days and swing-bed days meet all of the programs' 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

[9] See Providers' position paper at 8.

affect their availability.

Central to the Board's decision was the fact that the enabling regulation and manual instructions are meant to provide an all-inclusive listing of the excluded beds, and observation beds are not listed.

Additionally, the Providers claim in Commonwealth of Kentucky 92-96 DSH Group, the Board set forth the necessary requirements for a bed to be included in the DSH bed size calculation. According to the Board, a bed meets the "program requirements" if the following elements are met:

1. the beds at issue are licensed acute care beds located in the acute care area of the providers' facilities; and

2. the beds are permanently maintained and available for lodging inpatients.

Relevant to this test and to the Board's decision with respect to the observation bed days, the Board found that the Commonwealth of Kentucky 92-96 DSH Group providers established the following facts:[10]

- all of the observation beds at issue are licensed acute care beds located in the acute care areas of the providers' facilities and staffed for acute care;

- all of the beds at issue are maintained for lodging inpatients;

- each of the beds is fully staffed to furnish inpatient services throughout the subject cost reporting periods;

- none of the beds at issue were added to or taken out of service during the fiscal years at issue;

- there is no observation department; and

- acute care beds are used for observation at various times.

Based on the above facts, the Board in Commonwealth of Kentucky 92-96 DSH Group held that the providers' observation bed days met the program's requirements and ordered the intermediary to include those days in the bed count calculation for DSH.

In this case, the Provider group establishes the same set of material facts. As demonstrated by the Provider Affidavits and its exhibits submitted in the record,[11] each Provider in the

[10] See Providers' position paper Exhibit P-1.
[11] See Providers' position paper Exhibit P3-P5.

group at times used acute care beds for observation services. The acute care beds at issue were licensed, certified, and staffed as acute care beds during the applicable cost report periods. The beds were maintained for lodging inpatients and located in acute areas of the facilities. The beds remained in service throughout the applicable period. Each Provider had no observation department or unit.

The Providers contend the Intermediary has not challenged the facts presented by the Provider Group.[12] In its description of the factual background for this appeal, the Intermediary stated that the Providers included "total hospital beds" in their DSH bed counts on the as-filed cost reports. As mentioned above, the Providers included essentially total available inpatient beds, not simply "total hospital beds" or licensed beds.

Based on these facts, which are materially identical to the facts in Commonwealth of Kentucky 92-96 DSH Group, the Board must find that the observation beds for each Provider in the group meet the Program's requirements. Given the legal and factual identity with the Commonwealth of Kentucky 92-96 DSH Group, the Board should apply its decision in that case to the Provider Group in this appeal.

INTERMEDIARY'S CONTENTIONS:

The Intermediary notes that short-term acute care hospitals are reimbursed under PPS and are paid based on a Federal rate per discharge. This rate reflects a national average and is not specific to a particular hospital in most instances. Congress recognized the fact that some hospitals provide services to a higher percentage of low-income patients and as a result incur additional costs, which are not considered in the Federal rate under PPS. The Intermediary contends that Congress implemented DSH payments to hospitals with the intention of providing additional payments to consider this factor and should not consider observation bed days and cost since these services are paid on an outpatient basis. The formula used to calculate DSH payments at 42 C.F.R. § 412.106 is correlated to a hospital's DRG payments. Since observation services are not bundled in the prospective payment to the hospitals, the Intermediary believes that the inclusion of observation beds in the DSH calculation is improper and inconsistent with the purpose of the DSH payment.

The Intermediary asserts that HCFA Pub.15-1 § 2405.3.G was revised to provide intermediaries guidance on the methodology of counting beds for purposes of IME and DSH.[13]

> 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)

[12] See Providers' Reply to Intermediary's final position paper at 3.
[13] See Intermediary's position paper Exhibit I-3.

> 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 put the beds into use when they are needed. <u>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</u>.
>
> <u>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</u>.

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

Based on these instructions, the Intermediary insists that it properly removed the observation bed days from the bed count since these beds are not permanently maintained for lodging hospital inpatients and were used for outpatient related services. The Providers contend that inpatient beds are only "sporadically" used for observation beds; however, hospitals frequently monitor patients in an observation setting. In response, the Intermediary asserts that observation beds that are used occasionally is inconsistent with hospital trends which

increasingly provides observation services as hospital technology and payor restrictions require doctors to monitor patients prior to admitting the patient to the hospital. Thus, beds for observation are not available for lodging an inpatient.

The Intermediary contends that the Providers' reference of 42 C.F.R. § 412.105(b)[14] and HCFA Pub. 15-1 § 2405.3.G does not specifically exclude observation beds in its determination of bed days to use for DSH payments. The Intermediary does not believe that the regulatory and manual provisions mentioned above are all inclusive, as does the Provider.

To further clarify their contentions the Intermediary alludes to a letter from CMS' regional office, which specifically instructs all Region IV Intermediaries to properly exclude observation bed days from the count of available bed days for the purpose of IME and DSH adjustments:[15]

> [i]f a hospital provides 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 beds days for the purposes of 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, the observation bed days are excluded from the available bed day count.

The Intermediary also cites the HCFA Administrator's decision in Commonwealth of Kentucky 92-96 DSH Group, supra, which directly addresses the count of available beds for the determination of the DSH payment. In that case, the Intermediary referenced the CMS regional office letter dated March 28, 1997 as further justification of its exclusion of observation bed days in the calculation of the DSH payment. In the reversal of the Board's decision, the CMS Administrator stated the following:[16]

> [CMS] has a longstanding policy of only considering bed days in the bed count if the costs of such days were allowable in the determination of Medicare inpatient cost. Notably, PPS was implemented to replace the reasonable cost method of reimbursing hospitals for the operating costs of inpatient hospital services. Thus, [CMS] maintained a consistent policy in defining available beds throughout the change from the cost based inpatient hospital payment system to a prospective-based inpatient hospital payment system. As [CMS] noted, this interpretation of available beds is

[14] See Intermediary's position paper at 5.
[15] See Intermediary's position paper Exhibit I-4.
[16] See Intermediary's position paper Exhibit I-5.

> 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). [CMS] explained that in determining eligibility for a DSH adjustment: We believe that, based on a reading of the language in Section [1886(d)(5)(F)] of the Act, which implements the disproportionate share provision, we are in fact required to consider only those inpatient days to which the prospective payment system applies in determining a prospective payment hospital's eligibility for a disproportionate share adjustment. Congress clearly intended that a disproportionate share hospital be defined in terms of a subsection (d) hospital, which is the only type of hospital subject to the prospective payment system.

The Administrator further stated that consistent with the payment of observation services, HCFA Pub. 15-2 § 3605 clarifies how the costs of observation bed patients are to be extracted from the inpatient hospital costs and are not recognized, under PPS as part of the inpatient operating cost of the hospital.[17] In review of the applicable law and CMS' longstanding policy concerning the counting of bed days, the Administrator agreed that the intermediary properly extracted observation bed days from the bed count. CMS has consistently excluded from the bed count, bed days not remitted as part of the inpatient operating cost of the hospital.

Consequently, the Intermediary rejects the argument that total available beds should be the determining factor in the criteria for DSH payments. The Intermediary states that manual and regulatory provisions were written for calculating both IME and DSH payments for hospitals. If intermediaries were to use total available beds in determining a hospital's IME payment instead of bed days available, which exclude the observation bed days, Providers would be devastated by the reimbursement impact. The Intermediary asserts that hospitals clearly want observation beds removed for purposes of calculating IME payments and included for DSH payments and DSH eligibility requirements. The Intermediary contends the manual and regulatory provisions were written to address both IME and DSH payments and should be consistently applied by the intermediaries in the same manner.

Therefore, the Intermediary insists that it is not appropriate for the hospital community to benefit from both arguments as a means of maximizing reimbursement. Based on these arguments the Intermediary believes it appropriately removed observation beds as instructed by CMS and outlined in the manual and regulatory provisions.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

[17] See Intermediary's position paper Exhibit I-6.

§ 1395ww(d)(5)(F) - Payment to Hospitals for Inpatient Hospital Services

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

§§ 405.1835-.1841 - Board Jurisdiction

§ 412.105 et seq. - Determination of Number of Beds

§ 412.106 et seq. - Special Treatment: Hospitals: that serve a Disproportionate Share of Low Income Patients

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

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

4. Program Instructions-Provider Reimbursement Manual (HCFA Pub. 15-2):

§ 3605 - Worksheet S-3 Hospital and Hospital Health Care Complex Statistical Data and Wage Index Information

5. Case Law:

Clark Regional Medical Center et al. v. Shalala, 136 F. Supp.2d 667 (E.D. Kentucky March 30, 2001)

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 (CCH) & 80,322, rev'd, CMS Administrator, November 8, 1999, Medicare and Medicaid Guide (CCH) & 80,389

Pacific Hospital of Long Beach v. Aetna Insurance Company, PRRB Dec No. 93-D5, December 16, 1992, Medicare & Medicaid Guide (CCH) & 40,987, rev'd, CMS Administrator, February 11, 1993, Medicare and 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, CMS Administrator, June 20, 1994, Medicare and 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 and Medicaid Guide (CCH) & 42,603, rev'd, CMS Administrator, October 11, 1994, Medicare and Medicaid Guide (CCH) & 42,792

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

6. Other:

CMS Letter to All Region IV Intermediaries, March 28, 1997

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration and analysis of the controlling law, regulations and manual guidelines, the facts of the case, parties' contentions, and evidence presented, the Board finds and concludes that the Intermediaries exclusion of observation beds days from the calculation of "total beds" used to determine DSH eligibility was not proper.

The enabling 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 fiscal years under appeal by the Providers. 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 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) 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 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).

Based on the above-cited authorities, the Board finds that the proper application of these governing provisions to observation beds would have resulted in the Providers meeting the 100-available bed threshold requirement for the calculation of the DSH payment adjustment. The criteria applied by the Intermediaries 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 also finds that the Providers met all of the Medicare program's requirements to be included in the bed size calculation used to determine DSH eligibility. The Board specifically notes that all of the observation beds at issue were licensed acute care beds located in the acute care area of the Providers' hospital facilities. Further, 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 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 Intermediaries' 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 was 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 finds further support for its decision in HCFA Pub. 15-1 § 2405.3.G.2, which provides an example for determining bed size. In this example, a hospital has 185 acute care beds, including 35 beds that were used to provide long-term care. CMS 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 <u>otherwise certified</u>.

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

The Boards 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, identical to the observation beds at issue in this case, are included in the count.

The Board finds the informal instructions set forth in the CMS Memorandum dated March 11, 1997, which served as the basis for the Intermediaries' 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, for the cost reporting periods in contention, the Board finds that such instructions cannot be retroactively applied even if their application was legitimate.

The Board notes that the Intermediary argues that treatment of observation beds under the same circumstances should be consistent for both IME and DSH, however, nothing in the Medicare regulations or manual provisions requires similar treatment.

Finally, the Board notes that the district court's decision in Clark Regional, 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."

DECISION AND ORDER:

The Intermediaries did not properly determine that the Providers had less than 100 beds for the fiscal years in question. The Intermediaries' adjustments disallowing observation

bed days from the Providers' count of available days used to determine bed size, as well as DSH eligibility, are improper and reversed.

BOARD MEMBERS PARTICIPATING:

Irvin W. Kues
Henry C. Wessman, Esquire
Stanley J. Sokolove
Gary Blodgett, D.D.S.
Suzanne Cochran, Esquire

Date of Decision: March 19, 2002

FOR THE BOARD

Irvin W. Kues
Chairman