PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2002-D16

PROVIDER -
Altoona Hospital
Altoona, PA

Provider No. 39-0073

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Veritus Medicare Services

DATE OF HEARING-
May 22, 2001

Cost Reporting Period Ended -
June 30, 1996

CASE NO. 98-2627

INDEX

ISSUE:

Was the Intermediary's adjustment to the Provider's number of beds by 116 and corresponding revision of the Provider's reimbursement for indirect medical education costs proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Altoona Hospital (the "Provider") is an acute care general hospital located in Altoona, Pennsylvania. On its fiscal year ended ("FYE") June 30, 1996 cost report, the Provider reported 171 available beds. Veritus Medical Services (the "Intermediary") modified the number of available beds to 278. The Provider filed a timely appeal with the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841 and has met the jurisdictional requirements of those regulations. The Medicare reimbursement at issue in this appeal is approximately $240,903.

Background

Section 1886(d)(5)(B) of the Social Security Act, 42 U.S.C. § 1395yy(d)(5)(B), provides that teaching hospitals subject to the prospective payment system ("PPS") shall receive an additional payment for the indirect costs of medical education ("IME"). This payment is designed to cover the increased operating or patient care costs that are associated with approved intern and resident programs and which are not separately identifiable on the cost report. These increased costs may reflect a number of factors such as: an increase in the number of tests and procedures ordered by the intern or resident as compared to a more experienced physician, higher staffing ratios, the need of hospitals with teaching programs to maintain more detailed medical records than other hospitals, and the presence of a more severely ill patient population.

The amount of payment is based on a hospital's ratio of full-time equivalent interns and residents to available beds. The regulation governing this provision is set forth at 42 C.F.R. § 412.105 and states, in pertinent part, the following:

> (a) *Basic data*. HCFA determines the following for each hospital:
> (1) The hospital's ratio of full-time equivalent residents....
> (2) The hospital's DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs....
>
> (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 bed days during the cost reporting period, not including beds or bassinets in the healthy newborn nursery, custodial care beds, or beds in distinct part hospital units, and dividing that number by the number of days in the cost reporting period.

The formula continues and can be seen in full as calculated for the Provider in the record;[1]

however, it is just the bed count that is at issue in this case.

The preamble to the final rule for "Changes to the Inpatient Hospital Prospective Payment System," as published in 50 Fed. Reg. 35646, 35683 (September 3, 1985) further defines an available bed:[2]

> For purposes of the prospective payment system, "available beds" are generally defined as adult or pediatric beds (exclusive of newborn bassinets, beds in excluded units, and custodial beds that are clearly identifiable) maintained for lodging inpatients. Beds used for purposes other than inpatient lodgings, beds certified as long-term and temporary beds are not counted. If some of the hospital's wings or rooms on a floor are temporarily unoccupied, the beds in these areas are counted if they can be immediately opened and occupied.

HCFA Pub 15-1 § 2405.3.G defines available beds as follows:

> 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 . . . . 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. <u>The hospital bears the burden of proof to exclude beds from the count</u>.

(Emphasis added.)

The Blue Cross and Blue Shield Association published an Administrative Bulletin #1841, 88.01 ("AB 1841") to additionally clarify the matter.[3] It states:

> A wing is considered permanently closed if the area in which the beds are contained is not included in a hospital's depreciable plant assets subject to capital-related cost reimbursement during a cost reporting period, and no available bed days for these beds should be counted. In a situation where rooms or floors are temporarily unoccupied, the beds in these areas must be counted, provided the beds can be adequately covered by either employed nurses or nurses from a nurse registry. In this situation, the beds are considered "available" and must be counted even though it may

> take 24-48 hours to get nurses on duty from the registry.
>
> Where a room is temporarily used for a purpose other than housing patients (e.g., doctors' sleeping quarters), the beds in the room must be counted, provided they are available for inpatient use on an as needed basis . . . .

AB 1841.

In the instant case, the Provider is licensed for 353 beds. The Intermediary conducted a census of beds at the facility and found 278 made-up beds in patient rooms with appropriate hook-ups and utilized this number for available beds. The Provider and Intermediary agreed that during the year under appeal the Provider had 278 beds (exclusive of newborn nursery and distinct part units) physically set up in the hospital.[4] The Provider reported the lower number because its average patient census was 162 patients and its maximum census was 201. The Provider claims that it could never accommodate more than 210 patients due to staffing, and thus 210 available beds should be the maximum counted.[5]

The Provider was represented by Edward V. Weisgerber, Esquire, of Kirkpatrick and Lockhart, LLP. The Intermediary was represented by James R. Grimes, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the Board is faced with a simple issue, which is whether the number of available bed days is determined by simply counting those beds which have linen on them (i.e., "set-up") or whether it is determined by examining all three of the factors that it contends comprise bed availability; namely (i) the number of set-up beds, (ii) the availability of professional staff, and (iii) the demand and usage by patients for those beds.

According to the Provider, the Intermediary would have you look solely to the number of set-up beds and nothing else and refers to the Intermediary witness testimony which stated that "[if] the bed is in the room, then it is available."[6] The Provider asserts that the Intermediary's inquiry is one-dimensional and that it should have also examined whether (i) the Provider's hospital had enough nurses to staff the number of beds claimed by the Intermediary, and (ii) there was a demand for the number of beds claimed by the Intermediary.

The Provider states that a collateral issue is whether beds are "available" for purposes of the IME calculation if even one patient is assigned to that bed during the course of the year. In other words, because 201 patients are distributed among 278 beds, it does not mean that the Provider is prepared to care for 278 patients or that it could "staff-up" from its "equilibrium point" of 162 patients to 278 patients within 24 to 48 hours.

The Provider points out these key facts:

1. The Provider is licensed as an acute-care hospital in Altoona, Pennsylvania.

2. Altoona, population 59,000, is the largest municipality in Blair County, population 130,000. Blair County is a semi-rural county in Central Pennsylvania.

3. The Provider is the largest hospital in Blair County. It offers open-heart, trauma, advanced cancer care, and a number of other services, including a GME program.

4. The Provider is licensed to operate 354 beds, although it has not operated that many beds for many years. The Provider no longer has 354 set-up and available beds.

5. The Provider is seeking IME reimbursement for its GME program. The relationship between the amount of the IME add-on and the number of beds in service is inverse. In other words, the larger the number of beds in service, the lower the Provider's IME reimbursement.

6. The Intermediary contends that the Provider's bed number, as a result of a physical inspection for fiscal year 1996, is 278 beds.

7. The Provider's claim is lower, namely 210 beds.

8. The number of patient days has been falling consistently in each year preceding 1996. In 1991, it was 74,170 days, but by 1996 it had fallen to 59,698 - a decrease of 14,472 days.

9. The average daily census for 1996 was 162 beds. The highest patient census for 1996 was 201 beds. The daily census exceeded 190 beds 25 times and exceeded 200 beds only three times in 1996; specifically, 200 beds twice and 201 beds once. The census never exceeded 190 beds for more than three consecutive days.

10. The Provider did not operate a nursing school and did not use outside nursing agencies.

11. The Provider divided its inpatient bed complement into three areas: specialty units (e.g., ICU, CCU), step-down units (e.g., progressive care), and general medical-surgical floors. Each of the general medical-surgical floors had a recognized specialty (e.g., orthopedics, post-surgical oncology).

12. The Provider did not close any of its units or any of its beds. The Provider does not dispute that it physically had 278 set-up beds into which it placed patients during the course of the year.

13. Although there were 278 "open" beds at any one time, on an average day there were no more than 162 patients distributed among these 278 beds. At the peak census, no more than 201 of the 278 "open" beds were occupied.

14. At 201 beds, the Provider had used virtually all of its full-time, part-time, and casual pool nurses. It had canceled elective admissions and diverted patients.

15. The Provider kept all of its units open for several reasons. First, it provided greater flexibility in assigning patients to rooms and particularly to private rooms. Second, it kept patients grouped according to similar ailments, which made it more efficient for the nursing staff, the physicians, and the Provider (e.g., specialty equipment could be concentrated on one unit). Third, it segregated patients whose medical conditions could be jeopardized if they came into contact with each other (e.g., an immunosuppressed chemotherapy patient in close proximity to an infectious disease patient).

16. In 1996, the Provider was reimbursed the flat federal rate as payment in full for all of its capital expenses.

The Provider contends that the Intermediary's only support in this case is AB 1841, a 13-year old administrative bulletin, from a private government contractor, which requires that it close beds and close units so that the cost of these unused units can be deducted from the Provider's cost-reimbursed capital payments. In 1996 the Provider was reimbursed a flat capital rate, the federal rate, for all of its capital expenses. The inclusion or exclusion of the space attributable to non-used rooms or beds did not increase or decrease the flat capital rate received by the Provider. The Provider's decision to keep all its units and all the beds on each unit open and to distribute its daily patient census among 278 beds rather than to close units and consolidate patients on fewer units did not result in any additional capital-cost reimbursement to the Provider and was capital-payment neutral to the Medicare program.

Even though there were 278 open beds in the inventory, the average daily census was 162 patients, and the highest census ever reached was 201 patients and that was for one day. The fact that on an average day 162 patients were distributed among 278 open beds does not mean that the size of the institution is 278 beds.

The Provider contends that the Intermediary's argument that the Provider should have closed units is without merit and places the Intermediary in the position of making care and treatment decisions. The Provider, as opposed to the Intermediary, is in the best position to evaluate medical and nursing care decisions and to determine how it should group patients with similar conditions, which patients should be placed on which units, whether units should be combined, what patient care efficiencies are impacted by closing and combining units, and whether it should use outside nursing agencies. These patient care decisions fall within the province and expertise of the Provider as opposed to its fiscal intermediary. The Intermediary seeks to impose its decision to close units on financial grounds (and because that is what its audit supervisor had seen at other hospitals), even though the Provider's retention of open units is capital-payment neutral to the Medicare program.

The Provider argues that the purpose of the IME add-on formula is to match the number of interns/residents to the number of patients. It is not to match the number of interns/residents to empty beds. Permitting the Intermediary to use a bed number which is 77 beds over the highest number of patients impermissibly distorts the IME formula in Medicare's favor.

The Provider further asserts that the bed number to be used for the IME formula is supposed to reflect the actual size and capacity of the provider. It is not to reflect day-to-day census fluctuations. The Provider indicates that the Intermediary conceded that the Provider's 210 bed number does not reflect day-to-day fluctuations.

In considering institutional capacity it is appropriate, if not essential, to consider the provider's capacity to staff acute care beds with a nursing staff that meets ratios required by state and federal law and that is consistent with professional standards of caring for inpatients. Looking only to beds, and not to the ability to staff those beds with the appropriate complement of registered nurses, produces a distorted bed complement and violates both 42 C.F.R. §§ 412.105(b) and 482.23 because it does not account for the Provider's ability to care for and lodge inpatients.

The Provider points out that the Intermediary had initially argued that the Provider should have contracted with outside nursing agencies. Presumably, these outside nurses would be used to staff empty beds (e.g., those beds between the highest daily census and the Intermediary's 278 bed number), since the Provider was able to staff-up to its highest census number of 201 with its full-time, part-time, and casual staff. The Provider testified that it could, in the right set of circumstances and for a very short duration, care for 210 patients using its own staff. The Intermediary conceded that there is no regulatory requirement to use outside nursing agencies and that its insistence on doing so was "not germane" to this case.[7] By doing so, the Intermediary has de facto recognized the reality that an institution's utilization of all its internal staffing resources is a tangible limitation on the number of beds which are available to treat patients. It is no less of a limitation than its physical inventory of set-up beds.

The Provider contends that the regulations and program instructions require that the Intermediary do more than simply count beds. In the years preceding 1984, HCFA Pub. 15-1 § 2405 directed the Intermediary to perform a simple and mechanical calculation to determine the number of beds in a hospital. It directed the Intermediary to physically count the number of beds as of a "picture" date, in this case the first day of the reporting period, and to use this number as the proxy for the entire period.

Medicare changed HCFA Pub 15-1 § 2405 in two respects for cost reporting periods after 1984. First, it adopted the concept of "available bed days" instead of beds. Second, it changed the measurement parameters to take into account events that occurred during the cost report period rather than on the first day of the period. The examples in HCFA Pub. 15-1 §§ 2405.G.1 and 2405.G.2 demonstrate how these changes result in different bed numbers of 210 beds vs. 200 beds.

This change is important because bed days is a broader and more accurate tool by which to measure the size and capacity of the hospital. Bed days incorporates changes in unit sizes that occur during the year as well as changes in unit usage, e.g., acute to skilled.

Counting bed days is also required by 42 C.F.R. § 412.105(b), which states that "[the] number of beds in a hospital is determined by counting the number of *available beds days* during the cost reporting period." (Emphasis added). The preamble to 42 C.F.R. § 412.105(b) defines "available bed days" as beds that are maintained for "lodging inpatients." Because the text of the preamble excludes custodial beds and beds in other excluded categories, the term "inpatient" refers specifically and exclusively to acute care patients. Once an individual becomes an acute care "inpatient," the institution must immediately satisfy staffing standards that are prescribed by other sections of the regulations. The regulation at 42 C.F.R. § 482.23, for instance, requires the hospital to provide the appropriate types and numbers of nurses "necessary to provide nursing care . . . [including] immediate availability of a registered nurse for bedside care of any patient."

The Provider asserts that, read together, 42 C.F.R. §§ 412.105 and 482.23, and HCFA Pub. 15-1 require more than the mere counting of beds. Rather, they require and include in the category of available beds only those beds that are sufficiently staffed to qualify as beds for "lodging inpatients." A bed without adequate nursing staff is not and cannot be qualified under Medicare's rules as an acute care bed and cannot be properly included in the available bed count. Such a bed might qualify as a hotel bed, a hospice bed, or even a custodial care bed, but it would not qualify as an inpatient bed even though it is a bed with clean linen on it.

The Provider points out that the Intermediary, however, still counts beds. The practices of the Intermediary are in stark contrast to the regulations and revised HCFA Pub 15-1 § 2405. The Intermediary applies a mechanical analysis and does not make any effort to evaluate the level, type, or frequency of use of the beds, "[i]f the beds were in the room I don't ask if you're going to use them."[8] Moreover, in further contrast to the regulations, the Intermediary does not recognize staffing as having anything to do with bed availability. In fact, in response to questions posed by the Intermediary's counsel, the Intermediary's witness characterized staffing as having no connection whatsoever to available bed-days.

> Q. So staffing is an internal decision of a hospital?
>
> A. Yes.
>
> Q. But [it] does not relate to available beds. It can't be an excuse for saying that a bed is not available?
>
> A. That's correct.

Tr. at 135-136, L. 21-3.

The Provider contends that there are sound reasons for its decision to distribute its patients among available beds in open units rather than close units and concentrate patients in a reduced number of remaining open units. The Provider's Vice-President of Nursing indicated that each of its open units cares for certain types of patients. She indicated that it was not medically prudent to combine immuno-suppressed chemotherapy patients with pneumonia patients.[9] Additionally, the extra beds provided nurses with the ability to give patients private rooms, even if that decision meant that the nurses themselves were inconvenienced by having to travel further to render patient care.[10]

The Provider points to the Intermediary's changed position as further support for the Provider's position that it is the Provider's prerogative to manage and govern itself within the confines of the program. The Provider questions the extent to which the Intermediary either has the expertise for or should be involved in staffing and operational questions. First, the Intermediary initially thought that the Provider should engage outside staffing agencies to staff beds 202 through 278, even though these beds were not being used. Its witness stated that the Provider "should be looking to those people, those agencies, to fill any need, to fill any shortages."[11] The Intermediary initially advanced this position despite the fact that outside nursing agencies are expensive, there was no demonstrated patient demand that exceeded the capacity of the Provider to satisfy with its own staff, and it could not identify any agencies located in Altoona.

The Provider points out that, during the hearing the Intermediary changed its position and conceded that there are no Medicare rules which require the use of outside nursing agencies and that the Intermediary's insistence on the use of agency nurses was "not germane" to this case.[12] By doing so, the Intermediary is tacitly acknowledging that there is a finite supply of nurses available to staff beds. Once a hospital has applied its full complement of full-time, part-time, and casual nurses, then, by definition, there cannot be additional inpatient days available. It is no different than if a hospital had exhausted its supply of set-up beds.

The Intermediary's second position is more problematic. The Intermediary believes, based purely on what it had seen at other hospitals, that it would have been "helpful in maintaining operations" for the Provider to close units and concentrate its patients on the remaining open units.[13] Its only support for this contention is that this is what its chief auditor had seen other hospitals do. There was no analysis by operational or nursing experts to reach this conclusion. The Intermediary offered no evidence to suggest whether, if or how, the Provider compared to these other unidentified hospitals. Nor did it analyze or suggest why the Provider's approach is functionally any different than closing units. The Intermediary's decision is purely anecdotal, devoid of any operational analysis or expertise, and displays the same rigidity that the regulations have sought to avoid.

The Provider contends that the Intermediary is mistaken in that there is no adverse economic impact to Medicare. The only rationale advanced by the Intermediary for requiring the Provider to close units is that the failure to do so deviates from AB 1841.[14] The Provider points out that

AB 1841 (which is not a regulation nor a program instruction) was published in 1988, several months after HCFA Pub. 15-1 § 2405 had been revised. HCFA Pub. 15-1 § 2405.3.G makes a reference to completely or partially closed units. AB 1841 expands on the definition of a permanently "closed" unit to require that the unit be removed from the inventory of depreciable plant assets "subject to *capital-related* cost reimbursement." (Emphasis added).

There is no corresponding program instruction in HCFA Pub. 15-1 or the regulations relating to AB 1841's instruction requiring units to be closed and depreciable assets to be removed from the inventory. In effect, this is an interpretation of HCFA Pub. 15-1 prepared by the Blue Cross and Blue Shield Association which is not and should not be binding upon the Provider or the Board.

Nonetheless, the Intermediary has quoted AB 1841 as standing for the proposition that unless the capital costs are removed, the provider ends up with enhanced capital reimbursement, i.e., receiving reimbursement for space which is not (or which should not) be used for patient care. Indeed, the Intermediary testified that unless the space was closed and removed from the inventory of depreciable assets, the Provider would be double reimbursed. The Intermediary witness stated that "[t]hey would get the square feet, the area where those beds are located. They would also get reimbursed for that and they would also get reimbursed, for example, for all the equipment in those rooms."[15]

The Provider contends that the Intermediary's reliance on AB 1841 is wrong for four reasons. First, AB 1841 is not authoritative. It is not a regulation, program manual, agency directive, Board decision, HCFA Administrator Decision, or federal court decision. It is nothing more than the opinion of a government contractor. As such, the Board is not bound by it.

Second, by its own terms, AB 1841 does not apply. AB 1841 makes a specific reference to cost-reimbursed capital. The Provider was not cost reimbursed for capital expenses during this period. To the contrary, it was reimbursed a fixed rate, namely 100 percent of the fixed federal rate for this period.[16] AB 1841 and the changes to HCFA Pub. 15-1 § 2405 were made in 1988 and preceded Medicare's adoption of prospective payment for capital.

Third, because the Provider was receiving the fixed federal capital rate, the inclusion or exclusion of this space has absolutely no impact upon the reimbursement received by the Hospital. The Intermediary is incorrect in its testimony to the contrary, and its witness' answer to the Board Member (cited above) is mistaken.

Fourth, the Intermediary seems to be extending AB 1841's specific reference to capital costs to also encompass non-capital costs. "There's other things like for example housekeeping costs would then be -- square feet would be housekeeping, operation of plant, things of this nature . . ." (sic)[17] AB 1841 makes a specific and exclusive reference to capital costs - it does not mention operating costs. Operating costs were subject to prospective reimbursement in any event in 1996.

The Provider contends that the Intermediary is confusing availability with use. The Intermediary argues that because 278 beds are physically present and because a patient could be put into any one of these beds, 278 beds accurately reflects the size of the facility. This argument ignores the reality that there is insufficient staff to care for 278 patients and that the actual census never exceeded 201 patients. More importantly, it also ignores the reality that at the end of the day there are still, at most, 201 patients at the Provider (which occurred once), regardless of whether these patients are distributed among 201, 278, or 500 physically present beds. The Provider's witness testified that at peak capacity (i.e., 200-210 beds) it would require 15 new nursing staff (registered nurses and others) to increase 10 beds for a week. She testified that even if her analysis was half wrong, she would still need seven additional personnel.[18] Adding 68 new beds (278-210) would therefore require between 47 and 102 additional staff.

In short, the Intermediary is confusing bed use with bed availability. Bed "availability" determines whether a patient can be cared for; bed "use" reflects which bed is used to care for that patient. The Provider is better positioned than the Intermediary to evaluate to which bed a patient should be assigned. There are a number of factors which enter into staffing and bed assignment decisions, including the patient's medical status, the efficiencies achieved by grouping patients with similar medical conditions on one unit, patient preferences for private rooms, and geography.

The Provider's suggested bed number, 210, is beyond the day-to-day census fluctuations and relates directly to a limiting factor; e.g., the number of staff available to care for patients. The Provider's decision to preserve patient placement options and flexibility by preserving 278 beds is revenue-neutral to Medicare because it has no effect on the capital reimbursement received by the Provider.

By contrast, the bed number advocated by the Intermediary will have an inequitable and disproportionate effect on the Provider's IME add-on reimbursement, because 278 bears no rational relationship to the actual operating size of the hospital.

The Provider contends using an artificial bed number which systematically credits empty beds skews the IME formula and understates the resources the hospital devotes to its GME program. The IME add-on formula is designed to reflect the additional resources used and costs absorbed by hospitals offering teaching programs. The polestar of the formula is the relationship between the number of interns/residents on the one hand and the number of beds actually available to treat patients on the other. The Provider argues that HCFA Pub 15-1 § 2405 describes the "curvilinear" relationship between the number of interns/residents and the number of beds (and, by implication, the number of discharges). The underlying tenet of the formula is the proposition that as the ratio between interns/residents and beds increases:

> [t]he hospital operating costs per discharge also increase but the

> rate of increase is smaller for successive equal increments in the ratio. This means that a slightly smaller education adjustment factor is applied to each incremental increase in the ratio.

The "slightly smaller" resources consumed by incremental increases in the ratio is derived by raising the intern/resident to bed ratio by an exponential power specified in the formula. The intern/resident to bed ratio in turn is increased either by increasing the number of interns/residents or decreasing the number of beds. If the number of interns/residents remains constant, the only way the ratio can increase is by using a lower bed number. (Assume, for example, a constant of 20 residents. If the number of beds is 278, the ratio is 0.07; if the number of beds is 210, the ratio increases to 0.09.) If the purpose of the formula is to accurately capture the indirect teaching costs of interns/residents who are treating patients instead of empty beds, then using a bed number which deliberately includes a substantial number of empty beds sabotages this formula. It does so because it artificially suppresses the ratio and prevents the hospital from ever realizing the "incremental" increase in the ratio which would otherwise occur by using a bed number which is reflective of total patients rather than total beds.

It is not enough for the Intermediary to walk around the Provider facility and count beds in a vacuum. The objective of the exercise after all is not to measure actual or potential capacity for capacity's sake. Rather, it is to arrive at a number outside of the day-to-day census fluctuation, which accurately reflects the size of the institution across which teaching costs can be spread. "Costs per discharge" cannot be measured if beds are included from which there will be no discharges. No teaching occurs in empty beds.

The Provider notes that the Intermediary cites Mt. Zion Medical Center v. Blue Cross and Blue Shield Association, PRRB Case No. 97-D98, September 11, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,647, HCFA Administrator declined review, November 4, 1997 ("Mt. Zion"), apparently to describe the difference between temporary and permanently closed beds. The Mt. Zion decision involved a hospital which sought a lower number of beds because it had temporarily closed a number of beds due to a nursing strike. The Board held that the units were not permanently closed and held the hospital to the higher number.

The Provider asserts that Mt. Zion has no impact or bearing on this case, because that Provider was attempting to claim relief for 137 beds which it closed during a strike. When the strike was over, the beds were immediately reopened. There are two critical distinctions between Mt. Zion and the Provider. First, Mt. Zion had sufficient staff available to instantly reopen its closed beds when the strike was over. The Provider does not have furloughed staff waiting in the wings who can reappear upon the stroke of a pen. Secondly, the decreased bed count during the strike was temporary. The Provider, on the other hand, has experienced a continuous and non-reversible decrease in patient days (a 6,000 decrease between 1995 and 1996 alone).[19]
The Provider also notes that the Intermediary's "count-the-beds-only" method appears straightforward, but that the Intermediary admitted that it applied the test inconsistently. One of

the main weaknesses of relying too heavily upon AB 1841's "count-the-beds-only" test is that the Intermediary becomes so focused upon trying to determine whether a hospital bed is temporarily or permanently out of service that it can actually miscount beds. Close questioning of the Intermediary revealed that it does not have a consistent or universal rule for how it counts beds. In direct examination the Intermediary said that, if upon physical inspection beds are present in a room, it makes no further inquiry and counts those beds:

> I ask if the beds were in the room I don't ask if you're going to use them. I'm going to assume that they're there to be used. They're there to be used.

Tr. at 131, L. 11-15.

However, if no beds are in the room, instead of making the corresponding assumption that the beds are out of service and automatically excluding the nonexistent beds, it proceeds instead to ask a series of questions as to the whereabouts and possible intended future use of the beds. The objective of the Intermediary's questioning is to determine if the hospital is going to use the beds at some point in the future, which implies that there must be some minimum period of exclusion.

The Provider points out that AB 1841 does not provide a time interval for how long a bed would have to be out of service to be considered closed and excluded from the count. The Intermediary does not have a consistent time interval either. In response to a series of questions, the Intermediary offered differing periods. In response to Board Chairman, the Intermediary said that a bed out-of-service for three months might be excluded ("[it was] a "fine line."),[20] that a bed out-of-service for six months "would <u>probably</u> be excluded."[21] On cross-examination, the Intermediary said that a bed would have to be unavailable for "the immediate one to two year future."[22] Moreover, in addition to not using the bed for a year, the Provider would also have to disassemble the bed, move it out of the room, and cap the oxygen supply.[23] Even keeping the bed in the room but marking it as "unavailable" would not work.

> Q. Would you have accepted that as the equivalent of a closed bed if we put duct tape across the bed that said 'we will not use this bed all year,' would that be a closed bed?
> A. No.

Tr. at 157, L. 18-25.

The Intermediary is focused on the physical location because it believes that unless a bed is completely removed, it could easily be put back into service at some point, thereby making it "available" regardless of whether there are nurses available to attend to these empty beds or not. The Intermediary justifies its inclusion of any set-up bed on the basis of "how do you know you're not going to use them."[24]

The Provider asserts that the Intermediary can answer the question by looking at the day-to-day census fluctuation, but it is an immutable fact that this was not done. The Intermediary is examining the year after the fact, so it, to, would know whether the census had increased and additional beds had been used during the year. In reality, however, the patient days were decreasing and had been decreasing precipitously for the previous five years. The hospital never did and never could have treated more than 210 patients in 1996. There is no better, more reliable indicator of size than this.

The Provider argues that the Board should find that while the Provider had 278 set-up beds (by physical count), it did not use and did not have the resources to use more than 210 beds at any one time and in fact never used more than 201 beds. The number of beds was limited by the availability of nurses to staff these beds in accordance with state and Medicare staffing requirements. Because the Provider was receiving the federal rate for capital reimbursement, there was no adverse impact to Medicare by permitting the Provider to keep its units open and distribute its patients among 278 beds. Finally, using the Intermediary's 278 bed number would, in this case, result in an impermissible distortion of the IME add-on formula.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider in this case is a general acute care hospital which is licensed by the State of Pennsylvania to operate 353 beds. However, the parties agree that during the year under appeal, the Provider had some 278 beds (exclusive of the newborn nursery and distinct part units) physically set up in the hospital.[25] The Intermediary contends that for purposes of the additional payment for indirect medical education costs pursuant to 42 C.F.R. § 412.105, all 278 beds must be included in the bed count. Regulations at 42 C.F.R. § 412.105(b) state "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 or bassinets in the healthy newborn nursery, custodial care beds, or beds in excluded distinct part hospital units . . . ."

HCFA Pub. 15-1 § 2405.3.G defines an available bed for purposes of the IME bed count as a bed:

> permanently maintained for lodging inpatients. It must be available for use and housed inpatient 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 fluctuation in patient rooms and wards being used. Rather, the count is intended to capture changes

> in the size of the facility as beds are added and taken out of service.

There is no dispute that the Provider had 278 beds set up and ready for use during the cost year under appeal.[26] The Intermediary witness testified these beds were set up in patient rooms, the rooms were clean, the beds had sheets on them, and the necessary hook-ups were present.[27] The Provider's witness indicated there were 278 beds that were ready to go at all times, and that any one of the 278 beds could be used on any given day.[28] No rooms had been vacated and no beds were designated as not to be used.[29] Based on that testimony, there is no question that the Provider had 278 beds permanently maintained for lodging inpatients. All 278 beds were in patient rooms, with proper nurse call buttons and oxygen hook-ups and were ready to receive patients. Under the requirements of the regulation and manual instructions, these beds must be included in the bed count for purposes of the IME payment.

The Provider is attempting to argue that because the average daily census ran about 164 beds, the hospital didn't use all 278 beds and could not staff for 278 beds during the cost year. As a result, the hospital claims it had somewhere between 164 and 210 beds available. This argument is an attempt to add a new definition to the determination of what is an available bed. However, neither the regulation nor HCFA Pub. 15-1 § 2405 permit a reduction in the size of available beds based on staffing decisions of the hospital. A bed is an available bed when it is set up in a patient room and ready for use. A provider's staffing decision does not mean a bed is or is not available. HCFA Pub. 15-1 § 2405.3.G specifically states that the bed count is not intended to measure day-to-day fluctuations in the use of patient rooms. The Provider's approach to count beds based on staffed beds does just that. The staffing is based on census, and the census determined the number of set up and staffed beds.[30] As a result, the Provider is attempting to use a bed count that reflects the day-to day fluctuations in bed use. Further, the Intermediary witness pointed out that in the preamble to the final rule for "Changes to the Inpatient Hospital Payment System" published in 50 Fed. Reg. 35646, 35683 (September 3, 1985),[31] a commentator suggested that instead of using a ratio of interns and residents to beds, a better calculation would use patient days. The response indicated that such a change would require legislation. The Provider in this case is essentially trying to tie its bed count to patient days (the available bed count claimed in the cost report reflected nearly a 100 percent occupancy percentage). This we believe is in violation of the requirement of the controlling regulation and Manual instruction.

The Provider has also filed correspondence indicating its inpatient Medicare capital rate is reimbursed on the Federal rate. As a result, the fact that the hospital hasn't removed the beds from the depreciation schedules should have no impact on whether or not Medicare is sharing in the cost of maintaining the beds. It is true the hospital is now reimbursed for capital costs on the PPS methodology. However, that does not mean that keeping the beds available did not result in Medicare sharing in the costs of those beds. Because the square footage was included in a reimbursable area, the overhead costs associated with that would still be included.[32]

The Provider's witness indicated that it maintained the 278 beds to ensure they had capacity to meet patient demand and to allow for new and additional services.[33] The Intermediary asserts that it is not relevant why the Provider maintained the beds. Only that they chose not to permanently close the rooms and remove the beds from the Provider's books. As a result, there was no change in the size of the facility. The regulations and manual instructions then require that the full count of 278 available beds be included in the bed count for purposes of the IME payment calculation.

CITATIONS OF LAWS, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§ 1395yy et seq.	-	Payment to Skilled Nursing Facilities for Routine Service Costs

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

§§ 405.1835-.1841	-	Board Jurisdiction
§ 412.105 et seq.	-	Special Treatment: Hospitals that Incur Indirect Costs for Graduate Medical Education Programs
§ 482.23	-	Conditions of Participation: Nursing Services

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

§ 2405 et seq.	-	Payments Under the Prospective Payment System

4. Cases:

Mt. Zion Medical Center v. Blue Cross and Blue Shield Association, PRRB Case No. 97-D98, September 11, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,647, HCFA Administrator declined review, November 4, 1997

5. Other:

50 Fed. Reg. 35646 (September 3, 1985).

Blue Cross and Blue Shield Association, Administrative Bulletin #1841, 88.01, November 18, 1988.

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 post-hearing briefs, finds and concludes as follows:

The regulation and manual define available beds as those maintained for lodging inpatients. A provider may exclude beds that are used for purposes other that inpatient lodging, beds certified as long term, and temporary beds. The Board notes, however, that if some of the rooms or wards are temporarily unoccupied, the beds in these areas are counted if they can be immediately opened and occupied. The rules indicate that the term "available beds" is not used to capture the day-to-day fluctuation in patient rooms and wards being used but rather changes in the size of the facility as beds are added or taken out of service. The Board disagrees with the Provider's contention that "available beds" should be determined by the amount of staffing and patient census. The Board notes that the parties did not dispute that there were 278 beds set-up at its facility. The Board finds that despite low occupancy and staffing in its area, the Provider intentionally maintained 278 beds, that they could have been immediately occupied and must be considered available beds for IME purposes.

The regulations at 42 C.F.R. § 412.105(b) delineate how the number of beds will be determined. It states that:

> the number of beds in the hospital is determined by counting the number of available bed days during the cost reporting period, not including beds and 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).

A comment and response in the preamble published with this regulation directly addresses the Provider's arguments here. It states:[34]

> Comment: One commenter requested a more precise definition of the term "available bed days."
>
> Response: For purpose of the prospective payment system, "available beds" are generally defined as adult or pediatric beds (exclusive of newborn bassinets, beds excluded units, and

> custodial beds that are clearly identifiable) maintained for lodging inpatients. Beds used for purposes other than inpatient lodging, beds certified as long-term, and temporary beds are not counted. If some of the hospital's wings or rooms on a floor are temporarily unoccupied, the beds in these areas are counted if they can be immediately opened and occupied.

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

The concept of available beds is further defined in HCFA Pub. 15-1 § 2405.3.G. It states that:

> [t]o 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 fluctuation in patient rooms and wards being used. Rather, the count is intended to capture changes in the size of the facility as beds are added and taken out of service.

The Board notes that beds used for purposes other that inpatient lodging may be excluded, but beds in temporarily closed wings or rooms are counted if they can be immediately opened and occupied. The Board further notes that the term "available beds" is not used to capture the day-to-day fluctuation in beds being used, but instead, a change in the number of beds as they are added or taken out of service.

With regard to the Provider's contention that the number of available beds should be determined by the demand and usage of those beds by patients, the Board observes that the rules indicate that availability of beds is not related to fluctuation in patient use. HCFA Pub. 15-1 § 2405.3.G. If Congress had wanted to relate patient use to the IME calculation, it would have used <u>patient</u> days in lieu of available bed days. This was also subject of a comment and response in the preamble to the regulations. It states:

> Comment: One commenter suggested a change in the method of calculating the indirect medical education adjustment. Instead of using the ratio of interns and residents to beds, the commenter recommended that patient days would be used in lieu of available beds. The commenter believes that the use of patient days would not require an additional calculation, the data are readily available, and recommended a legislative change. Response: As the

> commenter points out, this change would require legislation. Thus, we cannot change the regulations to meet this suggestion. However, as we obtain more data, we will consider this approach and others. If our analysis indicates that a change is necessary, we will propose a legislative amendment.

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

With regard to the Provider's contention that the number of available beds should be limited by the number of available staff, the evidence revealed that the Provider's staffing levels are related to its level of utilization. The Board notes that the Provider continued to maintain 278 beds in the event that its utilization or market share increased.[35] The Provider indicated that it would increase its professional staffing with higher levels of utilization rather than turn away patients.[36] In addition, the Board did not find conclusive proof in the record that the Provider could not have obtained additional professional staff to meet an increase in utilization.[37]

The parties did not disagree that there were 278 set-up beds. Despite the Provider's low occupancy and limited staffing due to the low occupancy, the Board finds that the Provider did maintain 278 set-up beds and could have put the beds into use if they were needed. Therefore, the Board finds that the Intermediary's adjustment to count all 278 set-up beds as "available beds" for IME purposes was correct.

DECISION AND ORDER:

The Intermediary's adjustment increasing the Provider's number of available beds was correct. The Intermediary's adjustment is affirmed.

Board Members Participating:

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

Date of Decision: March 27, 2002

FOR THE BOARD:

Irvin W. Kues
Chairman