PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

ON THE RECORD
2003-D16

PROVIDER –
BBL 95-99 Observation Bed Days Group

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

vs.

INTERMEDIARY –
Blue Cross Blue Shield Association/
Premera Blue Cross/Riverbend
Government Benefits Administrator/
Trailblazer Health Enterprises, LLC

DATE OF HEARING-
January 21, 2003

Cost Reporting Periods Ended
Various

CASE NO. 02-0721G

INDEX

ISSUE:

Were the Intermediaries adjustments to exclude observation bed days from the providers' bed count in determining disproportionate share hospital ("DSH") eligibility and payments proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Governing Statues and Regulations:

This dispute arises out of the Intermediary's failure to reimburse the Providers amounts they claim are due under the Medicare program of the Social Security Act 42 U.S.C. §§ 1395 et seq. The amounts in contention relate to the exclusion of observation bed days in determining the DSH payment calculation for the Providers established in this group appeal.

The Medicare program was established in 1965 under Title XVIII of the Social Security Act (the Act) to provide health insurance to the aged and disabled. 42 U.S.C. §§ 1395 – 1395cc. The Health Care Financing Administration ("HCFA") (now Centers for Medicare and Medicaid Services) ("CMS") is the operating component of the Department of Health and Human Services charged with administering the Medicare program.

The Secretary's payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under the Medicare law and interpretative guidelines published by CMS. Id.

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and what portion of those costs are to be allocated to Medicare. 42 C.F.R. § 413.20. The fiscal intermediary audits the cost reports, determines the total amount of Medicare reimbursement due the provider, and informs the provider in a notice of program reimbursement ("NPR") that sets forth the individual expenses allowed and disallowed by the intermediary. 42 C.F.R § 405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board ("Board") within 180 days of the NPR. 42 U.S.C. § 1395oo(a); 42 C.F.R. § 405.1835.

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

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

42 U.S.C. § 1395ww(a)(2)(B).

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

Background of the Providers:

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 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 their available bed counts beds used for observation services in their determination of DSH on the as-filed cost reports. At audit, the servicing Intermediaries removed observation bed days from the bed counts, 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 their DSH payments were reduced by the Intermediaries determination.[2]

The amount of Medicare reimbursement in controversy is approximately $4,000,000.[3]

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[1] See Provider's position paper at 1.

[2] See Providers' position paper at 1 and Exhibits P-8, P-9.

[3] See Providers' position paper at 3 and P-2.

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.

PROVIDER'S CONTENTIONS:

The Providers contend that CMS's and the Intermediaries' policy to remove bed days from the DSH bed count for purposes of DSH qualification and payment violates relevant regulatory, manual, and statutory provisions. To illustrate its point, the Providers cite BBL 94-98 Observation Bed Day Group ("BBL") v. Blue Cross Association/Riverbend Government Benefits Administrator,[4] PRRB Dec No. 2002-D13, March 19, 2002, Medicare and Medicaid Guide (CCH) ¶ 80,799, aff'd CMS Administrator, May 23, 2002, where the Board held "the Intermediaries' exclusion of observation beds days from the calculation of "total beds" used to determine DSH eligibility was not proper."[5] The Board based its decision on the governing regulation and manual provision, finding that such provisions "identify the specific beds excluded from the bed count, and neither of those authorities provide for the exclusion of observation beds." Id. Also, in BBL, the Board found that the DSH regulation, 42 C.F.R. § 412.105(b), "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."[6] Id. The Board further found that HCFA Pub. 15-1 § 2405.3 specifically defined the word "bed," and it did not exclude acute care beds used at times for outpatient observation.[7] Id.

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[4] See Providers' position paper Exhibit P-4.

[5] BBL 94-98 Observation Bed Day Group v. Blue Cross Association/Riverbend Government Benefits Administrator, involves the same providers and same circumstances as this instant case. The Providers' position paper refers to BBL 94-98 as Group I, and this instant case as Group II. See BBL 94-98 Observation Bed Day Group ("BBL") v. Blue Cross Association/Riverbend Government Benefits Administrator, PRRB Dec No. 2002-D13, March 19, 2002, Medicare and Medicaid Guide (CCH) ¶ 80,799 at 202,622.

[6] 42 C.F.R. § 412.105(b) provides "the number of beds in a hospital is determined by counting the number of available beds 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 and dividing that number by the number of days in the cost reporting period."

[7] Section 2405.3.G provides: "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." The provision further clarifies what is meant by an "available bed:" "to be considered

The Providers assert that in BBL the Board relied on Clark Regional Medical Center et al. v. Shalala 136 F. Supp.2d 667,675-78 (E.D. Kentucky, March 30, 2001), ("Clark Regional") where the court held the plain meaning of the governing regulation and manual provision prohibits the exclusion of observation beds days from the count for determining DSH eligibility.[8]

The Provider group cites three additional cases, asserting that the legal issue and material facts are identical to the instant case. In Commonwealth of Kentucky 92-96 DSH Group ("Kentucky") 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 and Presbyterian Hospital of Greenville ("Presbyterian") v. Blue Cross Association/ Trailblazer Health Enterprises, LLC, PRRB Dec No. 2002-D1, November 21, 2001, Medicare and Medicaid Guide (CCH) ¶ 80,788, mod'd CMS Administrator, January 28, 2002, the Board determined that Medicare rules do not permit the exclusion from the DSH bed count inpatient beds that were used occasionally for outpatient observation services.[9]

In Alhambra Hospital ("Alhambra") & Memorial Hospital of Gardena v. Thompson 259 F. 3d 1071 (9th Cir. 2001), the Court stressed that 42 C.F.R. § 412.106 is plain on its face and requires the inclusion of sub-acute patient days as part of the DSH reimbursement. The Providers claim that the Alhambra case is binding in the circuit in which the Providers are entitled to seek judicial review.[10]

INTERMEDIARY'S CONTENTIONS:

The Intermediary asserts that HCFA Pub.15-1, § 2405.3G was revised to provide Intermediaries guidance on the methodology of counting beds for purposes of IME and DSH.[11]

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an available bed, a bed must be permanently maintained for lodging inpatients. It must be available for use and housed inpatient rooms or wards. The term "available beds" as used for the purposes of counting beds is not intended to capture the day-to-day fluctuations in patients' rooms and wards being used. The count is intended to capture changes in size of a facility as beds are added or taken out of service. The Provider bears the burden of proof to exclude beds from the count.

[8] See Providers' position paper Exhibit P-4. The 6th Circuit recently affirmed the District Court's decision in Clark Regional Medical Center et al v. Department of Health and Human Services, 2002 Fed. App. 0421P, 2002 U.S. App. LEXIS 25258 (6th Cir. 2002).

[9] See Providers' position paper at 10.

[10] See Providers' position paper at 12.

[11] See Intermediary's position paper Exhibit I-3.

Based on HCFA Pub.15-1, § 2405.3G, the Intermediary insists that it properly removed the observation bed days from the bed count since these beds were 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 the premise that observation beds 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' reliance on 42 C.F.R. § 412.105(b)[12] and HCFA Pub. 15-1 § 2405.3.G, not specifically excluding observation beds for DSH payment calculation is not determinative. Rather, the Intermediary does not believe that the regulatory and manual provisions mentioned above are all inclusive. In support of its position the Intermediary relies on a letter from CMS' regional office, which specifically instructs all Region IV Intermediaries to exclude observation bed days from the count of available bed days for the purpose of IME and DSH adjustments.[13] It states:[14]

> "If 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 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."

The Intermediary also cites the HCFA Administrator's decision in Kentucky, in which the CMS Administrator reversed the Board's decision[15] stating 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.[16] Citing 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.

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[12] See Intermediary's position paper at 5.

[13] See Intermediary's position paper Exhibit I-4.

[14] See Intermediary's Exhibit I-4.

[15] See Intermediary's position paper Exhibit I-5.

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

The Intermediary states that manual and regulatory provisions were written for calculating both IME and DSH payments for hospitals. It argues that if Intermediaries were to use total licensed 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.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration and analysis of the controlling law, regulations and manual instructions, the 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 also governs additional payments to hospitals for indirect medical education (IME) programs and 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.
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> To be considered an available bed, a bed must be permanently maintained for lodging inpatients. It must be available for use and housed in patient rooms or wards (i.e., not in corridors or temporary beds). Thus, beds in a completely or partially closed wing of the facility are considered available only if the hospital 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 clear 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 finds 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 were valid, Congress would simply have said that in the enabling statute, and a regulation could have been easily promulgated to accommodate a category for PPS -excluded beds. Instead, the controlling regulation and manual guidelines have been written in a manner which provide great specificity regarding beds that are included and excluded from the count.

The Board 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 otherwise certified.

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 prior to the effective date of the instructions, the Board finds that such instructions cannot be retroactively applied even if their application were otherwise proper.

Finally, the Board notes that the Sixth Circuit's decision in Clark Regional,[17] supra, recently upheld the decision rendered by the Board in Kentucky, 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, "even if they were to accept CMS's questionable distinction between 'bed' and 'available bed day' in § 412.105(b), we find CMS's own instruction conclusive proof that observation beds are intended to be counted in the tally of 'available bed days' in the DSH calculation."

The court concluded that CMS's decision in Clark Regional not to count the disputed beds "simply cannot be reconciled with CMS's own regulations and interpretive rules. CMS's application of its own regulations in this case cannot be squared with either the plain meaning of the regulations or with CMS's definition of 'available bed' set forth in HCFA Pub. 15-1 § 2405.3(G). As such CMS's interpretation of the regulation to exclude observation beds is arbitrary, capricious, and otherwise not in accordance with the law."

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 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:

Henry C. Wessman, Esquire

[17] The Board notes that two of the providers in this case are in the Sixth and Ninth Circuits where the courts have held in favor of the Providers on this issue. The remaining Provider in this case resides in the Fifth Circuit.

Gary Blodgett, D.D.S.
Suzanne Cochran, Esquire
Martin W. Hoover, Jr., Esquire

DATE OF DECISION: March 6, 2003

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairman