PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2003-D23

PROVIDER –
Edinburg Hospital
Edinburg, Texas

Provider No. 45-0119

vs.

INTERMEDIARY –
Blue Cross Blue Shield Association/
TrailBlazer Health Enterprises

DATE OF HEARING-
Hearing on the Record
May 23, 2002

Cost Reporting Period Ended
September 30, 1992

CASE NO. 99-0160

INDEX

ISSUE:

Was the Intermediary's determination of available beds for purposes of the disproportionate share payment calculation proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Edinburg Hospital ("Provider") is a 112-bed hospital located in the Rio Grande Valley of Texas. TrailBlazer Health Enterprises ("Intermediary") adjusted the Provider's count of PPS available beds by excluding observation days. This resulted in the Provider having fewer than 100 beds subject to PPS and a reduced DSH payment. The Provider filed a timely appeal and has meet the jurisdictional requirements of the Provider Reimbursement Review Board ("Board") at 42 C.F.R. § 405.1835-.1841. The amount of Medicare reimbursement at issue is $53,979.

From the Medicare program's inception in 1965 until 1983, hospitals were reimbursed the lower of their reasonable costs or customary charges for services provided to Medicare beneficiaries. 42 U.S.C. § 1395f(b)(1); see generally Good Samaritan Hosp. v. Shalala, 508 U.S. 402 (1993). In 1983, Congress established the Prospective Payment System ("PPS"), under which most acute care hospitals were no longer reimbursed based upon their reasonable costs. 42 U.S.C. §1395ww(d). Instead, under PPS, hospitals are reimbursed a prospectively determined rate for each Medicare inpatient, which is based upon the patient's diagnosis and other factors.

Following the institution of PPS, Congress authorized the Secretary to disburse extra Medicare funds, called DSH payments, to PPS hospitals that treat a disproportionate share of low-income patients. Social Security Amendments of 1983, Pub. L. No. 98-21 § 601(e).

Providers that qualify as DSHs under 42 U.S.C. § 1395ww(d)(5)(F)(i)(I) because they serve a significantly disproportionate number of low-income patients are entitled to a DSH adjustment. The amount of this adjustment varies, depending on whether the hospital is located in an urban or rural area and whether the hospital has 100 beds or more.

A hospital will be eligible for DSH payments if it either: (1) serves a significantly disproportionate number of low-income patients; or (2)(i) is located in an urban area, (ii) has 100 or more beds, and (iii) can demonstrate that during the cost reporting period in which the discharges occur, its net inpatient care revenues for indigent care from state and local government sources exceed 30 percent of its total net inpatient care revenues during the same period. 42 U.S.C. §1395ww(d)(5)(F)(i). An urban hospital, such as the Provider, "serves a

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significantly disproportionate number of low-income patients" if it has a disproportionate patient percentage that is either greater than or equal to fifteen percent if the hospital has 100 or more beds, or forty percent if the hospital has less than 100 beds. 42 U.S.C. § 1395ww(d)(5)(F)(v).

It is not disputed that the Provider qualifies for DSH reimbursement, regardless of the number of beds it had. Whether the Provider had at least 100 beds, however, radically affects its DSH percentage adjustment and, as a result, the bed count is at issue in this case. Whether the Provider had at least 100 beds also directly affects its eligibility for capital DSH payments.

Provider and Intermediary stipulations:

1. This case involves the Provider's appeal of the Intermediary's determination that Edinburg Hospital did not qualify as a Medicare disproportionate share hospital ("DSH") with 100 beds for the fiscal year ending September 30, 1992 ("FYE 9/30/92").

2. During FYE 9/30/92, the Provider was a hospital licensed for 112 beds located in the Rio Grande Valley of Texas. All of these 112 beds were licensed and available for inpatient care during FYE 9/30/92.

3. Of the Provider's 112 licensed beds, 10 beds were dedicated rehabilitation beds in a part of the Hospital excluded from the Prospective Payment System ("PPS"). In addition to these 112 licensed beds, the Provider also had 10 nursery bassinets not separately listed on the hospital license. Three of these ten nursery bassinets were neonatal sub-intensive care bassinets.

4. The parties agree that for DSH purposes, the Provider's rehabilitation beds and nursery beds are excluded from the count of available beds and that the Provider's neonatal sub-intensive care beds are included in the count of available beds. Thus, the parties agree that prior to any reduction for observation bed days, the Provider had 105 available beds during FYE 9/30/92.

5. According to the Provider's as-filed Worksheet S-3, during FYE 9/30/92, the Hospital had 40,992 inpatient hospital non-rehabilitative bed days available. See Exhibit 1 to Stipulation (Provider's as-filed Worksheet S-3).

6. According to the Provider's as-filed Worksheet S-3, the Hospital had 17,681 total hospital inpatient non-rehabilitative days during FYE 9/30/92.

7. By comparing the Provider's total actual hospital inpatient non-rehabilitation patient days during FYE 9/30/92 with its total available inpatient hospital non-rehabilitation bed days during FYE 9/30/92 (17,681 ÷ 40,992), the Provider's average daily census during FYE 9/30/92 was approximately 43 percent. See also Exhibit 2 to Stipulation (Declaration of Leon Belila, at ¶ 4).

8. During FYE 9/30/92, the Provider rendered approximately 1863 days of observation services.

9. The Provider did not have a dedicated observation unit nor a single bed dedicated to observation care during FYE 9/30/92.

10. Patients receiving observation care during FYE 9/30/92 were temporarily treated in unoccupied beds otherwise dedicated, permanently maintained, utilized and available for inpatient care and lodging.

11. Patients receiving observation services were placed in inpatient beds on floors or in departments located throughout the Hospital based, in part, on the availability of the beds.

12. At no time during FYE 9/30/92 was a prospective hospital inpatient denied admission to the hospital because observation patients were receiving observation care in inpatient beds.

13. Even assuming that on each day during FYE 9/30/92, the Provider temporarily utilized between five and six inpatient beds for observation services, the Provider still had at least twenty other beds unoccupied and otherwise permanently maintained and available for inpatient care during each day of the fiscal year. Dividing the observation days during FYE 9/30/92 (1,863) by the total days in the fiscal year (366) demonstrates that during FYE 9/30/92, the Provider utilized, on average, approximately 5.09 beds each day for observation care.

14. In light of this stipulation of uncontroverted facts, the parties agree that this case can and should proceed upon the written record without the need for a live evidentiary hearing before the Board.

The Provider was represented by Hope R. Levy-Biehl, Esquire, of Hooper, Lundy, & Bookman, Inc. The Intermediary was represented by Bernard M. Talbert, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS**:**

The Provider contends that it did have at least 100 beds during FYE 9/30/92. First, the Provider contends that neither the statute nor regulation governing DSH payments and outlining how to count beds excludes observation beds from a hospital's bed count. Rather, the statute indicates that all of a provider's beds should be included in the bed count. The applicable regulation also requires that all beds except certain specifically enumerated types of beds be included in the bed count, and the regulation does not exclude observation beds from the bed count. Thus, the exclusion of observation beds violates both the Medicare Act and applicable regulations. Furthermore, even if observation beds are excluded, the Provider did not have any observation beds during FYE 9/30/92. Rather, it had more than 100 licensed beds, some of which were used for observation, but none of which were dedicated to observation.

The Provider also contends that CMS' current policy to exclude observation beds from the bed count is inconsistent with Provider Reimbursement Manual, Part I ("CMS Pub. 15-1") § 2405.3.G. The DSH regulation expressly requires that the bed count be calculated according to the ("IME") provisions. 42 C.F.R. § 412.106(a)(i). CMS Pub. 15-1 § 2405.3.G is an interpretation of the IME regulation and is controlling in this DSH case. That manual provision, the only pertinent manual provision in effect during FYE 9/30/92, indicates that beds regularly maintained for lodging inpatients should be included in the bed count, and that the occasional or temporary use of a bed for other purposes does not eliminate the bed from the bed count. The Provider contends that the beds which it used for observation services were regularly maintained to lodge inpatients, and their occasional use for observation services does not affect their status as inpatient beds.

Further, the Provider contends that CMS did not have a policy of excluding observation beds from the inpatient hospital bed count until it revised the cost report instruction effective for cost reporting periods ending on or after September 30, 1996. See Provider Reimbursement Manual, Part II ("CMS Pub. 15-2") Chapter 36, p. 1 of Transmittal No. 1 (Oct. 1, 1996) (referencing effective date for new Chapter 36) (reprinted in [1997-2 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 44,588); see also CMS Pub 15-2 § 3630.1. The Provider contends that the new cost report instruction is not applicable to the fiscal period at issue in this case.

Moreover, even if the revised cost report instruction reflected in CMS Pub 15-2 § 3630.1 were applicable, the Provider contends, it is invalid to the extent it excludes observation beds from the bed count in that exclusion violates both the Medicare Act and applicable regulations.

Further, the Provider contends that a policy requiring the exclusion of observation days is a substantive rule that must be promulgated in accordance with the Administrative Procedure Act's ("APA's") notice and comment provision. The provider contends that CMS' current policy to exclude observation beds was not adopted in accordance with the APA and is therefore invalid.

Finally, even if the policy of excluding observation beds was valid and was appropriately applied, the Provider contends that, under generally accepted rounding principles, the Provider had 100 available beds during FYE 9/30/92. First, the Provider contends that the 5.09 beds excluded as observation beds should have been rounded down to 5. As a result, the Provider's bed count would continue to be 100 beds. Alternatively, even if it was appropriate for the Intermediary to subtract 5.09 beds from the Provider's bed count, the 99.91 beds computed by the Intermediary must be rounded upward to 100. The Provider therefore contends that it qualified for a DSH adjustment in the amount of 42.45267 percent instead of the 5 percent adjustment in the June 12, 1998 revised Notice of Program Reimbursement ("NPR"). The Provider also contends that it was entitled to $53,979 in capital DSH payments recouped in the revised NPR.

INTERMEDIARY'S CONTENTIONS:

The Intermediary agrees that the regulation at 42 C.F.R § 412.106(a)(1)(i) requires that "[t]he number of beds in a hospital is determined in accordance with §412.105(b)" which governs bed count for indirect medical education (IME). 42 C.F.R. § 412.105(b) states:

> Determination of number of beds. For purposes of this section, the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period, not including beds 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.

The Intermediary's relies on guidance provided by CMS Pub. 15-1 § 2405.3.G in the determination of the number of available beds to be used in the calculation of the indirect medical education adjustment. It states:

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

> locations are excluded from the definition: hospital-based skilled nursing facilities or in any inpatient area(s) of the facility not certified as an acute care hospital, labor rooms, PPS excluded units such as psychiatric or rehabilitation units, postanesthesia or postoperative recovery rooms, outpatient areas, emergency rooms, ancillary departments, nurses' and other staff residences, and other such areas as are regularly maintained and utilized for only a portion of the stay of patients or for purposes other than inpatient lodging.

The Intermediary interprets the above provisions as specifically providing that beds used by ancillary, outpatient areas, and other areas regularly maintained and utilized for only a portion of the stay of patients are not considered as available beds for lodging inpatients. Therefore, beds used for observation services, an ancillary service, should not be included in the determination of available beds.

The Intermediary also relies on the Hospital Manual, CMS Pub. 10 §§ 210 and 216.1, which address the definition of "covered inpatient hospital services" and the "counting of inpatient days." They state:

> [a]n inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services

CMS Pub 10 § 210 (emphasis added).

> The number of days of care charged to a beneficiary for inpatient hospital services is always in units of full days

CMS Pub. 10 § 216.1 (emphasis added).

The Intermediary reasons, therefore, that CMS Pub. 10 indicates that a patient day would only be counted where a patient was admitted for inpatient services. It also points out that, in the case of outpatient observation services, HCFA Pub. 10 § 230.6 offers further guidance by defining "Outpatient Observation Services" as follows:

> A. Outpatient Observation Services Defined.--Observation services are those services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient.

> B. Coverage of Outpatient Observation Services.--Generally, a person is considered a hospital inpatient if formally admitted as an inpatient with the expectation that he or she will remain at least overnight. (See § 210 regarding coverage of inpatient admissions.) When a hospital places a patient under observation, but has not formally admitted him or her as an inpatient, the patient initially is treated as an outpatient. The purpose of observation is to determine the need for further treatment or for inpatient admission. Thus, a patient in observation may improve and be released, or be admitted as an inpatient.

The Intermediary also relies on a February 27, 1997, CMS issued Memorandum F.A.-31 clarifying the treatment of observation beds in the count of available bed days for the purposes of the IME and DSH adjustments. CMS' memorandum stated:

> Observation Beds
>
> If a hospital provides observation 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 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.

Id.

The last paragraph of CMS' memorandum required intermediaries to review any cost report that was still within the three-year reopening period to ensure that the policies addressed in the memorandum were applied. Pursuant to these instructions, the Intermediary reviewed the Provider's 1992 cost report and determined the Provider did not have 100 or more beds.

In response to the Provider's argument that rounding would have produced a count of 100 beds, the Intermediary notes there are no specific requirements for the rounding of available beds in the regulations, manuals, or CMS instructions related to the available bed count for IME and DSH. However, the regulation at 42 C.F.R. § 412.106(c) defines the criteria for classification of a hospital as a DSH. It states:

> (c) Criteria for classification. A hospital is classified as a "disproportionate share" hospital under any of the following circumstances:
>
> (1) The hospital's disproportionate patient percentage, as determined under paragraph (b)(5) of this section, is at least equal to one of the following:
>
> (i) 15 percent, if the hospital is located in an urban area and has 100 or more beds, or is located in a rural area and has 500 or more beds.
>
> (ii) 30 percent, if the hospital is located in a rural area and either has more than 100 beds and fewer than 500 beds or is classified as a sole community hospital under § 412.92 of this subpart.
>
> (iii) 40 percent, if the hospital is located in an urban area and has fewer than 100 beds.
>
> (iv) 45 percent, if the hospital is located in a rural area and has 100 or fewer than 100 beds.
>
> (2) The hospital is located in an urban area, has 100 or more beds, and can demonstrate that, during its cost reporting period, more than 30 percent of its net inpatient care revenues are derived from State and local government payments for care furnished to indigent patients.

The plain reading of the regulation indicates that a provider classified as urban with fewer than 100 beds must have a disproportionate patient percentage of 40 percent to qualify as a DSH. Urban hospitals with 100 or more beds qualify with only a 15 percent disproportionate patient percentage. Applying the plain reading of the regulation to the Provider's situation, for fiscal year 1992, the Provider was an urban provider with fewer than 100 beds. The Provider had only 99.91 beds subject to the PPS for which disproportionate share payments applied. The Provider did not meet the minimum criteria of 100 beds or more for a larger DSH payment adjustment factor. Therefore, under 42 C.F.R. § 412.106(c)(2)(iii), the Provider is entitled to a payment adjustment factor equal to 5 percent.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration and analysis of the controlling law and manual guidelines, contentions and evidence, the Board finds and concludes that the Intermediary's exclusion of observation bed 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 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 Provider. The Board notes that the statute does not define 'bed'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 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 CMS 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.

CMS 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 Intermediary 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 Provider met all of the Medicare program's requirements to be included in the bed size calculation used to determine DSH eligibility. All of the observation beds at issue were licensed acute care beds located in the acute care area of the Provider's 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 Intermediary's argument that only beds reimbursed under PPS should be included in the count of available bed days since the purpose of DSH is to adjust PPS amounts. If this argument were valid, Congress would simply have said that in the 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 CMS Pub. 15-1 § 2405.3.G.2, which provides an example for determining bed size. In the 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.

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

The Board finds this example directly on point. Acute care beds that are temporarily or occasionally used for another type of patient care but not certified as such, 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 Intermediary's 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 otherwise appropriate.

Finally, the Board notes that the circuit court's decision in Clark Regional Medical Center v. U.S. Dept of Healthcare Human Services, (6th Cir. Sept. 13, 2002) Medicare and Medicaid Guide (CCH) [2002-1 Transfer Binder] ¶ 301,232, 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. With respect to the manual guidelines, the court found the instructions in CMS 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 CMS 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.

Since the Board has found for the Provider based upon the statutes and regulations, it finds that the rounding arguments are moot.

DECISION AND ORDER:

The Intermediary did not properly determine that the Provider had less than 100 beds for the fiscal years in question. The Intermediary's adjustment disallowing observation bed days from the Provider's count of available days used to determine bed size DSH eligibility is improper and reversed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Henry C. Wessman, Esquire
Gary Blodgett, D.D.S.

Date of Decision: April 29, 2003

FOR THE BOARD

Suzanne Cochran, Esquire
Chairperson