PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2006-D48

PROVIDER -
District of Columbia General Hospital
Washington, DC

Provider No.: 09-0007

vs.

INTERMEDIARY -
Blue Cross Blue Shield Association/
Carefirst of Maryland

DATE OF HEARING -
December 14, 2004

Cost Reporting Periods Ended -
September 30, 1994; September 30, 1995; September 30, 1996; September 30, 1998; September 30, 1999; September 30, 2000 and July 15, 2001

CASE NOs.: 98-2103; 99-1746; 00-2563; 03-0127; 03-0484; 03-1471 and 03-1472

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ISSUE:

Whether the Intermediary properly adjusted the Provider's available beds for the purpose of determining the amount of its indirect medical education payment.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The District of Columbia General Hospital (Provider) was an acute care hospital located in Washington, DC. The Provider experienced financial difficulties during the years under appeal and eventually closed in July 2001. The Provider's fiscal intermediary during the fiscal years under appeal was CareFirst of Maryland (Intermediary). In each of the years at issue, the Provider reported its available beds based on internal "available bed"[1] reports. The Intermediary adjusted the figures reported on the Provider's as-filed cost reports, increasing the number of available beds used to calculate the Provider's indirect medical education (IME) payments. The Provider filed timely appeals with the Provider Reimbursement Review Board (Board) pursuant to 42 C.F.R. §§405.1835-405.1841 and met the jurisdictional requirements of those regulations. The Medicare reimbursement at issue in this appeal is approximately $398,569 for fiscal year (FY) 1994, $1,047,840 for FY 1995, $765,402 for FY 1996, $156,008 for FY 1998, $582,725 for FY 1999, $708,529 for FY 2000 and $473,125 for FY 2001.

The Provider was represented by Barbara Straub Williams, Esquire, and Adam H. Greene, Esquire, of Powers Pyles Sutter & Verville, PC. The Intermediary was represented by James R. Grimes, Esquire, of Blue Cross Blue Shield Association.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' 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 Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20(b) and 413.24(b).

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 the proportion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the

[1] After 1995, the Provider changed the name to the "operating beds" report, but the basis of the report did not change. For clarity, the report will only be referred to as the available bed report.

provider and issues the provider a Notice of Program Reimbursement (NPR). 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 issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

Section 1886(d)(5)(B) of the Social Security Act, 42 U.S.C. §1395ww(d)(5)(B), provides that teaching hospitals subject to the prospective payment system (PPS) shall receive an additional payment for IME.

This payment is designed to cover the increased operating or patient care costs associated with approved graduate medical education programs which are not separately identifiable on the cost report.

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

> (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 excluded distinct part hospital units, and dividing that number by the number of days in the cost reporting period.

The preamble to the final rule for "Changes to the Inpatient Hospital Prospective Payment System" further defines available beds as follows:

> 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 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. 35,646, 35,683 (Sept. 3, 1985).

Furthermore, CMS Pub. 15-1 §2405.3.G defines an available bed 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[s] 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 the facility as beds are added to or taken out of service.

For FYs 1994 through 1996 and 1998 through 2001, the Provider used its internal available bed reports as the basis of the number of available beds it reported on its cost reports.[2] The Intermediary adjusted the totals reported on the Provider's as-filed cost reports and increased the number of available beds used to calculate the Provider's IME payments. For FY 1994 through 1996, the Intermediary adjusted the Provider's bed count to 380 beds. In FYs 1998 through 2001, the Intermediary reopened the Provider's cost reports and used the Provider's licensed bed capacity of 449 beds as the number of available beds.

The Provider presented evidence to substantiate the number of available beds for the years at issue including but not limited to:

1) Available bed reports for FYs 1990 through 2001 (Exhibits P-4 through P-15);
2) Capital Asset Study/Report as of September 30, 1992 (Exhibits P-17 through P-19);
3) Internal Memorandums re: Changes in Patient Bed Units (Exhibits P-21 through P-27; P-76 through P-78);
4) Newspaper Articles re: The reduction in the Provider's bed size (Exhibits P-29 though P-39);
5) Utilization/Trend Analysis Reports (Exhibits P-40 through P-53);
6) Audited Financial Reports for FYs 1996 and 1997 (Exhibit P-75)

The Provider presented a detailed description of all changes in available beds by hospital unit.[3] These changes are summarized in the following Table 1:[4]

[2] While there are some small differences between the Provider's and Intermediary's numbers, the parties agreed that the figures in the Revised Intermediary Exhibit 31 reflect the number of beds from the Provider's available bed report for the fiscal years at issue. They are: FY 1994 – 358; FY 1995 – 285; FY 1996 – 265; FY 1998 – 265; FY 1999 – 265; FY 2000 – 256; and FY 2001 – 185.

[3] Provider's Post-Hearing Brief, pages 5-19.

[4] The "Net Change" column in the table above does not reconcile because some of the changes were made during the period listed rather than at the beginning, so the beds were available for part of the period but not for all of it.

FY	Detailed Description of Changes	Change In Number of Beds	Net Change	YTD Total
Balance Forward				380
9/30/93	Closure of Unit OBI	(21)	(21)	359
9/30/94	No Changes/Diff due to rounding	(1)	(22)	358
9/30/95	Closure of Units (33S; 62; 53C; 32N; 2E)	(96)		
	Reduction of Beds on Units: (MICU and OB2)	(16)		
	Expansion of Beds on Units (52N and 63)	18	(73)	285
9/30/96	Reduction of Beds on Units (23S; 22N&S)	(4)		
	Expansion of Beds on Unit PEDS (Moved into old OB1 area)	5	(20)	265
9/30/97	No changes	0		265
9/30/98	No changes	0		265
9/30/99	No changes	0		265
9/30/00	Closure of Unit 63	(23)		
	Reduction/Consolidation of Beds (42 and 52N&S)	(1)		
	Expansion of Beds on Unit OB2	15	(9)	256
7/15/01	Reduction/Closure of Units (SICU; OB2; 23; 42; NICU; PEDS)	(256)	(71)	185

PARTIES' CONTENTIONS:

The Provider contends that it presented ample documentation that its available bed reports accurately reflect the number of beds that were available during the fiscal years at issue and should be used to calculate the IME payment on its cost reports. The Provider furnished internal memoranda announcing the closure or downsizing of the nursing units in question, and these correlate to changes reflected on its available bed reports. The Provider also provided an independent report completed in FY 1992, of its depreciable assets that support its lower bed count. This report was provided to and audited by the Intermediary for use in setting the Provider's hospital-specific rate under the capital prospective payment system. In addition, the Provider presented newspaper reports, as

well as reports from the District of Columbia Hospital Association (DCHA) and the American Hospital Association (AHA), all documenting the facility's decreasing bed size. The Provider's audited financial statements for fiscal years 1996 and 1997 further corroborate its available bed count for those years.

The Provider contends that the Intermediary has mischaracterized its available bed reports as patient census reports. The Provider indicates that it had separate patient census reports that differ significantly from its available bed reports. Also, the fact that the available bed reports show a stable available bed count from fiscal years 1996 through 1999 further demonstrates that these reports do not reflect day-to-day fluctuations in patient occupancy levels. The Provider also disagrees with the Intermediary's suggestion that the available bed report represents "staffed" beds. The Provider also points out that the available bed count was stable from 1996 through 1999 when it experienced nursing shortages; therefore, it cannot reflect staffed beds.

The Provider argues that the Intermediary's standard for determining whether beds are available for purposes of the IME bed count is contrary to Medicare law in that the Intermediary considers beds available unless the closed units were structurally changed in a way that would make the space unusable for patient care. The Provider asserts that there is no such requirement in the law that the space be physically altered and that the preamble to the regulation states that "[i]f 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. 35,646, 35,683 (Sept. 3, 1985) (emphasis added). The Provider's witness testified that, due to the age of its facilities, and changes needed to make units safe for patient care, it would take at least thirty days to put units back in service. Tr. at 51. Therefore, these units could not have been "immediately" available.

The Provider also points out that CMS Pub. 15-1 §2405.3.G states that ". . . beds in a completely or partially closed wing of the facility are considered available only if the hospital put[s] the beds into use when they are needed." The Provider testified that it did not put any completely closed units back into service.

The Provider further contends that the Intermediary improperly relied on Blue Cross Blue Shield Association's (BCBSA) Administrative Bulletin 1841 (AB 1841)[5] by claiming that it cannot decrease the Provider's available bed count because there was no adjustment to the hospital depreciation based on the closed units. The Provider indicates that AB 1841 is not Medicare law, has never been adopted by CMS, and does not indicate that an intermediary should increase a provider's available bed count to reflect changes in the hospital's depreciable assets. Instead, depreciation may be adjusted to reflect changes in the number of available beds.

The Intermediary acknowledged that the Provider closed wings and units during the cost years under appeal. However, the Intermediary asserts that mere closure of a unit is not

[5] Intermediary's Final Position Paper – Exhibit I-13 AB 1841, 88.01 Medicare Provider Cost Reports: Adjustment for the Indirect Cost of Medical Education, November 18, 1988.

enough to support the claim that the area or bed is permanently closed or no longer available for patient care. CMS Pub. 15-1 §2405.3G states that "[t]he hospital bears the burden of proof to exclude beds from the count." The Intermediary contends that the documentation supplied by the Provider is insufficient to support its position that the available bed count is lower than its licensed beds.

The Intermediary refers to memoranda issued by the Provider's management staff announcing the closing of units. See Exhibit I-23. These memoranda indicate that units were being closed but did not indicate that the area was permanently being taken out of service or that the area was going to be used for other than patient care. They merely state that the closures were due to underutilization or a need to reduce costs. In one case, the memorandum indicated that if utilization changed, the area might be reopened. Id. at 4.

The Intermediary points out that the testimony of the Provider's witness was that they did not have any written standard procedure for closing areas. Tr. at 84. Whether and when beds were removed was uncertain in most cases, Tr. at 89 and 93; and the witness could not provide any documentation to support that the area in question could not be used for patient care if needed. Tr. at 100-101. The Provider maintains that beds in closed units were removed and sent to storage, but the Intermediary responds that these beds could be made available in a reasonable amount of time.

The Intermediary further notes that the Provider is relying on its internal available bed report,[6] but that the Provider witness did not compile these reports, did not know when they were compiled, and could not show in the record that available beds were different from occupied beds. Tr. at 102-103 and 114-116. The Intermediary found these reports unreliable because there were instances where the number of beds reported in the hospital's census data exceeded the number reported in the available bed report. Tr. at 254-256. In addition, the available bed report does not indicate what happened to the other beds and why they could not be considered available.

The Intermediary also questioned relying on the asset valuation report from 1992 which was conducted by Valuation Counselors two years prior to the first cost year at issue. The Intermediary asserts that it is unclear whether the report includes beds that were in storage. Tr. at 222 and 253.

The Intermediary further contends that the hospital did not remove the asset depreciation expense from the cost report, Tr. 233-234, as required by CMS instructions. Although the hospital reported depreciation on major movable equipment based on square footage, Tr. 218, the Intermediary did not find that the hospital reported the square footage as being non-reimbursable on the cost report to correspond to the units its claimed were closed. Tr. at 234.

The Intermediary also states that there was no evidence to support the Provider's contention that the closed areas were permanently closed and could not be easily

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[6] Provider Exhibit P-62.

reopened. There were no work orders directing removal of beds or construction orders or contracts for changes to the physical space nor were there any orders to discontinue maintenance or housekeeping in these areas. Without any documentation that the areas were permanently closed and could not be quickly reopened if needed, the Intermediary's adjustments should be sustained.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of the Medicare law and guidelines, the parties' contentions, and evidence presented, the Board finds and concludes as follows:

During the years under appeal, the Provider experienced severe financial hardship that ultimately resulted in the closure of its inpatient facility in July 2001. During this period, the Provider reduced the number of beds in its facility from fiscal years 1994 through 2000 and ultimately to zero as of July 15, 2001. The Board finds that the Provider presented substantial evidence that its number of available beds, as that term is defined in the regulation, was less than its authorized number of licensed beds. The Board also finds that the Provider presented substantial evidence that the number of available beds during this period was accurately reflected in the Provider's available bed reports, and that the numbers derived from these reports should be used in the IME calculation rather than the number of licensed beds used by the Intermediary.[7]

The Board notes that the Provider contracted with Valuation Counselors Group, Inc. (k/n/a CBIZ Valuation Group, Inc.) to perform a capital asset study and evaluation. The principle purpose of this study was to value the Provider's assets to determine the Provider's hospital-specific rate under the capital prospective payment system (PPS). The study included an on-site inspection of the Provider and its assets, including all major moveable equipment. See P-17 and P-18. The Intermediary audited and verified the report of this study before using it to calculate the Provider's capital PPS hospital-specific rate. Valuation Counselors identified 412 beds based on their on-site inspection. This number closely ties to the 413 beds, which includes 57 nursery beds, reported by the Provider on its fiscal year 1993 cost report. Testimony at the hearing, Tr. at 20-21, indicated that the Provider's purchases of additional beds, after the date of the study, was strictly to replace beds in disrepair. Therefore, there is clear evidence that the number of

[7] The Board notes that Revised Exhibit I-31 provides the number of available beds from the Provider's available bed reports in column IV and column V. The bed counts differ because the available bed counts in column IV reflect reductions in the bed count as a result of beds being removed from service during the cost reporting period, while the counts in column V assume a bed to be available if it was available at any time during the cost report period year. The Intermediary proposed using the latter approach due to the following language in the CMS instruction at CMS Pub. 15-1 §2405.3(G): "In the absence of evidence to the contrary, beds available at any time during the cost reporting period are presumed to be available during the entire cost reporting period. The Hospital bears the burden of proof to exclude beds from the count." The Board questions counting a bed as available for the whole year if it has been taken out of service for a portion of that year. Since the Board finds that the Provider's available bed reports document the removal of beds during the cost reporting period, it would not be proper to use column V, which assumes they were available for the entire year.

available beds at the Provider's facility was less than its licensed beds and was accurately reflected in the Provider's available bed report in FY 1993.

The Board also notes that in FY 1993 the Provider closed its OB1 (Gynecology) Unit, and this reduced the Provider's bed count by 21 beds. The closing of this unit was documented in the Provider's available bed report from FY 1993 onward. See P-7 through P-15. The Provider also presented documentation of the closure and conversion of some of the space associated with the OB1 Unit for administrative purposes. See P-21 at 117. The reduction of beds was also evident in the night shift statistical report dated July 13, 1994. P-20 at 116. Even the Intermediary conceded at the hearing that the beds attributable to the OB1 Unit should not be included in the available bed count. Tr. at 43. Based on the bed count from the Valuation Counselor's Report in FY 1992 and the closure of the OB1 Unit in FY 93, the Board finds that the Provider's available bed report for FY 1994 which reported 358 beds was correct, and that the Intermediary's adjustment adding 22 beds was incorrect in FY 1994 and thereafter.[8]

The Board further finds that, beginning in late 1994, there was substantial evidence in the form of numerous news reports that the Provider planned to substantially reduce the number of beds in its facility. See P-29 through P-39, at 129, 135, 142, 146, 148, 152, 153, 155, 157, 159, and 168. The Provider also presented evidence in the form of a detailed plan to reorganize that it was pursuing its stated goal of reducing the size of the facility. See P-27. In addition, the Provider's DCHA reports reflected the decrease in operating beds at the facility. See P-40 through P-46.

The Provider also presented detailed testimony and evidence that it was reducing the number of beds available in its facility. All of these changes were reflected on the Provider's available bed report as detailed on Table 1, supra.

In summary, the Board finds that the Provider was suffering from financial distress and had a plan to confront its problems by downsizing the institution. This is reflected in newspaper articles as early as 1994 and institutional plans to accomplish this goal. There are also internal memoranda that reflect that these plans were being implemented. And finally, the Provider's available bed report accurately reflected these changes in its facility's beds overall. See I-31.

Prior to 1994, the Intermediary had accepted the Provider's available bed reports and used those figures to calculate the Provider's IME payment. The Intermediary multiplied the number of beds in each unit by the number of days for each month and divided the total number by the number of days in the year (365 or 366) to determine the total number of available beds for each unit per year. See P-4 through P-17. Beginning in fiscal year 1994, the Intermediary no longer accepted the Provider's report on available beds as valid. Starting with fiscal year 1994, the Intermediary continued to use the number it used in fiscal year 1993 but did not accept the reduction of 21 beds that the

[8] Provider's Post-Hearing Brief at 7. Twenty-one of these beds are attributable to the closed OB1 Unit and the other one bed difference is due to rounding differences.

Provider reported on its available bed report from fiscal year 1993.[9] The Intermediary continued to use the carry-over figure from fiscal year 1994 to adjust FYs 1995 through 1996. Beginning in FY 1998, the Intermediary asserted that there was insufficient evidence of the reduction of available beds from the number of licensed beds and issued a revised NPR changing the bed count to the total number of licensed beds (449) at the Provider's facility in FY 1998. For FYs 1999 through 2001, the Intermediary continued to use the total number of licensed beds.[10]

The Intermediary does not dispute that the units were closed and remained closed for extended periods but expressed concern whether the Provider could have placed the beds in the closed units back in service within a reasonable period of time. The Intermediary rejected the evidence of planned reductions in bed size due to the Provider's financial distress as insufficient to prove that the closed units would remain closed and that it could not be put into service within a relatively short period of time. Instead, the Intermediary insisted on evidence such as workorders directing removal of beds, construction orders or contracts for changes to the physical space, and written evidence to stop maintenance or housekeeping in certain areas, capping of gas lines, or removal of beds. When the Provider could not produce this documentation, the Intermediary reverted to using the Provider's total number of licensed beds.

In evaluating the number of available beds, the Board first finds that it agrees with CMS' recent statement that the number of beds a hospital is licensed for is not a reliable basis for determining the hospital's available bed count. See 69 Fed. Reg. 48,916, 49,096 (Aug. 11, 2004). In reviewing the record, the Board found substantial evidence that the Provider was closing units and decreasing its bed size in response to its worsening financial condition. As previously noted, the Provider presented newspaper accounts internal plans and memoranda, DCHA reports and AHA guides as documentation of planned reductions in bed size at the facility. In addition, the physical condition of the property, economic environment and declining census all lend credence to the Provider's assertion that the closure of the units and beds was permanent. The Board notes that numerous units were closed in 1995 and never reopened which included Units 33, 62, and 53C. In FY 2000, the Provider started closing units and decreasing their size and did not cease until ultimately closing the facility in July of 2001. Again, the Board finds that the Provider's intention to reduce the number of its available beds was clear, and it was accurately reflected in its available bed reports.

The Board finds credible the Provider's testimony regarding the difficulty of reopening closed units; that it would take a minimum of 30 days to complete; and that beds could not be made available in a reasonably short period of time as suggested by the Intermediary. Tr. at 51-52.

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[9] This relates to the closure of beds in the OB1 Units which the Intermediary acknowledged was in error. Tr. at 43.

[10] It appears that this position was precipitated by a CMS quality review as noted in the Intermediary workpapers.

The Board also acknowledges that the Intermediary found some instances where the occupancy of a unit exceeded the available bed count. Tr. at 255 -256. The Board notes that this may have occurred with a shift of beds from one unit to another, but does not find this persuasive that the Provider's available bed reports should be dismissed as unreliable. In fact, the Board finds that the Provider's available bed reports accurately reflect the decreasing number of beds, and that the occupancy rates were below the available bed count. With regard to the Intermediary's argument that the Provider needed to adjust its depreciation expense to reflect these changes in bed size, the Board notes that due to the age of the Provider's facility, beds and space may already have been fully depreciated or converted to other uses. Finally, the Board finds no clear evidence that depreciation adjustments were not made.

DECISION AND ORDER:

The Board finds that the Intermediary's adjustments increasing the number of available beds were improper. The Board further finds that the Provider's available bed report (as agreed to by the Provider in Intermediary Exhibit 31, column four) represents the correct number of available beds that should be used for the IME calculation. The Intermediary's adjustments are reversed and the matter is remanded to the Intermediary to calculate the amount using the figures in Intermediary Exhibit 31 column 4, which reads "IME Average Bed Days (Based on Provider operating Bed Day Report):"

Year	1994	1995	1996	1998	1999	2000	2001
Available Bed Count	358	285	265	265	265	256	185

Board Members Participating:

Suzanne Cochran, Esquire
Gary B. Blodgett, DDS
Elaine Crews Powell, CPA
Yvette C. Hayes
Anjali Mulchandani-West (recused)

FOR THE BOARD:

DATE: September 12, 2006

Suzanne Cochran, Esquire
Chairman