PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

ON THE RECORD
2006-D54

PROVIDER -
North Okaloosa Medical Center
Crestview, Florida

Provider No.: 10-0122

vs.

INTERMEDIARY-
BlueCross Blue ShieldAssociation/
First Coast Service Options, Inc.

DATE OF HEARING -
July 6, 2006

Cost Reporting Period Ended -
March 31, 1998

CASE NO.: 02-1420

INDEX

ISSUE:

Whether the Intermediary's adjustment of disproportionate share hospital (DSH) reimbursement based on its determination that the Provider had less than 100 available beds for DSH eligibility purposes was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This dispute arises under the Medicare program administered by the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA). The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395(c). CMS is the agency of the Department of Health and Human Services responsible for 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, regulations and interpretive guidelines published by CMS. *See* 42 U.S.C. §1395h, 42 C.F.R. §§413.20-413.24.

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 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.

In 1983, Congress changed the method of hospital reimbursement under the Medicare program by enacting Pub. L. No. 98-21, which created the Prospective Payment System (PPS). Under PPS hospitals are reimbursed for their inpatient operating costs on the basis of prospectively determined national and regional operating costs. Congress also provided for additional payments for certain hospitals that met specific criteria with respect to their inpatient population. The statutory provision at 42 U.S.C.§1395ww(d)(5)(F)(i) requires that the Secretary provide for an additional payment for hospitals that serve "a significantly disproportionate number of low-income patients." To determine a hospital's eligibility to receive this additional DSH payment, the following factors are taken into consideration: 1) hospital's location status (urban or rural); 2) number of beds; and 3) Disproportionate Share percentage. The dispute in this case concerns the method by which the number of beds is determined.

Medicare regulations provide that the number of beds for purposes of DSH payment must be determined in accordance with the indirect medical education (IME) bed count rules set forth in 42 C.F.R. §412.105(b). See, 42 C.F.R. §412.106(a)(1)(i). Under the IME regulation:

> . . . 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.

42 C.F.R. §412.105(b) (emphasis added).

The Provider Reimbursement Manual (PRM) (CMS Pub. 15-1) §2405.3G further explains that, to be considered an available bed, a bed must be permanently maintained for lodging inpatients, available for use, and housed in patient rooms or wards. 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 being used, but rather, the count is intended to capture changes in the size of a facility as beds are added to or taken out of service. 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.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

North Okaloosa Medical Center (Provider) is an acute care facility located in Crestview, Florida. The facility is licensed by the state of Florida for 100 acute care beds and 10 skilled nursing facility (SNF) beds.[1] For the cost reporting period ended 3/31/98, the Provider claimed that it applied the methodology for counting available beds set out in 42 C.F.R. §412.105 and, accordingly, was due DSH reimbursement under the Medicare reimbursement formula for urban hospitals with 100 or more available acute care beds. First Coast Service Options (Intermediary) identified 10 beds within the acute care bed count as observation beds and removed them from the Provider's count of available beds. The reduction in the bed count disqualified the Provider from DSH eligibility, and the Provider appealed the adjustment. There is no dispute that the hospital has 100 beds, is located in an urban setting and that it exceeded the 15% disproportionate patient percentage. The sole issue to be determined is whether all 100 of the Provider's licensed, acute care beds (including the observation beds) should be included in the count for meeting the eligibility requirements of 42 U.S.C. §1395ww(d)(5)(F)(v).

PROVIDER'S CONTENTIONS:

Provider states that the statutory provisions at 42 U.S.C. §1395ww(d) *et seq.* provide for additional payments for certain hospitals which are located in an urban area, have 100 or more beds and that serve a significantly disproportionate number of low-income patients. The statute contains no reference to "PPS paid bed days" or other reimbursement issue in determining the 100-bed threshold for DSH eligibility. The Provider argues that patient days are specifically mentioned by Congress in establishing the actual DSH patient percentage calculation, and the term "beds" is a term that is uniformly interpreted by hospitals as meaning a hospital's licensed and certified beds.

Provider further notes that the DSH regulation at 42 C.F.R. §412.106 states that the bed-counting methodology for determining the number of beds for DSH status shall be the same as the indirect medical education (IME) bed count rules. The IME regulation at 42 C.F.R. §412.105(b) does not require the exclusion of licensed inpatient beds that are used for observation care, nor does it

[1] The SNF beds do not affect the issue under appeal.

require the counting of only days "subject to the prospective payment system." Rather, the regulation calculates "available bed days" by multiplying the number of beds by the number of days in a cost reporting period.

The Provider also argues that PRM §2405.3G clearly states that "available bed days" include all routine beds, regardless of usage. This manual provision indicates that the available bed count should not take into consideration "the day-to-day fluctuations in patient rooms and wards being used." The Provider argues that, a licensed inpatient room for the temporary stay of an observation patient must, therefore, be counted. Further, the manual clarifies that the available bed count is designed to capture changes in the "size of a facility as beds are added to or taken out of service." The size of the Provider's facility remained constant during the relevant time period, and there were no structural changes in the size of the facility that would have limited the use of any of the Provider's 100 beds during the entire cost reporting period. Therefore, under the definition set forth in PRM §2405.3.G, the beds used by the patients in observation status should be included in the bed count for purposes of DSH reimbursement.

Provider also contends that it has been longstanding CMS policy (which is consistent with the statutory and regulatory framework) that beds are presumed available and counted unless the provider presents evidence to exclude the beds,[2] and that observation beds shall be considered available beds for DSH purposes.[3]

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the definition of available beds in PRM §2405.3.G requires that a bed be regularly maintained and used for lodging inpatients and that patient days include only those days attributable to areas of the hospital subject to PPS. Further, this manual provision specifically indicates that beds used in outpatient areas and other such areas as are regularly maintained and utilized for only a portion of a patient's stay or for purposes other than lodging inpatients, are excluded. Observation bed days are billed and paid as outpatient services when a patient is not admitted as an inpatient. Therefore, for purposes of determining bed size, beds in outpatient areas (or used to provide outpatient services) should be excluded. This provision requires the removal of the 10 observation beds from the hospital's 100 total acute care beds used to determined bed size for the purpose of qualifying for a DSH payment.

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[2] *Natividad Medical Center v. Blue Cross & Blue Shield Association/Blue Cross of California*, PRRB Dec. No. 91-D58, August 9, 1991, Medicare and Medicaid Guide (CCH) ¶39,573, rev'd CMS Administrator, October 6, 1991, Medicare and Medicaid Guide (CCH) ¶39,611; see also *Edinburg Hospital v. Blue Cross & Blue Shield Assoc./TrailBlazer Health Enterprises, LLC*, PRRB Dec. No. 2003-D23, April 29, 2003, Medicare and Medicaid Guide (CCH) ¶80,891.

[3] *Pacific Hospital of Long Beach v. Aetna Life Insurance Company*, PRRB Dec. No. 93-D5, December 16, 1992, Medicare and Medicaid Guide (CCH) ¶40,987, rev'd in part, CMS Administrator, February 2, 1993, Medicare and Medicaid Guide (CCH) ¶41,355; see also *Clark Regional Medical Center v. U.S. Dept. of Health & Human Services* (hereinafter Clark Regional), 314 F.3d 241 (6th Cir. 2002).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law and guidelines, the Parties' contentions and stipulations, and evidence contained in the record, finds that the observation bed days should be included in the available bed count and used in determining the Provider's eligibility for DSH reimbursement.

The statute, 42 U.S.C. §1395ww(d)(5)(F), considers three factors in determining a hospital's qualification for a DSH adjustment: (1) the provider's location (urban or rural); [4](2) the number of patient days;[5] and (3) the number of beds.[6] In this case, the only criterion under dispute is the number of beds. The statute does not expound upon the meaning of "bed" with respect to DSH eligibility. However, the regulation, 42 C.F.R. §412.106, implements the statutory provisions and establishes factors to be considered in determining whether a hospital qualifies for a DSH adjustment. Section 412.106(a)(1)(i) requires that the number of beds be determined in accordance with 42 C.F.R. §412.105(b).[7] This regulation 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.

42 C.F.R. §412.105(b) (1995).

The Board finds that the controlling regulation, 42 C.F.R. §405.105(b), establishes the fundamental methodology for determining a hospital's bed size for purposes of DSH eligibility and requires that all beds be included in the calculation unless they are specifically excluded under the categories listed in the regulation. Furthermore, the Board finds that the word "bed" is specifically defined in PRM §2405.3.G for the purpose of calculating the adjustment for IME and DSH eligibility. The PRM states in relevant part:

> 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:

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[4] 42 U.S.C. §1395ww(d)(5)(F)(i)(II)

[5] 42 U.S.C. §1395ww(d)(5)(F)(vi)

[6] 42 U.S.C. §1395ww(d)(5)(F)(v)(I)

[7] 42 C.F.R. §412.105 provides for additional payments for IME costs of graduate medical education program.

> 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 a facility are considered available only if the hospital put the beds into use when they are needed. The term "available beds" as used for the purpose of counting beds is not intended to capture the day-to-day fluctuations in patient rooms and wards being used. Rather, the count is intended to capture changes in the size of a facility as beds are added to or taken out of service.

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

Based on the above-cited authorities, the Board concludes that the rationale applied by the Intermediary for the exclusion of observation beds is not supported by the correct and clear interpretation of the language set forth in the regulation and manual guidelines. The Board finds that all of the observation beds at issue were licensed acute care beds located in the acute care area of the Provider's hospital facility. The Board further finds that these beds were permanently maintained and available for inpatient lodging during the cost reporting period under appeal.

The Board's determination also relies upon the fact that the enabling regulation and manual instructions identify the specific beds that are to be excluded from the bed count, and neither of these authorities provides 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 types of beds that are to be excluded from the count, the Board finds that these comprehensive rules are meant to provide an exhaustive listing of excluded beds.

The Board rejects the Intermediary's contention that only beds reimbursed under PPS should be included in the count of available beds, since the purpose of DSH is to adjust PPS payment amounts. If this argument were valid, Congress would simply have said so in the statute, and enabling regulations could have been promulgated to accommodate a category for PPS-excluded beds. Instead, the controlling regulation and manual guidelines were written in a manner that provides great specificity regarding beds that are to be included and those that are to be excluded from the bed count.

The Board notes that the Secretary has stated in various decisions reversing the Board's interpretation of available beds that CMS has had a long-standing policy of using PPS days to determine the number of available bed days for DSH reimbursement. However, the Board finds

this statement inconsistent with the program instructions at PRM §2405.3.G. According to the example in the manual, a hospital that has 185 acute care beds, of which 35 beds are used to provide long-term care, would include all 185 beds to determine the available bed days, since the 35 beds are certified for acute care.

Finally, the Board observes that the Sixth Circuit decision in Clark Regional Medical Center[8] upheld the Board's decision that observation days meet the Medicare program's requirements to be included in the bed size calculation used to determine DSH eligibility. The Court found that HCFA's application of its own regulations and the PRM could not be reconciled with the plain meaning of the definition of "available beds." Because the regulation specifically listed certain types of beds that were excluded from the calculation but did not list swing-beds or observation beds, the plain meaning of the regulation suggested that it is permissible to count observation beds in the calculation of available beds. Further, the Court found that the PRM was conclusive proof that observation beds are intended to be counted in the tally of "available bed days" in the DSH calculation. PRM §2405.3.G. states that "to be considered an available bed, a bed must be permanently maintained for lodging inpatients." The beds in question were always staffed and available for acute care inpatient lodging. The PRM guidelines specifically states that the term 'available bed' . . . 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. The Court concluded that this was precisely the type of day-to-day fluctuation that should not be captured when counting beds under 42 C.F.R. §412.105(b).[9]

DECISION AND ORDER:

The Intermediary's determination of the number of available beds for DSH eligibility purposes was not proper. The determination should have included the Provider's observation bed days. The Provider had 100 available beds for Medicare DSH adjustment qualification and payment purposes. Accordingly, Provider is entitled to additional DSH payment adjustment.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esq., Chairperson
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, CPA
Anjali Mulchandani-West
Yvette C. Hayes

8 314 Fed. 3d 241 (6th Cir.. 2002)

9 Id.

FOR THE BOARD:

DATE: September 26, 2006

Suzanne Cochran
Chairperson