PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2008-D35

PROVIDER –
St. Vincent Mercy Medical Center
Toledo, Ohio

Provider No.: 36-0112

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
National Government Services - Ohio

DATE OF HEARING –
February 13, 2008

Cost Reporting Period Ended -
December 31, 2001

CASE NO.: 05-2054

INDEX

ISSUES:

1. Whether the Intermediary's adjustment to include outpatient observation bed days in the bed count for purposes of calculating the Provider's indirect medical education (IME) reimbursement was proper.

2. Whether the Intermediary's adjustment to include Medicaid outpatient observation days when determining disproportionate share hospital (DSH) eligibility and payment was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This dispute arises under the Federal 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. §§1395-1395cc. 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(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 portion 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.

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the Prospective Payment System (PPS). The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors. See, 42 U.S.C. 1395ww(d)(5). This case involves two of those provisions.

The provision at 42 U.S.C. §1395ww(d)(5)(F)(i) requires that the Secretary provide an additional payment for hospitals that serve "a significant disproportionate number of low-income patients." Whether a hospital qualifies for the DSH adjustment, and how large an adjustment it receives, depends on the hospital's "disproportionate patient percentage." 42 U.S.C. §1395ww(d)(5)(F)(v). The "disproportionate patient percentage" is the sum of two fractions, the "Medicare and Medicaid fractions," expressed as a percentage for a hospital's cost reporting period. 42 U.S.C. §1395ww(d)(5)(F)(vi). The Medicare fraction's numerator is the number of hospital patient days for patients entitled to both Medicare Part A and Supplemental Security Income, excluding patients receiving State supplementation only, and the denominator is the number of hospital patient days for patients entitled to Medicare Part A. Id. The Medicaid fraction's numerator is the number of hospital patient days for patients who

were eligible for medical assistance under a State plan approved under Title XIX for such period but not entitled to benefits under Medicare Part A, and the denominator is the total number of the hospital's patient days for such period. Id.; See also, 42 C.F.R. §412.106(b)(4). The Medicaid fraction is frequently referred to as the Medicaid Proxy and is the only fraction at issue in this case.

The provision at 42 U.S.C. §1395ww(d)(5)(B) recognizes that teaching hospitals have indirect operating costs that would not be reimbursed under the prospective payment system or by the Direct Graduate Medical Education (DGME) payment methodologies and authorizes an additional payment known as the Indirect Medical Education (IME) payment, to hospitals with GME programs. Specifically, the IME payment compensates teaching hospitals for higher-than-average operating costs that are associated with the presence and intensity of residents' training in an institution but which cannot be specifically attributed to, and does not include, the costs of residents' instruction. The IME adjustment attempts to measure teaching intensity based on "the ratio of the hospital's full-time equivalent interns and residents to beds." Id.

The DSH and IME calculations share a common element. Medicare regulations provide that the number of beds for purposes of DSH payment must be determined in accordance with the 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 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, "[t]o be considered an available bed, a bed must be permanently maintained for lodging inpatients. It must be available for use and housed in patient rooms or wards. . . . " The term "available 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 during any time during the cost reporting period are presumed to be available during the entire cost reporting period. At issue in this case, is the proper identification of available beds for use in both the IME and DSH calculations.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

St. Vincent Mercy Medical Center (Provider) is an acute care hospital that is located in Toledo, Ohio. For the fiscal period ended December 31, 2001, the Provider excluded from its available bed day count those days where beds were used to treat observation patients on an outpatient basis. The exclusion affected the Provider's calculation of its IME reimbursement as well as the calculation of its DSH eligibility and payment. National Government Services – Ohio (formerly AdminaStar Federal and hereinafter, Intermediary) adjusted the cost report

settlement data to include all observation bed days in both calculations based upon its interpretation of Clark Regional v. United States DHHS (314 F.3d 241 (6th Cir.2002)) (Clark Regional). The Provider challenged the Intermediary's application of Clark Regional and appealed the inclusion of observation bed days in both the IME and DSH calculations.

The Provider met the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841 and was represented by Keith D. Barber, Esquire, of Hall, Render, Killian, Heath & Lyman, P.S.C. The Intermediary was represented by Bernard M. Talbert, Esquire, Associate Counsel, Blue Cross Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider argues that CMS policy requires exclusion of observation bed days. In its "Identical Letter to All Fiscal Intermediaries" dated March 7, 1997,[1] CMS stated:

> 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 . . . all observation days are excluded from the available bed day count.

The Provider further contends that CMS confirmed this policy in the May 19, 2003, Federal Register (68 F.R. 27205) and, in the August 1, 2003 Federal Register (68 F.R. 45418), finalized changes to the regulations that clarified the existing policy. Specifically, the Administrator said that " . . . our policy is the bed days used for observation services are excluded from the counts . . ."[2] The Administrator stated further that the agency is " . . . required to consider only those inpatient days to which the prospective payment system applies" when counting beds for these purposes.[3] The Provider argues that the CMS publications make clear that the Intermediary's inclusion of observation bed days in the count of available bed days is incorrect.

The Provider also challenges the Intermediary's application of Clark Regional v. United States DHHS to the facts and circumstances of this case. The Provider argues that principles of res judicata and collateral estoppel do not apply because neither the parties nor the issues in this instance are the same as those in Clark Regional. Further, the Provider contends that the Administrator found that the decision in Clark Regional was representative of the Court's "misunderstandings about [CMS] policy regarding the exclusion of observation and swing- bed days."[4] The Administrator held that the language of the statute requires the agency " . . . to consider only those inpatient days to which the prospective payment system applies" when counting beds.[5]

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[1] Provider Exhibit P-1.
[2] 68 F.R. 45418.
[3] 68 F.R. 45419.
[4] 68 F.R. 27206, Provider Position Paper, pgs. 7-8
[5] 68 F.R. 45419.

The Provider further contends that the regulation at 42 C.F.R. §412.105(b)(4) should control. The regulation, although promulgated on August 1, 2003, was a clarification of existing policy, not a substantive change in policy. Accordingly, the Provider contends that the regulation is properly applied as it exists now.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that it is bound by the U.S. Court of Appeals for the Sixth Circuit decision which addressed the CMS policy that excludes observation beds from the count of available beds for purposes of the IME and DSH adjustments. In Clark Regional v. United States DHHS, the Court ruled that CMS' policy is inconsistent with the plain meaning of the regulation. The Intermediary must apply the Sixth Circuit's decision to providers located in the sixth circuit to assure consistent application among all providers.

The Intermediary also challenges the Provider's contention that the decision in Clark Regional is limited to its litigants and is not applicable to the facts and circumstances of this case. The Intermediary argues that the Court in Clark Regional found that the Congress had not explicitly addressed the inclusion of swing and observation beds in the determination of DSH eligibility but rather determined that the issue was whether CMS properly interpreted and applied its own regulations in determining the provider's eligibility for DSH. The Court concluded that the exclusion of the observation bed days could not be squared with the plain meaning of the regulations or CMS' definition of available beds as set forth in CMS Pub. 15-1 §2405.3(G). Further, the Court concluded that the regulation at 42 C.F.R. §412.106(a)(1)(i) makes clear that the terms defined for IME reimbursement calculation are also meant to govern the DSH reimbursement calculation and that swing and observation beds are properly considered available beds for purposes of the DSH adjustment.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and guidelines, the parties' contentions and the evidence, the Board finds that the beds used for observation services should be included in the computation of the FTE resident-to-bed ratio that is used to compute the Provider's IME reimbursement. The Board also finds that Medicaid observation bed days cannot be included as inpatient days in the Medicare fraction used to compute the Provider's DSH reimbursement

Issue 1: IME Bed Count

The Board finds that the controlling regulation, 42 C.F.R. §412.105(b), establishes the fundamental methodology for determining a hospital's bed size for purposes of calculating IME reimbursement. It requires that all beds be included in the calculation unless they are specifically excluded under the categories listed in the regulation.

Further, the Board finds that the word "bed" is specifically defined in PRM §2405.3.G for the purpose of calculating the adjustment for IME. In relevant part, the section states that:

> 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 using 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.

(Emphasis added)

Based on the cited authorities, the Board concludes that the argument advanced by the Provider for the exclusion of observation beds is not supported by the plain language of the controlling regulation or by the manual provisions. The Board finds the beds used by the Provider to furnish observation services were licensed acute care beds that were 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 the lodging of inpatients and were fully staffed to provide inpatient services during the cost reporting period under appeal.

The Board's determination also relies on the fact that the controlling regulation and the manual instructions identify the specific beds 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 controlling regulation has been modified on at least two occasions to clarify the types of beds excluded from the count, the Board finds these comprehensive rules are meant to provide an all-inclusive listing of the excluded beds.

In various decisions reversing the Board's interpretation of available beds, the Administrator stated that CMS has had a long standing policy of using PPS-reimbursed days to determine the number of available beds used to determine whether a provider qualifies for a DSH adjustment. However, the Board finds this statement inconsistent with the program instructions at CMS Pub. 15-1 §2404.3G regarding IME reimbursement. According to the example in the manual

provision, a hospital that has 185 acute care beds, 35 of which are used to provide long-term care, would include all 185 beds in the determination of the available beds for the IME calculation since the 35 beds are certified as acute care beds.

Finally, the Board observes that the Sixth Circuit decision in Clark Regional,[6] upheld the Board's decision that observation bed 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 manual provisions could not be squared 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 conclusive proof that observation beds are intended to be counted in the tally of "available bed days" in the DSH calculation, in PRM §2405.3G which states: "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 inpatients. The PRM explains that "the term 'available bed' is not intended to capture the day-to-day fluctuations in patient rooms and wards being used." Therefore, 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. §105(b).[7]

Issue 2: Medicaid Outpatient Observation Days in DSH Calculation

The Board finds that outpatient days should be excluded from both the numerator (Medicaid patient days) and denominator (total patient days) of the Medicare fraction of the DSH calculation. The regulation at 42 C.F.R. §412.106(b)(2)(i)(A) requires patient days used in the first DSH fraction calculation to be "associated with discharges occurring during each month." Likewise, in the second DSH fraction at 42 C.F.R. §412.106(b)(2)(iii)(A), days must be "associated with discharges that occur during that period." The Board finds that the term "discharges" would only be applicable to inpatients who had been admitted. Because the days being contested in this issue relate to outpatient services, they would not be associated with a discharge. This interpretation is supported by the applicable Medicare cost report instructions for the Worksheet E, Part A regarding the DSH calculation, CMS Pub. 15-2 §3630.1 which by formula excludes observation days reported on Worksheet S-3, Part I, from patient days used in calculating the DSH percentage. This finding is further supported by the letter from HCFA (CMS) to its Intermediaries stating:

> 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. . . .

6 314 F. 3d 241 (6th Cir.. 2002).

7 Id., pp. 247-249.

Provider Exhibit P-1, "Identical Letter to all Fiscal Intermediaries," page 2, dated March 7, 1997.

Contrary to the Intermediary's position, the Board finds the Clark Regional circuit court case does not address the issue of patient days used in the DSH calculation. The Clark Regional decision only addressed the determination of bed size as described in issue1. The Board notes the regulatory language in the DSH regulation is very specific when it states: The number of beds in a hospital is determined in accordance with §412.105(b) [the IME regulation]." See, 42 C.F.R. §412.106(a)(l)(i). The Board and the Court agree that the regulations require inclusion of beds used for both inpatient and observation patients when determining the *bed size* of a hospital. The Board finds the DSH regulation at 42 C.F.R. §412.106 does not reference the IME regulations for determining patient days used in the DSH calculation. Therefore, the Clark Regional decision does not apply to this issue.

DECISION AND ORDER:

Issue 1:

The Intermediary's adjustment to include outpatient observation bed days in the bed count for purposes of calculating the Provider's Indirect Medical Education (IME) reimbursement was proper.

Issue 2:

The Intermediary's adjustment to include Medicaid outpatient observation days when determining DSH eligibility and payment is reversed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esq., Chairperson
Elaine Crews Powell, C.P.A.
Yvette C. Hayes
Michael D. Richards, C.P.A.

FOR THE BOARD

Suzanne Cochran
Chairperson

DATE: September 15, 2008