PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2009-D33

PROVIDER -
Cleveland Regional Medical Center
Cleveland, Texas

Provider No.: 45-0296

vs.

INTERMEDIARY -
Wisconsin Physicians Service

DATE OF HEARING -
January 29, 2008

Cost Reporting Period Ended -
August 31, 2001

CASE NO.: 06-0814

INDEX

ISSUE

Whether the Intermediary's adjustment of the 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:

In 1983, Congress changed the system for hospital reimbursement under the Medicare program by enacting Public Law No. 98-21, which created the Prospective Payment System (PPS). Under PPS, hospitals are reimbursed their inpatient operating costs on the basis of prospectively determined national and regional operating costs.

Congress also provided for special adjustments to the PPS rates for certain hospitals meeting specific inpatient population criteria. Pursuant to 42 U.S.C. §1395ww(a)(2)(B), the Secretary was directed to provide for appropriate adjustments to the limitation on payments that may be made under PPS, to take into account "the special needs of psychiatric hospitals and of public or other hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under part A of this subchapter." 42 U.S.C. §1395ww(a)(2)(B). The statutory provision at 42 U.S.C. §1395ww(d)(5)(F)(i) further directs the Secretary to provide "for an additional payment amount for each subsection (d) hospital" serving "a significant disproportionate number of low-income patients…"[1] This payment adjustment is referred to as the DSH adjustment.

To be eligible for the additional payment, a hospital must meet certain criteria concerning its disproportionate patient percentage. Under 42 U.S.C. §1395ww(d)(5)(F)(v), a hospital that is located in an urban area and has 100 or more beds is eligible for the additional DSH payment, if its disproportionate patient percentage is at least 15 percent. However, if the urban hospital has less than 100 beds and a disproportionate patient percentage of 40 percent for discharges before April 1, 2001 or 15 percent for discharges on or after April 1, 2001, it is also eligible to receive DSH payments. It can receive 5 percent of its diagnostic related group (DRG) payments for discharges prior to April 1, 2001 and 5.25 percent for its discharges or or after April 1, 2001 (and before April 1, 2001).[2]

The regulation at 42 C.F.R. §412.106 establishes the factors to be considered in determining whether a hospital qualifies for a DSH payment adjustment. The factors to be considered include the number of beds, the number of patient days, and the hospital's location. With respect to the number of beds, the DSH regulation states, "[t]he number of beds in a hospital is determined in accordance with 42 C.F.R. §412.105(b)." 42 C.F.R. §412.106(a)(l)(i). 42 C.F.R. §412.105(b) is the regulation governing bed counting for purposes of the Indirect Medical Education (IME) adjustment.

The IME bed counting regulation states:

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[1] See, Provider Appendix A.

[2] 42 U.S.C. §1395ww(d)(5)(F)(iv)(II) and §1395ww(d)(5)(F)(xiii)(II). See. Intermediary Exhibit I-1 audit workpaper R-1.3 and Intermediary Position Paper at 5.

> *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)

The bed counting regulation and program instructions published by CMS establish the specific governing rules for determining the size of a hospital facility for DSH payment eligibility under the statutory provisions of 42 U.S.C. §1395ww(d)(5)(F)(v). As the regulation at 42 C.F.R. §405.105(b) indicates, "available days" are the result of multiplying the number of beds by the number of days in a cost reporting period.

The Provider Reimbursement Manual (PRM) provides further clarification of the available beds determination process set forth in the regulations. Section 2405.3.G of the PRM states:

> 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 post-operative recovery rooms, outpatient areas, emergency rooms, ancillary departments, nurses' and other staff residences, and other such areas as are regularly maintained and utilized for only a portion of the stay of patients or for purposes other than inpatient lodging.
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> To be considered an available bed, a bed must be permanently maintained for lodging inpatients. It must be available for use and housed in patient rooms or wards (i.e., not in corridors or temporary beds). Thus, beds in a completely or partially closed wing of the facility are considered available only if the hospital 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.
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> 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.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY

Cleveland Regional Medical Center (Provider) is an acute care hospital located in Cleveland, Texas which is considered a part of the greater Houston metropolitan statistical area. The Provider is an urban hospital with a disproportionate patient percentage exceeding 15 percent. The Intermediary removed observation and swing bed patient days from the Provider's available bed day count for purposes of determining the Provider's eligibility for DSH reimbursement. The approximate reimbursement impact of the removal of these bed days is 1.45 million.[3] Furthermore, in audit adjustment number 21[4], the Intermediary increased the number of swing-bed SNF-type inpatient days resulting in the reduction of an additional 2.06 beds from the Provider's available bed count.[5]

The sole issue to be determined with respect to the DSH available bed count issue is the size of the Provider's facility for the purpose of meeting the DSH eligibility requirements of 42 U.S.C. §1395ww(d)(5)(F)(v)(I).

The Provider's appeal meets the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841. The Provider was represented by Gregory N. Etzel, Esquire, of Baker & Hostetler, LLP. The Intermediary was represented by Terry Gouger, C.P.A., of Wisconsin Physicians Service.

BACKGROUND:

On its as-filed cost report for fiscal year ended August 31, 2001 (FY 2001), the Provider reported 104 total beds on line 12 of Worksheet S-3, Part I. Provider Exhibit 7. In 2001, the Provider was licensed by the state of Texas for 115 beds.[6] According to the Provider's licensure application, the beds fell into the following categories:

Medical/Surgical beds	83
OB/GYN	14
ICU/CCU	6
Pediatric	12
Total	**115**

Provider Exhibit 9.

No beds were licensed as skilled nursing beds, and the number of licensed beds did not include bassinets in the newborn nursery. Of the 115 licensed beds, some were used primarily as labor and delivery room (LDR) beds; however, these beds were permanently maintained as inpatient beds.[7] Additionally, in the 1998-99 edition of the *American Hospital Association Guide*, the Provider is listed as having 115 staffed beds.[8]

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[3] See, Provider Exhibit 16.
[4] See, Provider Exhibit 6.
[5] See, Provider's Position Paper at 3.
[6] See, Provider Exhibit 8.
[7] Transcript (Tr.) at 68-73.
[8] See, Provider Exhibit 10.

In response to the Board's request, the Provider located and produced worksheets relating to the bed counts utilized on the FY 2000 and 2001 cost reports (2001 being the fiscal year at issue in this appeal).[9] The 2000 cost report worksheets show 98 adult and pediatric beds, and 6 ICU beds for a total of 104 inpatient acute care beds.[10] The FY 2000 worksheet also shows 11 skilled nursing beds, bringing the total for the facility to 115 beds.[11] As the Provider's witnesses testified at hearing, the skilled nursing unit (SNF unit) was decertified in 2000.[12] The FY 2001 cost report worksheet lists the same 98 adult and pediatric beds and 6 ICU beds as the FY 2000 worksheet, but instead lists 0 as the number of skilled nursing beds in the facility.[13]

During the hearing before the Board, the Provider's witness, Mr. James Kelley, Director of Engineering conducted a virtual "walk-through" of the hospital, utilizing photographs of the oxygen and medical gas hookups in each room and a floor plan of the facility.[14] To summarize, Mr. Kelley testified to the licensed inpatient beds in the following areas of the hospital:

First Floor	
Obstetrics	12[14]
LDR	7[15]
Day Surgery	11[16]
ICU	6[17]
First Floor Subtotal	**36**
Second Floor	
Second Floor North	45[18]
Second Floor South (pediatrics)	33[19]
Second Floor Subtotal	**78**
Total	**114[20]**

[9] Tr. at 260-61.
[10] See, Provider Exhibit 23, page 1.
[11] Id.
[12] Tr. at 74, 147, 149-50.
[13] See, Provider Exhibit 23, page 2.
[14] Tr. at 46-137, Provider Exhibits 13 (floor plans) and 22 (room photographs).
[14] Tr. at 66-67.
[15] Tr. at 72-73.
[16] The area labeled as "Day Surgery" on the list at Provider Exhibit 12 contained licensed inpatient beds. This is the same area that formerly housed the SNF unit that was decertified in 2000. Tr. at 73-74. Mr. Kelley testified that the area was sometimes used as overflow to house day surgery patients if the census allowed. Tr. at 75-77. However, Mr. Kelley also testified that the rooms in this area of the hospital were all licensed for inpatient use and capable of supporting inpatients. Tr. at 77 and 82.
[17] Tr. at 83-84. These days are no longer being contested.
[18] Tr. at 90.
[19] Tr. at 103-104.
[20] Tr. at 104.

The licensed inpatient bed total differs from the bed count of 107 that the Provider noted in communications to the Texas Department of Health[21] dated December 18, 2001.[22] This count, of 107, excluded four rooms that were primarily used for LDR services and capable of housing 7 licensed inpatient beds.[23]

When the 7 LDR beds discussed by Mr. Kelley are added to the 107 beds on the list at Provider Exhibit 12, a total of 114 inpatient beds is reached. This number is consistent with the testimony of the Provider's former Chief Financial Officer, Mr. Phil Hacker, who testified that it was his understanding that the facility had 107 beds during 2001.[15] Mr. Hacker also testified that at that time, he did not know that LDR beds could be counted.[16] Therefore, if one accepts Mr. Kelley's testimony on the 7 available inpatient beds in the LDR rooms and adds those to the 107 testified to by Mr. Hacker, a total of 114 beds is again reached.

The precise number of beds is somewhat unclear—either 114, according to floor plans and witness testimony, or 115, according to the hospital's license.

In the calculation of the Provider's DSH adjustment, the Intermediary removed 409 patient days relating to patients who had received observation services while lodged in a licensed inpatient bed, and 2,528 swing bed days relating to patients who had received skilled nursing services while lodged in a licensed inpatient bed. The Intermediary's removal of these observation bed and swing bed days resulted in a bed count for the Provider of 95 beds during the fiscal year at issue. As a result, the Intermediary found that the Provider was not entitled to be paid the full DSH payment adjustment that is available to urban hospitals with 100 or more beds and disproportionate patient percentage of at least 15%.

PARTIES' CONTENTIONS:

The Intermediary contends that the Provider has less than 100 available beds for the purpose of determining DSH eligibility. Through testimony and evidence submitted, the Provider has an available bed count of less than 84. At the request of the Board, the Provider submitted documentation post-hearing that addressed how the Provider arrived at the 104 beds it claimed on its FY 2001 as-filed cost report. This documentation showed that the Provider used the prior year's (FY 2000) filing of 115 beds (which agrees to the total licensed beds) less 11 beds that were formerly designated as SNF beds. The SNF beds were decertified in 2000. These beds were located on the 1st floor and based on witness testimony, subsequently used for a number of purposes to include day surgery outpatient services.[17] The Intermediary argues that the Provider has not adequately documented the actual use of the beds during the period in question or provided evidence that these beds could be staffed within 24-48 hours as needed.

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[21] The Texas Department of Health (TDH) is the state agency responsible for the licensing of hospitals in Texas.
[22] See, Provider Exhibit 11.
[23] See, Provider Exhibit 12; Tr. at 67-73.
[15] Tr. at 244
[16] Tr. at 153-54.
[17] See Tr. at 73-78.

In addition, the Intermediary argues that the Provider cannot increase the bed count beyond what was originally claimed in the as-filed cost report, 104 total beds. Moreover, the seven (7) LDR beds are included in the 104 bed count claimed and should be excluded because there is no evidence that they were used for inpatients. See Tr. at 181-183.

The Provider contends that the Intermediary has undercounted the Provider's available bed for DSH purposes by focusing on the *use* of a bed on a given day, rather than the *availability* of the bed (*i.e.*, its status as a licensed inpatient bed capable of being put into use for inpatient services within 24-48 hours), as specified in the regulation. While the Provider admittedly occasionally utilized some of its inpatient beds to lodge observation and skilled nursing patients, the Provider contends that these beds were still "available beds" and could be used to house acute care inpatients up to the Provider's licensed capacity, if needed. The Provider's contention in this case is consistent with PRRB and federal court decisions that have been published. The Provider respectfully requests that in the present case, the Board act consistently with its well-reasoned decisions in *Commonwealth of Kentucky 92-96 DSH Group v. Blue Cross and Blue Shield Association/AdminaStar Federal,*[18] *Odessa Regional Hospital (Odessa, Texas) v. Mutual of Omaha Insurance Company/Intermediary,*[19] *Highland Medical Center (Lubbock, Tx.) v. Mutual of Omaha Insurance Co.,*[20] and *North Okaloosa Medical Center (Crestview, Fla.) v. BlueCross BlueShield Association,*[21] and hold that the Intermediary may not exclude observation or swing-bed days for purposes of calculating the Provider's DSH available bed count**.** The Provider, therefore, contends that observation and swing bed days should be added back into its available bed day count so that the proper number of beds can be calculated and the Provider's DSH payment can be properly determined and paid.

The Provider also contends that the DSH statute requires the counting of licensed beds for DSH eligibility purposes. The DSH statute provides an additional payment for certain hospitals which serve a significantly disproportionate number of low-income patients. In order to qualify for DSH status, a hospital must have a disproportionate patient percentage equal to or exceeding 15 percent, if the hospital is located in an urban area and has "100 or more beds." 42 U.S.C. §1395ww(d)(5)(F)(v) (2001).[22] The DSH statute does not elaborate on the meaning of the word "beds" for purposes of determining DSH eligibility; nor does it explicitly grant CMS permission to create its own interpretation of the meaning of "beds" through rulemaking.[23]

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[18] PRRB Hearing Dec. No. 99-D66 (Sept. 2, 1999) ("*Commonwealth of Kentucky* PRRB Decision") (Provider Appendix V), *affirmed by Clark Regional Medical Center v. Shalala,* 136 F.Supp.2d 667 (E.D. Kentucky 2001) and *Clark Regional Medical Center v. U.S. Dept. of Health and Human Services,* 314 F.3d 241 (6th Cir. 2002) (Provider Appendix D).

[19] PRRB Hearing Dec. No. 2004-D16 (April 29, 2004) ("*Odessa Regional* PRRB Decision"), *affirmed by Odessa Regional Hospital v. Leavitt,* 386 F.Supp.2d 885 (W.D. Tex. 2005) (Provider Appendix K).

[20] PRRB Hearing Dec. No. 2006-D10 (Dec. 22, 2005) ("*Highland* PRRB Decision") (Provider Appendix H), *affirmed by Highland Medical Center v. Leavitt,* Civ. Action No. 506-CV-082-C (N.D. Tex. 2007) (unpublished) (Provider Appendix X).

[21] PRRB Hearing Dec. No. 2006-D54 (Sept. 26, 2006) ("*North Okaloosa* PRRB Decision") (Provider Appendix E), *affirmed by North Okaloosa Medical Center v. Leavitt,* 2008 WL141478 (N.D. Fla. 2008) (Provider Appendix W).

[22] Provider Appendix A.

[23] In contrast, Congress granted the Secretary express authority to establish a definition of available beds for purposes of determining the intern and resident to bed ratio. 42 U.S.C. §1395ww(d)(5)(B)(vi)(I) (" 'r' may not

The Intermediary contends that the matching of any beds and associated bed days, that are recognized as part of a hospital's allowable inpatient operating costs, is consistent with the statutory intent of the DSH adjustment. A bed occupied by a patient on a given day results in a bed day. The bed is then matched with the day. It would be illogical to include observation bed days, swing bed days, labor and delivery room services, other ancillary services and outpatient services, for one purpose (such as bed count under 42 C.F.R. §412.105(b)) and exclude such days from other purpose (such as bed days under 42 C.F.R. §412.106(a)(1)(ii) for the same DSH payment. Further, observation beds, outpatient services, labor and delivery room ancillary services, other ancillary services and the associated days and bed days are not included in the calculation of Medicare's share of inpatient hospital costs.

The Provider asserts that CMS does not have the statutory authority to narrow the meaning of the term "beds" in the DSH statute to the meaning ascribed to the IME definition of "available beds" at 42 C.F.R. § 412.105(b). In fact, whereas the simple term "beds" is used in the bed-counting portion of the DSH statute, the statute specifically mentions "*patient days*" as the proper tool to use for purposes of calculating a different component of the DSH eligibility determination—the DSH patient percentage calculation (the second step in determining DSH eligibility).

> 42 U.S.C. §1395ww(d)(5)(F)(vi)(I) states: In this subparagraph, the term "disproportionate patient percentage" means, with respect to a cost reporting period of a hospital, the sum of – (I) the fraction (expressed as a percentage), the numerator of which is the number of such hospital's *patient days* for such period… (emphasis added) (Provider Appendix A).

The fact that the statute specifies that patient days are the proper measure for the DSH patient percentage, but does not mention patient days with respect to bed counting, suggests that Congress acted deliberately when it used the single term "beds" in the portion of the statute governing *bed counting* for DSH purposes. Congress could have easily added a reference to patient bed *days* in establishing the 100 bed size eligibility requirement, but it did not. Instead, Congress used the simple term "beds."

It is a well-established rule of statutory construction that each word and clause in a statute should be given effect and none should be presumed to be superfluous. *United States v. Menasche*, 348 U.S. 528, 538-39 (1955). When Congress uses different language in different sections of the statute, or mentions one thing in one part of a statute but omits it from another part of the statute, it is presumed that Congress acted intentionally. *Russello v. United States*, 464 U.S. 16, 23 (1983). It must therefore be presumed that Congress did not intend to apply an *available* bed *day* requirement to the determination of a hospital's DSH eligibility, nor did it intend to allow the Secretary to create his own definition of the term "beds" for DSH eligibility purposes.

The term "beds" is generally interpreted by the hospital industry as meaning a hospital's licensed and certified beds.[24] In Texas, in order to be a licensed "bed," the bed must meet the design specifications listed at 25 Texas Administrative Code (TAC) Ch 133.163, which include an

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exceed the ratio of the number of interns and residents . . . to the hospital's available beds (*as defined by the Secretary*) during that cost reporting period" (emphasis added)).

[24] Medicare has adopted the standardized definitions commonly used by hospitals. 42 C.F.R. § 413.20(a).

oxygen hookup, nurse call service, medical vacuum/suction, nursing service stations, and meet other Texas licensing requirements for inpatient use. 25 TAC Ch. 133.[25] In 2001, the Provider was licensed by the state of Texas for 115 beds. Not coincidentally, 115 is also the bed count listed for the Provider in the 1998-99 edition of the *American Hospital Association (AHA) Guide to the Health Care Field*.[26] The definition of "bed" utilized by the AHA in its Guide is based on the American Hospital Association's Hospital Administration Terminology. *See* 1998-99 AHA Guide at page A5. The Provider therefore contends that this standardized definition of "beds" is the definition that should be used when determining the Provider's size, pursuant to the DSH statute, which simply asks for the number of "beds" in a facility. With 115 licensed beds, it is clear that the Provider met the DSH statute's 100-bed threshold for DSH payment.

The Provider argues that even under the less inclusive "available beds" standard referenced by the Secretary's regulation 42 C.F.R. §412.105(b), it still meets the 100-bed threshold. With at least 114 "available beds," the Provider clearly exceeds 100 beds. In fact, even after the 9 beds attributable to swing and observation patient days were (erroneously) removed from the count, the provider still had over 100 beds.[27]

In the alternative, even if this Board does not find that the Provider had 114 or 115 available beds, the Provider *still* had over 100 available beds because the plain language of the bed-counting regulation mandates the inclusion of observation and swing-bed days in calculating the Provider's available bed count for DSH eligibility purposes.

The Provider contends that the Intermediary used the wrong standard in determining the number of "available beds" at the facility. The crux of the bed-counting issue is the appropriate treatment of observation bed and swing bed days related to services provided in licensed and available inpatient beds. Observation services are "those services furnished by a hospital on the hospital's premises that include use of a bed and periodic monitoring by a hospital's nursing or other staff in order to evaluate an outpatient's condition or to determine the need for a possible admission to the hospital as an inpatient." 68 Fed. Reg. 27,154, 27,205 (May 19, 2003). Observation services may be provided in routine inpatient care areas, in beds that are generally used to provide hospital inpatient services. Id. As the Provider's witness explained at the hearing, the Provider did not have a designated observation unit.[28] Rather, any available inpatient bed could be used for observation services.[29] If an observation patient was in a licensed inpatient room and a doctor decided to admit the patient, the patient could stay in the very same bed since that bed was, in fact, a licensed inpatient bed.[30] Additionally, an inpatient

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[25] See, Provider's Post-Hearing Brief and Proposed Decision at 15.
[26] See, Exhibit 10.
[27] The removal of 9 beds from the bed count of 104 erroneously reported by the Provider led to a total of 95 beds. Had the Provider correctly reported the 114 or 115 available beds it actually had, this issue would not exist – and it would not be necessary to debate the characterization of swing bed and observation bed patient days.
[28] Tr. at 195.
[29] Id.
[30] Id.

bed used to house an observation patient could also be cleared and used for an inpatient on the very same day, if necessary.[31]

Swing-beds are beds "otherwise available for use to provide acute inpatient care that is also occasionally used to provide [skilled nursing facility] care." 68 Fed. Reg. at 27,205. When a hospital is approved to provide post-hospital skilled nursing care in its inpatient beds, such "swing bed approval" does not involve the designation of specific beds in the facility. Rather, as the Provider's witness testified at the hearing, the "swing bed approval" applies to the entire hospital and allows a hospital to utilize its inpatient beds interchangeably to furnish either acute care services or skilled nursing facility (SNF) - type services to Medicare beneficiaries as needed, rather than transferring the patients to a separate skilled nursing unit or facility.[32] Swing beds are, by definition, inpatient beds that may be used to provide a skilled nursing level of care to a patient that has been receiving acute care services in that bed but no longer requires an acute level of care.[33] Skilled nursing care can be provided in *any* inpatient bed—in other words, any inpatient bed can be used as a "swing-bed" if a hospital is certified as a "swing-bed facility." Any swing bed services provided at the Provider during FY 2001 were not provided in a skilled nursing unit, since that unit was decertified in 2000.[34]

The Intermediary argues that these types of bed days – although occurring in licensed acute care inpatient beds – should be excluded when computing the Provider's DSH bed count because the services being temporarily provided are not reimbursed under the Inpatient Prospective Payment System (IPPS). Observation services are reimbursed as "outpatient" services unless the patient is later admitted into the hospital as an inpatient. Likewise, skilled nursing services are not reimbursed under the IPPS. The Provider notes that the Intermediary's arguments are focused not on the nature (*i.e.*, licensure and certification) of the bed but on the nature of the services provided to a particular patient in that bed.

In its Position Paper, the Intermediary argued that CMS has a longstanding policy of only considering bed days when calculating the bed count if the costs of such days were allowable in the determination of Medicare inpatient costs. Therefore, it stands to reason that observation bed days and swing-bed days, which are not payable under the inpatient prospective payment system, should not be included in the calculation of bed count for DSH purposes.[35]

The Provider states that the Intermediary's "inpatient PPS payable days only" argument has been subject to prior scrutiny and discredited by both the PRRB and federal courts. *See, e.g., Clark Regional Medical Center v. Shalala*, 136 F.Supp.2d 667, 676 (E.D. Kentucky 2001) (*"Clark v. Shalala*") (aff'd by *Clark Regional Medical Center v. U.S. Dept. of Health and Human Services*, 314 F.3d 241 (6th Cir. 2002) (*"Clark v. DHHS*"), Provider Appendix D.[36] As the court pointed out in *Clark v. Shalala*:

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[31] Tr. at 159-160.
[32] Tr. at 152; PRM §2230.
[33] Id.
[34] Tr. at 194-95.
[35] See, Intermediary's Position Paper at 6.
[36] As noted earlier, the *Clark* court decisions affirmed the decision of the PRRB in the *Commonwealth of Kentucky* (PRRB Dec. No. 99-D66).

> [t]he regulation does not say "not including non-PPS beds" or "not including bed days that are not allowable in the determination of Medicare inpatient costs." . . . Rather, a plain and common sense reading of the regulation requires that all beds and all bed days be included in the calculation unless they are in one of the specifically enumerated categories of excluded beds.
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> If the [CMS] meant specifically to exclude beds that are not included in the inpatient care cost calculation, it could have easily and directly done so in the regulation, but it did not.

136 F.Supp.2d at 676. Likewise, in *North Okaloosa*, the Board reached the same conclusion with respect to the intermediary's argument:

> [t]he 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.

North Okaloosa PRRB Decision, Provider Appendix E. The Board also discussed and rejected the Intermediary's "PPS services only" argument in its decision in the *Highland*, *Odessa Regional*, and *Commonwealth of Kentucky* PRRB Decisions.

The Provider asserts that a survey of the past PRRB decisions with respect to the DSH bed counting issue shows that observation and swing bed days must be included in computing a provider's bed count, because these days are not among the types of days specifically enumerated in the regulation as excluded. *See Odessa Regional* PRRB Decision[37] ("…the aforementioned regulation and manual instructions identify the specific beds excluded from the bed count and that neither of these authorities excludes observation beds. The Board finds that these rules are meant to prove an all-inclusive listing of the excluded beds, considering the great specificity with which they address this issue."); *North Okaloosa* PRRB Decision[38] ("…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…the Board finds that these comprehensive rules are meant to provide an exhaustive listing of excluded beds."); *Highland* PRRB Decision[39] ("This regulation [42 C.F.R. §412.105] 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."); *Commonwealth of Kentucky* PRRB Decision[40]

[37] Provider Appendix K at 5.
[38] Provider Appendix E at 6.
[39] Provider Appendix H at 10.
[40] Provider Appendix V at 12.

("The Board's decision also relies upon the fact that the enabling regulation and manual instructions identify the specific beds excluded from the bed count, and that neither of these authorities exclude observation beds and swing-beds. The Board also finds that these rules are meant to provide an all inclusive listing of the excluded beds…The Board also agrees…that…a listing of specific items in the manner employed by the regulations and manual instructions restricts the class to the items listed under the principle of *ejusdem generis*.")

Therefore, the Provider argues that since the PRRB has consistently held that since swing bed days and observation bed days are not listed in the regulation as types of bed days that should be excluded from a provider's bed count calculation for DSH purposes, the Intermediary's exclusion of such days was contrary to the plain language of the regulation, and should not be permitted.

The Provider Reimbursement Manual (PRM) Section 2405.3(G) provides further clarification and expands on the definition of the "available beds" determination process set forth in the bed-counting regulation, 42 C.F.R. §412.105(b). The PRRB has also held that, "[g]iven 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." *Observation Bed Days Group v. BCBS Ass'n/Premera BC/Riverbend Gov't Benefits Adm'r/Trailblazer Health Enter, LLC.*, PRRB Dec. No. 2002-D13 (March 19, 2002) ("*Observation Bed Days Group*"),[41] affirmed by CMS Administrator, May 21, 2002.[42]

In addition, the Provider points to PRM Section 2405.3(G) which expressly indicates that the available bed count should not take into consideration the "day to day fluctuations in patient rooms and wards being used," such as the use of a licensed inpatient room for the temporary stay of an observation or skilled nursing patient. The PRMManual gives the following example of beds that should be included in a provider's bed count: *"[a]lthough 35 beds are used for long-term care, they are considered to be acute care beds unless otherwise certified*." PRM § 2405.3.G.2 (emphasis added). The Provider contends that in many PRRB decisions, the Board has cited this example as proof that the certification or licensure of a bed is the key consideration in determining whether a bed should be counted, not its occasional usage**.**

The Sixth Circuit also stressed the importance of this manual instruction, stating, "[t]he use of acute care beds as swing and observation beds when not being otherwise used for acute care patients is precisely the type of day-to-day fluctuation that should not be captured when counting beds under § 412.105(b). The day-to-day, or perhaps even hour-to-hour, change in the occupancy of these beds does not reflect the overall size of the Plaintiff hospitals, which is what the bed count is intended to capture." *Clark Regional v. DHHS*, 314 F.3d at 248-49.

The Provider further contends that 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"—not the

[41] See, Provider appendix G.
[42] Commerce Clearing House (CCH) at ¶80,864

exact services being provided in a licensed inpatient bed on a given day. This reading of the manual was also confirmed by the PRRB and federal courts in multiple cases: "the Board agrees with the Provider's argument that the bed count for DSH eligibility is essentially intended to distinguish small and large hospitals, and that the temporary use of acute care beds for outpatient observation purposes does not change the size of a facility as stipulated in HCFA Pub. 15-1 § 2405.3.G." *Presbyterian*; *see also Odessa Regional* PRRB Decision, *Odessa Reg'l Hospital v. Leavitt*, 386 F.Supp.2d 885 (W.D. Tex. 2005) ("*Odessa v. Leavitt")* (Provider Appendix K).

The Provider states that in this instant case, the *size* of the Provider's facility remained constant during the 2001 cost reporting year. The Provider was licensed for 115 acute care inpatient beds, and had at least 114 beds available for providing inpatient services during the entire cost reporting period in question. The fact that a patient was placed in a licensed inpatient bed for observation or skilled nursing services did not change the *size* of the Provider's facility. The PRM states that "beds available at *any time* during the cost reporting period *are presumed to available during the entire cost reporting period*." As the size of the Provider's facility did not change, and the beds utilized for observation or swing bed services were available for inpatient care during the cost reporting period, the Intermediary has no basis under the PRM to exclude such observation and swing bed days.

It is the Intermediary's position that patients in observation, outpatient, labor & delivery room, and other ancillary status are not admitted as inpatients and are not lodging; they are considered outpatients. A bed cannot be simultaneously available for inpatient use when in use for outpatient observation. The PRM at Section 2405.3G explains that: "a bed must be permanently maintained for lodging inpatients" to be considered an available bed. Therefore, the Intermediary concludes that if a bed is used for another purpose such as for patient observation, it is not available for inpatient lodging and is not to be counted. The PRM also explains that beds used in ancillary, outpatient areas, or other areas regularly maintained and utilized for only a portion of a patient's stay are not considered available for lodging inpatients. Beds utilized partly for inpatient use and partly for outpatient use can not be considered fully available for inpatient lodging. In addition, the Intermediary contends that the term outpatient area, as referenced in the manual provision, refers to the area where the observation activity occurred, not to a geographical area.

During the hearing before the Board, the Intermediary suggested that the phrase in section 2405.3.G of the PRM, "utilized for only a portion of the stay of patients or for purposes other than inpatient lodging," justifies the removal of observation days from the Provider's bed count.[43] It is the Provider's position that the Intermediary takes this phrase out of context. The entire sentence states, "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 post-operative 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." PRM §2304.5.G. When read in its entirety (particularly within the context of the entire manual provision) it becomes clear that the manual intends to exclude beds in *areas*

[43] Tr. at 208.

maintained for purposes other than inpatient lodging. The Provider contends that had it maintained an observation *unit* or area specifically for observation, the Intermediary's argument would be relevant. However, as the Provider's representatives testified at the hearing, the Provider did not maintain a distinct observation unit.[44] Rather, observation services were occasionally provided in licensed inpatient beds, if census allowed, and any inpatient bed in any area of the hospital could temporarily be used to house an observation patient.[45] Furthermore, the manual provision relied upon by the Intermediary also emphasizes that to be excluded, a bed must be in an area regularly maintained for lodging patients other than inpatients. As the Provider's witness also testified at the hearing, the 114 beds at issue in the present case were *all* maintained for lodging inpatients.[46] The Intermediary's reliance on an isolated phrase within the PRM is therefore without merit.

The Provider points out that the PRM states that the hospital bears the burden of *excluding* beds from the calculation of its bed count. Clearly, the presumption is one of inclusion of beds and bed days when counting beds for purposes of the DSH payment adjustment eligibility.

The instructions in Administrative Bulletins published by the Blue Cross and Blue Shield Association provide some clarification as to CMS's actual policies relating to what it means to be an "available bed." Administrative Bulletin #1830, 87.01 states that beds should be considered "available" if they are *capable of being put into use* as follows:

> [A]n available bed is a bed *reasonably ready* for patient use with short notice. The fact that the bed is in an area of the hospital which has been closed and the area is unstaffed is not the major criterion. If the bed can be placed in service for patient care within a short period of time, the bed would be available. (emphasis added)

Administrative Bulletin #1830, 87.01 (January 28, 1987), Provider Appendix L.

Similarly, Administrative Bulletin #1841, 88.01 instructs that "[w]here a room is temporarily used for a purpose other than housing patients (*e.g.* doctors' sleeping quarters), the beds in the room *must be counted*, provided they are available for inpatient use on an "*as-needed basis*." (emphasis added). Further:

> [i]n a situation where rooms or floors are temporarily unoccupied, the beds in these areas must be counted, provided the area in which the beds are contained is included in the hospital's depreciable plant assets, and the beds can be adequately covered by either employed nurses or nurses from a nurse registry. In this situation, the beds are considered "available" and must be counted even though it may take 24-48 hours to get nurses on duty from the registry.

Administrative Bulletin #1841, 88.01 (Nov. 18, 1988), Provider Appendix M.

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[44] Tr. at 158.
[45] Tr. at 158-60.
[46] Tr. at 104.

It is clear from this guidance that in order for a bed to be considered "available," it does not have to be ready and staffed at all times. Rather, in order to count a bed, the provider must be able to have the bed staffed and ready for a patient within 24-48 hours.

The Provider notes that at the hearing, its witness confirmed that the Provider was able to obtain additional physical beds and other amenities for a room within hours of becoming aware of the need to house additional inpatients.[47] The witness testified that extra beds were kept at the hospital facility, and additional beds were also located in a warehouse approximately three-tenths of a mile from the hospital.[48] The Provider's second witness also confirmed that, if necessary, the Provider was capable of obtaining additional staff within 24-48 hours, through use of both existing staff and nurses obtained under contracts with nurse registries.[49]

The Provider explains that the fact that a bed was temporarily used for a skilled nursing or observation purposes does not mean that it ceased to be "available" for purposes of DSH eligibility. As the court held in *Clark Regional*, when faced with the intermediary's argument that beds temporarily occupied by skilled nursing and observation patients were not "available" under the regulation because they were not "permanently" maintained for lodging inpatients: "[a]s defined in the PRM guideline, these [swing and observation] beds were 'available,' even if they housed an observation or SNF patient on particular days." 136 F.Supp.2d at 677. "There is nothing in the language of the PRM that indicates that a bed is 'unavailable' simply because it is not exclusively designated for acute inpatient care. Indeed, the language of the PRM indicates that so long as a bed can be put to use for inpatient care - even if that means displacing an SNF or observation patient - it may be counted as an 'available bed.'" *Clark v. DHHS*, 314 F.3d at 248.

The Provider notes that every aspect of the present Available Bed Count issue has been consistently addressed by the PRRB and federal courts in prior cases. In *Natividad Medical Center v. Blue Cross & Blue Shield Association/Blue Cross of California* ("*Natividad"*), the Administrator held that the provider was required to count all of its licensed beds as available, concluding that there is a presumption that all licensed beds are available. CMS Administrator Decision, Oct. 6, 1991, Provider Appendix N. The provider in *Natividad* furnished the intermediary with the number of available beds it had reported to the State of California Office of Statewide Health Planning and Development. However, the CMS Administrator ruled that the bed count offered by the provider had no weight as evidence of the number of available beds at the facility, and instead held that *use of the licensed bed count was appropriate.* Likewise, in *Edinburg*, the Board held that because all the observation beds at issue were licensed acute care beds, they should all be included in the bed size calculation for determining DSH eligibility. In *Presbyterian*, the Board elaborated, stating that "[t]he Board finds the Provider's license to be a more accurate measure of the number of available beds at the Provider's facility than the number of set up and staff beds identified by the Intermediary. The record shows that the Provider's fourth floor inpatient beds were: (1) reasonably ready for immediate inpatient use within 24-48 hours; (2) maintained as depreciable plant assets on the Medicare cost reports; and (3) capable of

[47] Tr. at 60-61.
[48] Id.
[49] Tr. at 255-56.

being adequately covered by the Provider's nursing staff or nurses from a nurse registry if the need arose."

The courts have held that the Secretary must be consistent in his interpretation of regulation 42 C.F.R. §412.105(b). He cannot interpret it expansively in the IME context, while urging a narrow interpretation in the DSH context. As the district court explained in *Clark v. Shalala:*

> The defendant argues that this PRM guideline was never written for DSH adjustments, but for the IME adjustment. However, the defendant expressly determined that the same method would apply to both adjustments. Therefore, it is bound by its own interpretation of the IME counting regulation, which interpretation is found in the PRM guideline. Therefore, the burden should have remained on the hospital to exclude beds - necessarily placing the burden on the defendant to include beds - and should not have shifted simply because it would work to the defendant's detriment in this particular case.

136 F.Supp.2d at 677. The Sixth Circuit seconded this thought, stating that "[h]aving clearly coordinated the counting of beds for both the IME and DSH programs, the Department cannot simply interpret the regulation to vary so as to always disadvantage the subject hospital." *Clark v. DHHS*, 314 F.3d at 249.

In summary, the Provider believes it has been the longstanding policy of CMS and the Board to include *all* licensed beds in the available bed count (absent significant proof to the contrary), and this policy is consistent with the plain meaning of the DSH statute. The Intermediary completely ignored prior decisions by the courts, the CMS Administrator and the Board establishing the IME bed counting requirements, which must also be utilized to determine the number of beds for purposes of DSH status. The law requires that the IME bed counting rules be used for DSH purposes, and the Intermediary is bound by these rules. 42 C.F.R. §§412.106(a)(1)(i).

The PRRB has consistently held that observation bed days must be included when calculating a provider's bed count for DSH eligibility purposes. In fact, no cases can be found supporting a conclusion that such bed days must be excluded for DSH bed counting purposes. Thus, the Provider simply requests that the Board rule in the present case in a manner consistent with its large body of case law on this subject. The Provider also notes that every published federal court decision on this issue has agreed with the PRRB and held that observation days must be included in the calculations for DSH bed counting purposes.

The Provider contends that the PRRB has also consistently held that swing bed days must be included when calculating the provider's bed count for DSH eligibility purposes. The same general principles of inclusion that apply to observation bed days apply to swing bed days as well.

The Provider notes that one circuit court decision in the swing bed line of cases has been referenced by the Intermediary in support of its argument that a federal court case exists in which a court held that swing bed days should be excluded. *See District Memorial Hospital of Southwestern North Carolina v. Thompson,* 364 F.3d 513 (4th Cir. 2004) (*District Memorial).*

However, the Provider asserts that *District Memorial* actually involved an analysis of the inclusion of *patient days in the DSH patient percentage calculation* (which is governed by 42 C.F.R. §412.106(a)(1)(ii), not the bed-counting regulations at section 412.106(a)(1)(i) and 412.105(b). *Id.* Because *District Memorial* is not a bed-counting case, it is irrelevant for purposes of the Board's analysis in this case. The plain language of the regulations explicitly and purposefully treats bed days and patient days differently, stating that beds are counted unless they fall within certain enumerated categories, while patient days are included in the DSH patient percentage calculation only if they are "attributable to areas of the hospital that are subject to the prospective payment system." 42 C.F.R. §§412.105(b), 412.106(a)(l)(ii). While CMS included language limiting the types of patient days to those attributable to PPS areas of the hospital, CMS did not include that same language in the bed-counting regulation. It is a basic rule of statutory and regulatory construction that a regulation should be read so as to give meaning to each of the regulation's terms. *See Legal Environmental Assistance Foundation, Inc. v. U.S. E.P.A.*, 276 F.3d 1253, 1258 (11th Cir. 2001) ("it is an elementary principle of statutory construction that, in construing a statute, we must give meaning to all the words in a statute."); *see also General Electric Company v. United States*, 610 F.2d 730, 734 (Ct. Cl. 1979) (stating that rules of statutory construction are equally applicable to regulations).

In 2003, CMS amended the bed-counting regulations to specify that observation and swing bed days, among other types of bed days, are to be excluded from providers' DSH bed counts. 68 Fed. Reg. 45,345, 45,418 (Aug. 1, 2003). In the proposed rule, CMS explained, "we are proposing to amend §412.105(b) to indicate that the bed days in a unit that is unoccupied by patients receiving IPPS-level care for the 3 preceding months are to be excluded from the available bed day count for the current month. We are further proposing the beds in a unit that was occupied for IPPS-level care during the 3 preceding months should be counted unless they could not be made available for patient occupancy within 24 hours, *or they are used to provide outpatient observation services or swing-bed skilled nursing care*." 68 Fed. Reg. 27,153, 27,204 (May 19, 2003) (emphasis added). CMS also admitted that the guidance available to providers prior to 2003 did not state that such bed days were to be excluded, and that such guidance would have to be changed to conform to the new rule: "we recognize the need to revise some of our program instructions to make them fully consistent with these clarifications and will act to do so as soon as possible." 68 Fed. Reg. at 27,202.

The Provider notes that a basic rule of administrative law is that an agency cannot apply a rule retroactively. 5 U.S.C. § 551(4) (a "rule" is, by nature, of only future effect); *Georgetown University Hospital v. Bowen*, 821 F.2d 750, 760 (D.C. Cir. 1987). To the extent that the Intermediary is attempting to apply the 2003 rule to the Provider's FY 2001 cost reporting period, this action is impermissible under the APA's prohibition against retroactive rulemaking.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of the Medicare law and guidelines, the parties' contentions, evidence presented and contained in the record, the Board finds and concludes that observation and swing bed days must be included in the determination of the number of available beds the Provider has DSH eligibility purposes. The Board finds that the rationale for inclusion of these days in the Provider's bed count is the same as the Board's decision in *Commonwealth of Kentucky*, which

was later affirmed by the Eastern District of Kentucky and the Sixth Circuit Court of Appeals in the *Clark Regional Medical Center* cases. *See Clark Regional Medical Center v. Shalala*, 136 F.Supp.2d 667, 676 (E.D. Kentucky 2001), *affirmed by Clark Regional Medical Center v. U.S. Dept. of Health and Human Services*, 314 F.3d 241 (6th Cir. 2002).

The enabling statute, 42 U.S.C. § 1395ww(d)(5)(F), lists three factors which determine whether or not a hospital qualifies 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 in this case. The Board notes that the statute refers only to the singular word "bed," and does not expound upon its meaning with respect to DSH eligibility.

The controlling regulation, 42 C.F.R. §412.105, requires a hospital's size to be determined by dividing its "available bed days" by the number of days in the cost reporting period. The Board finds that the regulation contains the exclusive list of the types of beds that are excluded from a provider's bed count: beds or bassinets in the healthy newborn nursery, custodial care beds, and beds in excluded units. None of these excluded bed types are at issue in the present case.

The word "bed" is specifically defined in CMS's Provider Reimbursement Manual (CMS Pub. 15-1) § 2405.3.G, for purposes of calculating a provider's bed size for indirect medical education and DSH eligibility purposes. 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 post-operative 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 patients. 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 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.

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.

Based upon these authorities, the Board finds that the Provider's observation and swing-bed days meet all of the Medicare program's requirements for inclusion in the bed size calculation used to determine the Provider's DSH eligibility. In particular, all of the beds at issue in this case including the labor and delivery room beds are licensed acute care beds located in the inpatient

area of the Provider's facility. The Provider presented floor plans, detailed pictures and credible and convincing testimony from the Director of Engineering regarding the facility's capacity to provide inpatient care. Based on the evidence presented, the Provider has shown that it had at least 114 beds permanently maintained and available for lodging inpatients during the fiscal year at issue.

In addition, the Board finds support for its decision in the Provider Reimbursement Manual example provided by CMS for determining bed size. In the example, a hospital has 185 acute care beds, including 35 beds used to provide long-term care. CMS explains that all 185 beds are used to determine the provider's total available bed days. In part, CMS states, "although 35 beds are used for long-term care, they are considered to be acute care beds *unless otherwise certified*." PRM §2405.3.G.2 (emphasis added). The Board finds this example to be directly on point. Acute care beds that are temporarily or occasionally used for another type of patient care but are not certified as such (like the observation and swing-beds at issue in the present case), are included in a provider's bed count.

The Board rejects the Intermediary's argument that only beds reimbursed under inpatient PPS should be included in the count of available bed days since the purpose of DSH is to adjust PPS amounts. If only days reimbursed under IPPS were to be included in the bed count, there would be no reason for the controlling regulation and manual guidelines to be written in the manner that they are; that is, with great specificity regarding beds that are included and excluded from the count. Further contributing to this conclusion is the fact that CMS specified in the patient day counting portion of the regulation at 42 C.F.R. §412.106 that only *patient days payable under the inpatient PPS* are counted, while the portion of the regulation pertaining to counting *bed days* contains no similar restriction. *See* 42 C.F.R. §412.106(a)(1)(i) and (ii).

The Board did not find persuasive the Intermediary's assertion that a licensed inpatient bed occasionally utilized to provide observation or skilled nursing services is not "permanently maintained for lodging inpatients." The beds in the present case, while sometimes used to provide observation and skilled nursing services, were "permanently maintained for lodging inpatients." They were simply used on occasion, if the Provider's census allowed, to provide other types of services. As the Provider's witness made clear at the hearing, the Provider maintained all of the requisite items necessary for Texas licensure of an inpatient bed (e.g., medical gas hookups, physical beds) for at least 114 inpatient acute care beds.

The Board concludes that the bed count for DSH eligibility is essentially intended to distinguish small and large hospitals, and that the temporary use of acute care beds to provide observation or skilled nursing services does not change the size of the facility, as stipulated by CMS Pub. 15-1 §2405.3.G.

The Board finds that eleven of the 114 beds claimed by the Provider may have been established and maintained for outpatient day surgery. Although the beds could have been used for inpatient services, what is relevant for inclusion in the bed count for DSH is what the beds were maintained for. There was disputed testimony regarding the use of these beds, however, even if the 11 day surgery beds were eliminated from the bed count, the remaining 103 beds exceeded the regulatory threshold of 100 beds. The Board finds CMS policy is to include licensed beds

unless evidence shows they must be excluded. Therefore, due to conflicting evidence the Board will allow the 11 day surgery beds to remain in the bed count.

DECISION AND ORDER:

The Intermediary's determination that the Provider had less than 100 beds for DSH eligibility purposes was improper. The Intermediary's adjustments disallowing swing-bed days and observation bed days from the Provider's determination of available bed days used to determine bed size, and ultimately DSH eligibility, was improper and is hereby reversed.

MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Yvette C. Hayes
Michael D. Richards, CPA
Keith E. Braganza, CPA

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: July 16, 2009