PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2010-D32

PROVIDER -
Clinton Memorial Hospital
Wilmington, Ohio

Provider No.: 36-0175

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
National Government Services, Inc.

DATE OF HEARING -
October 27, 2009

Cost Reporting Periods Ended -
December 31, 2001 and
December 31, 2002

CASE NOs.: 05-1693 & 05-1694

INDEX

ISSUE:

Was 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 proper?

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

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

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services 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 and 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 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 one of those provisions directly and a second, indirectly.

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." This payment, known as the disproportionate share hospitals (DSH) adjustment provides that one of the factors considered in determining whether a hospital qualifies for such a payment adjustment is the number of beds.

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. 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: the number of beds. 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, to be available, a bed must be permanently maintained for lodging inpatients, 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 within the cost reporting period are presumed to be available for the entire cost reporting period. At issue in this case, is the proper identification of available beds for use in the IME calculation.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Clinton Memorial Hospital is a Medicare participating provider that is located in Wilmington, Ohio. The Provider operates an approved program for graduate medical education (GME). For the fiscal periods ended 12/31/01 and 12/31/02, in calculating its bed count, the Provider excluded those days where beds were used to treat observation patients on an outpatient basis. The exclusion affected the Provider's calculation of its indirect medical education reimbursement. National Government Services, Inc. (formerly AdminaStar Federal and hereinafter Intermediary) adjusted the cost report settlement data to include all observation bed days in the IME calculations based upon its interpretation of Clark Regional Medical Center 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.C. The Intermediary was represented by Bernard M. Talbert, Esquire, Associate Counsel, BlueCross BlueShield 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:

[1] Provider Exhibit P-1.

> 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 count.

The Provider further contends that CMS confirmed this policy in the May 19, 2003, Federal Register (68 F.R. 27205). In the August 1, 2003 Federal Register (68 F.R. 45418), CMS finalized changes to the regulations that clarified the existing policy. Specifically, the Administrator said that " . . . our policy is the bed days used for observation days 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 beds in the count is incorrect.

The Provider also challenges the Intermediary's application of Clark Regional 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 bed days."[4]

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, after the cost reporting years in issue, 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. Further, the United States Supreme Court made clear in Bradley v. School Board of Richmond, 416 U.S. 696, 711 (1974)(Bradley) that " a court is to apply the law in effect at the time it renders its decision unless doing so would result in a manifest injustice." The Provider argues further that retroactive application is particularly appropriate when it does not affect existing rights or impose new obligations on a party without notice[5] and contends that CMS cannot claim that it is the victim of any "new and unanticipated obligations" as a result of its own regulation clarifying existent policy.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the U.S. Court of Appeals for the Sixth Circuit addressed the CMS policy that excludes observation beds days from the count of available bed days for purposes of the IME adjustment. In Clark Regional, the Court ruled that CMS's policy was inconsistent with the plain meaning of the regulation. The Intermediary applied that decision to all providers located in the Sixth Circuit to assure consistent application.

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[2] 68 F.R. 45418.
[3] 68 F.R. 45419.
[4] 68 F.R. 27206.
[5] Bradley at 720.

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 and determined that the fundamental 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 beds could not be squared with the plain meaning of the regulations or CMS's definition of available beds as set forth in CMS publication 15-1 §2405.3(G). Further, the Court concluded that the regulations 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 evidence, the Board finds that the observation beds should be included in the calculation of available beds used to calculate the Provider's IME reimbursement.

It is undisputed 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, they 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 finds that the controlling regulation, 42 C.F.R. §412.105(b), which establishes the fundamental methodology for determining a hospital's bed size for purposes of calculating IME reimbursement, as well as the Medicare guidelines at PRM §2405.3G, require that all beds be included in the calculation unless they are specifically excluded under the categories listed in the regulation. The regulation states:

> 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 assigned to newborns, custodial care, and excluded in distinct part hospital units, and dividing that number by the number of days in the cost reporting period.

In relevant part, the PRM states:

> G. Bed Size- A bed is defined for this purpose as an adult or pediatric bed (exclusive of beds assigned to newborns which are not in intensive care areas, custodial beds, and beds in excluded units) maintained for lodging inpatients, including beds in intensive care areas, 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 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 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 or taken out of service. (Emphasis added)

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 and manual guidelines because those authorities identify specific beds to be excluded from the bed count, and neither of these authorities provide for the exclusion of observation beds. Given the degree of specificity with which the manual addresses this issue and the fact that the enabling regulation has been modified on at least two occasions to clarify the 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.

The Sixth Circuit's decision in Clark Regional upheld the Board's decision that observation beds meet the Medicare program's requirements to be included in the bed size calculation used to determine DSH eligibility. The Court found that CMS' application of its own regulations and the PRM 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 required counting 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, noting §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 inpatients. The Court also relied on the PRM's statement that "the term 'available bed' is not intended to capture the day-to-day fluctuations in patient rooms and wards being used" to conclude that the use of beds for outpatient observation services 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).[6]

The Provider complains that CMS improperly instructed the Intermediary to include observation beds based on the Clark Regional decision, asserting that the doctrines of res judicata and collateral estoppel do not apply because Clark Regional involved the bed counting regulation's

[6] Clark Regional, at 247-249.

application to the DSH adjustment, not the IME adjustment, and it involved different parties. The Board does not rely on CMS' instructions but rather on the plain meaning of the regulation and guideline.

The Provider also asserts that the Board's affirmation of the Intermediary's inclusion of observation bed days will result in an appeal to the United States District Court in the District of Columbia and put CMS in an untenable position of having to argue against the position that it has taken in other cases. The Board concludes there is no need for it to opine on hypothetical future appeals. The Board's decision is based on a reading of the law as it existed for the fiscal years at issue.

The Provider also argues that the Supreme Court precedent compels application of the 2003 regulations to this case. However, the Board finds that the case law upon which the Provider relies is not on point. In Bradley, there was no prior law governing payment of attorney fees in a discrimination suit. A law was enacted while the plaintiff's case and its fee application were pending. Here, there was prior law in regulations (applicable to both IME and DSH) that the Board finds directly governed the dispute.

The DSH and IME statutes both require a bed count. The regulations and CMS published policy have consistently interpreted the statutory bed count to apply equally to IME and DSH. It is undisputed that the manner in which the bed count is applied will typically have a beneficial effect for one purpose and a detrimental effect for the other. Consequently, even if the Board agreed with Provider that the days should be excluded, we would also require a commensurate adjustment to the DSH bed count pursuant to our authority under 42 U.S.C. §1395oo(d).[7] The principle of applying the bed count consistently for DSH and IME also mitigates the concern the Provider raises that providers outside the Sixth Circuit may be treated differently than those in the Sixth Circuit. Those outside the Circuit that have beds excluded for IME have beds excluded for DSH. Consequently there is typically a beneficial as well as a detrimental effect, albeit the reverse of the effect in the Sixth Circuit

The Intermediary's inclusion of observation bed days is appropriate.

DECISION AND ORDER:

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.

[7] See, Maine General Medical Center v. Shalala, 205 F .3d 493 (Cir. 2000); Loma Linda Univ. Medical Center v. Leavitt, 492 F .3d 1065 (9th Cir. 2007); HCA Health Services of Oklahoma v. Shalala, 27 F .3d 614 (D.C. Cir. 1994); UMDNJ v. Leavitt, 539 F. Supp. 2d. 70 (D.D.C. 2008).

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esq., Chairperson
Yvette C. Hayes
Keith E. Braganza, C.P.A.
John Gary Bowers, C.P.A.

FOR THE BOARD

Suzanne Cochran, Esquire
Chairperson

DATE: May 26, 2010