PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2013-D42

PROVIDER –
Health Alliance Hospital
Leominster, Massachusetts

Provider No.: 22-0001

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
NHIC Corp., c/o National Government
Services, Inc.

DATE OF HEARING -
August 29, 2012

Cost Reporting Period Ended -
September 30, 2003

CASE NO.: 06-0984

INDEX

ISSUE

Whether the observation bed days for the Provider's fiscal year ending September 30, 2003 ("FY 2003")[1] were properly netted from the calculation of the bed count for purposes of qualifying for a disproportionate share hospital ("DSH") payment, the DSH calculation?

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 under Title XVIII of the Social Security Act, as amended ("Act"), to provide health insurance to the aged and disabled. Title XVIII of the Act was codified at 42 U.S.C. Chapter 7, Subchapter XVIII. The Centers for Medicare & Medicaid Services ("CMS"), formerly the Health Care Financing Administration ("HCFA"), is the operating component of the Department of Health and Human Services ("DHHS") charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries ("FIs") and Medicare administrative contractors ("MACs"). FIs and MACs[2] determine payment amounts due the providers under Medicare law, regulation and interpretative guidelines published by CMS.[3]

Providers are required to submit cost reports annually, with reporting periods based on the provider's accounting year. A cost report shows the costs incurred during the relevant fiscal year and the portion of those costs allocated to the Medicare program.[4] Each 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").[5] 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 receipt of the NPR.[6]

Part A of the Medicare program covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[7] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[8]

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[1] The Provider also appealed the treatment of observation bed days for the fiscal years ending September 30, 2004 ("FY 2004") assigned Case No. 07-1255 and September 30, 2006 ("FY 2006") assigned Case No. 08-2853. These cases were consolidated with Case No. 06-0984 and a consolidated hearing was held. However, for FYs 2004 and 2006, the regulations were revised to specifically exclude observation bed days from the available bed day count and the Provider is challenging the validity of those revised regulations. On its own motion, the Board will be reviewing whether expedited judicial review (EJR) is appropriate for Case Nos. 07-1255 and 08-2853, and this motion will be unopposed. *See* Transcript ("Tr.") at 133-134. As a result, the Board is bifurcating these cases from Case No. 06-0984 and will be issuing decision for Case Nos. 07-1255 and 08-2853 under separate cover. To avoid confusion, all citations in this decision to a party's submission or exhibits shall be presumed to be to those submitted for Case No. 06-0984 unless it is stated otherwise.

[2] FIs and MACs are hereinafter referred to as intermediaries.

[3] *See* 42 U.S.C. § 1395h and § 1395kk-1; 42 C.F.R. §§ 413.20 and 413.24.

[4] 42 C.F.R. § 413.20.

[5] 42 C.F.R. § 405.1803.

[6] *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835-405.1837.

[7] *See* 42 U.S.C. § 1395ww(d); 42 C.F.R. Part 412.

[8] *Id.*

The statutory provisions addressing the IPPS are located in 42 U.S.C. § 1395ww(d) and they contain a number of provisions that adjust payment based on hospital-specific factors.[9] This case involves the hospital-specific DSH adjustment specified in 42 U.S.C. § 1395ww(d)(5)(F)(i)(I). This provision requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[10]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[11] The DPP is a proxy for utilization by low-income patients and determines a hospital's qualification for DSH designation. It also determines the amount of the DSH payment to a qualifying hospital.[12]

To be eligible for the additional payment, a hospital must meet certain DPP criteria. 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 DPP is at least 15 percent. However, an urban hospital with less than 100 beds and a DPP of at least 15 percent for discharges on or after April 1, 2001, is also eligible to receive DSH payments.

The regulation at 42 C.F.R. § 412.106 establishes the factors used to determine whether a hospital qualifies for a DSH payment adjustment and the amount of the payment. One of those factors includes the number of beds. With respect to the number of beds, this regulation specifies that "[t]he number of beds in a hospital is determined in accordance with 42 C.F.R. § 412.105(b)."[13] Section 412.105(b) also governs the counting of hospital beds for purposes of the Indirect Medical Education ("IME") adjustment and, during the time at issue, stated as follows:

> *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.[14]

The Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1"), provides further clarification pertinent to the determination of beds considered "available." In this regard, PRM 15-1 § 2405.3(G) 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

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[9] *See* 42 U.S.C. § 1395ww(d)(5).
[10] *See also* 42 C.F.R. § 412.106.
[11] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(l).
[12] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiv); 42 C.F.R. § 412.106(d).
[13] 42 C.F.R. § 412.106(a)(l)(i).
[14] 42 C.F.R. § 412.105(b) (2002).

> 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

Health Alliance Hospital ("Provider") is an acute care hospital located in Leominster, Massachusetts. The Provider is an urban hospital with a DPP exceeding 15 percent.

The cost reporting year at issue ends on September 30, 2003 ("FY 2003"). On its as-filed cost report for FY 2003, the Provider reported 103 total beds on line 12 of Worksheet S-3, Part I.[15] In determining the Provider's eligibility for DSH reimbursement, the Provider's designated intermediary ("Intermediary") removed "observation bed days" from the Provider's available bed day count. This reduction brought the bed count to below 100 beds, resulting in lower DSH payments of approximately $765,000 for FY 2003. There is no dispute that the hospital meets the other criteria for DSH (*i.e*, is located in an urban setting and exceeded the 15 percent disproportionate patient percentage threshold).

The sole issue to be determined with respect to the DSH available bed count issue for FY 2003 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 appeals meet the jurisdictional requirements of 42 C.F.R. §§ 405.1835-405.1841. The Provider was represented by Christopher Keough, Esq., of Akin, Gump, Strauss, Hauer & Feld, LLP. The Intermediary was represented by Arthur Peabody, Esq., of the BlueCross BlueShield Association.

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[15] Provider Exhibit 15.

PROVIDER'S CONTENTIONS:

The Provider contends that the disallowance or removal of those outpatient observation days from the determination of available bed count for FY 2003 is invalid for three reasons. First, it is inconsistent with the regulation in effect for FY 2003 and CMS' policy statements back to 1986. Second, the deduction of the observation time from the determination of bed count is inconsistent with the language and intent of the DSH statute. And finally, the reduction of the outpatient observation days is arbitrary and capricious.[16] The Provider relies on the 2002 decision by the U.S. Court of Appeals for the Sixth Circuit ("Sixth Circuit") in *Clark Regional Medical Center v. U.S. Department of Health and Human Services* ("*Clark*")[17] and several other federal district court cases[18] to argue that the Secretary's position cannot be squared with the plain meaning of the regulations and instructions in effect before they changed in 2004.

At the outset, the Provider refers to program guidance on what the term "observation services" means. Specifically, the Provider cites to the definition located in the Medicare Benefits Policy Manual, Chapter 6, § 20.6 [19] and notes that this definition establishes that:

1. Observation care is for the treatment and monitoring of an individual pursuant to a physician order to determine whether that individual should be admitted as an inpatient: and

2. Observation care is usually less than 24 hours and in "only rare and exceptional cases" is it more than 48 hours.[20]

Further the Provider asserts that, while observation services may be furnished in a discrete outpatient observation area, observation services are typically furnished using unoccupied inpatient routine beds as was done by the Provider in this case.

The observation bed days at issue are not in any of the areas excluded by the terms of the regulations: healthy newborn nursery, custodial care beds, or beds in excluded hospital units.[21] The Provider notes that observation services generally were not provided in discrete outpatient observation units, but rather were typically furnished using unoccupied inpatient routine beds.[22] Although these routine beds were used for the occasional observation services, they were otherwise immediately available for inpatient use if needed and, under the program instructions, may be counted as available beds. Further, these routine beds are licensed and certified as inpatient routine beds "maintained for lodging inpatients" which are included in CMS' own standard definitions of bed count used by all hospitals.

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[16] Tr. at 20.
[17] 314 F.3d 241(6th Cir. 2002).
[18] *Odessa Regional Hosp. v. Leavitt*, 386 F. Supp. 2d 885 (W.D. Tex. 2005); *Highland Medical Center v. Leavitt*, Civ. Action No. 5:06-CV-082-C, 2007 WL 5434880 (N.D. Tex. May 9, 2007); *North Okaloosa Med. Ctr. v. Leavitt*, Civ. Action No. 3:07cv26-WS, 2008 WL 141478 (N.D. Fla. Jan. 11, 2008).
[19] As amended by Rev. 107 (May 22, 2009) (copy included at Provider's Table of Authorities at Tab 34).
[20] *See* Provider's Opening Statement Power Point at 3.
[21] 42 C.F.R. § 412.105(b).
[22] Provider's Opening Statement Power Point at 4. *See also* Provider's Final Position Paper at 37. The Provider states that during the fiscal years as issue, the hospital had an occupancy rate of 75 percent and that 1 out of 4 beds were generally unoccupied. Provider's Opening Statement Power Point at 6.

The Provider notes that, since its inception in 1986, the regulation governing DSH, 42 C.F.R. § 412.106, has defined beds by reference to the regulation governing bed count for IME – 42 C.F.R. § 412.105(b).[23] The methodology to calculate available beds under § 412.105(b) was adopted as part of the final rule issued on September 3, 1985.[24] While this methodology excluded certain types of bed days, it did not exclude routine beds used to provide outpatient observation services. In the preamble to this final rule, CMS responded to a commenter requesting a more precise definition of the term "available bed days." CMS' response included the interpretation that "[i]f some of the hospital's wings or rooms on a floor are temporarily unoccupied, the beds in these areas are counted if they can be immediately opened and occupied."[25]

The Provider further notes that, consistent with 42 C.F.R. § 412.105(b) and the preamble statements regarding the intent of the regulation, contemporaneous program instructions did not exclude routine beds used for observation services from the bed count for IME/DSH. The program instructions cited by the Provider include PRM 15-1 § 2405.3(G) for determining IME bed count; the cost reporting instructions in PRM 15-2 for reporting available bed days and calculating IME payment and the audit program in the Medicare Intermediary Manual for determining bed count for IME & DSH.[26]

The Provider contends that CMS improperly changed its policy by issuing a February 27, 1997 memorandum to all CMS Regional Offices ("the 1997 Memorandum") in which CMS states its policy excluding observation bed days.[27] The Provider argues that this statement represents the first of many improper changes in Medicare policy regarding the exclusion of observation beds from the bed count that were not subject to notice and rulemaking and contrary to the statute and regulations and are, therefore, invalid.[28]

In support of its position, the Provider cites to the 1999 PRRB decision in *Commonwealth of Kentucky DSH Group v. Blue Cross & Blue Shield Association* ("*Commonwealth of Kentucky*")[29] which held that observation and swing bed days met all the requirements of the regulation and PRM to be used in the calculation of bed size used to determine DSH eligibility. It is this PRRB decision that was appealed and ultimately led to the 2002 Sixth Circuit decision in *Clark*.

The Provider contends that the 1997 Memorandum that the Intermediary relied on for guidance for the treatment of observation days is invalid because it was not promulgated in accordance with the

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[23] 51 Fed. Reg. 16772, 16777 (May 6, 1986).
[24] 50 Fed. Reg. 35646 (Sept. 3, 1985).
[25] *Id.* at 35646. The Provider also cites to a number of Administrator decisions supporting the propositions that, in the absence of convincing documentation, licensed beds are presumed to be available and that beds temporarily withheld from service are "immediately available" if they can be placed into service within 24 to 48 hours. Provider's Final Position Paper at 46-47 (citing, *e.g.*, *Natividad Med. Ctr. v. Blue Cross of California*, CMS Administrator Dec. (Oct. 6, 1991), *rev'g*, PRRB Dec. No. 1991-D58 (Aug. 9, 1991); Pacific Hospital of Long Beach v. Aetna Life, CMS Administrator Dec. (Feb. 11, 1993), *rev'g*, PRRB Dec. No. 1993-D5 (Dec. 16, 1992); *Rochester Methodist Hosp. v. Blue Cross & Blue Shield Ass'n of Mn.*, CMS Administrator Dec. (Oct. 11, 1994), *rev'g*, PRRB Dec. No. 1994-D71 (Aug. 9, 1994)). *See* Provider's Opening Statement Powerpoint Presentation at 21-28; Provider's Final Position Paper at 46-47.
[26] *See* Provider's Opening Statement Powerpoint at 28.
[27] Memorandum dated February 27, 1997 from CMS Acting Deputy Director for Bureau of Policy Development to all CMS Regional Offices (copy included in Provider's Legal Authorities at Tab 36).
[28] Provider's Final Position Paper at 47-50; Provider Exhibit 14.
[29] PRRB Dec. No 1999-D66 (Sept. 2, 1999), *rev'd*, Administrator Dec. (Nov. 8, 1999), *rev'd sub nom, Clark Reg'l Med. Ctr. v. Shalala*, 136 F. Supp. 2d 667, 678 (E.D. Ky, 2001), *aff'd sub nom, Clark Reg'l Med. Ctr. v. U.S. Dep't. of Health and Human Servs.*, 314 F.3d 241,243 (6th Cir., 2002).

Administrative Procedure Act ("APA"). Specifically, the 1997 Memorandum was a substantive rather than interpretive rule and CMS failed to engage in notice and comment rulemaking as required by the APA.[30]

Finally, the Provider argues that, subsequent to the 1997 Memorandum, CMS changed its observation bed day policy three times between 2003 and 2009 generally excluding some or all observation bed days.[31] The Provider argues that these regulatory changes have the effect of improperly equating the statutory language of "bed days" as used to determine whether the hospital qualifies for any DSH payment at all with "patient days" used in the DSH statute which calculates the disproportionate share percentage which is used to determine the amount of DSH payment.[32]

INTERMEDIARY'S CONTENTIONS

The Intermediary contends that the number of beds as determined under 42 C.F.R. § 412.105(b)(4) are the number of available bed days during the cost reporting period divided by the number of days in the cost reporting period. The available bed days exclude bed days associated with outpatient services.

The Intermediary reasons that while the regulation in effect for FY 2003 was silent on the observation bed day issue, CMS later clarified its intent to exclude these types of bed days from the DSH calculation. Also, the Intermediary relies on the CMS Administrator's numerous decisions that reversed the PRRB on the observation bed day issue to support its position.[33]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law and guidelines, the parties' contentions, and evidence presented and contained in the record, finds that the observation bed days should be included in the available bed count and used in determining the Provider's eligibility for DSH reimbursement. The Board finds that the rationale for inclusion of these days in the Provider's bed count is the same as that stated by the Board in its 1999 decision in *Commonwealth of Kentucky* which, as previously discussed was later affirmed by the Sixth Circuit Court of Appeals.

The statute, 42 U.S.C. § 1395ww(d)(5)(F), considers three factors in determining a hospital's payments for a DSH adjustment: (1) the provider's location (urban or rural); (2) the number of patient days; and (3) the number of beds.[34] In this case, the only criterion in dispute is the number of beds. The statute does not expound upon the meaning of "bed" with respect to DSH eligibility. However, 42 C.F.R. § 412.106 implements this statutory provision and establishes certain factors to be considered in determining whether a hospital qualifies for a DSH adjustment. In particular, § 412.106(a)(1)(i) requires that the number of beds be determined in accordance with 42 C.F.R. § 412.105(b).[35]
The Board finds that this controlling regulation establishes the fundamental methodology for determining a hospital's number of beds for purposes of DSH eligibility and that the plain language

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[30] Provider's Final Position Paper at 50.
[31] Tr. at 53-56.
[32] *Id.* at 62-63
[33] *See* Tr. at 84.
[34] 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(II), 1395ww(d)(5)(F)(vi), 1395ww(d)(5)(F)(v)(I).
[35] 42 C.F.R. § 412.105 provides for additional payments for IME costs of graduate medical education programs.

of this regulation requires that all beds be included in the calculation unless they are specifically excluded by the regulation.[36] The Board finds further support for this finding in PRM 15-1 § 2405.3(G) which specifically defines the word "bed" for the purpose of calculating the adjustment for IME and DSH eligibility. This section states in relevant part:

> G. Bed Size.—A bed is defined for this purpose as an adult or pediatric bed (exclusive of beds assigned to newborns which are not in intensive care areas, custodial beds, and beds in excluded units) maintained for lodging inpatients, including beds in intensive care units, coronary care units, neonatal intensive care units, and other special care inpatient hospital units. Beds in the following locations are excluded from the definition: 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.
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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 a facility are considered available only if the hospital put the beds into use when they are needed. *The term "available beds" as used for the purpose of counting beds is not intended to capture the day-to-day fluctuations in patient rooms and wards being used. Rather, the count is intended to capture changes in the size of a facility as beds are added to or taken out of service.*
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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. . . .[37]

The Board notes that the enabling regulation and PRM 15-1 instructions identify the specific types of beds that are to be excluded from the bed count, and that neither of these authorities provides for the exclusion of observation or swing beds. Given the great specificity with which PRM 15-1 addresses this issue and the fact that the enabling regulation has been modified on at least two occasions to clarify the types of beds that are to be excluded from the count,[38] the Board further finds that these rules are comprehensive and are meant to provide an exhaustive listing of excluded beds.

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[36] 42 C.F.R. § 405.105(b).

[37] (Italics emphasis added.)

[38] *See* 59 Fed. Reg. 45330, 45373, 45398 (Sept. 1, 1994) (revising 42 C.F.R. § 412.105(b) "to clarify our policy" which serves as "a reaffirmation of our longstanding position" and to "alleviate any future misunderstanding"); 60 Fed. Reg. 45778, 45810, 45848 (Sept. 1, 1995) (revising 42 C.F.R. § 412.105(b) "to further clarify our bed counting policy").

The Board recognizes that, in reversing prior Board decisions addressing the interpretation of available beds, the Secretary has asserted that CMS has had a long-standing policy of using IPPS days to determine the number of available bed days for DSH reimbursement.[39] However, the Board finds that this statement is inconsistent with the program policy and instructions specified at PRM 15-1 § 2405.3(G). According to the example in this section, a hospital that has 185 acute care beds, of which 35 beds are used to provide long-term care, would include all 185 beds to determine the available bed days, since the 35 beds are certified for acute care. 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 beds at issue in the present case) are included in a provider's bed count.

The Board agrees with the Provider that the 1997 Memorandum[40] that the Intermediary relied on for guidance is invalid because this policy statement was a substantive departure from the controlling regulation and related PRM 15-1 instructions and was not promulgated with notice and comment in accordance with the APA.[41] Moreover, this memorandum was not issued in a manner designed to place the public (*e.g.*, providers) on notice of this change in policy because the distribution list for the memorandum was only internal.[42] Accordingly, the Board declines to give any weight to the 1997 Memorandum.

Based on the Board's findings, the Board concludes that the rationale applied by the Intermediary for the exclusion of observation beds is not supported by the clear language of the regulation and PRM 15-1 guidelines. Based on the evidence of record, the Board finds that all of the observation beds at issue were licensed acute care beds located in the acute care area of the Provider's hospital facility. The Board further finds that these beds were permanently maintained and available for inpatient lodging during the cost reporting period under appeal.

The Board notes that its findings in this case are consistent with and supported by those of the Sixth Circuit decision in *Clark* which upheld the Board's 1999 decision that observation days meet the Medicare program's requirements to be included in the bed size calculation used to determine DSH eligibility. The Sixth Circuit found that, 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.[43] Further, the Sixth Circuit found that PRM 15-1 was conclusive proof

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[39] *See, e.g., Clinton Memorial Hosp. v. Blue Cross Blue Shield Ass'n*, CMS Administrator Dec. (July 26, 2010), *aff'g*, PRRB Dec. No. 2010-D32 (May 26, 2010).

[40] Provider Exhibit 14.

[41] 5 U.S.C. § 551 *et seq.*

[42] While the 1997 Memorandum was neither a joint signature memorandum ("JSM") nor a technical direction letter ("TDL"), the Board notes that the CMS instructions on the use of JSMs/TDLs provide additional support for the Board's decision to not give any weight to the 1997 Memorandum. CMS states JSMs/TDLs are used by CMS to communicate internally with its contractors and, thus, are not issued to the general public. "JSMs/TDLs are typically used to communicate information to . . . [CMS contractors] that does not warrant a contractor manual instruction." A JSM/TDL is appropriate for a contract award announcement, an emergency alert, and/or a one-time request for information. CMS "cannot use a JSM/TDL . . . [to c]onvey new instructions; or [p]rovide clarification of existing requirements that impact contractor operations" but rather "[i]n these situations, submit a manual instruction through the formal Change Management/Change Request (CR) process." *See* CMS Division of Change & Operations Management of CMS/CMM/Medicare Contractor Management Group, *About Joint Signature Memorandums (JSMs) and Technical Direction Letters (TDLs)*, §§ 1 – 2.2 (May 2010) (only available on the CMS Intranet).

[43] *See* 314 F.3d at 247-248.

that observation beds were intended to be counted in the tally of "available bed days" in the DSH calculation.[44] In this regard, the Sixth Circuit noted that PRM 15-1 § 2405.3(G) states that "to be considered an available bed, a bed must be permanently maintained for lodging inpatients" and that the beds in question were always staffed and available for acute care inpatient lodging. Further, these PRM 15-1 guidelines specifically state that "[t]he term 'available 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." The Sixth Circuit concluded that this was precisely the type of day-to-day fluctuation that should not be captured when counting beds under 42 C.F.R. § 412.105(b).[45]

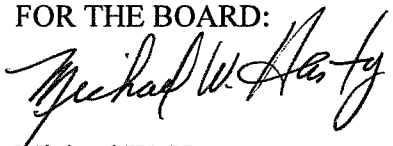
DECISION AND ORDER:

The Intermediary's determination of the number of available beds for DSH eligibility purposes was not proper pursuant to 42 C.F.R. §§ 412.106(a)(1(i) (2002), 412.105(b) (2002) and PRM 15-1 § 2405.3(G). The determination should have included the Provider's observation bed days for FY 2003. Therefore the Provider had 103 available beds for Medicare DSH adjustment qualification and payment purposes.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
Keith E. Braganza, CPA
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD:



Michael W. Harty
Chairman

DATE: SEP 24 2013

[44] *See id.* at 248.
[45] *See id.* at 248-249.