PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2004-D15

PROVIDER –
LAC + USC Medical Center
Los Angeles, CA

Provider No. 05-0373

vs.

INTERMEDIARY –
Blue Cross Blue Shield Association/
United Government Services, LLC- CA

DATE OF HEARING -
March 31, 2003

Cost Reporting Period Ended
June 30, 1994

CASE NO. 97-2025

INDEX

ISSUE

Whether the Provider's budgeted beds are the most appropriate measure of available beds for purposes of computing the indirect medical education (IME) payment.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The Medicare Program's payment and audit functions are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under the Medicare law and under interpretative guidelines published by the Centers for Medicare and Medicaid Services (CMS).

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 what proportion of those costs are to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost reports and determines the total amount of Medicare reimbursement due the provider, which it publishes in a notice of program reimbursement (NPR) that sets forth the individual expenses allowed and disallowed by the intermediary. 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 NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

Section 1886 (d)(5)(B) of the Social Security Act, 42 U.S.C. §1395yy(d)(5)(B), provides that teaching hospitals subject to the prospective payment system (PPS) shall receive an additional payment for the indirect costs of medical education (IME). This payment is designed to cover the increased operating or patient care costs that are associated with approved intern and resident programs and which are not separately identifiable on the cost report. These increased costs may reflect a number of factors such as: an increase in the number of tests and procedures ordered by the intern or resident as compared to a more experienced physician, higher staffing ratios, the need of hospitals with teaching programs to maintain more detailed medical records than other hospitals, and the presence of a more severely ill patient population.

The amount of payment is based on a hospital's ratio of full-time equivalent interns and residents to available beds. The regulation governing this provision is set forth at 42 C.F.R. §412.105 and states, in pertinent part, the following:

(a) Basic data. HCFA determines the following for each hospital:

(1) The hospital's ratio of full-time equivalent residents….
(2) The hospital's DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs….

> (3) 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 distinct part hospital units, and dividing that number by the number of days in the cost reporting period.

The preamble to the final rule for "Changes to the Inpatient Hospital Prospective Payment System," as published in 50 Fed. Reg. 35646, 35683 (September 3, 1985) further defines an available bed:

> For purposes of the prospective payment system, "available beds" are generally defined as adult or pediatric beds (exclusive of newborn bassinets, beds in excluded units and custodial beds that are clearly identifiable) maintained for lodging inpatients. Beds used for purposes other than inpatient lodgings, beds certified as long-term and temporary beds are not counted. If 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.

HCFA 15-1 §2405.3G[1] defines available beds as follows:

> 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. . . . .
>
> 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.

(Emphasis added.)

This appeal concerns the definition of "available beds" as used in the IME payment calculation. A significant component of the IME payment calculation is the available bed count, because the ratio that determines (in large part) the amount of the IME payment is the ratio of interns and residents to available beds. See, 42 C.F.R. §412.105(d)(1)(1993).

LAC + USC Medical Center (Provider) is one of the six acute care hospitals owned and operated by Los Angeles County (County) and is a major teaching institution. As the provider of last resort for the County's citizens, the Provider is obligated by law to

[1] HCFA is now known as CMS, however the Board will continue to use HCFA designation in older cases for the sake of consistency within the record.

provide medical services to patients without regard to their ability to pay.[2] The maximum amount of services available each year is based on a budget approved by the Los Angeles County Board of Supervisors. The budget for all aspects of inpatient care is expressed as the number of the "budgeted beds" for a given fiscal year.

During the FYE June 30, 1994, the Provider used the number of budgeted beds to calculate the amount of additional reimbursement that it was entitled to for IME.[3] The Intermediary increased the number of beds, believing that the IME computation should be based upon a formula that uses the number of beds physically available in the hospital's PPS-reimbursed inpatient areas.

Prior to the hearing, the parties stipulated that the number of beds physically located in the hospital during the fiscal year ended June 30, 1994 was 1,320 and that the number of "budgeted beds" was 1,197. Thus, there are 123 beds at issue in this case (1,320 versus 1,197).

The Provider filed an appeal of the Intermediary's determination with the Provider Reimbursement Review Board (Board) and satisfied the jurisdictional requirements of 42 C.F.R. §§405.1805 – 405.1841. The Provider was represented by Jon P. Neustadter, Esquire, and Stacy Rummel Bratcher, Esquire, of Hooper, Lundy and Bookman, Inc. The Intermediary was represented by Bernard M. Talbert, Esquire, of the Blue Cross Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider asserts that "budgeted beds" is the most appropriate measure of its "available beds" for purposes of the IME calculation because this figure represents the maximum County resources available to fund inpatient care. This interpretation is consistent with the great weight of authority, which interprets the term "available" to mean available for patient care use. HCFA Pub. 15-1 §2405.3G; Administrative Bulletin 1841, 88.01 (Nov.18, 1988).

The Provider disagrees with the Intermediary's argument that availability is defined as a provider's physical beds, regardless of whether there are any nurses in the entire hospital to treat patients.[4] Available Medicare Program guidance, in the IME context as well as in other Medicare contexts, requires that nursing staff be available in order to deem a bed available. Without nursing care, there can be no inpatient services. Furthermore, the Provider contends that there is no evidence that Centers for Medicare and Medicaid Services (CMS) ever intended fiscal intermediaries to base a provider's available beds on the number of physical beds.

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[2] See, California Welfare & Institutions Code § 17000.

[3] In prior years the Intermediary allowed the Provider to use budgeted beds in its IME adjustment calculation.

[4] Tr. at 18.

Specifically, the Provider contends that a variety of Medicare regulations rely upon the IME definition of available beds in contexts outside of the IME calculation. For example, 42 C.F.R. §412.96 sets forth the criteria that a provider must meet in order to be classified as a rural referral center, and sub-section (b)(1) discusses the definition of "beds available for use." Likewise, 42 C.F.R. §412.108 entitled " Special Treatment: Medicare-dependent, small rural hospitals" spells out how providers qualify for this classification, with the bed count issue being discussed in sub-section (a)(1)(i). Finally, 42 C.F.R. §412.348(g)(1)(ii) addresses the hospital bed size issue associated with the special exceptions process for capital PPS. With respect to the referral center regulation (which incorporates the IME available bed definition), CMS has stated in a Federal Register preamble:

> Also, we will count only licensed beds actually available for use, that is, beds in place, staffed and available to receive patients for inpatient lodging. (Emphasis added).

53 Fed. Reg. 38,476, 38,514 (Sept. 30, 1988)

The Provider also relies on guidance from the Prospective Payment Assessment Commission (ProPAC) which, in a 1988 report about linking payments to occupancy rates, clearly indicated that an available bed is "staffed and ready for use by patients."[5] The Provider contends that each of these interpretive provisions clearly and consistently indicates that a bed is not a bed if it cannot be staffed and used for patient care within 24 to 48 hours.

The Provider further contends that since Medicare regulations require providers to have adequate nursing coverage to care for inpatients, it is inappropriate to include unstaffed beds as available beds in the IME calculation. The Provider relies on 42 C.F.R. §482.23, which enumerates the conditions of Medicare participation regarding nursing services.

The Provider distinguishes itself from the recent Board decision in Altoona Hospital v. Blue Cross & Blue Shield Association/Veritus Medicare Services, PRRB Dec. No. 2002-D16, Mar. 27, 2002, Medicare & Medicaid Guide (CCH) ¶ 80,802 (Altoona). There, the Board rejected the provider's attempt to use its maximum census figure (determined by comparing the provider's available staff and its census data) as its available beds statistic in the IME calculation. The Board reasoned that the provider failed to present evidence that it could not obtain additional staff to treat patients in the hospital's 278 physical beds. In Altoona, the provider's evidence showed that if additional staff was needed, the provider could obtain additional nurses from a nurse registry or could hire more nurses. Specifically, the Board found that the provider maintained 278 beds in the event that utilization or market share increased. The provider indicated that it would increase its professional staffing with higher levels of utilization rather than turn away patients.

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[5] ProPAC Report, "Linking Capital Payments to Hospital Occupancy Rates," April 29, 1988, reprinted in [1988-2 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶37,098.

The Provider contends that the facts of Altoona are easily distinguishable from this case in that, unlike the provider in Altoona, it could not hire more nurses to staff all of its licensed beds or all of its physical beds. The Provider stated that it has repeatedly turned away patients and closed its emergency department to new patients because it did not have the resources to treat every patient that came through the door.

The Provider also relies on the dissent in Mount Zion Medical Center v. Blue Cross & Blue Shield Association/Blue Cross of California, PRRB Dec. No. 97-D98, Sept 11, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,647 (Mount Zion) to support is position. In this dissent it was noted that "[t]he nursing service must have adequate numbers of licensed registered nurses, license practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed." 42 C.F.R. §482.23. Based on the Mount Zion dissent and the Medicare nursing standards, availability of nursing staff (and any other factors impacting the ability to actually provide inpatient care) cannot be ignored when determining "availability" of beds.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the budgeted bed total is nothing more than a proxy for the average number of patients on a daily basis for which Los Angeles County had authorized funds for patient care. That figure does not correlate to what beds are actually available to care for the budgeted patients.

The Intermediary argues that the plain wording of 42 C.F.R. §412.105(b) requires a physical count. It states:

> (b) 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.

The reference to a count of beds requires a determination of what is physically present in a facility. Furthermore, HCFA Pub. 15-1 §2405.3 reinforces the position that the bed element of the IME calculation is based on physical availability:

> 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 in to use when they are needed. The term "available beds" as used for the purpose of counting beds is 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.

HCFA Pub. 15-1 §2202.2 also discusses beds maintained for lodging in patient rooms or wards. This section is directed at determining whether a facility has 100 beds or more, i.e., a physical count and review of space utilization.

Relevant to the instant case (and the time cycle ending in 1994), the Intermediary notes two points:

1. The number of licensed beds remained constant;
2. Utilization was dropping.

The stipulated number of 1,320 beds for the IME calculation was reached after an evaluation of documentation that identified which physical bed areas reflected on the license were converted to alternate uses or otherwise closed down. The Intermediary characterized the Provider's effort as "down-sizing" its bed capacity to come closer to meeting its expected needs. However, for the fiscal year under appeal, the Provider's bed number was objectively measurable or "countable," and "countable" beds should be used in the IME bed count.

The Intermediary argues that a "budgeted bed" is a financial rather than a physical concept. It is synonymous with an inpatient day of care. A maximum number of inpatient days is identified, and a budget is developed based on that number. This meaning was stated by the Provider's witness, Los Angeles County's Administrative Officer, who described the budgeted bed concept consistently on both direct and cross-examination. The budgeted bed total does not reflect the physical capacity, or in the words of the witness, the "number of mattresses."[6]

The Intermediary observes that the Provider's CFO under questioning from Board Member Hoover, clarified the difference between budgeted beds in the Provider's terminology and beds available for patient care.[7] It should be noted that the CFO was referring to total beds. Again, for the IME calculation, certain beds would be excluded. The point is that the facility had a physical capacity larger than its "budgeted patients" capacity. This difference is common.

The term "budgeted beds" does not help identify how many beds are available for patient care at any point in time. Beds are counted with floor plans and visual examinations; not by reading financial documents.

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[6] Transcript (Tr) at 117 and 118; Tr at 150 and 151.
[7] Tr at 222.

The Intermediary observes that one might argue whether the IME calculation would be more precise if some patient volume figure was used in the IME equation to measure the size of the facility. However, the choice reflected in the regulation at issue is to count beds, i.e., mattresses, that can be used if needed. The evidence and description of the whole budgeting process would not serve to lower the physical inventory of available bed space. The Intermediary states that it is intuitive that a hospital would need a total physical capability greater than 100% of its daily census to operate. However, it contends that bed availability cannot be reduced by a budget exercise. Bed availability can only be lowered by conversion or closure.

FINDING OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare Law and Program Instructions, the parties' contentions and evidence submitted, finds and concludes that the Intermediary properly used the number of physical beds located within Provider's facility as a measure of the available beds in computing the Provider's IME payment. The Board finds that the Provider's stipulation that it had 1,320 beds available for patient care is the strongest argument that this number is appropriate for the IME calculation. Budgeted beds may be an appropriate vehicle for establishing staffing levels and related ancillary and administrative activity. However, as the Intermediary argues, " budgeted beds" was in essence a proxy for the average number of beds available on a daily census; but "budgeted beds" cannot identify which beds were or were not available. The appropriate mechanism for determining available beds is the use of floor plans and visual examinations of a provider's facility, as the Intermediary did in this case.

The Board finds that budgeted number of beds is not an absolute cap on bed utility. The Provider had 1,320 beds available, and on any given day its budgeted cap of 1,197 may have been exceeded. The 123 beds at issue, i.e., the difference between the actual physical bed count and the number of budgeted beds, were available and could have been used for patient care.

Finally, the Board finds that there was no evidence that the Provider closed various floors or areas of the hospital on either a permanent or temporary basis. Thus, at all times, the "excess" beds were available for patient care use, and the Provider was reimbursed capital costs for those beds. The Board concludes that it would be inconsistent for the Provider to be reimbursed capital costs for those beds but not to include those beds in computing the Provider's IME adjustment.

DECISION AND ORDER:

The Intermediary properly used the physical bed count for determining the available beds used in computing the Provider's IME adjustment.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire

Gary B. Blodgett, DDS
Martin W. Hoover, Jr., Esquire
Elaine Crews Powell, CPA

Date: April 15, 2004

FOR THE BOARD:

Suzanne Cochran
Chairman