CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Central Texas Medical Center **Provider** **vs.** **Blue Cross/Blue Shield Association** **Trailblazer Health Enterprises, LLC** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 12/31/91** **Review of:** **PRRB Dec. No. 2003-D2** **Dated: October 16, 2002**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in §1878(f)(1) of the Social Security Act (Act), as amended (42 USC 1395oo(f)). The Intermediary submitted comments, requesting reversal of the Board's decision. Accordingly, the parties were notified of the Administrator's intention to review the Board's decision. Comments were also received from the Center for Medicare Management (formerly the Center for Health Plans and Providers (CHPP)) requesting reversal of the Board's decision. The Provider submitted comments, requesting that the Administrator affirm the Board's decision. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

BACKGROUND

For fiscal year 1991, the Provider was certified by the Texas Department of Health for 109 beds.[1] However, effective 5/15/91, the Provider allocated nine of the 109-inpatient beds to skilled nursing facility beds, and created a distinct part skilled nursing unit, sub-provider number 45-5924. Therefore, as of 5/15/91, only 100 of

[1] Exhibit P-15.

the State certified 109 beds were in used in the routine and special care areas of the facility.

For fiscal year 1991, the Provider stated that it had 119 places for beds that met Texas licensure requirements.[2] The Provider contends that if there is a headwall for a bed, oxygen, suction, nurse call system, ceiling rails for privacy curtains, bathroom facilities and adequate square footage, it complies with Texas law on licensure for a bed. Thus, for the period 1/1/91 - 5/14/91, the Intermediary analyzed the Provider's total possible beds by an actual bed count taking into account total licensed beds and the additional ten beds the Provider claimed should be counted as available. The Intermediary determined for this period (1/1/91 - 5/14/91) the Provider had included eight beds in the Labor/Delivery Room area and two beds for areas, which possibly had in-wall gas hookups. The Intermediary rejected the Provider's contention that the Labor/Delivery Room beds should be included in available beds. The Intermediary also rejected the Provider's contention that if a room had gas hookups in the wall, then the room could be converted to a patient room even though the room had no patient beds and had been converted to a purpose other than routine patient care.[3]

For the period 5/15/91 - 12/31/91 the Intermediary again analyzed the Provider's total possible beds by an actual bed count. The Intermediary determined that the Provider had a total of 117 beds. This number included total licensed beds (109), six Labor/Delivery Room beds, and two possible gas hookup beds. The Intermediary rejected the Provider's contention related to the Labor/Delivery Room and the possible gas hookups. In addition, the Intermediary disallowed two additional beds in the Labor/Deliver room area and nine additional beds in the Physical Therapy department that the Provider was including in their count of available beds. Finally, the Intermediary determined there were three rooms being used for recreational therapy services by the skilled nursing sub-provider. The Provider counted five beds for these three rooms even though the rooms were not in use for routine patient care and the floor space was included in the SNF sub-provider's total square footage. Thus, for the period 1/1/91 - 5/14/91 the Intermediary excluded ten beds from the Provider's count of 119 bed and excluded 24 beds from the Provider's count effective for period 5/15/19 through 12/31/91. Since the SNF sub-provider was certified during the fiscal year, the Intermediary calculated the total bed days available for the period 1/1/19 -5/14/91 and the 5/15/19 - 12/31/91 and divided the total bed days for the entire period by 365 days. The calculation reflected that the Provider had 93.18 available beds for the cost reporting period 1/1/91 - 12/31/91. The Intermediary then decreased the bed day

[2] Transcript of Oral Hearing (Tr.) at 44. Provider's Exhibit 15.

[3] Intermediary's Position Paper at 4.

calculation by swing bed days (1.25 beds) and observation bed days (1.95 beds) resulting in a net beds available for DSH as 89.98.

ISSUE AND BOARD'S DECISION

The issue is whether the Intermediary's determination that the Provider had less than 100 "beds" for DSH eligibility purposes was proper.

The Board held that the Intermediary's exclusion of maternity, observation, swing bed days and beds used for alternative purposes from the calculation of "total beds" used to determine the Provider's eligibility for a DSH adjustment was not proper. The Board concluded that the criteria applied by the Intermediary for the exclusion of observation, swing beds and beds used for alternative purposes could not be supported based on the Board's interpretation of the language set forth in the regulations and manual guidelines. The Board found that all of the observation and swing beds at issue were licensed acute care beds located in the acute care areas of the Provider's facility. The Board further found that these beds were permanently maintained and available for lodging inpatients and were fully staffed for the provision of inpatient services. The Board read the regulations and manual guidelines as including all beds and all bed days in the calculation, unless they were specifically excluded under the categories listed in the regulation. The Board found that 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 type of beds excluded from the count, the Board found that these comprehensive rules are meant to provide an all inclusive listing of the excluded beds.

The Board rejected the Intermediary's argument that only beds reimbursed under PPS should be included in the count of available bed days since the purpose of DSH is to adjust PPS amount. The fact that the beds were licensed acute care beds located in an acute care area of the Provider's facility and permanently maintained and available for lodging inpatients were grounds that the Board found to be determinate that all of the beds at issue met the requirements for inclusion in the bed size calculation.

With respect to beds used for alternative purposes the Board held that the beds on the fourth floor that were used for storage, office and therapy should have been included in the Provider's bed count. The Board concluded that these beds were readily available for inpatient use within 24-48 hours; maintained as depreciable plant assets on it's Medicare cost reports; and capable of being adequately covered

by the Provider's nursing staff or nurses from a nurse registry if the need arose. Thus, based on this determination the Board held that the Intermediary applied an erroneous standard in making its DSH eligibility determination. The Board determined that the Intermediary should have applied the standard of "maintained and available beds" rather than a "set up and staffed" standard.

SUMMARY OF COMMENTS

The Intermediary commented requesting that the Administrator reverse the Board's decision because it reflects an incorrect interpretation of the regulations and program instructions. Specifically, the Intermediary argued that, only beds reimbursed under PPS should be included in the count of available bed days since the purpose of DSH is to adjust PPS payment amounts.

CMM commented, requesting that the Administrator reverse the Board's decision. CMM disagreed with the Board's interpretation that the regulations require all beds and all bed days are included in the available bed calculation unless they were specifically excluded. With respect to observation beds being included in the available bed calculation, CMM stated that the policy to exclude observation beds was consistent with the manual instructions because the Provider Reimbursement Manual (PRM) at §2405.3(G) listed outpatient beds as being excluded from the available bed count and observation beds are paid as outpatient services.

With respect to swing beds being included in the available bed calculation, CMM does not agree because the regulations found at 42 C.F.R. §§413.114 and 482.66 do not recognize these days as inpatient operating costs. 42 C.F.R. §413.114(a) explains, "payments to these hospitals for post hospital SNF care furnished in routine inpatient beds are based on the reasonable costs of post hospital SNF care…"

With respect to beds used for alternative purposes CMM stated these bed should be excluded from the bed count because the PRM §2405.3(G) specifically states that ancillary, outpatient areas, and other areas regularly maintained and utilized for only a portion of the stay by patients should not be considered available beds for lodging inpatients.

The Provider commented requesting that the Administrator affirm the Board's decision. The Provider stated that the Board correctly found that all the beds in questions met the regulatory and manual requirements for inclusion in the DSH calculation. To support this position, the Provider stated that it had at least three (3) beds, which when added to the Intermediary's bed count of 97.98 (89.98 + 8), met the statutory requirement of 100 beds for DSH payments. In addition, the Provider added that the beds on the fourth floor that were used for alternative purposes were not taken

out of service, were capable of conversion into inpatient beds, and that the hospital remained licensed and capable of operating 100 beds.

Finally, to support its position that observation and swing beds should be included in the DSH calculation, the Provider cited to Clark Regional,[4] which held that observation beds should not have been excluded from the count for determining DSH eligibility.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

Pursuant to §1886(d)(5)(F)(i), the Secretary is mandated to provide, an additional payment per patient discharge, "for hospitals serving a significantly disproportionate number of low-income patients…."[5] The legislative history of Consolidated Omnibus Budget Reconciliation Act (COBRA) 1985 shows that, with respect to hospitals that serve a disproportionate share of low-income patients, Congress found that these hospitals have "a higher Medicare cost per case."[6] Congress noted that:

> There are two categories for these increased costs: a) low-income Medicare patients are in poorer health within a given DRG (that is, they are more severely ill than average), tend to have more complications, secondary diagnoses and fewer alternatives for out of hospital convalescence than other patients: b) hospitals having a large share of low-income patients (Medicare and non-Medicare) have extra overhead costs and higher staffing ratios which reflect the special need for such personnel such as medical social workers, translators, nutritionists and health education workers. These hospitals are frequently located in

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[4] Clark Regional Medical Center, et al. v. Shalala, 2001 W.L. 332063 (E.D. Ky7 2001) ("Clark Regional"). Commonwealth of Kentucky 92-96 DSH Group v. Glue Cross and Blue Shield Association/AdminaStar Federal, Admin. Dec. No. 99-D66, September 2, 1999, Medicare and Medicaid Guide (CCH) ¶80,332, rev'd CMS Administrator, November 8, 1999, Medicare and Medicaid Guide (CCH) ¶80,389 ("Commonwealth of Kentucky").

[5] Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. No. 99-272). See also 51 Fed. Reg. 16772, 16773-16776 (1986).

[6] H.R. Report No. 99-241 at 16 (1986); *reprinted* in 1896 U.C.C.A.N. 594

> central city areas and have higher security costs. They often serve as regional centers and have high standby costs….[7]

To be eligible for the additional payment, a hospital must meet certain criteria, concerning, inter alia, its disproportionate patient percentage. Generally, the location and bed size of a hospital determines the threshold patient percentage amount to qualify for a DSH payment. Relevant to this case, under §1886(d)(5)(F)(v) of the Act, for the cost year at issue, 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 15 percent.[8] However, if the urban hospital has less than 100 beds, it must have a disproportionate patient percentage of 40 percent to be eligible for the DSH adjustment.[9] With respect to the bed size, the H.R. Report explained:

> Based on the comprehensive analysis of cost data, the committee determined that the only hospitals that demonstrated a higher Medicare cost per case associated with disproportionate share low-income patients were urban hospitals with over 100 beds…. Since the rationale for making the disproportionate share adjustment is related directly to higher Medicare costs per case, the committee concluded that, based on available data, there was no justification for making these payments to …urban hospitals with fewer than 100 beds.[10]

Finally, the legislative history shows, with respect to Congress, that:

> The Committee believes that the Secretary should interpret the 100 bed threshold *narrowly*, that is, that the beds that should be counted should be staffed and available beds. The bed count would reflect beds staffed and available in the cost reporting period immediately prior to the costreporting period for which the adjustment would be made. (Emphasis added.)

Consistent with the Act, the regulation which further explains the DSH calculation at 42 C.F.R. §412.106,[11] states that:

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[7] Id.
[8] Supra n. 5.
[9] Id. Rural hospitals with more than 100 beds but less than 500 beds, must have a disproportionate patient percentage of 30 percent to be eligible for the DSH adjustment.
[10] H.R. Report No. 99-241 at 17 (1986) *reprinted* in 1986 U.C.C.A.N. 595.
[11] Formerly 42 C.F.R. §412.118(b).

> *(a) General considerations.* (1) The factors considered in determining whether a hospital qualifies for a payment adjustment include the number of beds, the number of patient days, and the hospital's location.
>
> (i) The number of beds in a hospital is determined in accordance with §412.105(b).
>
> (ii) The number of patient days includes only those days attributable to areas of the hospital that are subject to the prospective payment system and excludes all other….

Relevant to this case is the determination of the number of beds. 42 C.F.R. §412.105(b) reads 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 assigned to newborns, custodial care, and excluded distinct part hospital units, and dividing that number by the number of days in the cost reporting period.

Further, the preamble to the final rule for "Changes to the Inpatient Hospital Prospective Payment System" for 1986[12] states, regarding the definition of available bed, that:

> For purposes of the prospective payment system, 'available beds' are generally defined as adult or pediatric (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 wings or rooms on the floor are temporarily unoccupied, the beds in these areas are counted if they can be immediately opened and occupied.

Consistent with the regulations at 42 C.F.R. §412.105, the PRM at §2405.3(G) was revised (trans. No. 345, July 1988) to provide further guidance on the methodology of counting beds for purposes of DSH. The PRM states that:

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[12] 50 Fed. Reg. 35683.

> A bed is defined for this purpose as an adult or pediatric bed (exclusive of beds assigned to newborns which are not 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 areas(s) of the facility not certified as an acute care hospital, labor rooms, PPS excluded units such as psychiatric or rehabilitation units postanesthesia 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 inpatient rooms or wards (i.e., not in corridors or temporary beds). Thus, beds in a completely or partially closed wing of the facility are considered available only if the hospital puts the beds into use when they are needed. The term available bed 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.[13]

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[13] See also Administrative Bulletin No. 1841, 88.01, which further clarified the Manual instructions and noted that: "[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 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. Where a room is temporarily used for a purpose other than housing patients, … the bed in the room must be counted…"; CMS letter, dated March 7, 1997, stating, with respect to observation beds, that: "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 adjustment…."

In explaining the basis for the definition of available beds as set forth in 42 C.F.R. §412.105(b), CMS states that:

> Prior to the adoption of 412.105(b), the definition of available beds was at section 2510.5A of the Provider Reimbursement Manual—Part I, [[14]] which was originally used to establish bed-size categories for purposes of applying the cost limits under section 1861(v)(1)(A) of the Act …. The exclusion of newborn beds was consistent with the exclusion of newborn days and costs from the determination of Medicare's share of allowable routine services costs….
>
> In September 3, 1985 final rule, we added the definition of available beds to the regulations governing the IME adjustment (then 412.118(b)). The expressed purpose for the change was to stop counting beds "based upon the total number of available on the first day of the pertinent cost reporting period" and to begin counting based on "the number of available bed days (excluding beds assigned to newborns, custodial beds, and beds in excluded units) during the cost reporting period divided by the number of days in the cost reporting period (50 FR 35679). We did change the definition of available beds. Our current position regarding the treatment of these beds is unchanged from the time when cost limits established under section 1861(v)(1)(A) of the Act were in effect and is consistent with the way we treat beds in other hospital areas. <u>That is, if the bed days are allowable in the calculation of Medicare's share of inpatient costs, the beds within the unit are included as well.</u>[15]

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[14] Section 2510.5A of the PRM, as drafted in 1976, stated: <u>Bed Size Definition</u>. For purposes of this section, a bed (either acute care or long-term care is defined as an adult or pediatric bed (exclusive of a new-born bed) maintained for lodging inpatients, including beds in intensive care units, coronary care units, and other special care inpatient hospital units. Beds in the following locations are excluded from the definition: beds in sub-provider components, hospital-based skilled nursing facilities or beds located in any non-certified inpatient area(s) of the facility, beds in labor rooms, postanesthesia or postoperative recovery rooms, outpatient areas, emergency room, ancillary departments, nurses' and other staff residences and other such areas which are regularly maintained and utilized for only a portion of the stay of the patients or for purposes other than inpatient lodgings.

[15] 59 Fed. Reg. 45330, 45373 (1994). <u>See</u> <u>also</u> <u>id.</u> at 45374 (With respect to the inclusion of neonatal beds in the count: "We disagree with the position that neonatal intensive care beds should be excluded based on the degree of Medicare

Consequently, CMS has a longstanding policy of only considering bed days in the bed count if the costs of such days were allowable in the determination of Medicare inpatient costs. This did not mean that CMS policy requires that the bed day in fact must be paid by Medicare. Rather, the bed day must be used in the calculation of Medicare's share of the costs.

Under reasonable cost, the average cost per day for reimbursement purposes is calculated by dividing the total costs in the inpatient routine cost center by the "total number of inpatient days." Medicare reimbursement for routine inpatient services is based on an average cost per day as reflected in the inpatient routine cost center multiplied by the total number of Medicare inpatient days. Early in the program, an inpatient day was defined as a day of care rendered to any inpatient except a newborn. Consequently, a bed day included in either the total number of Medicare days (for example, if for a Medicare hospital inpatient) or the total number of inpatient days (including both Medicare and nonMedicare hospital inpatients) would impact the Medicare per diem payment.

Notably, PPS was implemented to replace the reasonable cost method of reimbursing hospitals for the operating costs of inpatient hospital services, but continued to require cost reporting consistent with that required under reasonable cost. Thus, CMS maintained a consistent policy in defining available beds throughout the change from a cost-based inpatient hospital payment system to a prospective-base inpatient hospital payment system.

As CMS noted, this interpretation of available beds is also consistent with that aspect of DSH eligibility concerning the determination of the patient percentage calculation, under 42 C.F.R. §412.106(a)(1)(ii). CMS explained that in determining a DSH adjustment:

> [W] e believe that, based on a reading of the language in section 1886(d)(5)(F) of the Act, which implements the disproportionate share provision, <u>we are in fact required to consider only those inpatient days to which the prospective payment system applies in determining a prospective payment hospital's eligibility for a</u>

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utilization. Rather, we believe it is appropriate to include these beds because the costs and the days of these beds are recognized in the determination of Medicare costs (nursery costs and days, on the other hand, are excluded from this determination)…." (Emphasis added.) As the *Federal Register* is the vehicle recognized under 5 USC 552(b) for providing notice and comment when formal rulemaking is under taken, policy statements published therein cannot be reasonable described as "hidden" in the *Federal Register*.

> disproportionate share adjustment. Congress clearly intended that a disproportionate share hospital be defined in terms of subsection (d) hospital, which is the only type of hospital subject to the prospective payment system….
>
> Moreover, this reading of section 1886(d)(5)(F) of the Act produces the most consistent application of the disproportionate share adjustment, since only data from prospective payment hospitals or from hospital units subject to the prospective payment system are used in determining both the qualifications for and the amount of additional payment to hospitals that are eligible for a disproportionate share adjustment.[16] (Emphasis added.)

Thus, CMS requirement that a bed day under 42 C.F.R. §412.105(b) only be included in the DSH bed count calculation when the costs of the day are reimbursed as an inpatient service cost is also consistent with the inclusion of only "inpatient days to which the prospective payment system applies" in determining a PPS hospital's eligibility for a DSH adjustment. The Administrator finds that, contrary to the Board's contention, the DSH adjustment is intended to be an additional payment to account for a "higher Medicare payment per case" for PPS hospitals that serve a disproportionate number of low-income patients. Accordingly, it is proper to determine a PPS hospital's eligibility for this additional payment based on beds that are recognized as part of the PPS hospital's inpatient operating costs.

This particular case centers on the meaning of the phrase "available bed days" during the cost reporting period. The Provider contended maternity beds, observation beds, swing beds and beds in rooms used for alternative purposes should be included in the bed count for purposes of determining DSH eligibility. The parties agreed that the Provider only requires approximately three beds in order to meet the criteria of a 100-bed hospital.[17]

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[16] 53 Fed. Reg. 38480 (Sept. 30, 1988); See also 53 Fed. Reg. 9337 (March 22, 1988).

[17] In its audit adjustment, the Intermediary excluded eight maternity beds from the bed count. The Intermediary characterized these beds as "labor room" beds. The Provider argued that while these rooms were used for maternity patients the service furnished in the maternity rooms were routine services as defined in 42 C.F.R. §413.53. Specifically, the Provider argued that since these beds are not located in a designated labor area but in the general inpatient area they should be included in the bed count for DSH purposes. The Intermediary conceded at the hearing that these eight maternity beds should be included in the bed count.

Observation/Swing Beds

The Provider contended that observation/swing beds should be included in the bed count for purposes of determining DSH eligibility because the beds are licensed acute care beds located in the acute care area of the hospital and maintained for inpatient lodging. The Board held that the criteria applied by the Intermediary for the exclusion of observation and swing beds could not be supported based on the Board's interpretation of the language set forth in the regulations and manual guidelines. The Board held that all of the observation and swing beds at issue were licensed acute care beds located in the acute care areas of the Provider's facility. The Board determined that these beds were permanently maintained and available for lodging inpatients and were fully staffed for the provision of inpatient services. The Board read the regulations and manual guidelines as including all beds and all bed days in the calculation, unless they were specifically excluded under the categories listed in the regulation. The Board found that 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 type of beds excluded from the count, the Board found that these comprehensive rules are meant to provide an all inclusive listing of the excluded beds.

The Administrator does not agree. As outline in §2405.3G of the PRM, " a bed must be permanently maintained for lodging inpatients" to be considered an available bed. The beds must be immediately opened and occupiable. (Emphasis added). Beds used for other than inpatient lodging, are not counted. Therefore, if a bed is being utilized for another purpose, i.e., lodging a skilled nursing patient or for patient observation, it is not available for inpatient lodging on the days that it is being utilized for another purpose. In this case the record is uncontested that observation patients sometimes occupied the beds at issue. In addition, the Administrator finds with respect to observation bed days that a patient in an observation bed has not been admitted into the hospital. The payment of observation bed days as outpatient services is consistent with §230.6 of the Hospital Manual, which provides that:

> A. Outpatient Observation Services Defined.—Observation services are those services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are

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The Administrator agrees with the Board's determination that these rooms were in fact maternity routine care beds, which should have been included in the available bed count for DSH purposes. Tr. at 34 and 144.

> reasonable and to evaluate an outpatient's condition or to determine the need for a possible admission to the hospital as an inpatient….
>
> B. Coverage of Outpatient Observation Services.—Generally, a person is considered a hospital inpatient if formally admitted as an inpatient with the expectation that he or she will remain at least over night… When a hospital places a patient under observation, but has not formally admitted him or her as inpatient, the patient initially is treated as an outpatient…. [Emphasis added.]

Consistent with the payment of these services as outpatient services, §3605 of the PRM-Part II explains that the costs of observation bed patients are to be carved out of the inpatient hospital costs. Line 26 of §3605.1 explains, "observation bed days only need to be computed if the observation bed patients are placed in a routine patient care area. The bed days are needed to calculate the costs of observation bed days since it cannot be separately costed when the routine patient care area is used. If, however, you have a distinct observation area, it must be separately costed (as are all other outpatient cost centers), and this computation is not needed." Consequently, consistent with the treatment under earlier reasonable cost methodology, the observation bed days are not recognized and paid under inpatient hospital PPS as part of a hospital's inpatient operating costs.

Thus, applying the relevant law and program policy to the foregoing facts, the Administrator finds that the Intermediary properly excluded observation bed days from the bed count. CMS has consistently excluded from the bed day count, those bed days not paid as part of the inpatient operating cost of the hospital, that is, in this case the day was not recognized under PPS as an inpatient operating cost. Observation bed days are not recognized under PPS as part of the inpatient operating costs of a hospital, if a patient has not been formally admitted as an inpatient, but rather billed under Part B as outpatient services.

In addition, just as observation bed days are not recognized as inpatient operating costs under PPS, the swing-bed hospital provisions set forth at 42 C.F.R. § 413.114 and 42 C.F.R. 482.66 reflect that these days are not recognized as inpatient operating costs of the PPS hospital. The regulation at 42 C.F.R. 413.144(a) explains that: "payment to these hospitals for post-hospital SNF care furnished in routine inpatient beds are based on the reasonable costs of post hospital SNF care…" Moreover, §415.B of the Hospital Manual explains that hospitals and distinct part hospital units excluded from PPS and paid on a reasonable cost or other basis include routine SNF-level services furnished in

swing beds. Thus, the swing bed days at issue were not recognized under PPS as inpatient operating costs of the hospital.

With respect to the observation and swing bed days, the Administrator disagrees with the Board's finding that the regulation and PRM listing of specific excluded items constituted an all-inclusive list. First, the Administrator finds that the listing of beds to be excluded in the regulation and the PRM is general in nature and not all-inclusive. A review of the beds listed to be excluded from the count of bed days show such beds to be, inter alia, not reimbursed as part of the hospital inpatient operating PPS payment. The Administrator finds that SNF swing bed days and observation bed days are not reimbursed as part of the inpatient PPS payment and are of the same nature as SNF excluded unit beds and outpatient beds, as opposed to inpatient adult and pediatric acute care beds. Such a finding is not inconsistent with the Congressional intent that the DSH payment is an additional payment for "subsection (d)" hospitals, i.e., PPS hospitals. Accordingly, such beds days are properly excluded from the count under 42 C.F.R. 412.105(b).

The Administrator also disagrees with the Board's conclusion that the PRM example at §2405.3. (G)(2), which includes long-term bed days in the count if the beds are not certified as long-term beds, is evidence that certification determines whether a bed is counted. Where a long-term bed is not certified, the bed is not excluded as part of a long-term bed hospital. Consequently, the payment of the related bed day is made under PPS as an operating hospital costs.[18] In that case, certification determines the payment and the payment indicates whether the bed was recognized under PPS and used for inpatient hospital services on that day. In contrast, the certification status of the beds used as swing beds and observation beds by the Provider, does not indicate whether the beds were used as inpatient hospital beds. Rather the method of payment of the swing bed days and observation bed days indicate whether that bed was used for inpatient hospital services for that day, as opposed to use for non-PPS SNF services or outpatient services. Thus, CMS has consistently excluded from the bed day count those bed days not paid as Medicare inpatient days and has consistently included such days paid as Medicare inpatient days, whether counting such beds for IME adjustment or a DSH adjustment. CMS has recognized that the exclusion or inclusion of beds for one PPS adjustment factor will have and effect on the other PPS adjustment factor.

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[18] See also Section 2510.5A of the PRM (1976), drafted pre-PPS and thus, pre-long-term care hospital PPS exclusion, which defines and adult or pediatric bed as "either acute care or long-term care."

Alternative Use

The Provider contends that the excluded beds on the fourth floor were used for alternative purposes from the period 5/15/91-12/31/91, but were not taken out of service. The Provider contended that they were capable of conversion into inpatient beds and, thus, that the hospital remained licensed and capable of operating 100 beds. For the period 5/15/91 - 12/31/91 the Provider contended that it had a total of 117 beds that met Texas licensure requirements. This number included beds on the fourth floor being used for alternative purposes.

Applying the statutes, regulations and PRM provisions to the facts of this case, the Administrator finds that beds used for physical therapy, ancillary services, and areas treated as part of the certified SNF should not be included in the determination of available beds. The PRM at §2405.3(G) states that:

> Beds in the following locations are excluded from the definition:.. PPS excluded units such as psychiatric or rehabilitation units, post-anesthesia or postoperative recovery room, 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….

Consequently, the Administrator finds that the Intermediary properly excluded beds in rooms used for a SNF recreational room and for physical therapy services.

However, the records shows that the alternative use rooms in dispute also include rooms that were being used for, at most, temporary office space and storage. With respect to these rooms, the Administrator notes the testimony of the Provider's witness Hass, the Affidavit of Morris[19] and related documents,[20] the Provider's Post-Hearing Brief pp. 33-34, and the Intermediary's workpapers including the document entitled "To Provide A Physical Bed Count After The SNF Unit Opened".[21] After a review of the record including these documents, the Administrator concludes that the Rooms 408 (2 beds), 409 (2 beds), and 412 (1 bed)[22] met the criteria of "available beds" for

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[19] Exhibit P-18.

[20] See, e.g., Exhibit P-38 (Provider's revised computation of beds); Exhibit P-39 (revised Floor Plans); Exhibit P-41 (census report showing inpatient use of fourth floor after 5/15/91).

[21] Exhibit I-3.

[22] While the Provider's Post-Hearing Brief suggests that Room 414 was also in dispute, the Intermediary's above workpaper showing a room-by-room inventory

purposes of the DSH calculation. The evidence shows that the rooms could have been converted for inpatient hospital use within 24-48 hours as set forth in the program guidelines and were not being used for SNF or physical therapy services. The addition of 5 beds to the available bed count for the period 5/15/91 - 12/31/91 (231 days) results in an additional 1155 bed days or 3.165 beds.[23] With the addition of the maternity routine bed days, the parties agreed that the bed count was at 97.98 beds. Accordingly, the Administrator finds that the determination that the alternative use beds in the foregoing specified rooms qualified as available beds results in the Provider meeting the 100 bed criteria.

DECISION

The decision of the Board's is affirmed in accordance with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 12/29/02 /s/

Ruben J. King-Shaw, Jr.
Deputy Administrator and Chief Operating Officer
Centers for Medicare & Medicaid Services

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shows that Room 414 (1 bed) was already included in the Intermediary's calculation of available beds.

[23] This would increase the number of available beds on the fourth floor from the Intermediary's count of 15 to a total of 20 beds.