CENTERS FOR MEDICARE & MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Highland Medical Center **Provider** **vs.** **Mutual of Omaha Insurance Company** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 9/30/99 and 9/30/00** **Review of:** **PRRB Dec. No. 2006-D10** **Dated: 12/22/06**

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 CMS Center for Medicare Management (CMM) 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 Intermediary 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

1999 Cost Reporting Period

The Provider is an acute care facility located in Lubbock, Texas. During its fiscal year 1999 (FY 1999), the Provider was licensed by the State of Texas for 123 total

beds.[1] By letter dated September 14, 1998, the Provider requested conversion of five rehabilitation beds into five medical/surgical beds.[2] The Provider's request was granted by the Texas Department of Health (TDH) on September 16, 1998.[3] As a result, at the beginning of Provider's FY 1999 cost reporting period, the Provider's licensed beds were arrayed as follows:

Medical/Surgical	85
Skilled Nursing	12
OB/GYN	13
ICU/CCU	7
Rehabilitation	6
Total	123

By letter dated November 2, 1998, the Provider made an additional request to convert four skilled nursing beds into four medical/surgical beds.[4] This request was granted by TDH in a letter dated November 9, 1999, resulting in the following array of licensed beds for 326 out of 365 days in Provider's FY 1999:

Medical/Surgical	89
Skilled Nursing	8
OB/GYN	13
ICU/CCU	7
Rehabilitation	6
Total	123

[1] Provider's Exhibit 3 (FY 1999); As indicated on Provider's license application, the facility's beds were originally broken into the following categories:

Medical/Surgical	81
Skilled Nursing	12
OB/GYN	12
ICU/CCU	7
Rehabilitation	11
Total	123

[2] Provider's Exhibit 6 (FY 1999).

[3] Provider's Exhibit 7 (FY 1999). The TDH letter indicated that one medical/surgical bed had been changed to an OB/GYN bed based on the presumed request of the Provider. TDH expressly acknowledged that beds licensed for OBG/GYN use may be used for medical/surgical services, and thus, are freely interchangeable.

[4] Provider's Exhibit 8 (FY 1999).

The Provider argued that it maintained 116 available beds during the reporting period and submitted floor plans identifying the layout of the 116 beds and a schedule indicating the location and usage of each available bed.[5] Thus, for FY 1999, the Provider claimed a disproportionate share hospital (DSH) adjustment based upon it being an urban hospital with at least 100 beds.[6]

The Intermediary reviewed the Provider's FY 1999 cost report and removed a total of 76.5 beds.[7] Upon receipt of its Notice of Program Reimbursement (NPR) for FY 1999, the Provider filed a timely appeal with the Provider Reimbursement Review Board (Board) pursuant to 42 C.F.R. §405.1835 et seq.

2000 Cost Reporting Period

During fiscal year 2000 (FY 2000), the Provider was licensed by the State of Texas for 123 total beds.[8] The Provider also maintained that it had 116 beds available.[9] On April 1, 2000, the Provider decertified its Skilled Nursing Facility (SNF) program.[10] On June 5, 2000, the Intermediary did a walk through of the Provider's facility and identified 113 beds as being in service in the following categories: Routine Beds—

[5] Provider's Exhibit 10 (FY 1999); Provider's Exhibit 8 (FY 2000). According to the floor plans, the Provider's facility contained the following array of rooms and beds:

First Floor:	43 Patient Rooms (46 Beds)
Second Floor:	34 Patient Rooms (38 Beds)
Third Floor:	29 Patient Rooms (32 Beds)
Total	106 Patient Rooms (116 Beds)

[6] While the Provider did not actually utilize all of its licensed beds for inpatient care, the Provider asserted that 109 were available for inpatient care (123 licensed beds minus 8 SNF and 6 rehab beds for a total of 109).

[7]

Skilled Nursing	8
Rehabilitation	6
Observation	1.5
Labor/Delivery	6
Outpatient & Chemo	31
Beds to be Staffed	24
Total	76.5

[8] Provider's Exhibit 5 (FY 2000).

[9] Supra, note 5.

[10] Intermediary's Exhibit I-11 (FY 2000).

105; Pediatric Isolation/NICU—1; ICU—7.[11] Using the Intermediary's bed count of 113 the Provider filed its FY 2000 cost report claiming a Medicare DSH payment as an urban hospital with 100 or more beds.

The Intermediary reviewed the Provider's FY 2000 cost report and removed a total of 72.5 beds.[12] Upon receipt of its Notice of Program Reimbursement (NPR) for FY 2000, the Provider filed a timely appeal with the Provider Reimbursement Review Board (Board) pursuant to 42 C.F.R. §405.1835 et seq.

ISSUE AND BOARD'S DECISION

The issue is whether the Intermediary's determination that the Provider had less than 100 "beds" for purposes of disproportionate share hospital (DSH) eligibility purposes under the inpatient prospective payment system (IPPS) was proper.

The Board held that the Intermediary's determination of the number of available beds for DSH eligibility purposes was not proper. The Board determined that the Provider had at least 109 available beds for Medicare DSH adjustment qualification and payment purposes for FYs 1999 and 2000.

In reaching this conclusion, the Board determined that the criteria applied by the Intermediary for the exclusion of observation bed days could not be supported based on the Board's interpretation of the language set forth in the regulations and manual guidelines. 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 regulations. The Board cited an example in the PRM at §2405.3G2, requiring the inclusion of licensed acute care beds in the available bed count even though the beds were used as long-term care beds as evidence that the beds in questions should be included. The Board rejected the Intermediary's argument that only beds reimbursed under IPPS should be included in the count of available bed days since the purpose of DSH is to adjust IPPS amount. The fact that the beds were licensed acute care beds located in an acute care area of the Provider's

[11] Intermediary's Exhibit I-30 (FY 2000).

[12]

Skilled Nursing	4
Rehabilitation	6
Observation	15
Labor/Delivery	6
Outpatient & Chemo	31
Beds to be Staffed	24
Total	72.5

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. The fact that observation patients sometimes occupied these beds did not affect their availability.

The Board found further support for it conclusion in the district court's decision in *Clark Regional*.[13] Clark Regional, upheld the Board's decision in *Commonwealth of Kentucky 92-96 DSH Group*, where the Board found that under 42 C.F.R. §412.105(b), observation bed days met the Medicare requirements necessary to be included in the bed size calculation used to determine DSH eligibility. The court in *Clark Regional* found that PRM §2405.3G supported the inclusion of observation days because any temporary use did not alter the fact that the beds were permanently maintained and staffed for acute care inpatient lodging.

With respect to the exclusion of beds used for alternative (i.e., non-patient care) purposes, such as office space or storage, the Board held that these beds must be included in the Provider's bed count for DSH purposes. In reaching this determination, the Board held that the regulations and manual provisions required that such beds be included in the Provider's DSH calculation because the evidence and testimony presented by the Provider demonstrated that the beds were licensed inpatient beds in routine areas that were maintained to provide inpatient services even though some were used for other purposes.

The Board further held that the exclusion of beds in the labor and delivery area must be included in the Provider's bed count for DSH purposes. The Board concluded that the PRM exclusion of "labor rooms" was limited to unlicensed beds and did not included licensed beds capable of inpatient care. The Board found that these beds were not used solely as labor rooms but were in fact used to provide inpatient care. Therefore, beds used in the labor and delivery area must be included in the Provider's available bed count.

With respect to the Provider's ability to staff the 24 beds the Intermediary disallowed, the Board held that the beds in dispute were licensed beds that could be made ready for inpatient use within 24-48 hours, maintained as depreciable plant assets on the Medicare cost reports, and capable of being staffed in a variety of ways. Finally, the fact that the Intermediary identified 113 beds during its walk-through on June 5, 2000, as being available, further support the Provider's argument that it had greater than 100 beds for DSH purposes.

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[13] See *Clark Regional Med. Ctr. v. Shalala*, 314 F.3d 241 (5th Cir. 2002) (Clark Regional).

SUMMARY OF COMMENTS

The Intermediary commented requesting that the Administrator reverse the Board's decision. The Intermediary argued that the Board erred when it considered licensed beds to be available. The Intermediary noted that many providers would be harmed if they were to use the licensed bed count for Indirect Medical Education (IME) reimbursement as oppose to available beds since a licensed bed count usually exceeds the available bed count. As such, providers have consistently filed their cost reports for IME reimbursement using an available bed count instead of a licensed bed count.

In further support that the Provider did not have 100 or more beds for DSH purposes the Intermediary argued that §2405.3G focused on "locations" or areas excluded from the definition of beds. Based upon this determination hospital-based SNF beds, PPS excluded rehabilitation unit beds, labor room beds and beds in outpatient areas and areas that are maintained and utilized for only a portion of the stay or for purposes other than inpatient lodging should not be considered beds for DSH qualification.[14] Specifically, the Intermediary argued that, only beds reimbursed under IPPS should be included in the count of available bed days since the purpose of DSH is to adjust PPS payment amounts. Based on this determination, the outpatient and chemo area beds (31) cannot be considered in the qualifying bed count since they are not located in areas subject to IPPS.

The Intermediary argued that the Provider supplied no documentation to show that the 24 beds to be staffed could be staffed with competent nurses within 24-48 hours. The Intermediary noted that the Board commented that it was unrealistic to expect all the available beds to become immediately available except perhaps in a disaster management situation. The Intermediary argued that if the Provider seeks to have all 24 beds counted for DSH purposes, the Provider should be required to produce documentation that it could staff the additional 24 beds within 24-48 hours. Furthermore, the Intermediary argued that additional staffing would be required for the 31 outpatient and chemo beds located on the second floor which the Provider has not documented their ability to staff. Therefore, when the Provider's bed count of 116 is reduced by eight SNF beds (reduced by four SNF for FY 2000), six rehabilitation unit beds, one and half observation beds, six labor and delivery room beds, thirty-one outpatient and chemo beds, and twenty-four beds to be staffed, the

[14] For FY 2000 the Provider's as filed cost report reported $4,692,643 in total outpatient surgery charges (revenue). See Worksheet C, Part I, column 7. This demonstrates that some beds were used significantly for outpatient services.

resultant available bed count for FY 1999 is 39.5 and 43.5 for FY 2000. Thus, the Provider did not meet the 100 available bed count requirement.

CMM commented, requesting that the Administrator reverse the Board's decision. CMM argued that inpatient beds used for observation, outpatient surgery, outpatient chemotherapy and beds for which the Provider did not provide documentation as to when they were used for outpatient versus inpatient services, should not be included in the available bed count for DSH purposes. In reaching this conclusion, CMM explained that CMS' policy to exclude observation and other outpatient days was based on a reading of the DSH payment provision found at §1886(d) (5) (F) of the Act, which required CMS to consider only those inpatient days to which the prospective payment system applied.[15] CMM stated that it is the nature of the services that are provided in outpatient beds that necessitates their exclusion from the count of available inpatient beds. Thus, because observation services are either provided pre-admission or on an outpatient basis, the beds where these services are provided are similarly excluded from the count.

CMM also noted that the Provider submitted a floor plan dated January 20, 1999 with areas marked "Outpatient Chemo" and "Outpatient Surgery." CMM further noted that the Provider's witness testified that the floor plan was inaccurate and that beds in those areas were used for both inpatient and outpatient services. However, the Provider's failed to submit documentation demonstrating the proportion of total time the beds were in use for inpatient hospital services.

CMM argued that the beds used for labor and delivery services should not be included in the available bed count for DSH purposes. CMM explained that CMS' policy to exclude labor and delivery bed days was based on a reading of §2205.2 of the PRM, which stated that a maternity patient in the labor/deliver room … at midnight is not included in the census of inpatient routine care if the patient has not occupied an inpatient routine bed at some time since admission. CMM noted that hospitals are increasingly redesigning their maternity areas from separate labor and deliver rooms and postpartum rooms, to single multipurpose labor, delivery, and postpartum (LDP) rooms and in order to appropriately track the days and costs associated with LDP rooms, it is necessary to apportion them between the labor and delivery cost center.

CMM stated that this is done under our policy by determining the proportion of the patient's stay in the LDP room that the patient was receiving ancillary services (labor and delivery) as opposed to routine adult pediatric services (postpartum).[16] The time

[15] See 68 Fed. Reg. 45346, 45419 (August 1, 2003).
[16] See 68 Fed. Reg. 45346, 45420 (August 1, 2003).

spent in labor and delivery is excluded, while the time the patient received routine inpatient care is included. Therefore, the time that the beds are unoccupied should be counted as available bed days using an average percentage based on all patients. Finally, CMM noted that in the August 1, 2003 Federal Register, CMS responded to comments arguing that LDP days were being provided in licensed beds and should therefore be counted in their entirety. CMS responded by stating that they believed the LDP apportionment described above was an appropriate policy and that this policy would be applied to all current open and future cost reports. Therefore, the Intermediary adjustment of excluding six labor and delivery beds from the Provider's count of inpatient beds was appropriate since the Provider's cost reports were open at the time of publication.[17]

The Provider commented requesting that the Administrator affirm the Board's decision. The Provider argued that it maintained more than 100 beds for the fiscal periods in dispute and, thus, is eligible for the additional DSH payment. For the FY 1999 period in dispute, the Provider argued that it maintained 116 available beds. For FY 2000, the Provider argued that it maintained 113 available beds. The Provider disagreed with the Intermediary's exclusion from the available bed count of 31 outpatient and chemotherapy beds located on the Provider's second floor. The Provider also disagreed with the Intermediary's exclusion of one and a half observation beds, six labor/delivery and post-partum (LDRP) beds and the 24 unstaffed beds that were out of service or used for other purposes like office or storage space from the available bed count for DSH purposes.

With regard to beds used for outpatient surgery and outpatient chemotherapy patients, the Provider argued that the rooms on the second floor were permanently maintained for lodging inpatients. In addition, while the second floor housed the operating room and recovery area those areas were separate and apart from the patient rooms on the second floor. The Provider argued that outpatient surgery patients were treated in the recover area or, if necessary, in ICU. Concerning beds used for outpatient chemotherapy patients, the Provider argued that outpatient chemotherapy patients were few in number and mobile enough so that if the Provider needed to admit a patient in a room being used by the outpatient chemo patient, the patient could have been easily be moved to another area. Thus, the 31 beds located on the second floor should be included in the bed count of available beds for DSH purposes.

With respect to the one and a half observation beds that the Intermediary excluded from the Provider's available bed count, the Provider argued that even if they were removed that the Provider had more than 100 available beds (109#1.5=107.5) to qualify for the additional DSH payment.

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[17] Id.

Further, with respect to the six LDRP rooms excluded by the Intermediary, the Provider argued that the rooms were not simply labor rooms. The Provider argued that the rooms in question were licensed inpatient rooms used for inpatient acute care for the entire stay of the birthing mothers, as well as for other patients. The Provider further argued that the removal of the six LDRP beds from the available bed count cannot be supported by a plain reading of CMS' policy articulated in the August 1, 2003 Federal Register. The Provider stated that nothing in CMS' clarification supports the exclusion of all beds associated with LDRP beds. At best it only supports the removal of one and a half beds (25 percent of the six LDRP beds). Even excluding the six LDRP beds and one and a half observation beds from the available bed count, the Provider maintained a bed count of 101.5. Thus, the Provider qualified for DSH as an urban hospital with 100 or more beds.

Moreover, the Provider disagreed with the Intermediary's exclusion of 24 beds because the rooms in question were used for office space or storage or was unstaffed. The Provider argued that Intermediary improperly focused upon a perceived inability to staff the beds and on the perceived use of the room or bed in question, rather than upon the availability of the bed. The Provider acknowledged that it did not utilize all of its licensed rooms for inpatient care but contended that the rooms in questions were licensed inpatient beds capable of being put into service within 24-48 hours. The Provider noted that while the number of available nurses at a given staffing registry may vary from time to time, the Provider had multiple agreements and relationships with various other staffing agencies to staff the full complement the beds claimed by the Provider if necessary.

Finally to support its position that the rooms used for storage or office space should be included in the available bed count for DSH purposes, the Provider cited *Presbyterian Hospital of Greenville v. BCBS Ass'n/ TrailBlaizer Health Enterprises*, Administrator Dec. (January 25, 2002), which held that rooms used for storage and office space should be counted as available beds because they could have been place into service within 24-48 hours.

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.

The Social Security Amendments of 1965,[18] established Title XVIII of the Social Security Act, which authorized the establishment of the Medicare program to pay part of the costs of the health care services furnished to entitled beneficiaries. The Medicare program primarily provides medical services to aged and disabled persons and consists of two Parts: Part A, which provides reimbursement for inpatient hospital and related post-hospital, home health, and hospice care, and Part B, which is supplemental voluntary insurance program for hospital outpatient services, physician services and other services not covered under Part A. At its inception in 1965, Medicare paid for the reasonable cost of furnishing covered services to beneficiaries.

From the beginning of the program, under reasonable cost hospital inpatient reimbursement, the average cost per day for reimbursement purposes was calculated by dividing the total costs in the inpatient routine cost center by the "total number of inpatient days."[19] Generally, Medicare reimbursement for routine inpatient services was based on an average cost per day as reflected in the inpatient routine cost center multiplied by the total number of Medicare inpatient days.[20] Consequently, the inclusion or exclusion of a bed day in the per diem calculation would impact the Medicare per diem payment.

However, concerned with increasing costs, Congress enacted Title VI of the Social Security Amendments of 1983.[21] This provision added §1886(d) to the Act and established the inpatient prospective payment system for reimbursement of inpatient hospital operating costs for all items and services provided to Medicare beneficiaries, other than physician's services, associated with each discharge. The purpose of PPS was to reform the financial incentives hospitals face, promoting efficiency by rewarding cost effective hospital practices.[22]

These amendments changed the method of payment for inpatient hospital services for most hospitals under Medicare. Under IPPS, hospitals and other health care providers are reimbursed their inpatient operating costs on the basis of prospectively determined national and regional rates for each discharge rather than reasonable operating costs. Thus, hospitals are paid based on a predetermined amount depending on the patient's diagnosis at the time of discharge. Hospitals are paid a fixed amount

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[18] Pub. Law No. 89-97.

[19] *See e.g.* 42 CFR 413.53(b); 42 CFR 413.53(e)(1) ("Departmental Method: Cost reporting periods beginning on or after October 1, 1982.")

[20] *Id. See also* Section 2815 PRM-Part II, "Worksheet D-1 Computation of Inpatient Operating costs" sets forth definitions to apply to days used on Worksheet D-1 which has been in place since 1975. 60 Fed. Reg. 45778, 45810 (1995).

[21] Pub. L. No. 98-21.

[22] H.R. Rep. No. 25, 98th Cong., 1st Sess. 132 (1983).

for each patient based a diagnosis-related groups (DRG) subject to certain payment adjustments. Notably, while IPPS was implemented to replace the reasonable cost method of reimbursing hospitals for the operating costs of inpatient hospital services, it continues to require cost reporting consistent with that required under the reasonable cost methodology including the principles guiding the inpatient routine per diem methodology.

Concerned with possible payment inequities for IPPS hospitals that treat a disproportionate share of lowincome patients, pursuant to §1886(d)(5)(F)(i) of the Act, Congress directed the Secretary to provide, for discharges occurring after May 1, 1986, an additional payment per patient discharge, "for hospitals serving a significantly disproportionate number of low-income patients…."[23] The legislative history of Consolidated Omnibus Budget Reconciliation Act (COBRA) of 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."[24] 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 central city areas and have higher security costs. They often serve as regional centers and have high standby costs…. [25]

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. For the cost years at issue, under §1886(d)(5)(F)(v) of the Act, 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. However, if the urban hospital has less than 100 beds, it must have a disproportionate

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[23] Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. Law No. 99-272). *See also* 51 Fed. Reg. 16772, 16773-16776 (1986).
[24] H.R. Report No. 99-241 at 16 (1986); *reprinted* in 1896 U.C.C.A.N. 594
[25] Id.

patient percentage of 40 percent to be eligible for the DSH adjustment. 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.[26] (Emphasis added.)

Finally, the H. R. Report states 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 cost-reporting period for which the adjustment would be made.[27]

Consistent with the statute, the governing regulation at §412.106 (1992), which addresses the DSH payment, states that:

> (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 others.

The regulation at §412.105(b)(1992), cross-referenced at 42 CFR 412.106(a)(1)(ii), addresses the indirect medical education (IME) payment and explains that:

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[26] H.R. Report No. 99-241 at 17 (1986) *reprinted* in 1986 U.C.C.A.N. 595.
[27] Id.

> 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.

The preamble to the final rule for the Federal Fiscal Year (FFY) 1986 IPPS rates[28] gave further explanation as to the definition of available beds, stating 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. (Emphasis added.)[29]

Consistent with the regulations at 42 C.F.R. §412.105, the Provider Reimbursement Manual (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.[30] Section 2405.3(G) of the PRM states that:

> 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,

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[28] 50 Fed. Reg. 35683.

[29] *Id.*

[30] See also Section 3630.1 PRM-Part II; 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….")

> 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.
>
> To be considered an available bed, a bed must be permanently maintained for lodging inpatients. It must be available for use and housed in 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.

This principle guiding the counting of bed days for purposes of determining a hospital's bed size is also the same as that guiding the determination of the DSH patient percentage calculation, under 42 CFR 412.106(b)(1)(ii). The Secretary explained in the preamble promulgating that regulatory provision that:

> [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, *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 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.[31] (Emphasis added.)

The Secretary has consistently applied the policy for both DSH and IME payment provisions mindful of the fact that, as a general matter, the same bed counting policy will favorably affect one payment, while adversely affecting the other payment. Generally, the inclusion of bed days will increase DSH payments and decrease IME payments, while the exclusion of beds days increases IME payments and decreases DSH payments. In particular, the Secretary, observed that:

> We believe we have a responsibility to apply this policy consistently over time and across providers. Excluding these beds from the determination of bed size would have an adverse impact on some hospitals. Several prospective payment system special adjustments are based on bed size: for example the threshold and adjustment for the disproportionate share (DSH) adjustment for urban hospitals with 100 or more beds. If we no longer considered neonatal intensive care beds in determining bed size, DSH adjustments to some hospitals would be sharply reduced….[32]

Since the establishment of the DSH and IME payment provisions, the Secretary has taken the opportunity to clarify the types of beds days to be included in the bed count and discuss the general principle guiding such clarifications. For example, the Secretary stated in discussing the counting of bed days in the FFY 1995 IPPS rule, 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, [[33]] which was originally used to establish bed-size categories for

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[31] 53 Fed. Reg. 38480 (Sept. 30, 1988); *See also* 53 Fed. Reg. 9337 (March 22, 1988).
[32] 59 Fed. Reg. 45374.
[33] Section 2510.5A of the PRM, as drafted in 1976, stated: Bed Size Definition. 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

> 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 beds 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. 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.[34]

Beds used for outpatient services are clearly not included in determining Medicare's share of inpatient costs as are bed days relating to custodial or ancillary services. Observation bed days fall under the former category of bed days. An observation bed day is a day when the bed is used for "outpatient observation services." Observation services are those services "furnished by a hospital on the hospital's premises, including use of a bed … to evaluate an outpatient's condition or to determine the need for a possible admission to the hospital as an inpatient …."[35] In addition, when a hospital places a patient under observation, but has not formally admitted him or her as an inpatient, the patient initially is treated as an outpatient.[36]

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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.

[34] 59 Fed. Reg. 45330, 45373 (1994). See also id. 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 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.)

[35] Section 230.6.A of the Hospital Manual.

[36] Section 230.6.B of the Hospital Manual.

Because, under these circumstances, the observation services are paid as outpatient services, the costs of observation bed patients are to be carved out of the inpatient hospital costs as they are not recognized and paid under inpatient hospital PPS as part of a hospital's inpatient operating costs.[37] 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.[38]

The labor delivery room days fall into the second category of days as ancillary services. Original Medicare policy with respect to the counting of days for maternity patients for purposes of determining Medicare's share of inpatient costs was to count an inpatient day for an admitted maternity patient in the labor delivery room at the census taking hour. This was consistent with Medicare policy for counting days for admitted patients in any other ancillary department at the census taking hour. However, after December 1991 and pursuant to adverse case law, this policy was revised to the current policy as described in §2205.2 of the PRM. That provision states that a maternity patient in the labor/delivery room ancillary area at midnight is included in the census of the inpatient routine (general or intensive) care area only if the patient has occupied an inpatient routine bed at some time since admission. If a patient is in the labor room at the census and has not yet occupied a routine inpatient bed the bed day is not counted as a routine bed day of care under 42 CFR 412.105(b). If the patient is in the labor room at the census but had first occupied a routine bed, a routine inpatient bed day is counted for DSH purposes and for apportioning the costs of routine care in the cost report consistent with CMS policy of treating days, costs and beds similarly.[39]

While the Secretary had stated the underlying principle for counting bed days under the DSH and IME provision, the Secretary first specifically discussed observation bed days in the final rule for the FFY 2004 IPPS rates[40] in response to an adverse Court of Appeals case.[41]

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[37] Section 3605 of the PRM-Part II.

[38] Section 3605.1, line 26.

[39] See also 68 Fed. Reg. 45419 (August 1, 2003).

[40] 68 Fed Reg. 45346, 45418-45419 (Aug 1, 2003).

[41] CMS specifically addressed observation bed days in a 1997 Memorandum to the CMS Regional Offices stating that: "[I]f 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." *See* CMS

The court in *Clark Regional Medical Center v. Shalala*, 314 F.3d 241 (6th Cir. 2002), found that the regulatory listing of beds to be excluded from the count restricts the class of excluded beds only to those specifically listed. Because observation beds and swing beds are not currently specifically mentioned in 412.105(b) as being excluded from the bed count, the *Clark* court ruled that these beds must be included.

In the FFY 2004 IPPS rule preamble, the Secretary took the opportunity to point out that, contrary to the court's findings, the listing at 42 CFR 412.105(b) was not intended to be all-inclusive list and, in fact, specific bed types had been added to the list as clarifications of the type of beds to be included and excluded.[42] The Secretary also observed that the Clark court found that observation and swing bed days were included under the plain meaning of the regulatory text at 412.106(a)(1)(ii). However, the Secretary noted that the court failed to address the preamble language that promulgated the regulatory provisions at 42 CFR 412.106(a)(1)(ii) and clarified its meaning.[43] That language specifically stated that based on the statute the Secretary is "in fact required to consider only those inpatient days to which the prospective payment system applies in determining a hospital's eligibility for a disproportionate share adjustment." The policy of excluding observation bed days is also consistent with this regulatory interpretation of days to be counted under 42 CFR 412.106(a)(1)(ii). The Secretary concluded that this general policy had also been reviewed and upheld previously by several courts. Consequently, the Secretary clarified the regulation to state that observation bed days were to be excluded from the determination of number of beds under 42 CFR 412.105(b) and the determination of the DSH patient percentage under 42 CFR 412.106.[44]

Memorandum, dated Feb. 27, 1997, from Acting Deputy Director/Bureau of Policy Development to Associate Regional Administrator/Division of Medicare/All Regional Offices, Subject: Counting Beds and Days for Purposes of the Medicare Hospital Inpatient Disproportionate Share and Indirect Medical Education Adjustments.''

[42] Citing to 59 Fed. Reg. 45373 (Sept.1, 1994) and 60 Fed Reg. 45810 (Sept. 1, 1995).

[43] Citing to 53 Fed. Reg. 38480 (Sept. 30, 1988).

[44] Subsequently, the Fourth Circuit Court of Appeals in *District Memorial Hospital of Southwest North Carolina v. Thompson*, 346 F.2d 513 (2004), ruled favorably on the Secretary's interpretation of the 42 CFR 412.106 as requiring the exclusion of swing bed days. The *District Memorial* court, *inter alia*, deferred to the Secretary's assertion that the term "areas" in the phrase 42 CFR 412.106 refers to the scope or sphere of operation or action as opposed to the more narrow "geographical" definition of "areas" argued by the provider in that case. The court also found that even if one were to insist that the word "areas", as used in the regulation at 42 CFR 412.106, be read to carry geographical connotations, the Secretary's interpretation would remain a reasonable construction of the regulatory language. The word "areas"

Because of changes in the provision of health care, the policy on counting labor/delivery room days was also clarified in the IPPS FFY 2004 final rule.[45] The Secretary recognized that, increasingly, hospitals have redesigned maternity areas to be multi-purpose labor, delivery and postpartum (LDP) rooms. Accordingly, in order to appropriately track the days and costs associated with LDP rooms, the Secretary noted that it was necessary to apportion them between the labor delivery cost center, which is an ancillary cost center, and the routine adult and pediatric cost center. This is done under present CMS policy by determining the proportion of the patient's stay in the LDP room that the patient was receiving ancillary services (labor and delivery as opposed to routine adult and pediatric services (postpartum) services.[46] The Secretary also noted that:

> Although we have not previously formally specified in guidance or regulations the methodology for applying this policy to LDP rooms, this is not a new policy. However, as suggested by commenters, we believe this policy may not have been applied consistently. Therefore, we believe it is important to clarify the policy as part of our discussion of our polices pertaining to the counting of patient bed days.
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> We continue to believe the LDP apportionment described above is an appropriate policy and does not in fact impose a significant additional burden because hospitals are already required to allocate costs on the cost report between ancillary and routine costs. In addition, this allocation is already required to be consistent with our treatment of costs, days, and beds and is consistent with our other patient bed day polices. Therefore this policy will be applied to all currently opened and future cost reports. However, it is not necessary to reopen previously settled cost reports to apply this policy.[47]

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would then refer to the location of any bed used to provide acute care when such services were being provided and the disproportionate share adjustment would apply to that calculation at that time. Similarly, the word "areas" would not refer to the location of a bed when skilled nursing services were being provided at that bed because such services were not subject to the prospective payment system. Under this interpretation, the word "areas" in a geographical sense would be referring to the locations of individual beds, as opposed to wings or units of the hospital *District Memorial Hospital of Southwest North Carolina v. Thompson*, 346 F.2d 513, 519-520 (2004).

[45] 68 *Federal Register* 45346 at 45420 (August 1, 2003)

[46] 68 Fed. Reg. at 45420.

[47] 68 Fed. Reg. at 45420

The regulation at 42 CFR 412.105 was clarified, *inter alia*, to state that:

> (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 days in the cost reporting period. The count of available beds excludes bed days associated with—
> …
> (4) Beds otherwise countable under this section used for outpatient observation services, skilled nursing swing bed services; or ancillary labor/delivery services.[48]

Finally, the Secretary again restated his longstanding policy of excluding observation bed days from the available bed day count for DSH purposes in the final rule for the FFY 2005 IPPS rates.[49] In that rule, the Secretary also specifically promulgated in the regulation under 42 CFR 412.105(b) and 412.106(a)1)(ii), that observation bed days are to be excluded from the counts of both available beds and patient days, unless a patient, who receives outpatient observation services is ultimately admitted for acute inpatient care, in which case the beds and days would be included in those counts.[50] The Secretary, addressed certain characteristics of an observation bed days, that are equally applicable to when inpatient beds are used for non-inpatient services. The Secretary stated that:

> Observation services and swing-bed skilled nursing services are both special, frequently temporary, alternative use of acute inpatient care beds. Thus the days a bed in an (otherwise occupied) acute inpatient care unit or ward is used to provide outpatient observation services are to be deducted from the available bed count under 42 CFR 412.105(b) and the patient day count under 412.106(b). Otherwise, the bed would be considered available for IPPS-level acute care services (as long as it meets the other criteria to be considered available.) This same policy applies to any bed days the bed is used to provide SNF level care. The

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[48] See 68 Fed. Reg. 45470 (2003).

[49] 69 Fed. Reg. 48916, 49096-49097 (Aug. 11, 2004).

[50] 69 Fed. Reg. 49097, 49245 (Aug 11, 2004) The regulation at 42 CFR 412.105(b) was clarified *inter alia*, to state that: (4) Beds otherwise countable under this section used for outpatient observation services, skilled nursing swing bed services; or ancillary labor /delivery services. This exclusion would not apply if a patient treated in an observation bed is ultimately admitted for acute inpatient care, in which case the beds and days would be included in those counts. 69 Fed. Reg. 49245 (2004).

> policies to exclude observation days and SNF-level swing-bed days from the count of available bed days and patient days, as described above stem from the fact that although the services are provided in beds that would otherwise be available to provide an IPPS level of services, these days are not payable under the IPPS, except in the case of observation days when the patient is ultimately admitted as an inpatient.[51]

The Administrator recognizes that, under the statute, the DSH adjustment is intended to be an additional payment to account for a "higher Medicare payment per case" for IPPS hospitals that serve a disproportionate number of low-income patients. The Administrator finds that the policy to only include bed days that are recognized as part of hospital's inpatient operating costs is consistent with that overarching statutory intent.

Further, with respect to the regulation at 42 CFR 412.105(b) and the PRM, the Administrator finds that the listing of beds is general in nature and not all-inclusive. A review of the beds listed to be excluded from the count of bed days shows as a general matter that these beds are not allowable in the calculation of Medicare's share of inpatient costs. The Administrator finds that observation bed days are treated for purposes of inpatient costs like outpatient beds and are not treated like inpatient adult and pediatric acute care beds. Similarly, beds used for outpatient surgery and outpatient chemotherapy are clearly outpatient beds, while beds in use for patients in labor delivery which have received inpatient routine care are ancillary in nature. None of these bed days are included in the calculation of the Medicare's share of the inpatient hospital costs.

Notably, most courts have found that 42 CFR 412.105(b) is not an all-inclusive list. Rather, the courts have found that the list is not confined to the literal terms of 42 CFR 412.105(b) in assessing its meaning.[52] Thus, the Administrator finds that the

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[51] 69 Fed Reg. 49096-49097. See also 68 Fed. Reg. 45418-45419.

[52] *See*, e.g., *AMISUB d/b/a/ St. Joseph's Hospital v. Shalala*, No. 94-1883(TFH) (D.D.C. 1995); *Grant Medical Center v. Shalala*, 905 F. Supp. 460, 1995 U.S. Dist. Lexis 17398; *Sioux Valley Hospital v. Shalala*, 29 F.3d 628, 1994, U.S. App. Lexis 26519. In these cases, the Secretary was faced with similar arguments concerning neonatal intensive care beds and was successful in arguing that the regulation as written at that time did not clearly exclude all beds assigned to newborns, but could reasonably be interpreted to apply only to newborns in bassinets. The neonatal intensive care beds at issue in those cases were more like intensive care beds, which were listed as beds to be counted, and less like newborn bassinets, which were listed as beds to be excluded. The courts' held that the language of 42 CFR 412.105(b) with

exclusion of these bed days is a reasonable interpretation of the regulatory language set forth at 42 CFR 412.105(b).[53]

Moreover, the exclusion of these types of beds is proper under the language set out in the preamble of the final rule for the FFY 1986 IPPS rates and §2405.3.G of the PRM. Specifically, both the preamble and the PRM explains that: "a bed must be permanently maintained for lodging inpatients" to be considered an available bed. The beds must be "immediately opened and occupiable" to be countable.[54] The 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, labor/delvery, it is not available for inpatient lodging. In addition, Section 2405.3(G) of the PRM specifically states that beds used for ancillary, outpatient areas, and other areas regularly maintained and utilized for only a portion of the stay by patients are not considered available beds for lodging inpatients. The number of patient days for purposes of determining DSH eligibility includes only those days attributable to areas of the hospital that are subject to the prospective payment system.[55]

Factually, the record shows the discrete number of times the beds were used as observation beds and, thus, the discrete number of bed days that should be excluded from the count. In addition, the record shows that beds located in the areas marked as outpatient chemotherapy and outpatient surgery on the contemporaneously dated floor plan were used for outpatient surgery and outpatient chemotherapy.[56] The Provider submitted a floor plan dated January 20, 1999 to support its contention of 116 beds.[57] A review of the floor plan shows outpatient chemotherapy and outpatient

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respect to neonatal intensive care beds was ambiguous and, thus, the Secretary's interpretation was entitled to deference.

[53] The exclusion of observation beds, outpatient beds and labor/delivery ancillary beds is also consistent with the definition of "patient day" under 42 CFR 412.106(b) in that the bed day is not "attributable to the areas of the hospital subject to the prospective payment system." *See also District Memorial Hospital of Southwest North Carolina v. Thompson*, 346 F.2d 513, 519-520 (2004).

[54] 50 Fed. Reg. at 35683.

[55] The Administrator finds 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. The Administrator finds that this example does not rebut or address the principle that a bed day is included if the day was used in the calculation of the inpatient operating costs.

[56] See, e.g., Worksheet C, Part I, column 7. (For FY 2000 the Provider's filed cost report reported $4,692,643 in total outpatient surgery charges (revenue)).

[57] Intermediary Exhibit 3.

surgery marked on the second floor plan. Pictures used to support that various rooms could be used for inpatient services were taken in 2005. The pictures do not exclude the use of the beds for outpatient services. Other evidence also indicates that the second floor was used for outpatient services.[58] The record shows that through discovery the Intermediary requested but did not receive outpatient or inpatient utilization for beds on the second floor.[59] The Administrator finds that in the absence of documentation demonstrating the proportion of total time the beds were in used for inpatient hospital services, the Intermediary properly excluded 31 beds in areas marked as outpatient from the available bed count.[60]

With respect to the beds used for LDP, the Administrator finds that in the absence of documentation demonstrating the proportion of total time the beds were in used for labor and delivery as opposed to postpartum services, the Intermediary properly excluded the beds used for labor and delivery services. The Administrator finds that the current policy regarding the treatment of labor and deliver bed days is described in §2205.2 of the PRM, which states that a maternity inpatient in the labor/delivery room at midnight is not included in the census of the inpatient routine care if the patient has not occupied an inpatient routine bed at some time since admission. CMS recognized that hospitals are redesigning their maternity areas from separate labor and delivery rooms and postpartum rooms, to single multipurpose labor, delivery, and postpartum (LDP) rooms. Therefore, providers are required to track and apportion the costs between the ancillary labor and delivery cost center and the routine cost center. It is undisputed that the beds were used for ancillary services. In the alternative, a provider may calculate an average percentage of time patients receive ancillary services, as opposed to routine inpatient services, in the LDP rooms during a typical month and apply that percentage through the rest of the year.[61] The Provider failed to document the days these beds were used for inpatient routine services using any of the methods offered by CMS. In the absence of documentation demonstrating the proportion of total time the beds were in used for labor and delivery, as opposed to postpartum services, the Administrator finds that the Intermediary appropriately excluded the six labor and delivery beds from the Provider's count of inpatient beds.

Based on the exclusion of one and a half observation beds, six labor and delivery bed and the exclusion of 31 beds in areas marked as outpatient from the available bed count the Administrator finds that these adjustment would make the Provider's total count of available beds less than 100 and thus ineligible to receive Medicare DSH payments if its DSH patient percentage is less than 40 percent. Based on the

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[58] See e.g. Transcript of Oral Hearing at 180.
[59] Intermediary's Exhibit 30 (FY 2000).
[60] 42 C.F.R. §413.106(a)(1)(ii).
[61] 68 Fed. Reg.45420.

foregoing, a ruling with respect to the 24 unstaffed beds is not determinative to this case.[62]

However, the Administrator does note the concern of CMM regarding the availability of nursing staff for the unoccupied beds at issue. The Provider submitted standard staffing agreements which it claimed showed they could provide nursing staff for the 24 unoccupied beds within 24-48 hours.[63] A review of the agreements however shows that one requires the "contracting party" to "call provider (contractor) before 5:00 pm on Wednesday for services to be rendered beginning 7-3 am Monday through 11-7am Sunday (weekly basis) of the following week.[64] The other contract, while difficult to read, does not appear to require the provision of personnel within any certain timeframe. It also specifies that: "the parties agree that [contractor] duty to supply personnel on request of facility is subject to availability of qualified … personnel … [F]ailure of [contractor] to provide personnel will not constitute a breach of this agreement."[65] Consequently, the Administrator agrees with CMM that the record does not support a finding that the 24 unstaffed beds could be staffed within 24-48 hours and, thus, those beds are not properly included in the available bed count.

[62] The Administrator notes that the Secretary revisited the issue of unoccupied beds in the IPPS FFY 2005 final rule at 69 Fed. Reg. 48916, 49093-49098 (August 11, 2004).
[63] Provider Exhibits 34 and 35.
[64] Provider Exhibit 34. While Provider Exhibit 33 states that the contractor can meet the needs of the hospital, that statement must be qualified by the contractual timeframes provided in the agreement.
[65] Provider Exhibit 35.

DECISION

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

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

Date: 2/24/06 /s/

Leslie V. Norwalk, Esq.
Deputy Administrator
Centers for Medicare & Medicaid Services