CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
College Station Medical Center **Part C Days Group** **Provider** **vs.** **Wisconsin Physician Service** **Intermediary**	**Reimbursement Determination for Cost Reporting Period ending: October 31, 1999** **Review of:** **PRRB Dec. No. 2009-D31** **Dated: July 9, 2009**

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 commented, requesting reversal of the Board's decision. The parties were notified of the Administrator's intention to review the Board's decision. The Provider commented, requesting affirmation. CMS' Center for Medicare Management (CMM) also commented, requesting reversal of the Board's decision. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD DECISION

The issue is whether the Intermediary properly excluded observation bed days for purposes of determining whether the Provider had less than 100 available beds for disproportionate share hospital (DSH) eligibility purposes.

The Board, reversing the Intermediary's adjustment, concluded that the Provider's observation bed days should be included in the available bed count and used in determining the eligibility of the Provider for DSH reimbursement. The Board found that, as the legal and factual circumstances of the instant appeal are identical to its decision in *North Okaloosa Medical Center v. Blue Cross & Blue Shield*

Association,[1] the adjustment of the Intermediary should be reversed. The Board found that the regulation, at 42 C.F.R. §412.106, sets forth the factors to be considered in determining whether a hospital qualifies for a DSH adjustment and states that the number of available beds is to be determined in accordance with 42 C.F.R. §412.105(b). Further, the regulation at 42 C.F.R. §412.105(b) establishes the methodology for the determination of the bed size of a hospital for purposes of DSH eligibility, requiring that all beds be included in the calculation, unless specifically excluded. That regulation specifically excludes beds or bassinets in a newborn nursery, custodial care beds, or beds in excluded distinct part hospital units. The Board also noted that the term "bed" is specifically defined in section 2405.3.G of the Provider Reimbursement Manual (PRM) for purpose of calculating the adjustment of IME/GME and DSH eligibility and specifically lists beds to be included and beds to be excluded. Based on a reading of the Manual provision, the Board found that observation beds were not specifically excluded from the bed count. The Board determined that the beds at issue were acute care beds which are to be included in the bed count. Thus, the Board concluded that since the Provider's observation beds should be included, the Provider had 100 beds permanently maintained for lodging patients.

In sum, the Board concluded that the controlling regulation and Manual guidelines were written with great specificity regarding beds that are to be included and excluded and noted that CMS has provided clear guidance in the Manual, including an example directly on point. Finally, the Board noted that several courts have upheld the Board on its findings that observation beds must not be excluded from the count as the bed count is specifically "not intended to capture day-to-day … [Changes] 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."[2] Accordingly, the Board determined that the Intermediary's determination of the number of available beds for DSH eligibility purposes was not proper.

COMMENTS

[1] See PRRB Dec. No. 2006-D54 (Sept. 26, 2006); *rev'd* Admin. Dec. No. 2006-D54.

[2] See *Clark Regional Med. Ctr. v. U.S. Dep't of Health and Human Servs.* 314 F. 3d 241 (6th Cir. 2002); *Odessa Regional Hos. v. Leavitt*, 386 F.Supp.2d 885 (W.D. Tex. 2005); *Highland Med. Ctr. V. Leavitt*, 2007 WL 5434880 (N.D. Tex. 2007); and *North Okaloosa med. Ctr. v. Leavitt*, 2008 WL 141478 (N.D. Fla. 2008).

The Intermediary commented, requesting that the Administrator reverse the decision of the Board, both on the merits and on jurisdiction. The Intermediary argued that the Board erroneously accepted jurisdiction. Since the Provider had never claimed DSH on its as-filed cost report, there is no corresponding adverse finding and, therefore, the Provider cannot show dissatisfaction with a final determination. The Intermediary noted that the DSH was not claimed on the as-filed cost report on Worksheet E, Part A, nor disclosed as a protested item. The Intermediary further stated that if the regulation and the Manual instructions are so clear on the inclusion of observation bed days in the bed count, as the Provider and the Board contended, then the Provider should have made a claim on the as-filed cost report. Clearly, there was nothing preventing the Provider from claiming DSH on its as-filed cost report if it qualified.

Further, the Intermediary argued that the Board erred in finding that it is not necessary for DSH hospitals to formally apply for DSH, since intermediaries have been given instructions to make a DSH determination based on Medicare data from the hospital's latest available cost report and SSI percentages all of which are supplied by CMS. However, the Intermediary argued that there was no data on the latest available cost report to render a determination, such as Medicaid eligible days. Thus, the Intermediary contended that a claim must be made on the cost report.

The Provider commented, requesting that the Administrator affirm the Board's decision. The Provider argued that the Board properly assumed jurisdiction. The Provider argued that the Intermediary's assertion that no adverse finding was made is legally inapplicable. The Provider claimed that the fact that it failed to claim for DSH on the as-filed cost report (and therefore prompted no adjustment by the Intermediary) is not dispositive. The Provider pointed out that in the stipulation, the Intermediary recognized the only obstacle to DSH reimbursement was whether there were 100 available beds. Further, at the hearing before the Board, at issue was the removal by the Intermediary of 420 beds from the available bed count for DSH reimbursement purposes which resulted in the Provider's bed count of 98 bed days, thereby impairing its 100-bed threshold for receiving DSH reimbursement. The Provider contended that the observation services must be included in the bed count as they were provided in impatient beds. Further, the Board relied on the plain language of the regulations, the Manual, and the Board, as a result, has been upheld by each Federal court reviewing this matter.

Moreover, the Provider argued that this is a typical self-disallowance case envision by the Supreme Court under *Bethesda v. Bowen*.[3] The Provider pointed out that

[3] 485 U.S. 399 (1988).

although it disagreed with the policy of CMS; it was aware of the 1997 policy issued by CMS instructing intermediaries to remove observation beds from the bed count and, thus, to claim DSH would been futile. The Provider, however, noted that the Intermediary did make a determination as to available bed days, removing 420 days from the bed count. This was the threshold issue for qualification of the Provider for DSH reimbursement. Although the determination of the Intermediary was not in the form of an adjustment, the Intermediary did audit the number of beds claimed by the Provider on the as-filed cost report (100), removing 2 beds from this, resulting in a bed count of 98. Thus, there was a final determination by the Intermediary.

In the context of self-disallowance, the Provider argued that the courts have viewed jurisdictional grants as broader than simply including audit appeals of self-disallowances. The Provider stated that, in Bethesda, the Supreme Court analyzed the jurisdictional statute at 42 U.S.C. §1395oo, holding that the prerequisite for Board jurisdiction is dissatisfaction with the total amount of reimbursement. Citing to other caselaw, the Provider argued that even if this were not a case involving, self-disallowance, jurisdiction would still be proper; because it was dissatisfied with the total amount of the adjustment of the Intermediary. The Provider claimed that it appealed several issues, including IME and GME FTE counts, Home Office costs, and various aspects of the DSH calculation, including, the bed count issue that is the subject of the present dispute. Thus, according to the body of case law, Board jurisdiction is not premised on the existence of an identifiable adverse determination, (an audit adjustment), but rather on dissatisfaction with the total amount of reimbursement as is the circumstance in the instant appeal.

CMM commented, requesting reversal of the Board's decision. CMM noted that the intent of the regulation and manual provision on this issue is to provide hospitals the ability to determine the number of beds that are available for inpatient use. If a bed is available for inpatient use, the number of days it has that status would be counted toward the available bed days to determine the bed count. CMM explained that by counting available bed days and not occupied bed days, the rules provide the ability to quantify how many beds are available to acute-care inpatients. Thus, beds being used to provide outpatient observation services are not available for inpatient use and should be excluded in the available bed day count.

Pointing to a March 11, 1997, instruction, CMM stated that its CMS' longstanding policy to only count inpatient bed days subject to the inpatient prospective payment system (IPPS) in the count of available bed days for Medicare DSH purposes. In addition, CMM disagreed with the Board's reading of the regulations and manual guidelines as being all-inclusive, unless they were specifically excluded under the categories listed in the regulation. CMM stated that over the years, specific bed

types have been added to the list as clarification of the types of beds to be excluded, not as new exclusions. Furthermore while the PRM does not explicitly list observation beds among those that are excluded, the PRM does state that beds in outpatient areas and beds that are used for purposes other than inpatient lodging are to be excluded. CMM noted it explained, in its clarification issued on August 1, 2003, that observation services whether provided in a distinct observation bed are or a routine inpatient care were excluded from the counts of available bed days and patient days. Further, CMM stated that the explanation of CMS policy to exclude observation and other outpatient days is based on a reading of the DSH payment provisions in the statute. CMM also disagreed with the Board's reliance on certain court decisions.

Finally, CMM maintained that the Board incorrectly assumed jurisdiction. CMM argued that since the Provider never claimed to receive DSH on its cost report, no adjustment was made on DSH for which the Provider could appeal.

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) of the Social Security Act, the Secretary is mandated to provide, an additional payment per patient discharge, "for hospitals serving a significantly disproportionate number of low-income patients…."[4] 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."[5] 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

[4] 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).
[5] 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….[6]

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.[7] 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.[8] 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.[9]

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 cost-reporting 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,[10] states that:

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[6] Id.
[7] Supra n. 5.
[8] Id. Rural hospital 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.
[9] H.R. Report No. 99-241 at 17 (1986) *reprinted* in 1986 U.C.C.A.N. 595.
[10] 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.
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> (i) The number of beds in a hospital is determined in accordance with §412.105(b).
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> (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. The regulation at 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[11] 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 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.[12] The PRM states that:

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[11] 50 Fed. Reg. 35683.

[12] 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

> 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.

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

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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….”)

> 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, [13] 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….
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> 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. 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.[14] (Emphasis added.)

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[13] 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 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.

[14] 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

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, IPPS 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). The Secretary 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, 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 ….

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costs (nursery costs and days, on the other hand, are excluded from this determination)…." (Emphasis added.)

> 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.[15] (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 IPPS hospital's eligibility for a DSH adjustment.[16] 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 an IPPS hospital's eligibility for this additional payment based on beds that are recognized as part of the PPS hospital's inpatient operating costs.

In this particular case, the Provider contends that observation 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 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 held that all of the observation 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

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[15] 53 Fed. Reg. 38480 (Sept. 30, 1988); See also 53 Fed. Reg. 9337 (March 22, 1988).

[16] This is also consistent with the treatment of patient days for purposes of the DSH patient percentage calculation at 42 CFR 412.106 which states that: "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." (Emphasis added.) See also District Memorial Hospital of Southwestern North Carolina v. Thomas, 364 F. 3d 513 (4th Cir. 2004) (agreeing with the Secretary's non-geographical reading of the term "area", in excluding swing bed days, by arguing that the term refers to the scope of activity-the provision of acute care-rather than all beds geographically located in a hospital wing licensed to provide acute care.)

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.[17]

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 reasonable and to evaluate an outpatient's condition or to determine the need for a possible admission to the hospital as an inpatient….
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> 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.]

[17] For the cost period at issue, the Provider's cost report reflected 27,300 available bed days (32,487 total available bed days less 5,187 nursery bed days based on a cost reporting period with 273 calendar days). From this total, the Intermediary reduced the available bed count by 420 reported observation bed days. As a result, the Provider's bed size was determined to be 98 less than the 100 bed threshold requirement for DSH eligibility.

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. Moreover, as the bed is being used for another purpose, outpatient services, it cannot be argued that it may be immediately made available for inpatient use.

In addition, in contrast to the Board's conclusions, courts have rejected earlier attempts by providers to argue that 42 C.F.R. 412.105(b) is an all-inclusive list. Instead, 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.

Indeed, contrary to the Board's narrow reading of 412.105(b) and the manual as an all inclusive list, courts have found that the list is not confined to the literal terms of 412.105(b) in assessing its meaning. 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. The language of 42 CFR 412.105(b) with respect to neonatal intensive care beds was ambiguous and, thus, the Secretary's interpretation was entitled to deference.

Similarly, 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 shows such beds to be, inter alia, not paid as part of the hospital inpatient operating PPS payment. The observation beds at issue, which are being used for outpatient beds, are more like those beds located in the outpatient area.

The Administrator also notes that CMS has been consistent, as mandated by the regulation, in its policy for counting bed days in determining a provider's number of beds under 42 C.F.R. §412.105(b), whether for the indirect medical education adjustment or the DSH adjustment and have consistently excluded from that count bed days not paid under inpatient hospital PPS. The Secretary observed that:

> Our policy to include the costs, days and beds of neonatal intensive care units has been in place since prior to the prospective payment system and has been the subject of considerable attention. 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….[18]

The Board's reading is also inconsistent with the Congressional intent that the DSH payment be an additional payment for "subsection (d)" [IPPS] hospitals' higher Medicare "costs per case." The higher Medicare cost per cost necessarily reflects higher inpatient costs. Thus, CMS has reasonably used "inpatient hospital" bed days as the measure for the DSH adjustment. The Administrator finds that the Board's conclusion that the beds at issue are available for inpatient lodging is inconsistent with the fact that the beds were being used to maintain outpatients for the bed days at issue.

Finally, the Administrator disagrees with the Board's determination that the final rule published August 1, 2003, revising 42 C.F.R. §412.105 does not apply to the subject cost reporting periods at issue in this case.[19] The Administrator finds that the modification of 42 C.F.R. §412.105 does apply in this case because the modification only represents a clarification of CMS' longstanding policy of

[18] 59 Fed. Reg. 45374.
[19] 68 Fed. Reg. 45346 (August 1, 2003).

excluding outpatient observation bed days from the bed count for DSH determination. As the Secretary explained: "[O]ur consistent and longstanding policy, which … is based on the principle of counting beds in generally the same manner as the patient days and costs are counted. Our policy to exclude observation and swing bed days under the regulations at 412.105(b) … stems from this policy."[20]

In conclusion, the Administrator affirms the Intermediary's determination of the Provider's bed size as less than 100 beds.

[20] Id. at 45419 and 45668 ("We are revising our regulations to clarify that…observation bed days are to be excluded from the count of bed and patient days …[W]e do not anticipate this clarification would have a significant impact on payments.")

DECISION

The decision of the PRRB is reversed in accordance with the foregoing opinion.

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

Date: 9/01/09

/s/
Michelle Snyder
Acting Deputy Administrator
Centers for Medicare & Medicaid Services