CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Cleveland Regional Medical Center **Provider** **vs.** **Wisconsin Physician Service** **Intermediary**	**Reimbursement Determination For Cost Reporting Period Ending: October 31, 2001** **Review of:** **PRRB Dec. No. 2009-D33** **Dated: July 16, 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 parties were notified of the Administrator's intention to review the Board's decision. The Intermediary and CMS' Center for Medicare Management (CMM) commented, requesting reversal of the Board's decision. The Provider commented, requesting affirmation. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD DECISION

The issue is whether the Intermediary's adjustment of disproportionate share hospital (DSH) reimbursement, based on its determination that the Provider had less than 100 available beds for DSH eligibility purposes.

The Board, reversing the Intermediary's adjustment, concluded that the Provider's observation and swing 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 the rationale for inclusion of these days in the bed count is the

same as that in an earlier case, which was later affirmed by the Eastern District of Kentucky and the Sixth Circuit Court of Appeals.[1]

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, which the Board found requires 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 available "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 all the beds at issue, including the labor and delivery room beds, were acute care beds located in the inpatient area of the Provider's facility. Thus, the Board concluded that, based on statutory, regulatory and manual authorities and, the evidence presented, the Provider has shown that it had at least 114 beds permanently maintained and available for lodging inpatients during the cost year at issue.

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. 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." Accordingly, the Board determined that the Intermediary's determination of the number of available beds for DSH eligibility purposes was not proper.

Finally, the Board found that eleven of the 114 beds claimed by the Provider may have been established and maintained for outpatient day surgery. The Board noted

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[1] *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).

that there was disputed testimony regarding the use of these beds, and even if the eleven day surgery beds were eliminated from the bed count, the remaining 103 beds exceeded the regulatory threshold of 100 beds. The Board found that CMS policy is to include licensed beds unless evidence shows they must be excluded. Thus, the Board concluded that, due to the conflicting evidence, it will allow the eleven day surgery to remain in the bed count.

COMMENTS

The Intermediary commented, requesting that the Administrator reverse the decision of the Board. The Intermediary argued that the Board erred in allowing the eleven day surgery beds in the bed count. The Intermediary maintained that these beds were previously used as skilled nursing facility (SNF) beds and were located on the first floor of the hospital. In addition, during the cost year at issue, these beds were used for day surgery outpatient services. Citing to specific testimony, the Intermediary argued that the Provider has not met its burden to prove that these eleven beds were maintained for inpatient lodging.

Moreover, the Intermediary contended that the Provider's available bed count is less than 84. The Intermediary claimed that the Provider had a low inpatient utilization percentage. Thus, it would be unlikely that the provider could staff over 100 beds within 24-48 hours. In addition, the Intermediary noted that the Provider's available bed count appears to be a moving target as evidence from various exhibits in the record. Regardless, the Intermediary maintained that the Provider cannot claim more beds than is reflected on the cost report, or 104 beds, and that this figure should be reduced by the beds not maintained/staffed for inpatient lodging.

The Provider commented, requesting that the Administrator affirm the Board's decision.[2] With respect to the DSH bed count, the Provider argued that the Board's decision is correct and consistent with the plain language of the applicable regulations and manual provisions. The Provider, referring to testimony and

[2] The Provider also argued that the Board improperly denied jurisdiction over the bad debt issue, and requested Administrator's review of that denial. The Provider, pointing to its position paper for support, argued that the Board erred in its jurisdictional decision. The Administrator, however, hereby summarily affirms the Board's denial of jurisdiction over the bad debt issue. Assuming *arguendo*, one were to adopt the broadest reading of Board jurisdiction under Section 1878, the Board properly declined to use its discretion to exert jurisdiction over the bad debt issue. Likewise, under a stricter reading of section 1878, which the Administrator has adopted in the past, no Board jurisdiction is properly found.

exhibits in the record, maintained that the record supported the Board's finding that the Provider had 114 beds for DSH purposes. The Provider also pointed out that even if the skilled nursing day and observation days were removed from the bed count, the Provider would still have at least 106 beds for DSH purposes based on the number of beds in the Provider's facility.

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 or skilled nursing services, or are used for non-patient care purposes 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 CMS' longstanding policy is 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 area, 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 Intermediary properly excluded beds that were used for outpatient, skilled nursing swing and beds that were out of service or used for non-patient care. CMM noted that the record contained insufficient documentation indicating that that these beds could be put into service within 24 to 48 hours. Thus, the Provider should receive the DSH adjustment abed on a bed count of less than 100.

DISCUSSION

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

Pursuant to §1886(d)(5)(F)(i) 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…."[3] 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."[4] 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….[5]

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.[6] However, if the urban hospital has less than 100 beds, it

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[3] 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).
[4] H.R. Report No. 99-241 at 16 (1986); reprinted in 1896 U.C.C.A.N. 594
[5] Id.
[6] Supra n. 5.

must have a disproportionate patient percentage of 40 percent to be eligible for the DSH adjustment.[7] 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.[8]

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,[9] 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.
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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….

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[7] Id. Rural hospitals with more than 100 beds but less than 500 beds, must have a disproportionate patient percentage of 30 percent to be eligible for the DSH adjustment.

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

[9] Formerly 42 C.F.R. §412.118(b).

Relevant to this case is the determination of the number of beds. The regulation at 42 C.F.R. §412.105(b) (2000) 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 or bassinets assigned to newborn in the healthy newborn nursery, custodial care beds, and or beds in 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[10] 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.[11] The PRM states that:

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[10] 50 Fed. Reg. 35683.

[11] *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

> 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:

> 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, [12] which was originally used to establish bed-size categories

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observation services should be excluded from the count of available bed days for purposes of the IME and DSH adjustment….")

[12] 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

> for purposes of applying the cost limits under section 1861(v)(1)(A) of the Act…. The exclusion of newborn beds was consistent with the exclusion of newborn days and costs from the determination of Medicare's share of allowable routine services costs….
>
> In September 3, 1985 final rule, we added the definition of available beds to the regulations governing the IME adjustment (then 412.118(b)). The expressed purpose for the change was to stop counting beds "based upon the total number of available on the first day of the pertinent cost reporting period" and to begin counting based on "the number of available bed days (excluding beds assigned to newborns, custodial beds, and beds in excluded units) during the cost reporting period divided by the number of days in the cost reporting period (50 FR 35679). We did change the definition of available beds. Our current position regarding the treatment of these beds is unchanged from the time when cost limits established under section 1861(v)(1)(A) of the Act were in effect and is consistent with the way we treat beds in other hospital areas. 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.[13] (Emphasis added.)

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

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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.

[13] 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.)

"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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> 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.[14] (Emphasis added.)

[14] 53 Fed. Reg. 38480 (Sept. 30, 1988); See also 53 Fed. Reg. 9337 (March 22, 1988).

Thus, the 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.[15] The Administrator finds that, 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. 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 IPPS hospital's inpatient operating costs.

Beds at Issue

The beds in controversy involve beds used for outpatient surgery recovery;[16] beds in labor/delivery rooms;[17] bed days for observation,[18] and NF//SNF level swing bed days.[19] The record is inconsistent regarding the number of beds at the facility that has been claimed or reported. However, the Provider stated that it had erroneously claimed 104 beds on its cost report, as it failed to include the 11 newly decertified former SNF beds. However, the Provider, although pointing out the license shows 115 beds, only identifies at the most its basis for now claiming 114 beds.[20]

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[15] 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.)

[16] There are 11 beds on a First Floor unit and 19 beds in a Second Floor unit. There were also an additional three beds used for ancillary purposes such as doctor sleeping quarters and ancillary diagnostics.

[17] There are seven beds identified in the four labor/delivery rooms.

[18] The Intermediary identified 409 observation bed days (or 1.1 beds).

[19] The Intermediary identified 2, 528 skilled nursing swing beds (or 6.9 beds).

[20] The Provider does not clearly identify, either in floor plans or bed counting charts, an "115th" bed.

1. Day surgery beds

The exclusion of beds contended by the Intermediary to have been used for day surgery for the cost reporting period at issue are an 11 bed unit formerly certified as a SNF unit on the First Floor and the 19 bed unit located on the Second floor.[21] The record shows that the first floor 11 bed unit were used as outpatient day surgery beds.[22] The Intermediary pointed out that the Provider's witness conceded that the beds were not fully used, were only staffed during the daytime hours and most of the day surgery patients were moved up to the second floor.[23] The Provider also failed to present nursing contracts showing that the beds could be staffed within 24-48 hours. Because the Board found the evidence for the 11 bed unit was conflicting, the Provider submitted further clarification in its comments. In particular, the Provider pointed out that, although the Provider's witness testified that they were used for day surgery, the testimony was also that they were designed for the care of inpatients and could have been used to house inpatient if the need arose.[24] In addition, the Provider contended that this testimony was ratified by the Provider's Director of Engineering, who also conceded that the beds had, at times, been used for recovering outpatient surgery patients but also maintained that the beds could be ready to house inpatients within a few hours and that he had in fact observed the beds being used to house inpatients.[25]

The Provider also addressed the 19 bed unit, noting the change in the designation on the floor plan. The second floor 19 bed unit was also conceded by the Provider to be used for outpatient services.[26] The extent of the outpatient use was unknown as it was not documented. The Provider also again, while conceding the beds were at times used for outpatient surgery, pointed out that the beds were licensed and maintained for inpatient use and that the Board agreed that the Provider could staff the beds within 24-48 hours. The Provider stated that the Board clearly found that it had met the burden of proof that all of the beds at issue were maintained for inpatient lodging and capable of being returned to inpatient service within 24-48 hours.

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[21] Provider Exhibit P-13. Both floor plan sets show the 11 bed first floor unit (formerly the SNF unit) with the words “Day Surgery” crossed out and a handwritten “Med/Surg” designation. Of the two sets of floor plans, one set shows the second floor 19 bed unit designated as “Day Surgery”; the second set shows the words “Day Surgery” crossed out and a handwritten “Med/Surg 19” designation. Both sets show "Post Recovery 8 Beds" in the 19 bed unit.
[22] Transcript of Oral Hearing (Tr.) 73-75, 175-176, 219-220 and 230-232.
[23] Tr. 230-232.
[24] Tr. 155-56.
[25] Tr. 77.
[26] Tr. 75, 91 and 118.

The Administrator agrees that based on the foregoing, the evidence is conflicting as to whether these two units, the 11 bed First Floor unit and the 19 bed Second Floor unit were in fact capable of being made available for inpatient use within 24-48 hours. First, the manual guidance makes clear that, if a bed is being used for another non-inpatient purpose, it cannot be found to be an available inpatient bed. It would seem that there is a reasonable presumption that, under those circumstances, where the bed is being used for a non-inpatient use there is a need for that use and the bed cannot be simultaneously used for inpatient purposes. That situation is distinguished from where a provider has unused or temporarily closed wings where the ability to convert beds and rooms to inpatient use within 24-48 hour does not displace another use of the beds. While the Provider concedes these beds had been used for outpatient surgery recovery, the extent of that use is not documented. However, the contemporaneous designation of the units as "day surgery" and "post recovery beds" on the floor plans would suggest extensive and, for the most part, exclusion use for a non-inpatient purpose. In addition, even if one did treat these units as underused inpatient areas, instead of outpatient surgery recovery areas, there is a lack of evidence other than testimony, not corroborated by contracts, that would demonstrate that there was sufficient nursing staffing that could be made available within the 24-48 hour time period. These beds had no regular 24 hour staffing in place as they were beds otherwise used only during the daytime hours for outpatient surgery recovery.

Finally, the Administrator finds that the Board erroneously determined that the burden of proof was weighted on the exclusion of the beds, not the inclusion of the beds. This Board premise was based on the fact that, for purposes of the IME adjustment, a provider must carry the burden of proof to have beds excluded from the bed count, as the exclusion of beds will increase the IME payment. In this case, the opposite effect occurs as the inclusion of the beds will increase the Provider's DSH payment. Generally, in administrative proceedings, a provider must prove its case by a preponderance of the evidence for which an exception is not created here. Using that proof standard, the Provider did not demonstrate by a preponderance of the evidence that the beds designated as "day surgery" did in fact meet the criteria as "available beds"[27] and should be included in the bed count.

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[27] The Provider also identified two additional rooms (two beds) used for ancillary diagnostic services, which, based on the foregoing analysis, the Administrator finds should be should be excluded. An additional room (one bed) was used for physicians' sleeping quarters. As this use is more analogous to unused space/beds, in light of the absence of a contractual employment requirement for such physician sleeping space, the Administrator finds this one bed may be included. Because of

2. Labor/Delivery Room Beds

The Provider's floor plan[28] and the document labeled "Bed Count as of 11/26"[29], among others, shows four rooms with seven bed capacity. These rooms are designated as labor/delivery rooms in both the "11/26" bed count and the floor plans. The Administrator finds that as a result of litigation that occurred before IPPS was implemented, CMS has consistently treated labor/delivery rooms as ancillary areas and has, as reflected in §2405.3(G) of the PRM, consistently excluded such beds from the bed count.[30] Consequently the Provider has not proven by a preponderance of the evidence that these beds meet the definition of "available bed" and should be included in the bed count.

3. Observation Beds and Swing Beds

The intermediary identified 409 observation bed days and 2,528 swing bed day for approximately 8 beds identified as being used for non-inpatient purposes and, in particular, being used for outpatient services and SNF services. 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 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…."[31] In addition, 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. However, 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.[32]

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the limited number of beds (one), the room also would not give raise to the same concerns regarding nursing staff coverage.

[28] Provider's Exhibit P-13.

[29] Provider Exhibit P-12.

[30] The evidence also does not support a finding that these beds are in fact specifically designated as "labor delivery postpartum beds", that is, beds in which the mother is intended to stay postpartum and also do not give the appearance of such suites in the photographs.

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

[32] Section 230.6.B of the Hospital Manual.. The payment of observation bed days as outpatient services is consistent with §230.6 of the Hospital Manual, which

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.[33] This is done by the counting of observation bed days. The bed days are needed to calculate the costs of observation bed days since it cannot be separately costed when the patient is located in the routine patient population.[34] CMS specifically addressed observation bed days in a 1997 Memorandum to the CMS Regional Offices[35] 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."

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provides that: "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…. A. Coverage of Outpatient Observation Services. - Generally, a person is considered a hospital inpatient if formally admitted as an inpatient with the expectation that he or she will remain at least over night … When a hospital places a patient under observation, but has not formally admitted him or her as inpatient, the patient initially is treated as an outpatient …." [Emphasis added.] Consistent with the payment of these services as outpatient services, §3605 of the PRM-Part II explains that the costs of observation bed patients are to be carved out of the inpatient hospital costs. Line 26 of §3605.1 explains, "observation bed days only need to be computed if the observation bed patients are placed in a routine patient care area. The bed days are needed to calculate the costs of observation bed days since it cannot be separately costed when the routine patient care area is used. If, however, you have a distinct observation area, it must be separately costed (as are all other outpatient cost centers), and this computation is not needed." Consequently, consistent with the treatment under earlier reasonable cost methodology, the observation bed days are not recognized and paid under inpatient hospital PPS as part of a hospital's inpatient operating costs.

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

[34] Section 3605.1, line 26.

[35] *See* CMS 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."

In addition, certain hospitals are allowed to use inpatient beds for skilled nursing services.[36] Generally, acute level inpatient hospital care and skilled nursing level care are provided in distinct and separate parts of a facility. However, the Secretary recognized that maintaining separate facilities for different types of care was particularly difficult for small rural hospitals with the limited resources. Thus, the original swing bed hospital provisions were put into place to allow rural hospitals with less than 100 beds to use their inpatient acute care beds for services of the type that would be provided at a skilled nursing facility. Hence, the term "swing bed."

The swing bed provisions were enacted for smaller hospitals with more limited resources in lieu of the requirement for distinct part SNF to allow the hospital to use the swing beds in the same capacity as a distinct part SNF unit. Notably in this case, the hospital had recently been decertified for a SNF unit and instead offered the same service in essence in the form of swing bed availability. If a patient is admitted to a swing bed hospital as an inpatient requiring a hospital level of care and subsequently requires a reduced level of care at a SNF or NF (custodial care) level, the situation is treated as a discharge from the hospital and an admission to a SNF or ICF (or NF). This occurs despite the fact that the change in the level of care may not involve a physical move of the patient. The day on which the patient begins to receive a lower level of care is considered to be the day of discharge from the hospital and the day of admission to a SNF or ICF (or NF) bed.[37] The swing-bed hospital provisions reflect that these swing bed days are not recognized as inpatient operating costs of an IPPS hospital.[38] Payment to these hospitals for post-hospital SNF care furnished in general routine inpatient beds are based on the reasonable cost of post hospital SNF care.[39] Hospitals and distinct part hospital units excluded from IPPS and paid on a reasonable cost or other basis include routine SNF-level services furnished in swing beds.[40] Thus, the swing bed days are not recognized under IPPS as inpatient operating costs of the hospital.

While the Secretary had stated the underlying principle for counting bed days under the DSH and IME provision, the Secretary first specifically discussed observation and swing bed days in the final rule for the FFY 2004 IPPS rates in

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[36] *See District Memorial Hospital of Southwest North Carolina v. Thompson*, 346 F.2d 513 (2004) and Administrator's Decision, *District Memorial Hospital of Southwestern North Carolina*, PRRB Dec. No. 2001-D37. (August 27, 2001) pp 7-8 for a general discussion of the swing bed provisions.

[37] Section 2230.2 of the PRM.

[38] 42 CFR 413.114; 42 CFR 482.66

[39] 42 CFR 413.114(a).

[40] Section 415.B of the Hospital Manual

response to an adverse Court of Appeals case.[41] 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 this 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. 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 and swing 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.[42]

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

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[41] 68 Fed Reg. 45346, 45418-45419 (Aug 1, 2003)

[42] 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." Similarly, the regulation at 42 CFR 412.106(a)(1)(ii) was clarified, inter alia, to state read, that: "(ii) For purposes of this section, the number of patient days in a hospital includes only those days attributable to units or wards of the hospital providing acute care services generally payable under the prospective payment system and excludes patient days associated with—…. (B) Beds otherwise countable under this section used for outpatient observation services, skilled nursing swing bed services; or ancillary labor /delivery services…." See 68 Fed. Reg. 45470 (2003).

regulatory language. The word "areas" 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.[43]

Finally, the Secretary again restated his longstanding policy of excluding observation bed days and swing bed days from the available bed day count for DSH purposes in the final rule for the FFY 2005 IPPS rates.[44] 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 and swing-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.[45] Applicable to both observation bed days and swing bed days, 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

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[43] *District Memorial Hospital of Southwest North Carolina v. Thompson*, 346 F.2d 513, 519-520 (2004).

[44] 69 Fed. Reg. 48916, 49096-49097 (Aug. 11, 2004).

[45] 69 Fed. Reg. 49097, 49245, 49246. The regulation at 42 CFR 412.106(a)(1)(ii) was clarified, inter alia, to state that: "(B) 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." 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, 49246 (2004).

> available.) This same policy applies to any bed days the bed is used to provide SNF level care. The 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.[46]

In this particular case, the Provider contended that observation beds and swing beds should be included in the bed count for purposes of determining DSH eligibility because the beds are licensed acute care beds located in the acute care area of the hospital and maintained for inpatient lodging. However, 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. 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 or swing bed NF/SNF patients sometimes occupied the beds at issue. In addition, the Administrator finds that a patient in an observation bed has not been admitted into the hospital and a swing bed NF/SNF patient is not a hospital inpatient.

Thus, applying the relevant law and program policy to the foregoing facts, the Administrator finds that the Intermediary properly excluded observation bed days and swing 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 IPPS as an inpatient operating cost. Observation bed days are not recognized under IPPS 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. Likewise, a swing bed day is occupied by a patient who is not a hospital inpatient on that day and thus the bed is being used for other than non-inpatient lodging and is not available for inpatient lodging on the days that it is being utilized for another purpose.

As earlier noted by the Secretary, the 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

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[46] 69 Fed Reg. 49096-49097. *See also* 68 Fed. Reg. 45418-45419.

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 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 bed days at issue, which are being used for outpatient beds, are more like those beds located in the outpatient area, just as the swing bed days are in lieu of, and in this case replaced, a distinct part SNF unit.

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….[47]

[47] 59 Fed. Reg. 45374.

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 finds that the final rule published August 1, 2003, revising 42 C.F.R. §412.105 can be applied to the subject cost reporting periods at issue in this case.[48] The Administrator finds that the modification of 42 C.F.R. § 412.105 only represents a clarification of CMS' longstanding policy of excluding outpatient observation bed days from the bed count for DSH determination. As the Secretary explained: "[O]ur consistent and longstanding policy,…. 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."[49]

Summary

In sum, the Administrator finds that it is improper to include the 11 beds in the First Floor unit; the 19 beds in the Second Floor unit; the seven beds in the labor delivery rooms, the two beds in the ancillary diagnostic rooms, the 1.1 observation beds and the 6.9 swing beds. Thus the Provider fails to meet the 100 bed threshold for purposes of the DSH adjustment.[50]

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[48] 68 Fed. Reg. 45346 (August 1, 2003).

[49] 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.")

[50] In addition,, as the cost reporting period crosses April 1, 2001, the DSH adjustment will be limited to five percent of the DRG for discharges prior to April 1, 2001, and the DSH adjustment will be limited to 5.25 percent of the DRG for discharges on or after April 1, 2001.

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: 9/21/09

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