PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
2001-D37

PROVIDER -
District Memorial Hospital of
Southwestern North Carolina, Inc.
Andrews, NC

Provider No. 34-0054

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Blue Cross and Blue Shield of
North Carolina

DATE OF HEARING-
May 3, 2001

Cost Reporting Periods Ended -
September 30, 1991 -
September 30, 1997

CASE NOS. 94-2298, 95-1213, 96-0132, 96-2235, 98-0023, 99-0057, 98-2943

INDEX

ISSUE:

Was the Intermediary's adjustment to the disproportionate share amount proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

District Memorial Hospital of Southwestern North Carolina, Inc. ("Provider") is a rural acute care facility located in Andrews, North Carolina. During each of its seven cost reporting periods ended September 30, 1991 through September 30, 1997, the Provider claimed a disproportionate share hospital ("DSH") adjustment to its Prospective Payment System ("PPS") payments. The Provider determined the amount of each adjustment by including swing bed patient days in the DSH calculation formula found at 42 U.S.C. § 1395ww(d)(5)(F)(vi). Blue Cross and Blue Shield of North Carolina ("Intermediary") reviewed the Provider's cost reports and effectuated adjustments removing the swing bed patient days from the Provider's determinations. As a result, the Provider was found not to be eligible for the DSH adjustments.

The Intermediary reflected its adjustments in a Notice of Program Reimbursement pertinent to each reporting period. The Provider appealed these adjustments to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835.-1841, and met the jurisdictional requirements of those regulations. The amount of program funds in controversy is approximately $615,600 in total for all seven periods.[1]

The Provider was represented by Maureen Demarest Murray, Esq., of Smith Helms Mulliss & Moore, L.L.P. The Intermediary was represented by Eileen Bradley, Esq., Associate Counsel, Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the pertinent statute authorizes the inclusion of swing bed days in the calculation of the DSH adjustment. The Provider cites 42 U.S.C. § 1395ww(d)(5)(F)(vi), which states:[2]

> [i]n this subparagraph, the term "disproportionate patient

---

1 See Appendix for details of each individual cost reporting period.

2 Provider's Consolidated Final Position Paper at 5.

> percentage" means, with respect to a cost reporting period of a hospital, the sum of
>
> (I) the fraction. . . [the SSI percentage]
> (II) the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consisted of patients who (for such days) were eligible for medical assistance under a State plan approved under title XIX, but who were not entitled to benefits under part A of this title, and the denominator of which is the total number of the hospital's patient days for such period.

42 U.S.C. § 1395ww(d)(5)(F)(vi).

Notably, this statutory language does not contain any restriction concerning which Medicaid days, or what level of care is provided, for purposes and including those days in the DSH calculation. Rather, the statute states that all of a provider's Title XIX days are to be divided by total patient days. There is no language authorizing exclusion of swing bed days from the DSH calculation.

The Provider contends that the pertinent DSH regulations support including swing bed days in the DSH calculation. The Provider cites 42 C.F.R. § 412.106(a) which states in part:

> (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.
>
> (ii) The number of patient days includes only those days attributed to areas of the hospital subject to the prospective payment system and excludes all others.

42 C.F.R. § 412.106(a).

The Provider asserts that according to these regulations, Medicaid patient days should only be excluded from the DSH calculation when such patients are treated in an area of the hospital that is exempt from PPS. Moreover, swing beds are not certified by Medicare as a distinct skilled nursing unit nor otherwise exempt from PPS. Therefore, swing bed days should be counted for purposes of the DSH adjustment.

The Provider contends that the statutory and regulatory provisions concerning swing beds are also consistent with the inclusion of swing bed days in the DSH calculation. The Provider explains that 42 U.S.C. § 1395tt provides that if the appropriate requirements are satisfied, inpatient hospital facilities may be used to furnish services of a type which, if furnished by a skilled nursing facility, would constitute extended care services. These services are characterized as post-hospital extended care services. The post-hospital services are furnished in

general routine inpatient beds and are reimbursed based upon an average reasonable cost per patient day. See also 42 C.F.R. § 413.114(a) and 42 C.F.R. §§ 409.20 and 482.66. Accordingly, the Provider notes that swing beds remain inpatient beds that are not exempt from PPS. Nothing in the statutory or regulatory swing bed provisions suggest that costs or days associated with swing beds should be separated out for purposes of the DSH calculation.

The Provider contends that the Health Care Financing Administration ("HCFA") has indicated that Medicaid swing bed days should be included in the DSH calculation. Specifically, in a letter dated December 17, 1992, the Chief of the Audit Review Section of the Division of Medicare, HCFA, Region IX states in pertinent part:

> [i]n summary, a provider's disproportionate patient percentage is the sum of the following ratios:
>
> ·[The SSI percentage]
>
> ·The number of patient days during the hospital's cost reporting period of those patients who are entitled to Medicaid but not to Medicare Part A, divided by the total number of patient days in that same period. [The Medicaid percentage].
>
> Per 42 C.F.R. § 412.106(a)(1)(ii), for the purpose of computing the above ratios, patient days are determined by counting those days attributable only to the areas of the hospital subject to the prospective payment system (PPS). Patient days attributable to areas or units of the hospital excluded from the PPS are not included in the count of patient days. . . . As for the days associated with the swing beds (where either sub-acute or skilled nursing services are furnished), the provider needs to include the patient days associated with sub-acute services.

HCFA Letter, December 17, 1992.[3]

The Provider contends that the Board's reasoning in Memorial Hospital of Gardena v. Blue Cross of California, PRRB Dec. No. 98-D91, September 11, 1998, Medicare and Medicaid Guide (CCH) ¶ 80,069, rev'd. HCFA Administrator, November 10, 1998, Medicare and Medicaid Guide (CCH) ¶ 80,122, ("Memorial Hospital") and Alhambra Hospital v. Blue Cross

[3] Exhibit P-16.

of California, PRRB Dec. No. 98-D85, August 28, 1998, Medicare and Medicaid Guide (CCH) ¶ 80,050, rev'd. HCFA Administrator, October 14, 1998, Medicare and Medicaid Guide (CCH) ¶ 80,123, ("Alhambra Hospital") equally applies to care provided in swing beds. The Provider explains that in Memorial Hospital and Alhambra Hospital the Board concluded that subacute care patient days should have been included in the DSH calculation. The Board reasoned that the subacute care patient days were provided in general acute care beds and not in a PPS exempt unit. Likewise, the Provider argues that it furnished care in general acute care beds, swing beds, that were not in a PPS exempt unit. Moreover, no statutory or regulatory language mandated exclusion of the patient days in either Memorial Hospital, Alhambra Hospital or the instant case.

The Provider contends that the Administrator's decision to reverse the Board in Memorial Hospital and Alhambra Hospital was in error. However, the Provider also asserts that applying the Administrator's decision to the instant case would still result in its swing beds being included in the calculation of the subject DSH adjustments. In contrast to Memorial Hospital and Alhambra Hospital, the Provider's swing beds were licensed in the State of North Carolina as general acute care beds and were attributable to the area of the hospital that is subject to PPS.[4] The Provider's swing beds were also part of the general acute care hospital and not a separately certified or distinct unit. Also, the Provider's swing bed days are shown on its cost report in the inpatient PPS column and not in a SNF column since they were not in a separately certified unit. According to the Administrator's decisions, what is significant is whether the patients received care in the inpatient setting of the hospital and not the type or characteristics of the care provided.

The Provider contends that including swing bed days in the DSH calculation fulfills the purposes of both the DSH and swing bed provisions. The DSH adjustment is designed to help alleviate the unequal burden of indigent care borne by some hospitals: "[Congress' overarching goal was to reimburse hospitals for the added expense of serving low-income patients." Legacy Emanuel Hospital & Health Center v. Shalala, 97 F.3d 1261, 1266 (9th Cir. 1996) ("Legacy Emanual").[5] Congress created the DSH adjustment to: "ensure the continued operation of these [PPS] facilities for the benefit of those persons who have no health care alternative." Jewish Hospital v. Secretary of Health and Human Services, 19 F.3d 270, 275 (6th Cir. 1994) ("Jewish Hospital").[6]

---

4 Exhibit P-1.

5 Exhibit P-21.

6 Exhibit P-22.

The purpose of swing beds is to allow small rural hospitals the flexibility to meet patient needs whether for acute, subacute, or nursing services. Both provisions exist to enable a hospital to serve the needs of its diverse and indigent population. To accomplish these purposes and safeguard the economic viability of small, rural hospitals, a hospital's swing bed days should be included in the DSH calculation. Such an interpretation is consistent with Congress' goals and with the court's interpretation of the calculation of DSH adjustments. See Legacy Emanuel, 97 F.3d 1261 and Jewish Hospital, 19 F.3d 270 (expanding the calculation of patient days to include not only those for patients entitled to Medicaid but those for patients eligible for Medicaid).

The Provider contends that in other cases analogous to the instant case the Board has taken the position that when determining whether a particular patient day should be included or excluded from the DSH adjustment calculation, the decision should be one of inclusion rather than exclusion. The Provider asserts that in both St. Mary's Hospital v. Empire Blue Cross and Blue Shield, PRRB Dec. No. 99-D6, November 17, 1998, Medicare and Medicaid Guide (CCH) ¶ 80,144, decl'd rev. HCFA Administrator, December 15, 1998 ("St. Mary's") and Jersey Shore Medical Center, Neptune v. Blue Cross and Blue Shield of New Jersey, PRRB Dec. No. 99-D4, August 26, 1998, Medicare and Medicaid Guide (CCH) ¶ 80,083, rem'd. HCFA Administrator, January 4, 1999 ("Jersey Shore") the Board held that the intermediary had improperly limited the number of Medicaid days to be considered in the hospitals' DSH adjustments. In St. Mary's the intermediary erred by counting only those days for which the hospital actually received payment from Medicaid rather than those days where patients were eligible to receive Medicaid payments.
The Board noted that HCFA had in fact changed its interpretation of the statutory and regulatory provisions concerning DSH adjustments to include all patients days for patients eligible for Medicaid without regard to whether the hospital actually received payment for those days. In Jersey Shore the Board found that a hospital was entitled to include in its DSH calculation the outlier days of service furnished by the hospital to dual-eligible patients after their Medicare Part A benefits had been exhausted and they were eligible for reimbursement under the State's Medicaid plan. The Board also found that days of service rendered to patients through New Jersey's Charity Care Program should be included in the computation of patient days for the purpose of calculating the DSH adjustment. Just as patient days were considered and included in these cases, the Provider's patient days that were not in a PPS exempt unit should be included in the DSH calculation.

The Provider acknowledges the Intermediary's argument that swing beds should not be included in the DSH determination because they are not paid under PPS. The Provider disagrees with this argument for the following three reasons.[7]

[7] Provider's Response to Intermediary's Consolidated Position Paper at 3.

First, the Provider asserts that no regulation or guideline articulates the Intermediary's position. The regulations have defined the term "bed" for DSH purposes. According to 42 C.F.R. § 412.106, the number of beds for DSH purposes is determined in accordance with 42 C.F.R. § 412.105(b) which governs the indirect costs of graduate medical education. This regulation states in part: "the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period." 42 C.F.R. § 412.105(b).

These rules specifically exclude many types of beds from the bed count but no where does it exclude swing beds. The regulations particularly exclude healthy newborn beds, custodial care beds and beds in excluded distinct part hospital units. Swing beds are clearly absent from this list of excluded beds. The language of the regulations explicitly state that: "beds in excluded distinct part hospital units" are excluded from the count. 42 C.F.R. § 412.105(b). This means that beds in nondistinct units, such as the swing beds at issue, are included even if used temporarily and paid on given days as a non-PPS service. The plain language of the regulations should be given effect, and HCFA should not be permitted to supply interpretative language that does not exist in the regulations. Jewish Hospital, 19 F.3d 270 (1994).

Also, in an effort to clarify how the number of beds would be determined, HCFA promulgated instructions in the Provider Reimbursement Manual, Part I ("HCFA Pub. 15-1") § 2405.3.G, which defines a bed as:[8]

> Bed size. A bed is defined for this purpose as an adult or pediatric bed (exclusive of beds assigned to newborns which are not in 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 area(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 residencies, and other such areas as are regularly maintained and utilized for only a portion of the stay of patients or for purposes other than inpatient lodging.
>
> To be considered an available bed, a bed must be permanently maintained for lodging inpatients. It must be available for use and

[8] Exhibit P-30.

> housed in patient rooms or wards (i.e., not in corridors or temporary beds). Thus, beds in a completely or partially closed wing of the facility are considered available only if the hospital put the beds into use when they are needed. The term "available beds" 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 the absence of evidence to the contrary, beds available at any time during the cost reporting period are presumed to be available during the entire cost reporting period. The hospital bears the burden of proof to exclude beds from the count.

HCFA Pub. 15-1 § 2405.3.G.

Notably, HCFA's manual exhaustively lists the beds excluded from the bed count. The guideline leaves little doubt that only the beds on the list are excluded by stating: "beds in the following locations are excluded from the definition." HCFA Pub. 15-1 § 2405.3.G. There is no indication that other beds, not included on the list, may be excluded. This is not a general "catch-all" provision. The guideline specifically states what beds are excluded. Therefore, because the list specifically excludes certain beds and not others, under the legal principle of ejusdem generis the listing of items in this manner restricts the class to those specifically listed. Grammatico v. United States, 109 F.3d 1198 (1997).[9]

The Provider also notes that an example of how to count beds is provided at HCFA Pub. 15-1 § 2405.3.G. The example explains that beds used for long term care but not certified as such are included in the bed count. Specifically, the manual states:"[a]lthough 35 beds are used for long term care, they are considered to be acute care beds unless otherwise certified." Id. Respectively, the Provider explains that it was licensed for 60 to 61 acute care beds. During the subject periods, however, it staffed and operated only 49 or less beds. These beds were certified by HCFA for Medicare purposes as part of the general acute care hospital. All of the beds, therefore, were certified for acute care and maintained in the acute care area of the hospital.

The Provider asserts that the example provided in the manual is directly on point. Beds used for another purpose (e.g. long term care) but licensed or certified for acute care are counted as acute care beds. Swing beds are simply beds temporarily used for long term care type services but still certified for acute care services. The use of these beds for long term care is irrelevant. As the

[9] Exhibit P-3 1.

example plainly demonstrates, the beds are included in the count for disproportionate share purposes based upon their certification as acute care beds.

Also, in several cases the Secretary of Health and Human Services ("Secretary") has treated the provisions of HCFA Pub. 15-1 § 2405.3.G as binding statements of policy and used the provisions as a basis to justify decreasing reimbursement to the hospitals involved. Therefore, the Intermediary in these consolidated cases should not be allowed to now ignore established policy by setting forth the method for counting beds. See Sacred Heart Medical Center v. Blue Cross of Washington, HCFA Administrator Decision, December 21, 1998, Medicare and Medicaid Guide (CCH) ¶ 80,154; Baystate Medical Center v. Aetna Life Insurance Company, HCFA Administrator Decision, November 1, 1996, Medicare and Medicaid Guide (CCH) ¶ 44, 979; St. Joseph Hospital v. Mutual of Omaha, HCFA Administrator Decision, June 20, 1994, Medicare and Medicaid Guide (CCH) ¶ 42,559; and, Sioux Valley Hospital v. Blue Cross and Blue Shield Association, HCFA Administrator Decision, October 16, 1992, Medicare and Medicaid Guide (CCH) ¶ 41,044.

The Provider maintains, in all, that the relevant guideline and regulation are both clear that a bed is counted so long as it is merely available for inpatient care, and that its swing beds were clearly available. Under its agreement with HCFA, the Provider is eligible to "swing" any of its acute care beds between inpatient and nursing services as needed. The purpose of swing beds is to be able to utilize them for long term care when needed but to be able to immediately swing them back to inpatient services as the need arises. Therefore, all of the patient days in the swing beds should be counted for DSH purposes regardless of whether those patient days were for acute care or for long term care.

The second reason the Provider disagrees with the Intermediary's argument that only days paid under PPS are to be included in the DSH calculation is because that is not a requirement of the pertinent regulations. Specifically, the language at 42 C.F.R. § 412.105(b) does not reference PPS payments. Rather, the regulation states:

> (b) Determination of number of beds. For purposes of this section, the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period, not including beds or bassinets in the healthy newborn nursery, custodial care beds, or beds in excluded, distinct part hospital units, and dividing that number by the number of days in the cost reporting period.

42 C.F.R. § 412.105(b).

The Provider asserts that DSH adjustments are payments to hospitals for the additional costs associated with treating a disproportionate share of low income patients. There is no connection between PPS services and the basis for DSH payment. This is reflected by the fact that the DSH

calculation includes counting indigent patients who have no connection to PPS. 42 C.F.R § 412.106(b)(2)(i)(B). A key element of the DSH calculation involves counting patients treated by the hospital, as inpatients, who were not eligible for payment under Medicare's PPS. 42 C.F.R § 412.106(b)(4).

In addition, the applicable interpretive guideline at HCFA Pub. 15-1 § 2405.3.G does not offer any support for the Intermediary's argument that only patient days reimbursed under PPS can be counted for the DSH adjustment. The guideline only mentions PPS in its statement that "PPS excluded units such as psychiatric or rehabilitation units" are excluded from the count. HCFA Pub. 15-1 § 2405.3.G. Therefore, the proposition that swing beds are excluded from the bed count is completely undermined as the guideline explicitly states that only beds in units excluded from PPS fall within the exclusion. This emphasis on the unit as the basis for including or excluding a bed from the count is consistent with HCFA's Federal Register notice stating that its "policies have consistently followed the general principle that we do not attribute cost or days to individual beds, but rather to units or departments." 60 Fed. Reg. 45777 at 45811.[10]

The Provider also asserts that in the past HCFA has not counted beds based upon PPS services. Under HCFA's current interpretation, a bed licensed for acute care that sits empty all year and for which no PPS reimbursement is received must be included from the bed count when calculating the DSH adjustment. This HCFA interpretation is inconsistent with the Intermediary's position that a bed day should only be included in the bed count when the costs of that inpatient day have been reimbursed as an inpatient service under PPS. If PPS services were truly the determining factor, then actual inpatient days (days in which the beds were actually occupied by inpatients and paid under PPS) would be the appropriate measure. This has not been the case.

Finally, the Provider disagrees with the Intermediary's argument that only days paid under PPS are to be included in the DSH calculation because including swing bed days in the calculation is consistent with statutory intent.

The Provider asserts that given the reference to "beds" in the DSH statute, Congress intended the word "bed" to have its common meaning and encompass all licensed acute care beds. 42 U.S.C. § 1395ww(d)(5)(F)(vi). If Congress had intended otherwise, it would have used different language. Regulations at 42 C.F.R § 412.105 and 42 C.F.R. § 412.106, as interpreted by the Intermediary, are invalid if they run counter to the clear intent of Congress to include all licensed acute care beds for DSH eligibility purposes. Also, HCFA Pub. 15-1 § 2405.3.G is invalid to the extent it contradicts Congress' purpose. The Board's interpretation of the regulations and manual instructions must have a foundation in 42 U.S.C. § 1395ww. Interpreting these

---

[10] Exhibit P-36.

provisions to include swing beds in the bed count is in harmony with the statute and avoids the invalidation. The Provider's licensed acute care beds were permanently maintained for lodging inpatients and their use for skilled nursing does not change their character. Nothing in the DSH statute suggests or permits diminution of the Provider's bed count if beds are used for swing bed purposes. Surely, this was a use that was known to Congress when it enacted the DSH legislation.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider, for each of the subject cost reporting periods, was not eligible for a DSH adjustment pursuant to the relevant statutory, regulatory and program instruction authorities.[11] The Intermediary contends that for purposes of calculating a hospital's DSH adjustment, days attributable to swing beds should not be considered. The Intermediary asserts that only days reimbursed under PPS should be included in the computation detailed at 42 C.F.R § 412.106(b).

The Intermediary asserts that 42 U.S.C. § 1395ww(d)(5)(F)(1) directed the Secretary to provide for an additional payment for each subsection (d) hospital serving a significantly disproportionate number of low-income patients. Subsection (d) clearly refers to hospitals that are to be reimbursed for inpatient operating costs under PPS.

With respect to the DSH calculation, regulations at 42 C.F.R § 412.106 state:

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

42 C.F.R § 412.106 (emphasis added).

The Intermediary maintains that hospitals subject to PPS have their inpatient hospital services

---

[11] Intermediary Position Paper at 3.

paid pursuant to a set Federal rate per discharge. Generally, this rate reflects a national average which, under usual circumstances, is not adjusted to account for particular hospital costs. Congress implemented DSH to recognize that some hospitals providing services to a significant number of low-income patients incur costs that are not reflected in the Federal rate. Therefore, the Intermediary concludes that this additional payment for inpatient operating costs should only be applied to inpatient hospital services reimbursed under PPS.

The Intermediary also contends that Medicare regulations governing swing beds, 42 C.F.R § 413.114 and 42 C.F.R § 482.66, also reflect that swing bed days are not recognized as inpatient operating costs of a PPS hospital. In part, 42 C.F.R § 413.114 states:

> [p]ayments to these hospitals for posthospital SNF care furnished in routine inpatient beds are based on the reasonable costs of posthospital SNF care . . .

42 C.F.R § 413.114. See also 42 C.F.R § 440.10.

The Intermediary also relies upon HCFA Pub. 15-1 § 2230.2 to support its position. In part, the manual states:

> [u]nder the swing-bed reimbursement method, a patient may be admitted to a swing-bed hospital as an inpatient requiring a hospital level of care and subsequently require a reduced level of care at the SNF or NF level (or before October 1, 1990, care at the SNF or ICF level). When a patient's level of care is reduced, the situation is treated as a discharge from the hospital and an admission to a SNF, ICF (or NF) bed, even though the change in level of care may not involve a physical move of the patient. The day on which a 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.

HCFA Pub. 15-1 § 2230.2.

The Intermediary notes that the definitions at HCFA Pub. 15-1 § 2230.3 specifically exclude services furnished in swing beds as general routine hospital services.

The Intermediary also relies upon the HCFA Administrator's decision in Commonwealth of Kentucky 92-96 DSH Group v. Blue Cross and Blue Shield Association/AdiminaStar Federal, PRRB Dec. No. 99-D66, September 2, 1999, Medicare and Medicaid Guide (CCH) ¶ 80,332, rev'd., HCFA Administrator, November 8, 1999, Medicare and Medicaid Guide (CCH) ¶ 80,389

("Commonwealth of Kentucky "). In that decision the Administrator states:

> [s]ection 415.B of the Hospital Manual explains that hospitals and distinct part units excluded from PPS and paid on a reasonable cost or other basis include routine SNF-level services furnished in swing beds. Thus the swing bed days at issue were not recognized under PPS as inpatient operating costs of the hospitals.

HCFA Administrator Decision, November 8, 1999.

Moreover, the Administrator found:

> SNF swing bed days and observation bed days are not reimbursed as part of the inpatient PPS payment. . . . Such a finding is not inconsistent with the Congressional intent that the DSH payment is an additional payment for "subsection (d)" hospitals, i.e., PPS hospitals.

Id.

The Intermediary concludes that the swing bed days in contention are not recognized under PPS as inpatient operating costs of the Provider and as such cannot be included in the calculation of the Provider's DSH calculation.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - 42 U.S.C.:

§ 1395ww(d)(5)(F) et seq.	-	PPS Transition Period; DRG Classification System; Exceptions and Adjustments to PPS [Disproportio

nate Share Adjust ment]

§ 1395tt	-	Hospital Providers of Extended Care Services

2. Regulations - 42 C.F.R.:

§§ 405.1835.-1841	-	Board Jurisdiction
§ 409.20	-	Coverage of Services
§ 412.105(b)	-	Determination of Number of Beds
§ 412.106 et seq.	-	Special Treatment: Hospitals that Serve a Disproportionate Share of Low-Income Patients
§ 413.114 et seq.	-	Payment for Posthospital SNF Care Furnished by a Swing-Bed Hospital
§ 440.10	-	Inpatient Hospital Services, Other Than in an Institution for Mental Diseases
§ 482.66	-	Special Requirements for Hospital Providers of Long-Term Care Services ("Swing-Beds")

3. Program Instructions-Provider Reimbursement Manual, Part I (HCFA Pub. 15-1):

§ 2230.2	-	Patient Days for Purposes of Swing-Bed Reimbursement
§ 2230.3	-	Definitions

§ 2405.3.G et seq. - Bed Size

4. Case Law:

Memorial Hospital of Gardena v. Blue Cross of California, PRRB Dec. No. 98-D91, September 11, 1998, Medicare and Medicaid Guide (CCH) ¶ 80,069, rev'd. HCFA Administrator, November 10, 1998, Medicare and Medicaid Guide (CCH) ¶ 80,122.

Alhambra Hospital v. Blue Cross of California, PRRB Dec. No. 98-D85, August 28, 1998, Medicare and Medicaid Guide (CCH) ¶ 80,050, rev'd. HCFA Administrator, October 14, 1998, Medicare and Medicaid Guide (CCH) ¶ 80,123.

Legacy Emanuel Hospital & Health Center v. Shalala, 97 F.3d 1261 (9th Cir. 1996).

Jewish Hospital v. Secretary of Health and Human Services, 19 F.3d 270 (6th Cir. 1994).

St. Mary's Hospital v. Empire Blue Cross and Blue Shield, PRRB Dec. No. 99-D6, November 17, 1998, Medicare and Medicaid Guide (CCH) ¶ 80,144, decl'd rev. HCFA Administrator, December 15, 1998.

Jersey Shore Medical Center, Neptune v. Blue Cross and Blue Shield of New Jersey, PRRB Dec. No. 99-D4, August 26, 1998, Medicare and Medicaid Guide (CCH) ¶ 80,083, rem'd. HCFA Administrator, January 4, 1999.

Grammatico v. United States, 109 F.3d 1198 (1997).

Sacred Heart Medical Center v. Blue Cross of Washington, HCFA Administrator Decision, December 21, 1998, Medicare and Medicaid Guide (CCH) ¶ 80,154.

Baystate Medical Center v. Aetna Life Insurance Company, HCFA Administrator Decision, November 1, 1996, Medicare and Medicaid Guide (CCH) ¶ 44, 979.

St. Joseph Hospital v. Mutual of Omaha, HCFA Administrator Decision, June 20, 1994, Medicare and Medicaid Guide (CCH) ¶ 42,559.

Sioux Valley Hospital v. Blue Cross and Blue Shield Association, HCFA Administrator Decision, October 16, 1992, Medicare and Medicaid Guide (CCH) ¶ 41,044.

Commonwealth of Kentucky 92-96 DSH Group v. Blue Cross and Blue Shield Association/AdminaStar Federal, PRRB Dec. No. 99-D66, September 2, 1999, Medicare and Medicaid Guide (CCH) ¶ 80,332 rev'd. HCFA Administrator, November 8, 1999,

Medicare and Medicaid Guide (CCH) ¶ 80,389 rev'd. Clark Regional Medical Center, et al., v. Shalala, Civil Action No. 99-465, 2001 U.S. Dist. Lexis 4658 (E.D. Ky, March 30, 2001).

5. Other:

HCFA Letter, December 17, 1992.

60 Fed. Reg. 45777 (September 1, 1995).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, and evidence presented, finds and concludes as follows:

The Intermediary effected cost report adjustments excluding swing bed patient days from the determination of the Provider's DSH eligibility. As a result, the Provider did not meet the required "disproportionate patient percentage" defined at 42 U.S.C. § 1395ww(d)(5)(F)(vi), and was therefore denied a DSH adjustment for each of the subject cost reporting periods. In general, the Intermediary maintained that only patient days stemming from patient beds being reimbursed under PPS should be included in the patient day count, and that would exclude swing bed patient days since they are reimbursed based upon reasonable cost.

The Board finds, however, that there is no authoritative basis for the Intermediary's adjustments. Rather, the Board finds that the pertinent statute, regulations, and manual instructions support the Provider's argument that swing bed patient days should be included in the DSH determination.

With respect to Medicare law, and as mentioned above, 42 U.S.C. § 1395ww(d)(5)(F)(vi) defines the term "disproportionate patient percentage," which is the factor used to determine DSH eligibility. In part, the statute explains that a provider's disproportionate patient percentage is the sum of:

> (I) the fraction. . . [the SSI percentage], and
>
> (II) the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consisted of patients who (for such days) were eligible for medical assistance under a State plan approved under title XIX, but who were not entitled to benefits under part A of this title, and the denominator of which is the total number of the hospital's patient

> days for such period.

42 U.S.C. § 1395ww(d)(5)(F)(vi) (emphasis added).

The Board finds that the statute openly allows all patient days pertaining to patients eligible for Medicaid but not Medicare Part A to be included in the DSH calculation, which would include swing bed patient days. Notably, the statute does not specifically exclude swing bed patient days from the eligibility determination nor does it restrict patient days to those stemming from beds reimbursable under PPS.

With respect to program regulations, 42 C.F.R. § 412.106(a) states in part:

> [t]he factors considered in determining whether a hospital qualifies for a [DSH] payment adjustment include the number of beds, the number of patient days, and the hospital's location.
>
> (i) The number of beds in a hospital is determined in accordance with § 412.105(b).
>
> (ii) The number of patient days includes only those days attributed to areas of the hospital subject to the prospective payment system and excludes all others.

42 C.F.R. § 412.106(a) (emphasis added).

As stated, the pertinent rules explain that patient days used in the DSH determination must be derived from an "area" of a provider's facility "subject" to PPS. The rules do not say that the patient days must be reimbursed under PPS as interpreted by the Intermediary. Respectively, the Board notes that the subject swing bed days were, in fact, derived from licensed acute care beds that were certified by HCFA as part of the Provider's general acute care area.

The Board also notes the regulations' reference to the "number of beds in a hospital," and finds that this requirement further supports the inclusion of swing bed patient days in the DSH determination. That is, since there is a direct relationship between patient beds and patient days.

Specifically, 42 C.F.R. § 412.105(b) requires a hospital's bed size to be determined by dividing its "available bed days" by the number of days in the cost reporting period. The regulation specifically excludes nursery beds assigned to newborns that are not in intensive care areas from the determination of available bed days, as well as custodial care beds and beds in excluded units. The regulation, although specific with respect to excluded beds, does not exclude swing beds.

With respect to program instructions, the Board finds the word "bed" further defined at HCFA Pub. 15-1 § 2405.3.G for the purpose of calculating the adjustment for indirect medical education and DSH eligibility. In part, the manual states:

> G. Bed Size.- A bed is defined for this purpose as an adult or pediatric bed (exclusive of beds assigned to newborns which are not in 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 area(s) of the facility not certified as an acute care hospital, labor rooms, PPS excluded units such as psychiatric or rehabilitation units, postanesthesia or postoperative recovery rooms, outpatient areas, emergency rooms, ancillary departments, nurses' and other staff residences, and other such areas as are regularly maintained and utilized for only a portion of the stay of patients or for purposes other than inpatient lodging.
>
> To be considered an available bed, a bed must be permanently maintained for lodging inpatients. It must be available for use and housed in patient rooms or wards (i.e., not in corridors or temporary beds). Thus, beds in a completely or partially closed wing of the facility are considered available only if the hospital put the beds into use when they are needed. The term "available beds" 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.

HCFA Pub. 15-1 § 2405.3.G (emphasis added).

The Board finds that these manual instructions, which do not exclude swing beds, are meant to provide an all inclusive listing of those beds that are excluded. That is, considering the great specificity with which the manual addresses this issue. Moreover, the Board agrees with the Provider regarding this matter, in that, a listing of specific items in the manner employed by the manual instructions, as well as the regulations quoted above, restricts the class to the items listed under the principle of *ejusdem generis*. The Board notes that 42 C.F.R. § 412.105 (b) has been modified on at least two occasions to clarify beds excluded from the count, while never being modified to address swing beds or swing bed days. The Board also notes that no disputes were

raised in this case regarding the subject beds being permanently maintained and available for lodging inpatients, or less than fully staffed to furnish inpatient services throughout the subject cost reporting periods. And, as discussed immediately below, the fact that the beds were sometimes occupied by patients requiring skilled nursing care rather than inpatient hospital care does not affect their availability.

The Board cites the example provided by HCFA for determining bed size at HCFA Pub. 15-1 § 2405.3.G.2. In this example, a hospital has 185 acute care beds including 35 beds that were used to provide long-term care. HCFA explains that all 185 beds are used to determine the provider's total available bed days since the 35 beds are certified for acute care. In part, HCFA states:

> [a]lthough 35 beds are used for long-term care, they are considered to be acute care beds unless otherwise certified.

HCFA Pub. 15-1 § 2405.3.G.2 (emphasis added).

The Board finds this example directly on point. Acute care beds that are temporarily or occasionally used for another type of patient care but not certified as such, identically to the swing beds at issue in this case, are included in the count.

The Board rejects the Intermediary's argument that only patient days reimbursed under PPS should be included in the count since the purpose of DSH is to adjust PPS amounts. The Board finds that if this argument were true Congress would simply have said that in the enabling statute. And, even with the statute written as it is, if only days reimbursed under PPS were to be included in the count there would be no reason for the controlling regulation and manual guidelines to be written in the manner that they are, i.e., with great specificity regarding beds that are included and excluded from the bed size determination.

Finally, the Board acknowledges but rejects the Intermediary's reliance upon the Administrator's decision in Commonwealth of Kentucky. The Board finds that that decision was reversed in Clark Regional Medical Center, et al., v. Shalala, Civil Action No. 99-465, 2001 U.S. Dist. Lexis 4658 (E.D. Ky, March 30, 2001). In part, the court states:

> [t]he IME regulation at 42 C.F.R. § 412.105(b) states that "the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period, not including beds or bassinets in the healthy newborn nursery, custodial care beds in excluded distinct part hospital units, and dividing that number by the number of days in the cost reporting period. Id. (emphasis supplied). Under the plain meaning of this regulation, written by the defendant, the observation and swing

bed days at issue here should not have been excluded from the count, as these beds are not "beds or bassinets in the healthy newborn nursery, custodial care beds, or beds in excluded distinct part hospital units."

The defendant's proposed construction tortures the plain language of the regulation. The regulation does not say "not including non-PPS beds" or "not including bed days that are not allowable in the determination of Medicare inpatient costs. It also does not say "not including beds such as" the beds listed. Rather, a plain and common sense reading of the regulation requires that all beds and all bed days be included in the calculation unless they are in one of the specifically enumerated categories of excluded beds. . . .

The PRM guideline states that to be considered "available," the beds must be "permanently maintained for lodging inpatients." The defendant reads this to say "exclusively maintained for lodging inpatients." There is no question that these beds are permanently maintained and staffed for acute care inpatient lodging. The fact that they are temporarily used for other purposes does not change this. Most importantly, the PRM guideline specifically states that the term "'available 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." The defendant argues that this simply means that a bed does not have to be empty to be "available." However, read together, these sentences mean what they say--that the number of "available beds" does not change based on a day-to-day fluctuation in patient rooms being used and only changes as beds are added to or taken out of service. It also reiterates the guidelines' earlier mandate that beds are only excluded based on the area in which they were permanently maintained. In this case, there is no evidence that the beds at issue were ever added to or taken out of service during the cost reporting period in question or ever permanently maintained in any area other than the acute care areas of the hospitals. Again, if the defendant intended the regulation to simply mean "a bed does not have to be empty to be available," it could have directly and easily said so, but it did not. . . .

Given the above, the court finds that the HCFA Administrator's

> decision was arbitrary and capricious and not supported by the applicable regulations and PRM guidelines. In so holding, it is not simply that this court has determined that an alternative construction of the regulations and PRM guideline would be better -- that would not be proper. Rather, the court finds that the HCFA Administrator's construction is unreasonable and is not based upon the language of its own regulations and guidelines. Therefore, it was a clear error of judgement for the HCFA Administrator to ignore the language of the regulations and guideline and instead construe eligibility based solely upon its own statements of intent hidden in the Federal Register. The defendant's application of the regulation with respect to the plaintiffs was arbitrary and capricious and, therefore, must be set aside in accordance with 5 U.S.C. § 706(2)(A).

Id. (emphasis added).

DECISION AND ORDER:

The Intermediary's adjustments excluding swing bed patient days from the Provider DSH determinations are improper. The Intermediary's adjustments are reversed.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esq.
Martin W. Hoover, Jr. Esq.
Charles R. Barker
Stanley J. Sokolove

Date of Decision: June 28, 2001

FOR THE BOARD:

Irvin W. Kues
Chairman

APPENDIX

FYE	Case No.	NPR Date	Appeal Request Date	Reim. Effect
9/30/91	94-2298	9/23/93	3/17/94	$61,358
9/30/92	95-1213	9/13/94	3/3/95	73,009
9/30/93	96-0132	9/5/95	11/6/95	88,108
9/30/94	96-2235	4/4/96	6/17/96	92,379
9/30/95	98-0023	8/11/97	10/10/97	86,882
9/30/96	99-0057	8/24/98	9/28/98	84,393
9/30/97	98-2943	8/31/99	6/25/98	129,478
TOTAL				$615,607