PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2009-D31

PROVIDER -
College Station Medical Center
College Station, Texas

Provider No.: 45-0299

vs.

INTERMEDIARY -
Wisconsin Physicians Service

DATE OF HEARING -
January 29, 2008

Cost Reporting Period Ended -
October 31, 1999

CASE NO.: 05-2010

INDEX

ISSUE:

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, was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

In 1983, Congress changed hospital reimbursement under the Medicare program by enacting Pub. L. No. 98-21 which created the Prospective Payment System (PPS). Under PPS, hospitals are reimbursed their inpatient operating costs on the basis of prospectively determined national and regional operating costs. However, Congress also provided for adjustments to the PPS rates for certain hospitals that meet specific criteria with respect to their inpatient population. Pursuant to 42 U.S.C. §1395ww(a)(2)(B), the Secretary was directed to provide for appropriate adjustments to the limitation on payments that may be made under PPS to take into account:

> (B) the special needs of psychiatric hospitals and of public or other hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under part A of this subchapter.

The statutory provision at 42 U.S.C. §1395ww(d)(5)(F)(i) further directs the Secretary to provide "for an additional payment amount for each subsection (d) hospital" serving "a significant disproportionate number of low-income patients...." To be eligible for the additional payment, a hospital must meet certain criteria concerning its disproportionate patient percentage. Under 42 U.S.C. §1395ww(d)(5)(F)(v), a hospital that is located in an urban area and has 100 or more beds is eligible for the additional DSH payment if its disproportionate patient percentage is 15 percent. However, if the urban hospital has less than 100 beds and a disproportionate patient percentage of 40 percent for discharges before April 1, 2001, it is eligible to receive additional reimbursement limited to 5% of its diagnostic related group (DRG) payments for discharges prior to April 1, 2001.[1]

The regulation at 42 C.F.R. §412.106 establishes the factors to be considered in determining whether a hospital qualifies for a DSH payment adjustment. Those factors include the number of beds, the number of patient days and the hospital's location. With respect to the number of beds for purposes of DSH payments, the regulation at 42 C.F.R. §412.106(a)(1)(i) states that "the number of beds in a hospital is determined in accordance with 42 C.F.R. §412.105(b)." The bed count rules set forth in 42 C.F.R. §412.105(b), which pertain to additional payments to hospitals for indirect medical education (IME) costs, state the following:

> *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

[1] See, 42 U.S.C. §§1395ww(d)(5)(F)(iv)(II) and 1395ww(d)(5)(F)(xiii)(II).

> units, and dividing that number by the number of days in the cost reporting period.

The bed counting regulation and program instructions published by CMS establish the specific governing rules for determining the size of a hospital facility for DSH payment eligibility under the statutory provisions of 42 U.S.C. §1395ww(d)(5)(F)(v). As the regulation at 42 C.F.R. § 405.105(b) indicates, "available bed days" are the product of multiplying the number of beds by the number of days in a cost reporting period.

In the September 3, 1985 *Federal Register*, in response to a commenter's request for a more precise definition of "available bed days" CMS stated:

> For purposes of the prospective payment system, "available beds" are generally defined as adult or pediatric beds (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 lodging, beds certified as long-term, and temporary beds are not counted. If some of the hospital's wings or rooms on a floor are temporarily unoccupied, the beds in these areas are counted if they can be immediately opened and occupied.

50 Fed. Reg. 35646, 35683 (Sept. 3, 1985).

The Provider Reimbursement Manual (PRM) provides further clarification of the available beds determination process set forth in the regulations and includes and expands upon the definition contained in the preamble to the final rule discussed above. Section 2405.3(G) of the PRM states:

> 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, post anesthesia 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.

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.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

College Station Medical Center (Provider), is a 119 bed short-term acute care facility located in College Station, Texas, an urban area approximately 100 miles from the city of Houston. The Provider is an urban hospital with a disproportionate patient percentage exceeding the 15 percent DSH threshold. The sole issue relating to the Provider's appeal involves whether the Provider has 100 beds to qualify for DSH eligibility under 42 U.S.C. §1395ww(d)(5)(F)(v)(I).

The relevant facts in this appeal are undisputed. The Provider's settled cost report during its fiscal year 1999 (February 1, 1999 through October 31, 1999) contained 119 hospital beds, 100 acute care beds and 19 nursery beds.[2] The Provider's cost report reflected 27,300[3] available bed days (or 100 available beds), and the Intermediary's work papers prepared in connection with the finalization of the cost report reflects this basic count.[4] From this total, the Intermediary reduced the available bed count by 420 reported observation bed days.[5] After the reduction of the 420 observation bed days, the Provider's bed size was determined by the Intermediary to be 98, which is less than the 100 needed to qualify for the 15% DSH percentage floor category, urban hospitals with less than 100 beds must exceed a 40% DSH percentage in order to receive DSH reimbursement.[6]

During the time period at issue, the Provider did not have a distinct observation unit, or separately designated area within the hospital for treatment of patients requiring observation services.[7] All patients requiring observation care were placed in available inpatient acute care beds to receive observation services.[8] But for the temporary use to furnish observation services, the beds were part of the Provider's inpatient hospital bed capacity.

In addition, the parties have agreed that the number of Medicaid eligible days for purposes of calculating the DSH Medicaid percentage is 1412 and the revised DSH patient percentage is 25.31%. The estimated reimbursement impact is $325,744.[9]

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[2] See, Stipulation at 4.
[3] Total bed days available of 32,487 'less 5,187 nursery bed days. Based on a cost reporting period with 273 calendar days.
[4] Id. See, also Provider Exhibit 3.
[5] Id. at 2.
[6] Id.
[7] See, Stipulation at 6.
[8] See, Stipulation at 7.
[9] See, Provider Exhibit 5

The Provider's appeal meets the jurisdictional requirements of 42 C.F.R. §§405.1835 – 405.1841. The Provider was represented by Gregory N. Etzel, Esquire, of Baker & Hostetler, LLP. The Intermediary was represented by Mr. Terry Gouger, C.P.A., of Wisconsin Physicians Service.

PROVIDER'S CONTENTIONS:

The Intermediary improperly computed the Provider's bed count or size for purposes of the DSH adjustment. A hospital's bed size determines the threshold for qualification as a DSH hospital, and the bed count is determined by using the methodology established in the IME regulation. 42 C.F.R. § 412.106(a)(l)(i).

The Intermediary undercounted the Provider's available bed count for DSH because, contrary to the plain language of the regulation. The Intermediary focused on the temporary use of the room or bed in question rather than upon the overall availability of the bed i.e., its status as a licensed inpatient bed capable of being put into use for inpatient services within 24-48 hours. While the Provider may periodically have used licensed inpatient beds to provide observation services, those beds were in areas of the hospital subject to inpatient PPS and capable of being immediately put into service as inpatient beds if necessary. The Intermediary's determination of the bed count contravenes the applicable regulation in effect at the time, Medicare program instructions, Federal case law, and prior Board decisions regarding the bed count. The Provider, therefore, contends that observation days should be added back to its available bed count so that that the proper DSH qualification threshold (15 percent for urban hospitals with at least 100 beds) is applied.

The regulation, in effect during the time period at issue in this case, requires the inclusion of the observation bed days at issue. Under the IME bed count regulation, there is simply no basis for the Intermediary's exclusion of days of observation care in inpatient licensed beds. The IME bed count rule in effect for the Provider's FY 1999 cost year provided the following:

> *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) (1999).[10]

The starting point under the regulation for computing a provider's bed count is "available bed days," and bed days in certain categories are subtracted from that number. There is no requirement in the regulation that a bed be used exclusively for inpatient services to be considered available.

[10] See, Provider Exhibit 4.

Furthermore, the observation bed days at issue in this case are not attributable to beds located in areas excluded by the plain language of the regulation: healthy newborn nursery, custodial care beds, or beds in excluded distinct part hospital units. Under the plain language of the regulation, a bed day must be counted so long as it is an "available bed day," unless the day falls within one of the categories of beds specifically excluded by the regulation. Because the observation bed days at issue in this case are not expressly excluded by the regulation, they must be included in the Provider's DSH bed count.

The Provider relies on the Sixth Circuit's decision in *Clark Regional Medical Center v. U.S Department of Health & Human Services*, for support. 314 F.3d 241(6th Cir. 2002), and the District Court's decision in that case *Clark Reg'l Med. Ctr. v. Shalala*, 136 F.Supp.2d 667 (E.D. Ky. 2001) [*Clark Regional*]. The Sixth Circuit held that the plain language of the regulation requires that observation bed days be counted for purposes of DSH. Specifically, the Court stated:

> Because the regulation specifically lists certain types of beds that are excluded from the bed count, but does not list...observation beds, the plain meaning, of the regulation suggests that it is permissible to count observation beds. Further, ... observation beds are not of the same class or type as "beds or bassinets in the healthy newborn nursery, custodial care beds, or beds in excluded distinct part hospital units." Although these beds listed as excluded are, as the HCFA concluded, all non-PPS reimbursable beds, the...observation beds at issue in this case are actually used for PPS-reimbursable services more often than not. None of the beds described as excluded may be used primarily for acute inpatient care as the...observation beds are. This is because these excluded beds are located in areas of the hospital that, by definition cannot come within PPS.

Clark Reg'l, Med. Ctr. v. U.S. Dept. of Health & Human Servs., 314 F.3d 241, 247 (6th Cir. 2002).

The District Court's decision in *Clark Regional* found that CMS' proposed construction "tortures the plain language of the regulation." *See* 136 F.Supp.2d at 676. The District Court found that "a plain and common sense reading of the regulation requires that all beds and bed days be included in the calculation unless they are one of the specifically enumerated categories of excluded beds." *Id*. at 676. The Court further found that if CMS had intended to exclude observation beds from the bed count, it could have "easily and directly done so." *Id*. at 676. Similarly in *Odessa Reg'l Hosp. v. Leavitt*, 386 F. Supp. 2d 885, 891 (W.D. Tex. 2005) the court found that "the plain meaning of the [regulation] dictates that observation beds should not have been excluded from the bed count, as they are not beds or bassinets in the healthy newborn nursery, custodial care beds or beds in excluded distinct part units" and that if CMS had "meant to exclude observation beds from the calculation, it could have "easily and directly done so."

Furthermore, the Board has consistently held that days such as observation bed days should be included in the available bed count because they are not excluded under the plain meaning of the regulation. In *Central Texas Medical Center v. Blue Cross Blue Shield Assoc.*, PRRB Dec. No. 2005-D59, Medicare & Medicaid Guide (CCH) ¶ 81,386 (Aug. 30, 2005), for example, the

Board applied the explicit language of the bed count regulation to reverse the Intermediary's exclusion of observation bed days from the Provider's bed count. The Board noted that the *Clark Regional* court found that "because the regulation specifically listed certain types of beds that were excluded from the calculation but did not list . . . observation beds, the plain meaning of the regulation suggested that it is permissible to count . . . observation beds in the calculation of available beds." *Id*. *See also North Okaloosa Med. Ctr. v. Blue Cross Blue Shield Assoc.*, PRRB Dec. No. 2006-D54, Medicare & Medicaid Guide (CCH) ¶ 81,611 (Sep. 26, 2006); *Highland Med. Ctr. v. Mutual of Omaha*, PRRB Dec. No. 2006-Dl0, Medicare & Medicaid Guide (CCH) ¶81,458 (Dec. 22, 2005).

The Provider notes that CMS amended the DSH/IME bed count regulation in the Federal Fiscal Year (FFY) 2005 Inpatient PPS Final Rule, effective for cost reporting periods beginning on or after October 1, 2004. See 69 Fed. Reg. 48916, 49096 (Aug. 11, 2004). The new language of the rule provides that bed days associated with "beds otherwise countable under this section used for outpatient observation services" are excluded from the count of available bed days.[11] The Intermediary's reliance on the current regulatory language to support its position that observation beds should be excluded from the Provider's FY 1999 bed count is misplaced. In the FFY 2005 IPPS Final Rule, CMS specifically stated that the new policy is applicable only for cost reporting periods beginning on or after October 1, 2004, and it is well settled that CMS may not enact retroactive rules. *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 215 (1988).

In fact, CMS' new rule actually provides further support to the Provider's position that the plain language of the regulation in effect during the Provider's FY 1999 mandates that days associated with observation beds be counted in the DSH bed count. If the language of CMS' prior rule had excluded observation bed days from the bed count, then CMS would have had no reason to enact the new policy. But the language of CMS' prior language was clear: beds are counted unless they fall into one of the specific categories of beds excluded by the regulation, and observation beds are not excluded.

The Provider contends that the Provider Reimbursement Manual and other prior guidance also require the inclusion of observation beds in the available bed count. The PRM provisions regarding bed counting provide "conclusive proof" that observation beds must be included in the Provider's bed count. *See*, *Clark Reg'l Med. Ctr. v. U.S. Dept. of Health and Human Servs.*, supra at 248 (6th Cir. 2002).

PRM § 2405.3(G), which deals with the computation of the IME adjustment, states that "available beds" include all routine beds, regardless of usage. The beds at issue are located in rooms in areas of the hospital that are fully open and staffed. The Provider argues that CMS has previously taken the position that beds are presumed to be available and are counted unless the Provider presents affirmative evidence to exclude the beds. In *Natividad Medical Center v. Blue Cross of California*, the provider argued that it had only 121 available beds rather than its full complement of 152 licensed beds. HCFA Adm'r Dec., Medicare & Medicaid Guide (CCH) ¶39,611 (Oct. 6, 1991). In *Natividad*, the Administrator held that the provider was required to count all of its licensed beds as available, concluding that there is a presumption that all licensed

[11] See, 42 C.F.R. §412.105(b)(4) (2004).

beds are available. *See also Pacific Hosp. of Long Beach v. Aetna Life*, HCFA Adm.'r Dec., Medicare & Medicaid Guide (CCH) ¶ 41,355 (Feb. 11, 1993).

Furthermore, the observation bed days at issue do not fall into any of the categories that are excluded by the PRM. The observation beds at issue in this case are not in a dedicated outpatient area,[12] but rather are located in routine areas "maintained for lodging inpatients." The fact that an inpatient bed may temporarily house an observation patient does not somehow change the location of that bed to an "outpatient area." Indeed, it is undisputed that the beds at issue are routine beds in the IPPS area of the Hospital. *See* Stipulation at 7. Therefore, because the observation beds do not fall within any of the excluded categories, they must be counted. The Sixth Circuit found in *Clark Regional*, "there is nothing in the language of the PRM that indicates that a bed is 'unavailable' simply because it is not exclusively designated for acute inpatient care." 314 F.3d at 248.

PRM § 2405.3(G) gives a clear example that requires licensed inpatient beds to be included in the available bed count even though they are set up and used as long-term care beds:

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

In CMS' own example, a bed certified as an inpatient acute care bed must be included in the hospital's bed count even if the bed is actually used for long term care, which is, by definition, not an acute care hospital service. By analogy, the use of licensed and certified inpatient beds for observation services does not make the beds any less available to furnish inpatient routine services than beds used for long term care. The Board has previously found this example to be "compelling evidence" that licensed acute care beds used for other purposes, like the beds at issue here, should be included in the bed count. *See Highland Med. Ctr. v. Mutual of Omaha*, PRRB Dec. No. 2006-D10, Medicare & Medicaid Guide (CCH) ¶81,458 (Dec. 22, 2005); *see also North Okaloosa Med. Ctr. v. Blue Cross Blue Shield Assoc.*, PRRB Dec. No. 2006-D54, Medicare & Medicaid Guide (CCH) ¶81,611 (Sep. 26, 2006).

In addition, the manual provision expressly indicates that the available bed count should not take into consideration "the day-to-day fluctuations in patient rooms and wards being used," such as the use of a licensed inpatient bed for the temporary stay of an observation patient. The use of inpatient beds for observation patients when they are not otherwise being used for inpatients "is precisely the type of day-to-day fluctuation" that is contemplated by the Manual. *Clark Regional*, supra at 248. The bed count is intended to reflect the overall size of a particular provider, not the day-to-day change in the occupancy of a particular bed. Id. at 248-49. *See also Odessa Regional Hosp. v. Leavitt*, 386 F.Supp.2d 885, 892 (W.D. Tex. 2005). Further, the manual clarifies that the available bed count is designed to capture changes in the "size of a facility as beds are added to or taken out of service." PRM § 2504.3(G). Using a bed is not taking it out of service. The use of a licensed inpatient bed for observation services does not change the size of a hospital facility.

Moreover, the Provider contends that the instructions set forth in Administrative Bulletins published by the Blue Cross Blue Shield Association (BCBSA) provide further clarification to

[12] See, Stipulation at 6

CMS' policy relating to available bed determinations. The Provider argues that Administrative Bulletin No. 1830, 87.01 (dated January 28, 1987) provides for the counting of beds if they are capable of being put into use. It states in part that:

> [A]n available bed is a bed reasonably ready for patient use with short notice. The fact that the bed is in an area of the hospital which has been closed and the area is unstaffed is not the major criterion. If the bed can be placed in service for patient care within a short period of time, the bed would be available.

Provider Exhibit 6.

Similarly, BCBSA's Administrative Bulletin No. 1841, 88.01 (dated Nov. 18, 1988) instructs that [w]here a room is temporarily used for a purpose other than housing patients (e.g., doctors' sleeping quarters), the beds in the room must be counted, provided they are available for inpatient use on an as needed basis." (Emphasis added). Moreover,

> [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 plant 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. (Emphasis added).

Provider Exhibit 7.

In *Santa Clara Valley Med. Ctr. v. Blue Cross Blue Shield Assoc.*, HCFA Adm'r Dec., Medicare & Medicaid Guide (CCH) ¶ 45,230 (Mar. 28, 1997), the CMS Administrator found that beds utilized for physician sleeping quarters were "available for inpatient lodging" as described in PRM § 2405.3(G), despite the fact that they were temporarily occupied by physicians. Therefore, the Provider contends if actual use of a bed as a physician sleeping bed, which requires no nurse staffing, does not render the bed unavailable, then the use of a bed for a few hours by an observation patient receiving services indistinguishable from those furnished to inpatients should also not render the bed unavailable.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the matching of any beds and associated bed days, that are recognized as part of a hospital's inpatient operating costs, is consistent with the statutory intent of the DSH adjustment. A bed occupied by a patient on a given day results in a bed day. The bed is then matched with the day. It would be illogical to include observation bed days for one qualifying criterion (such as bed count under 42 C.F.R. §412.105(b), and exclude such days from other qualifying criteria (such as bed days under 42 C.F.R. §412.106(a)(1)(ii), for the same DSH payment. Further, observation beds and bed days are not included in the calculation of Medicare's share of inpatient hospital costs.

The exclusion of observation beds and bed days is proper under the language set out in the preamble to the Final Rule for FFY 1986 IPPS rates and in CMS Pub. 15-1 §2405.3G. The 1986

Final Rule indicated that if the bed days are allowable in the calculation of Medicare's share of inpatient costs for inpatient lodging, then the beds within the unit are included as well. Patients in observation status are not admitted as inpatients but are considered outpatients. A bed cannot be simultaneously available for inpatient use when in use for outpatient observation. The PRM at Section 2405.3G explains that: "a bed must be permanently maintained for lodging inpatients" to be considered an available bed. Therefore, the Intermediary concludes that if a bed is used for another purpose such as for outpatient observation, it is not available for inpatient lodging and is not to be counted. The PRM also explains that beds used in ancillary, outpatient areas, or other areas regularly maintained and utilized for only a portion of a patient's stay are not considered available for lodging inpatients. Beds utilized partly for inpatient use and partly for outpatient use can not be considered fully available for inpatient lodging. In addition, the Intermediary contends that the term outpatient area, as referenced in the PRM provision, refers to the area where the observation activity occurred, not to a geographical area.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and guidelines, the parties' contentions and stipulations, and evidence contained in the record, the Board finds and concludes that the observation bed days should be included in the available bed count and used in determining the Provider's eligibility for DSH reimbursement. The Board finds that the factual and legal circumstances of this appeal are identical to the Board's decision in *North Okaloosa Medical Center v. Blue Cross Blue Shield Assoc.*, and thus, the outcome is the same as it was in that case.

The statute 42 U.S.C. §1395ww(d)(5)(F), considers three factors in determining a hospital's qualification for a DSH adjustment: (1) the provider's location (rural or urban); (2) the number of patient days; and (3) the number of beds. In this case, the only criterion under dispute is the number of beds. The statute does not expound upon the meaning of "bed" with respect to DSH eligibility. However, the regulation, 42 C.F.R. §412.106, implements the statutory provisions and establishes factors to be considered in determining whether a hospital qualifies for a DSH adjustment. This regulation states that the number of beds in a hospital is determined in accordance with §412.105(b) which states:

> *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 Board finds that the controlling regulation, 42 C.F.R. §412.105(b), establishes the fundamental methodology for determining a hospital's bed size for purposes of DSH eligibility and requires that all beds be included in the calculation unless they are specifically excluded under the categories listed in the regulation. Furthermore, the Board finds that the word "bed" is specifically defined in PRM §2405.3.G for the purpose of calculating the adjustment for IME and DSH eligibility. The PRM states in relevant part:

> 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, post anesthesia 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. <u>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</u>.
>
> 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.

PRM (CMS Pub. 15-1) § 2405.3.G. (Emphasis added).

Based on the controlling authorities, the Board concludes that the rationale applied by the Intermediary for the exclusion of observation bed days is not supported by the plain language of the regulation and manual guidelines. The Board finds that all of the observation bed days at issue were provided in acute care beds located in the acute care areas of the hospital facility. The Board finds that the Provider therefore had 100 beds permanently maintained for lodging inpatients.

The Board's determination relies on the fact that the enabling regulation and manual provisions identify the specific beds that are to be excluded from the bed count, and neither of these authorities provides for the exclusion of observation beds. Given the degree of specificity with which the manual addresses this issue, and the fact that the enabling regulation has been modified to change the types of beds that are excluded from the count, the Board finds that these comprehensive rules are meant to provide an exhaustive listing of excluded beds.

The Board rejects the Intermediary's argument that only beds reimbursed under PPS should be included in the count of available beds, since the purpose of the DSH adjustment is to provide an add-on to the PPS payment amounts. If the Intermediary's argument were valid, Congress would

have simply said so in the statute. Instead, the controlling regulation and manual guidelines were written in a manner that provides great specificity regarding beds that are to be included and those that are to be excluded. The Board finds that the agency has provided clear guidance including an example directly on point in which a hospital that has 185 acute care beds, of which 35 beds are used to provide long-term care (but not certified for such care), would include all 185 beds to determine the available bed days, since the 35 beds are certified for acute care.

Finally, the Board observes that each Federal court that has reviewed this matter has upheld the Board's prior decisions with respect to this issue. *See Clark Regional*, 314 F3d at 247; *Odessa Regional*, 386 F.Supp2d at 891; *North Okaloosa*, 2008 W.L.141478; *Highland Medical*, Civ. Action No. 5:06-CV-082-C (N. D. Tex. 2007). Courts have consistently found that the application of the regulation and manual provisions advanced by CMS (and the Intermediary in this case) cannot be reconciled with the plain meaning of the definition of "available beds" as defined in the regulation. Because the regulation specifically lists certain types of beds that were excluded from the count but did not list beds such as observation beds, the plain meaning of the regulation suggests that it is permissible to count observation beds in the calculation of available beds. Further, courts have found that the PRM supports the position that observation beds must not be excluded from the count as the bed count is specifically "not intended to capture 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." See, PRM §2405.3.G.

DECISION AND ORDER:

The Intermediary's determination of the number of available beds for DSH eligibility purposes was not proper. The determination should have included the Provider's observation bed days. The Provider therefore had 100 available beds for Medicare DSH adjustment qualification and payment purposes. Accordingly, the Provider is entitled to its DSH payment adjustment.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Yvette C. Hayes
Michael D. Richards, CPA
Keith E. Braganza, CPA

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: July 9, 2009