CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Edinburg Hospital **Provider** **vs.** **Blue Cross /Blue Shield Association** **Trailblazer Health Enterprises, LLC** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 09/31/92** **Review of:** **PRRB Dec. No. 2003-D23** **Dated: April 29, 2003**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in § 1878(f)(1) of the Social Security Act (Act), as amended (42 USC 1395oo(f)). The Intermediary submitted comments, requesting reversal of the Board's decision. Accordingly, the parties were notified of the Administrator's intention to review the Board's decision. Comments were also received the Provider requesting that the Administrator affirm the Board's decision. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

BACKGROUND

The Provider is an urban hospital located in Rio Grande Valley, Texas. For fiscal year ending (FYE) 1992, the Provider was certified by the State of Texas for 112

beds.[1] The certification did not include nursery beds. Of those 112 beds, 10 beds were dedicated Rehabilitation beds, which were excluded from the inpatient hospital Prospective Payment System (PPS).[2] In addition, the Provider operated a 10-bed nursery, which included three neonatal sub-intensive care beds, comprised of one isolated nursery bed and two special care nursery beds. The remaining seven nursery beds were considered "well" baby bassinets.

For the fiscal period in dispute, the Intermediary conducted an audit and issued a Notice of Program Reimbursement (NPR) dated September 24, 1994. Initially, the Intermediary determined that the Provider was a disproportionate share hospital (DSH) located in an urban area with at least 100 beds.[3] As a result of this determination the Provider was entitled to a DSH adjustment of 42.45267 percent.[4] However, by letter dated May 16, 1997, the Intermediary reopened the cost report for FYE 90/30/92.

The Intermediary determined that the Provider had less than 100 available bed and a revised NPR was issued June 12, 1998. According to the Intermediary's workpapers, the Provider had 105 available beds after excluding the Provider's rehabilitation beds and including the 3 neonatal, sub-intensive care bassinets. The Intermediary's workpapers also indicated that during FYE 9/30/92, the Provider had 1863 days of observation services. By dividing 1863 observation days, by the 366 days comprising the fiscal period in question, the Intermediary determined that the Provider had 5.09 equivalent observation beds. The Intermediary then reduced the Provider's number of available beds, 105 by 5.09 observation bed days resulting in net beds available for DSH of 99.91.[5] This determination had an adverse effect on the Provider's DSH payment and capital DSH payment.

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[1] Intermediary's Final Position Paper p. 3. The 112 beds were composed of the following types of beds: 52 Medical/Surgical, 20 OB/GYN, 10 ICU/CCU, 13 Pediatric, 10 Rehabilitation and 7 other.

[2] Id. Provider's Comments, p. 2.
[3] Provider's Final Position Paper, Exhibit P-3.
[4] Provider's comments, p. 3.
[5] Intermediary's Exhibit I-3.

ISSUE AND BOARD'S DECISION

The issue is whether the Intermediary's determination that the Provider had less than 100 "beds" for DSH eligibility purposes was proper.

The Board held that the Intermediary's exclusion of observation bed days from the calculation of "total beds" used to determine the Provider's eligibility for a DSH adjustment was not proper. The Board concluded that the criteria applied by the Intermediary for the exclusion of observation bed days could not be supported based on the Board's interpretation of the language set forth in the regulations and manual guidelines. The Board found that all of the observation beds at issue were licensed acute care beds located in the acute care areas of the Provider's facility. The Board further found that these beds were permanently maintained and available for lodging inpatients and were fully staffed for the provision of inpatient services. The Board read the regulations and manual guidelines as including all beds and all bed days in the calculation, unless they were specifically excluded under the categories listed in the regulation. The Board found that given the degree of specificity with which the manual addresses this issue and the fact that the enabling regulation has been modified on at least two occasions to clarify the type of beds excluded from the count, the Board found that these comprehensive rules are meant to provide an all inclusive listing of the excluded beds.

The Board rejected the Intermediary's argument that only beds reimbursed under PPS should be included in the count of available bed days since the purpose of DSH is to adjust PPS amount. The fact that the beds were licensed acute care beds located in an acute care area of the Provider's facility and permanently maintained and available for lodging inpatients were grounds that the Board found to be determinate that the beds at issue met the requirements for inclusion in the bed size calculation.

SUMMARY OF COMMENTS

The Intermediary commented requesting that the Administrator reverse the Board's decision because it reflects an incorrect interpretation of the regulations and program instructions. Specifically, the Intermediary argued that, only beds reimbursed under PPS should be included in the count of available bed days since the purpose of DSH is to adjust PPS payment amounts.

The Provider commented requesting that the Administrator affirm the Board's decision. The Provider argued that the exclusion of observation beds from its DSH calculation violates the statute. To support this position the Provider argued that the DSH statute does not distinguish between types of beds or types of service performed in such beds in evaluating whether the hospital meets the 100-bed threshold. The statute only requires that a hospital have "100 or more beds." In this case at all times during the period under dispute the Provider had more than 100 beds. Therefore the beds should be included in the bed count based on a plain reading of the statute.

To further support the Provider's position that observation beds should be included in the bed count for DSH purposes the Provider argued the DSH regulation neither mandates nor permits the exclusion of observation beds from a hospital's bed count. The Provider stated: that the language of the regulation includes various restrictions but includes no restriction concerning the counting of beds used for observation services. To the contrary, the methodology for determining the bed count, as outline in 42 C.F.R. § 412.015, provides that all of a provider's available beds during the cost reporting period are to be counted except beds falling within the specifically enumerated exceptions.

The Provider argued that the DSH regulations found at 42 C.F.R. § 412.105, provide no indication that inpatient beds used temporarily for observation services should be excluded from a hospital's count of available beds. The regulation only excludes three categories of beds: newborn beds, custodial beds, or beds in a distinct part unit. Accordingly, all other beds that do not explicitly fall within one of these three categories must be included within a hospital's bed count. Furthermore, although § 412.105 has been amended several times since 1991, neither the amended regulatory language nor the related regulatory history have explicitly or implicitly suggested that observation beds should be excluded from the types of beds that are to counted in ascertaining the number of available beds a hospital has during a particular cost reporting period. In addition, the Provider argued that the beds used for observation

purposes were maintained for lodging inpatients and therefore must be included in the bed count under the applicable manual provision.

The Provider argued that the Intermediary's reliance upon the CMS letter dated March 7, 1997 and the cost report instructions contained in PRM – II § 3630.1 constitutes impermissible rulemaking under the Administrative Procedure Act. The Provider stated that the March 7, 1997 CMS letter to all fiscal intermediaries was published after the cost reporting year at issue. Accordingly, the Administrator's acceptance of this letter as policy would constitute impermissible retroactive rule making.

The Provider also argued that, even assuming that it was proper for the Intermediary to exclude observation beds days from the available bed count, the Provider still qualifies for DSH reimbursement because the Intermediary should have rounded down to five instead of rounding to two decimals for a total of 5.09 beds when determining whether the Provider had 100 available beds. Furthermore, if it was proper for the Intermediary to round to 5.09, the Intermediary's determination of 99.91 beds should have been rounded up to reflect that the Provider had 100 beds.

Finally, to support its position that observation beds should be included in the DSH calculation, the Provider cited to Clark Regional,[6] which held that observation beds should not have been excluded from the count for determining DSH eligibility.

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), the Secretary is mandated to provide, an additional payment per patient discharge, "for hospitals serving a significantly disproportionate number of low-income patients…."[7] The legislative history of Consolidated Omnibus

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[6] Clark Reg'l Med. Ctr. v. United States HHS, 314 F.3d 241, (6th Cir. 2002); Clark Reg'l Med. Ctr. v. Shalala, 136 F. Supp. 2d 667 (E.D. KY 2001).

[7] 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).

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."[8] 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….[9]

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. However, if the urban hospital has less than 100 beds, it must have a disproportionate patient percentage of 40 percent to be eligible for the DSH adjustment.[10] 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

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[8] H.R. Report No. 99-241 at 16 (1986); *reprinted* in 1896 U.C.C.A.N. 594

[9] Id.

[10] Id. For the pertinent cost year, 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.

> available data, there was no justification for making these payments to …urban hospitals with fewer than 100 beds. [11]

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,[12] 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….

Relevant to this case is the determination of the number of beds. 42 C.F.R. § 412.105(b) reads as follows:

> *Determination of number of beds*. For purposes of this section, the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period, not including beds assigned to newborns, custodial care, and excluded distinct part hospital units, and dividing that number by the number of days in the cost reporting period.

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

[12] Formerly 42 C.F.R. § 412.118(b).

Further, the preamble to the final rule for "Changes to the Inpatient Hospital Prospective Payment System" for 1986[13] 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 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. The PRM states that:

> A bed is defined for this purpose as an adult or pediatric bed (exclusive of beds assigned to newborns which are not intensive care areas, 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

[13] 50 Fed. Reg. 35683.

> 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.[14]

In explaining the basis for the definition of available beds as set forth in 42 C.F.R. § 412.105(b), CMS states 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, [[15]] which was originally used to establish bed-size categories for purposes of applying the cost limits under section 1861(v)(1)(A) of the Act…. The exclusion of newborn beds was consistent with the exclusion of newborn days and costs from the determination of Medicare's share of allowable routine services costs….
>
> 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

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[14] See also Administrative Bulletin No. 1841, 88.01, which further clarified the Manual instructions; CMS letter, dated March 7, 1997, stating, with respect to observation beds, that: "if a hospital provides observation services in beds that are generally used to provide hospital inpatient services, the equivalent days that those beds are used for observation services should be excluded from the count of available bed days for purposes of the IME and DSH adjustment…."

[15] Section 2510.5A of the PRM, as drafted in 1976, stated: Bed Size Definition. For purposes of this section, a bed (either acute care or long-term care) is defined as an adult or pediatric bed (exclusive of a new-born bed) maintained for lodging inpatients, including beds in intensive care units, coronary care units, and other special care inpatient hospital units. Beds in the following locations are excluded from the definition: beds in sub-provider components, hospital-based skilled nursing facilities or beds located in any non-certified inpatient area(s) of the facility, beds in labor rooms, postanesthesia or postoperative recovery rooms, outpatient areas, emergency room, ancillary departments, nurses' and other staff residences and other such areas which are regularly maintained and utilized for only a portion of the stay of the patients or for purposes other than inpatient lodgings.

> 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.[16]

Consequently, CMS has a longstanding policy of only considering bed days in the bed count if the costs of such days were attributable or allocatable in the determination of Medicare inpatient hospital 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.[17] That is, consistent with the regulation, the count of patient days includes only those days "attributable to areas of the hospital that are subject to PPS" for purposes of determining inpatient hospital costs.

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[16] 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.) As the Federal Register is the vehicle recognized under 5 USC 552(b) for providing notice and comment when formal rulemaking is under taken, policy statements published therein cannot be reasonable described as "hidden" in the Federal Register.

[17] Under reasonable cost, the average cost per day for reimbursement purposes is calculated by dividing the total costs in the inpatient routine cost center by the "total number of inpatient days." Medicare reimbursement for routine inpatient services is based on an average cost per day as reflected in the inpatient routine cost center multiplied by the total number of Medicare inpatient days. Early in the program, an inpatient day was defined as a day of care rendered to any inpatient except a newborn. Consequently, a bed day included in either the total number of Medicare days (for example, if for a Medicare hospital inpatient) or the total number of inpatient days (including both Medicare and non-Medicare hospital inpatients) would impact the Medicare per diem payment

Notably, PPS 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 has maintained a consistent policy in defining available beds as those bed days attributable to the inpatient area of the hospital throughout the change from a cost-based inpatient hospital payment system to a prospective-base inpatient hospital payment system.

Not only is this interpretation consistent with the regulation that includes bed days attributable to the inpatient area of the hospital but 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).[18] CMS 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

[18] See also St. Joseph Medical Center, PRRB 94-D76, Where the Board stated: "Therefore, the Board concludes that although the regulations at § 412.106 (October 1, 1986) were not clear, a review of the statute indicates that a DSH hospital is defined in terms of a subsection (d) hospital, which is the only type of hospital subject to the [PPS]."

> additional payment to hospitals that are eligible for a disproportionate share adjustment.[19] (Emphasis added.)

Thus, CMS requirement, that a bed day under 42 C.F.R. § 412.105(b) only be included in the DSH bed count calculation when the costs of the day are reimbursed as an inpatient service cost, is also consistent with the policy expressed in the preamble of including only "inpatient days to which the prospective payment system applies" in determining a PPS hospital's eligibility for a DSH adjustment. The Administrator finds that, contrary to the Board's contention, the DSH adjustment is intended to be an additional payment to account for a "higher Medicare payment per case" for PPS hospitals that serve a disproportionate number of low-income patients. Accordingly, it is proper to determine a PPS hospital's eligibility for this additional payment based on beds that are attributable and allocatable to the PPS hospital's inpatient operating costs.

The Provider contended that observation beds should be included in the bed count for purposes of determining DSH eligibility because the beds are licensed acute care beds located in the acute care area of the hospital and maintained for inpatient lodging. The Board held that the criteria applied by the Intermediary for the exclusion of observation beds could not be supported based on the Board's interpretation of the language set forth in the regulations and manual guidelines. The Board held that all of the observation beds at issue were licensed acute care beds located in the acute care areas of the Provider's facility. The Board determined that these beds were permanently maintained and available for lodging inpatients and were fully staffed for the provision of inpatient services. The Board read the regulations and manual guidelines as including all beds and all bed days in the calculation, unless they were specifically excluded under the categories listed in the regulation. The Board found that given the degree of specificity with which the manual addresses this issue and the fact that the enabling regulation has been modified on at least two occasions to clarify the type of beds excluded from the count, these comprehensive rules are meant to provide an all inclusive listing of the excluded beds.

The Administrator finds with respect to observation bed days that a patient in an observation bed has not been admitted into the hospital. The payment of observation bed days as outpatient services is consistent with § 230.6 of the Hospital Manual, which provides that:

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[19] 53 Fed. Reg. 38480 (Sept. 30, 1988); See also 53 Fed. Reg. 9337 (March 22, 1988).

> A. Outpatient Observation Services Defined. – Observation services are those services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and to evaluate an outpatient's condition or to determine the need for a possible admission to the hospital as an inpatient….
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> B. Coverage of Outpatient Observation Services. – Generally, a person is considered a hospital inpatient if formally admitted as an inpatient with the expectation that he or she will remain at least over night… When a hospital places a patient under observation, but has not formally admitted him or her as inpatient, the patient initially is treated as an outpatient…. [Emphasis added.]

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 attributable to the inpatient hospital as part of a PPS hospital's inpatient operating costs.

Thus, applying the relevant law and program policy to the foregoing facts, the Administrator finds that the Intermediary properly excluded observation bed days from the bed count. CMS has consistently excluded from the bed day count, those bed days not paid as part of the inpatient operating cost of the hospital. That is, in this case, the observation bed day was not allocatable or attributable to PPS as an inpatient operating cost. Observation bed days are not allocatable or attributable to the PPS inpatient hospital, if a patient has not been formally admitted as an inpatient, but rather billed under Part B as outpatient services.

In addition, the Administrator disagrees with the Board's finding that the regulation and PRM listing of specific excluded items constituted an all-inclusive

list. In contrast to the Board's conclusions, courts have rejected earlier attempts by providers to argue that 42 C.F.R. 412.105(b) is an all-inclusive list. Instead, the Secretary was faced with similar arguments concerning neonatal intensive care beds and was successful in arguing that the regulation as written at that time did not clearly exclude all beds assigned to newborns, but could reasonably be interpreted to apply only to newborns in bassinets. The neonatal intensive care beds at issue in those cases were more like intensive care beds, which were listed as beds to be counted, and less like newborn bassinets, which were listed as beds to be excluded. [20]

Indeed, contrary to the Board's narrow reading of 42 C.F.R. § 412.105(b) and the manual as an all inclusive list, courts have found that the list is not confined to the literal terms of 412.105(b) in assessing its meaning. See, e.g., AMISUB d/b/a/ St. Joseph's Hospital v. Shalala, No. 94-1883(TFH) (D.D.C. 1995); Grant Medical Center v. Shalala, 905 F. Supp. 460, 1995 U.S. Dist. Lexis 17398; Sioux Valley Hospital v. Shalala, 29 F.3d 628,1994, U.S. App. Lexis 26519. The language of 42 CFR 412.105(b) with respect to neonatal intensive care beds was ambiguous and, thus, the Secretary's interpretation was entitled to deference.

Similarly, the Administrator finds that the listing of beds to be excluded in the regulation and the PRM is general in nature and not all-inclusive. A review of the beds listed to be excluded from the count of bed days shows such beds to be, inter alia, not paid as part of the hospital inpatient operating PPS payment. The observation beds at issue, which are being used for outpatient beds, are more like those beds located in the outpatient area and thus are properly excluded.

The Administrator 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.

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[20] See also Section 2510.5A of the PRM (1976), drafted pre-PPS and thus, pre-long-term care hospital PPS exclusion, which defines and adult or pediatric bed as "either acute care or long-term care." The Administrator disagrees with the Board's conclusion that the PRM example at § 2405.3. (G)(2), which includes long-term bed days in the count if the beds are not certified as long-term beds, is evidence that certification determines whether a bed is counted. In that case, certification determines the payment and the payment indicates whether the bed was recognized under PPS and used for inpatient hospital services on that day.

CMS 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….[21]

The Board's reading is also inconsistent with the Congressional intent that the DSH payment be an additional payment for "subsection (d)" hospitals, i.e., PPS hospitals, higher Medicare "costs per case." The higher Medicare cost per case necessarily reflects higher inpatient costs. Thus, consistent with the plain language of the regulation, CMS has reasonably used bed days attributable to the inpatient hospital as the measure for the DSH adjustment.[22]

The Administrator also 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. As outlined in § 2405.3G of the PRM, "a bed must be permanently maintained for lodging inpatients" to be considered an available bed. The beds must be immediately opened and occupiable. (Emphasis added). Beds used for other than inpatient lodging, are not counted. Therefore, if a bed is being utilized for another purpose, i.e., lodging a skilled nursing patient or for patient observation, it is not available for inpatient lodging on the days that it is being utilized for another purpose. In this case the

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[21] 59 Fed. Reg. 45374.

[22] At this time, neither Congress, nor CMS, has extended a DSH-type payment beyond inpatient hospital PPS. Notably, CMS decided not to pay a DSH adjustment under outpatient PPS because the estimated effect on the DSH patient percentage on costs was small and most often statistically insignificant. 64 Fed. Reg. 35260.

record is uncontested that observation patients occupied the beds on the days at issue.[23]

However, the Administrator notes that removing the observation bed days results in the Provider having 99.91 beds. The Administrator finds that it is appropriate to round this number to 100 beds in determining whether the provider meets the qualifying criteria for a DSH payment. Accordingly, the Administrator finds that the Provider meets the qualifying threshold of 100 beds after the removal of the observation bed days.

[23] The Secretary has restated this longstanding observation bed day policy in the proposed inpatient hospital PPS rule, published at 68 Fed. Reg. 27154, 27205-27206 (2003).

DECISION

The decision of the PRRB is affirmed on the grounds set forth in the foregoing opinion.

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

Date: 7/3/03

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