PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2002-D1

PROVIDER -
Presbyterian Hospital of Greenville
Greenville, TX

Provider No. 45-0352

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Trailblazer Health Enterprises, LLC
(formerly Blue Cross and Blue Shield of
Texas)

DATE OF HEARING-
January 31, 2001

Cost Reporting Periods Ended -
September 30, 1994; September 30,
1995;and September 30, 1996

CASE NOS. 00-1056**,** 99-3600
and 00-1057 (respectively)

INDEX

ISSUE:

Were the Intermediary's adjustments to the number of available beds for disproportionate share (DSH) qualification purposes proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Presbyterian Hospital of Greenville ("Provider") is a general, short term hospital located in Greenville, Texas. The Provider is owned and operated by the Hunt Memorial Hospital District, a political subdivision and municipal corporation, under the laws of the State of Texas. During the relevant fiscal periods under appeal, the Provider was licensed to operate 148 general acute care beds under Chapter 241 of the Texas Health and Safety Code and the Hospital Licensing Standards established by the Texas Department of Health.[1]

During the field audit of the Provider's cost report for the fiscal year ended ("FYE") September 30, 1995, Blue Cross and Blue Shield of Texas ("Intermediary") requested documentation from the Provider to support the total number of beds (i.e., bed size) used in calculating the amount of the DSH payment.[2] Relying upon a tour of the Provider's facility in May of 1997 and information obtained from the annual survey of the Texas Hospital Association/American Hospital Association filed with the Texas Department of Health, the Intermediary determined that the Provider had a total of 101 available beds. The Intermediary also determined that the Provider was using routine beds for ancillary observation services which were included in the 101-bed count. In compliance with instructions issued by the Health Care Financing Administration ("HCFA"), the Intermediary deducted five inpatient beds from the total count of 101 available beds to account for observation bed days utilized in the Provider's inpatient beds. As a result of the Intermediary's determinations, the Provider did not meet the 100-bed threshold for an urban provider in the calculation of the DSH payment.

The Intermediary's determination that served as the basis for its DSH adjustment for the FYE

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[1] See Provider Exhibit P-1.

[2] In January of 1999, Blue Cross and Blue Shield of Texas withdrew from the Medicare Program and Trailblazer Health Enterprises, LLC assumed their fiscal intermediary duties as a subcontractor of the Blue Cross and Blue Shield Association.

September 30, 1995 was also used to adjust the Provider's DSH payments for FYEs September 30, 1994 and 1996. Upon receipt of the Notices of Program Reimbursement ("NPRs") for each fiscal year, the Provider filed timely hearing requests with the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841 and has met the jurisdictional requirements of those regulations. Since the facts, issues and legal analysis for all of the appeals are identical, the cases were consolidated for a single hearing before the Board. The relevant data for each case are as follows:

Case No.	FYE	Date of NPR	Date of Appeal	Amount in Controversy
99-3600	9/30/95	6/16/99	7/23/99	$ 944,721
00-1056	9/30/94	12/20/99	1/13/00	$ 763,929
00-1057	9/30/96	9/15/99	1/13/00	$1,092,028

The Provider was represented by J.D. Epstein, Esquire, of Vinson & Elkins L.L.P. The Intermediary's representative was James R. Grimes, Esquire, of the Blue Cross and Blue Shield Association.

Medicare Statutory and Regulatory Background:

In 1983, Congress completely changed hospital reimbursement under the Medicare program by enacting Pub. L. No. 98-21 which created the Prospective Payment System ("PPS"). Under PPS, hospitals and other health care providers 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 share of patients who have low income or are entitled to benefits under Part A of this title.

42 U.S.C. § 1395 ww(a)(2)(B).

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, which was the Intermediary's determination in the instant case, the provider must have a disproportionate patient percentage of 40 percent to be eligible for the DSH adjustment.

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. The factors to be considered 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 status, 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 payment 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 units, and dividing that number by the number of days in the cost reporting period.

42 C.F.R. §412.105(b)

The bed counting regulation and additional guidance published by HCFA and the intermediaries 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(5)(F)(v).

PROVIDER's CONTENTIONS:

I. General:

The Provider contends that the sole issue to be determined in the instant case is the size of its facility for purposes of 42 U.S.C. § 1395ww(5)(F)(v). Since 1987, the Provider's facility has existed as an eight floor hospital designed and licensed for 148 acute care beds.[3] The licensed acute care beds were distributed among the hospital's floors as follows:

Second Floor	-10 Intensive Care Unit Beds.
Third Floor	- 40 Medical/Surgical Beds. - Originally designed to house 42 beds, but two beds were removed to create a pediatric play area.
Fourth Floor	- 42 Medical Surgical Beds. Fourth Floor is the central focus of this appeal.
Fifth Floor	- 40 Medical/Surgical Beds.

[3] See Provider Exhibit P-1.

- Only 36 beds were utilized for inpatient care during the periods under appeal.

Seventh Floor - 14 OB/Postpartum Beds.

The Provider acknowledges that it did not actually utilize all of its 148 licensed beds for inpatient care. Although some patient rooms were occasionally used for other purposes, the Provider contends that the rooms were capable of being used to house acute care beds up to the full complement of 148 licensed beds. Further, the Provider also maintained an Emergency Preparedness Plan[4] in accordance with state law, which detailed the immediate use of hospital areas to care for 141 inpatients. According to Provider testimony, the 141 bed capacity was an "immediate capacity" with no notice of a disaster and was expandable to a capacity of well above 148 beds within 48 hours should an emergency so require.[5] Thus the size of the Provider's facility was clearly large enough to fully treat well over 100 patients.

The Provider points out that the central controversy in this appeals revolves around the beds housed on its fourth floor. During the time period in controversy, the Provider contends that the fourth floor was utilized for multiple purposes. Of the 42 rooms licensed to house a general acute care bed, 26 contained fully equipped inpatient beds which were used for pre- and post-surgical care, and 16 were utilized for temporary office space or storage.[6] At the hearing, the Provider testified that a portion of the fourth floor was used for its surgical patients to have preparatory services performed prior to a surgical procedure. The patients were then transported to the second floor for surgery and, after surgery, would be placed in a recovery area also on the second floor. Recovered patients would be transported back to the fourth floor for a period of assessment prior to their leaving the hospital. If a patient's condition required admission as an inpatient, the patient would be admitted and transferred to the third or fifth floor when a room became available. If the need arose, the surgical patient could stay in the inpatient bed on the fourth floor overnight bed as there was no difference between the beds on the fourth floor and the other inpatient floors.[7]

The Provider insists that it utilized its fourth floor in an efficient manner recognizing the needs of its patient population. By combining inpatient operations on the third and fifth floors, the Provider recognized economies from a staffing perspective, as nursing staff did not need to be spread over three floors for 24-hour shifts. Rather than completely closing the fourth floor, the Provider utilized its extra inpatient beds as pre- and post-surgical areas, office space, and storage. Regardless of their actual use or disuse, the Provider argues that all of the rooms on the fourth floor remained part of the Provider's license for 148 acute care beds during the periods in

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4 See Provider Exhibit P-4.

5 Tr. at 57-58, 68.

6 Tr. at 62.

7 Tr. at 87-89, 122-125. See also Provider Exhibits P-17 and P-18.

controversy. In addition, all of the fourth floor rooms were included as depreciable plant assets in the routine areas on the Provider's cost report, and the overhead of the fourth floor operations was allocated to routine areas.[8] Nonetheless, the Intermediary did not count any of the beds or rooms on the fourth floor in making its DSH eligibility determination.

[8] Tr. at 84-85.

The Provider points out that, prior to the Intermediary's finalization of the NPR for the FYE December 31, 1995, the Provider and the Intermediary met on several occasions to exchange information relating to the bed count at the Provider's facility. At the time of the Intermediary's field audit and tour of the hospital facility in May of 1997, the fifth floor was partially closed for renovation and conversion into a transitional care unit. It was this construction on the fifth floor that caused the Intermediary to believe that the Provider "may not have 100 beds available as required by the regulations."[9] Based on the tour of the hospital facility and nurse interviews, the Intermediary reported the fourth floor as "day surgery, Endo (laser), offices" and did not include a single bed from the fourth floor in its total bed count for the Provider.[10] According to the testimony of the Provider's witness, the Intermediary's auditors did not actually tour the fourth floor during the field audit. Further, the Intermediary had previously conducted a field inspection in 1994 and made a determination that the Provider's facility contained more than 100 beds. The Provider's witness further testified that there were no changes to the Provider's operation or number of beds at the facility from 1992 through 1996.[11]

In response to the Intermediary's request, the Provider furnished the Intermediary with bed count information from various sources including: (1) a 1995 Texas Hospital Association/American Hospital Association Survey ("THA/AHA Survey"); (2) floor plans of the facility; (3) bed tracking charts; (4) bed license information; and (5) interviews with Provider staff. Despite the other evidence furnished, the Intermediary utilized information from the THA/AHA Survey as its basis for determining the number of available beds at the Provider's facility.[12] The Provider notes that the THA/AHA Survey is not a Medicare required document and is maintained by the Texas Department of Health to track the number of "set up and staffed beds" at the Provider's facility. At the hearing, the Intermediary's witness acknowledged that "setup and staffed beds"

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9 See Provider Exhibit P-5.

10 See Provider Exhibit P-6.

11 Tr. at 79-81.

12 See Provider Exhibit P-7.

are completely different from "available beds" for purposes of making its DSH eligibility determination.[13] Despite this acknowledgment, the Intermediary equated the two and concluded that the Provider's facility had 101 "available beds" prior to making its observation bed days reduction.

[13] Tr. at 192-194.

With respect to the reduction for observation bed days, the Intermediary retroactively applied a 1997 HCFA policy to the 1995 time period. On February 27, 1997, HCFA issued a Memorandum, the subject of which was "Counting Beds and Days for Purposes of the Medicare Hospital Inpatient Disproportionate Share and Indirect Medical Education Adjustments" (the "HCFA Memorandum").[14] The HCFA Memorandum included the following instructions:

> 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 adjustments. If a patient in an observation bed is later admitted, then the equivalent days before the admission are also excluded. Thus all observation bed days are excluded from the available bed day count.

Although the Provider did not have a dedicated observation area during the cost reporting periods at issue, the Intermediary used "scattered observation bed days" to calculate five "observation beds," which it deducted from the 101 available beds initially determined to arrive at its final total of 96 available beds. The Provider testified that all of the "observation bed days" used by the Intermediary involved the intermittent use of licensed inpatient beds scattered throughout the facility (exclusive of the fourth floor) that were not only capable of immediate use as inpatient beds, they were actually being used as inpatient beds during the relevant time periods.[15]

The Provider contends that the Intermediary committed two independent errors in making its DSH eligibility determination relating to the number of available beds at its hospital facility. The first relates to the use of an inappropriate standard (i.e., "set up and staffed beds" as opposed to "available beds") in determining the number of beds at the Provider's facility. The second error relates to the Intermediary's retroactive application of the HCFA Memorandum to scattered observation beds in the Provider's facility, thereby reducing the Provider's bed count from 101 to 96 available beds. The correction of either error would result in the Provider being eligible for DSH payments as an urban hospital with more than 100 beds.

II. Proper Standard for Counting Available Beds:

The Provider contends that the evidence and testimony presented by the Intermediary clearly demonstrates that it utilized the number of beds "set up and staffed" at the Provider's facility in making its bed count for DSH purposes.[16] The use of the "set up and staffed" standard to

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[14] See Provider Exhibit P-16.

[15] Tr. at 91, 128-130.

[16] Tr. at 192-193. See also Provider Exhibit P-6 and P-7.

calculate available beds is in complete contravention of the applicable statutes, regulations, program instructions and HCFA Administrator decisions regarding the appropriate counting of available beds. In support of these contentions, the Provider offers the following:
A. Statutory and Regulatory Authority Relating to the Counting of Beds for DSH Purposes:

The statutory provisions at 42 C.F.R. § 1395ww(d) et seq. provide for additional payments for certain hospitals which serve "a significantly disproportionate number of low-income patients" which is defined as having "a disproportionate patient percentage . . . which equals or exceeds: (I) 15 percent, if the hospital is located in an urban area and has 100 or more beds." The regulations at 42 C.F.R. §§ 412.105 and 412.106 provide the methodology for determining the number of beds for DSH status, which is in accordance with the indirect medical education ("IME") bed count rules. Under the IME regulation:

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

42 C.F.R. § 412.105(b)

In the September 3, 1985 Federal Register, HCFA provided a clarification in responding to a commenter's request for a more precise definition of "available bed days" by stating:

> 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 further notes that the Blue Cross and Blue Shield Association issued Administrative Bulletin #1841, 88.01 on November 18, 1988 to clarify certain points concerning the definition of available bed days.[17] This Bulletin advised that beds are considered "available" and must be counted "even though it may take 24-48 hours to get nurses on duty from the

[17] See Provider Exhibit P-10.

registry." Accordingly, the Intermediary's reliance on the THA/AHA Survey and the "setup and staffed" standard as the basis for its bed count at the Provider's facility is not supportable by the regulations or HCFA Policy. Beds in use for treating inpatients are counted as "available" despite the fact that they are occupied. As the regulation at 42 C.F.R. § 405.105(b) indicates, "available bed days" are simply the product of multiplying the number of beds by the number of days in a cost reporting period. There is no regulatory requirement that a bed be used to be considered available. Contrary to the Intermediary's determination, it is clear from HCFA's policy that beds do not have to be set up or staffed to be counted as available beds so long as they are capable of being staffed in 24-48 hours.

B. The Provider Reimbursement Manual ("HCFA Pub.15-1") Requires Counting All Inpatient Routine Beds:

The Provider contends that HCFA Pub.15-1 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. The manual provisions at § 2405.3.G state the following:

> 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.
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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 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 (emphasis added).

The Provider argues that the manual provisions clearly state that "available bed days" include all routine beds, and there is no reference that bed size be determined solely on beds that are "set up and staffed." 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." The Provider asserts that the beds on the fourth floor of its facility were not taken out of service, and that the size of its facility remained constant during the relevant time period. The hospital facility remained licensed and capable of operating 148 beds, and there were no structural changes in the size of the facility that would have limited the use of the beds on the Provider's fourth floor.

C. Intermediary's Interpretation of HCFA Pub. 15-1 is Without Merit:

The Intermediary emphasizes a single sentence of HCFA Pub. 15-1 § 2405.3.G to establish a basis for its bed count noting that, "[t]o be considered an available bed, a bed must be permanently maintained for lodging inpatients." (emphasis added). Relying on this sentence, the Intermediary concludes that: (i) a provider would be required to keep beds in their existing usable state as inpatient routine care beds in order for the beds to be considered available; and (ii) conversion of rooms to uses other than inpatient routine care would eliminate those rooms from being "permanently maintained" as routine inpatient beds. The Provider contends that the Intermediary's conclusion ignores other portions of the manual provision which state that, for a bed to be permanently maintained, it must be available for use and housed in patient rooms or wards.

While it is inappropriate to count beds for which a facility is not designed to hold (i.e., beds in corridors and temporary beds), if the bed is housed in a patient room and available for use it must be counted pursuant to the regulatory and manual provisions. The Provider argues that the floor plans furnished to the Intermediary, as well as the testimony of its witnesses, provide ample evidence that the fourth floor contained 26 beds in patient rooms which were immediately available for use as inpatient beds, and that an additional 16 beds could also have been available within 24-48 hours. The Intermediary's focus on the actual use of the fourth floor beds as pre- and post-surgery beds caused it to inappropriately ignore the availability of the beds in accordance with the manual provisions.

At the hearing before the Board, the Intermediary's witness testified that "[t]aking beds in and out of service . . . means [that the Provider is] changing the character of the beds. It doesn't mean that [the Provider is] physically moving the beds out of that room . . . it means [the Provider is] changing its definition or character as an inpatient PPS routine bed and utilizing it

for some other type [of] service that is not an inpatient routine PPS service."[18] The Provider argues that the portion of the manual provision upon which the Intermediary relies specifically addresses "changes in the size of a facility," not changes in the nature or character of the beds within the facility. The Provider asserts that it had not changed the size of its facility during the relevant time period by adding new beds to the facility or removing rooms capable of treating inpatients. The Provider further notes HCFA's example presented under HCFA Pub. 15-1 § 2405.3.G.(2) wherein a bed licensed as a hospital acute care bed must be included in the hospital's available bed count even if the bed is actually used for long term care. For the same reason, the Provider asserts that its fourth floor beds that were used to treat pre- and post-surgery patients must be counted because they remained licensed as acute care beds throughout the relevant time period.

D. HCFA Policy and Administrator Decisions Further Emphasize the Intermediary's Inappropriate Available Bed Determination:

The Provider contends that, if the Intermediary's available bed count determination can be described as inconsistent with the regulatory and manual provisions when compared with prior HCFA policy and Administrator decisions relating to available beds, then the Intermediary's determination in the instant case becomes wholly arbitrary. The Provider points out that HCFA has clearly stated that beds are presumed available and counted unless the provider presents affirmative evidence to exclude the beds. In support of this contention, the Provider cites various Board/HCFA Administrator decisions.

In Natividad Medical Center v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 91-D58, August 9, 1991, Medicare and Medicaid Guide (CCH) ¶ 39,573, rev'd HCFA Administrator, October 6, 1991, Medicare and Medicaid Guide (CCH) ¶ 39,611, ("Natividad")[19] 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 beds are available. The provider in Natividad furnished the intermediary with the number of available beds it had reported to the State of California Office of Statewide Health Planning and Development, an annual report similar to the THA/AHA Survey in the instant case. Ironically, the annual survey used in Natividad carried no weight as evidence of the number of available beds at the facility, and the HCFA Administrator ruled that the Intermediary's use of the licensed bed count was appropriate. By contrast, the Intermediary in the instant case has given such enormous weight to the THA/AHA Survey that no other evidence offered by the Provider is acceptable.

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[18] Tr. at 188-189.

[19] See Provider Exhibit P-12.

The Provider also cites the HCFA Administrator's decision in Pacific Hospital of Long Beach v. Aetna Life Insurance Company, PRRB Dec. No. 93-D5, December 12, 1992, Medicare and Medicaid Guide (CCH) ¶40,987, rev'd in part, HCFA Administrator, February 2, 1993, Medicare and Medicaid Guide (CCH) ¶ 41,355 ("Pacific").[20] In Pacific, the provider attempted, for IME purposes, to exclude beds on two of its units by demonstrating that one unit was used as office space and that construction was in process on the second unit. The HCFA Administrator ruled that the provider failed to meet the burden of proof to exclude the beds. According to the Administrator, "[t]he [p]rovider's census records alone [do] not provide the basis for determining whether beds are available; rather it merely shows that they were not put in service." Id. If the beds, although temporarily withheld from service, were "immediately occupiable" (i.e. if they could be placed in service within 24-48 hours) the provider, and the intermediary, were required to include them in the bed count. The Provider insists that the situation on its fourth floor for the periods in controversy was identical to the Pacific case. The Provider contends that all of the beds on the fourth floor were capable of conversion into inpatient beds ready for immediate occupancy, even though some of the beds were being temporarily used for other purposes. If the beds are required to be counted for IME purposes, the DSH regulation requires the Intermediary to count them as available beds for DSH determinations. The Intermediary's refusal to follow clearly established legal precedent is another example of the arbitrary and capricious nature of its determination methodology.

The Provider further notes that the Board has upheld the broad definition of "available beds" that has been promulgated by the HCFA Administrator in the past. In United Hospitals Medical Center v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of New Jersey, PRRB Dec. No. 2000-D23, March 2, 2000, Medicare and Medicaid Guide (CCH) ¶ 80,399, the Board agreed with the intermediary that the beds in question would have to be included in the available bed count if the provider made no adjustment to remove the depreciation for these beds as required by Administrative Bulletin # 1841, 88.01. In this DSH appeal, the Provider did not remove its fourth floor beds from its depreciable assets on the cost report. The Provider notes that the Board's reliance upon HCFA Administrative Bulletins is consistent with previous HCFA Administrator decisions, and reflects the importance of these bulletins in establishing HCFA's available bed policy.

In summary, the Provider argues that the Intermediary has completely ignored prior decisions by the HCFA Administrator and the Board in establishing the IME bed counting requirements, which must also be utilized to determine the number of beds for purposes of DSH status. The law requires that the IME bed counting rules be used for DSH purposes, and the Provider should not be burdened with a determination based on an inexplicable departure from the Medicare program's well established bed counting rules.

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[20] See Provider Exhibit P-13.

E. Administrative Bulletins Reinforce Broad Definition of Available Beds:

The Provider contends that the instructions set forth in Administrative Bulletins published by the Blue Cross and Blue Shield Association provide clarification to HCFA's longstanding policy relating to available bed determinations. Administrative Bulletin #1830, 87.01[21] (dated January 28, 1987) provides for the counting of beds if they are capable of being put into use as follows:

> [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 a major criterion. If the bed can be placed in service for patient care within a short period of time, the bed would be available.

Administrative Bulletin #1830, 87.01 (emphasis added).

Similarly, Administrative Bulletin #1841, 88.01[22] (dated November 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.

Administrative Bulletin #1841, 88.01 (emphasis added).

Accordingly, the Provider contends that the lack of use of its fourth floor beds, or using the beds as pre- and post-surgical beds during the relevant time period is not sufficient to overcome their status as available beds. The beds were included in the Provider's depreciable assets, were

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[21] See Provider Exhibit P-15.

[22] See Provider Exhibit P-10.

located in inpatient rooms, and were clearly capable of being set up and staffed within 24-48 hours.

F. Evidence Does Not Support Intermediary's Contentions:

The Provider notes that the Intermediary acknowledged that its 101 bed count represents "staffed and ready beds" and not "available beds" as required by Medicare regulations and instructions.[23] Accordingly, the Intermediary used the wrong standard to make its DSH eligibility determination and did not include any rooms on the fourth floor of the hospital facility. The Intermediary has attempted to justify the exclusion of the entire fourth floor based upon its strained interpretation of the manual instructions that the Provider's use of the beds for pre- and post-surgery care took these beds out of service. The Provider argues that the evidence indicates that only five to fifteen of the 42 fourth floor rooms were utilized for such pre- and post-surgery services.[24] The remaining rooms on the fourth floor were idle or contained temporary offices or storage space and were capable of being shifted into inpatient use within 24-48 hours.

Even if the Intermediary is allowed to ignore certain language in HCFA Pub.15-1 and adopt its own personal interpretation, such interpretation can only be relied upon to remove a portion of the beds on the fourth floor from the available bed count. The Provider contends that the manual provisions, HCFA Administrator decisions and Administrative Bulletins would all require that at least the 16 rooms that were used as offices and storage space should be included in the available bed count. The Provider points out that, when confronted with the evidence that these rooms could be made available for inpatient care within 24-48 hours, the Intermediary's witness conceded that the rooms would have to be counted as available beds:

> Q: And if the other 16 rooms on that floor housed, as you saw on this chart, some cleaning equipment, et cetera, but all [Provider witnesses] as you heard, testified all the connections were in place and you heard testimony that they could be made ready in 24 to 48 hours...provided the testimony is accurate, you can verify it, that to would be counted as available beds?
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> A: Yes, I would if it was temporary usage of the room for storage and it could be converted within that time period , yes I would.
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> * * *
>
> Q: But you have heard testimony that ... every one of the 42 beds on the fourth floor are capable of being staffed and opened within

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[23] Tr. at 195.

[24] Tr. at 121.

> 24-48 hours, then you have no - there is no independent. . .
>
> A: I have no reason to doubt her testimony or challenge her testimony, no.

Tr. at 224-227.

Based on the evidence presented, the Provider concludes that even under the broadest reach of the Intermediary's contentions, at least 16 beds must be added to the Provider's available beds. Additionally, some of the pre- and post-surgery patients on the fourth floor were admitted as inpatients to the Provider's facility and, thus, were not dedicated to outpatient services as asserted by the Intermediary. Accordingly, the evidence presented in this DHS appeal cannot support the contentions of the Intermediary.

G. Burden of Proof:

The Intermediary has asserted that it is the Provider's burden of proof to show that it has more beds available than it listed on the THA/AHA Survey. It was due to this lack of documentation that the Intermediary adopted the "set up and staffed" standard and relied upon the THA/AHA Survey to make its bed count determination. The Provider points out that the Intermediary has taken this position despite the clear instructions in HCFA Pub. 15-1 § 2405.3.G which states that: "[i]n 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." The Provider further notes that the Intermediary has rejected floor plans, licensing information and Provider testimony as evidence of the number of available beds at the hospital facility. While such evidence has been accepted in prior HCFA Administrator's decisions on the available bed issue, the Intermediary has steadfastly relied upon the THA/AHA Survey's "set up and staffed" bed count. Additionally, the Intermediary has required bed census data or utilization statistics to prove a different number, despite the fact that the HCFA Administrator has held that this type of evidence is irrelevant to the determination of available beds. According to the Intermediary, the "most reliable documentation" is the unacceptable evidence of the Provider's THA/AHA Survey, and the Provider has the duty to overcome this unacceptably derived presumption solely by producing irrelevant bed use statistics.

III. Removal of Scattered Observation Beds from Available Bed Count is Inappropriate:

The Provider contends that, even assuming that the Intermediary's initial count of 101 available beds was appropriate, the Provider would still have been eligible to receive DSH payments but for the Intermediary's retroactive application of the proposed HCFA policy set forth in the HCFA Memorandum dated February 27, 1997.[25] The Provider insists that this HCFA Memorandum is wholly inconsistent with Medicare regulations, instructions and previous HCFA

[25] See Provider Exhibit P-16.

policy regarding the counting of available beds for DSH purposes. In support of this contention, the Provider presents the following:

A. Policy in 1997 HCFA Memorandum Should Not Apply:

The Intermediary relied upon the following statement in the HCFA Memorandum to make its determination of the Provider's available beds:

> 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 adjustments. If a patient in an observation bed is later admitted, then the equivalent days before the admission are also excluded. Thus, all observation bed days are excluded from the available bed day count.

The Provider contends that this proposed HCFA policy should not be applied because it substantively changes the regulations regarding DSH and IME bed counting. While the proposed policy may provide a basis for the Intermediary's exclusion of five observation beds, it does not serve as a basis for excluding the inpatient beds on the Provider's fourth floor. The Provider insists that the proposed policy is clearly inconsistent with HCFA's prior policies, and effectively attempts to substantially modify the DSH and IME bed counting regulations. Accordingly, if the proposed HCFA policy is implemented, it would clearly violate the rule making requirements of the Administrative Procedures Act (5 U.S.C. §553) and violate the Provider's right to due process.

B. Observation Days are Not Excluded by the Regulation:

The Provider contends that observation days are not in any of the areas excluded by the terms set forth in 42 C.F.R. § 412.105(b) (i.e., healthy newborn nursery, custodial care beds, or beds in excluded hospital units). Thus, beds used for observation services must be counted if they fit within the definition of an "available bed day." The scattered observation beds used by the Intermediary to determine the reduction in the Provider's DSH bed count are those routine beds which are universally interpreted as being within a hospital's bed count (i.e., the beds are licensed and certified). Pursuant to 42 C.F.R. § 413.20 (a), the Medicare program has adopted standardized definitions commonly used by hospitals. A hospital's temporary use of a licensed and certified inpatient routine bed to furnish observation services does not reduce a hospital's bed size under standard and accepted definitions of bed size.

C. Observation Days are Not Excluded by HCFA Pub. 15-1:

The Provider argues that, when the manual provision of HCFA Pub. 15-1 § 2405.3.G is read in conjunction with the regulation at 42 C.F.R. § 412.105(b), it is clear that the manual's reference

to beds in "outpatient" departments is limited to unlicensed beds. The excluded beds listed in the regulation do not include ancillary or outpatient beds because such beds are not within accepted industry definitions and would not be counted in the first instance. Accordingly, the manual's exclusion of unlicensed beds is not inconsistent with the regulation. Since the manual cannot contradict or go beyond an acceptable interpretation of a regulation, the reference to ancillary or outpatient beds in HCFA Pub. 15-1 § 2405.3.G must be read as a reference to unlicensed beds.

The Provider notes that the Intermediary's witness testified that the manual instructions do not include observation days among those bed days to be excluded from the available bed count as follows:

> Q: Does Section 2405.3.G [of the PRM] list observation days as days that should be excluded from the ...
>
> A: No, I do not believe 2405 does, and I think this has been discussed earlier too and information using as a guide. We know that it specifically mentions four or five different categories but observation beds is definitely not one of the categories.
>
> * * *
>
> Q: Because you've been given a directive instruction?
>
> A: Exactly. We've been given specific instructions as Intermediary how to treat the observation beds which obviously has led to a lot of confusion and problems over the years but . . . They are the instructions we must follow.

Tr. at 204-206.

The Provider also refers to the available bed calculation example cited in HCFA Pub. 15-1 § 2405.3.G(2) which included the following notation - "[a]lthough 35 beds are used for long term care, they are considered to be acute care beds unless otherwise certified." The Provider argues that the use of licensed and certified inpatient beds for observation services does not make the beds any less available for inpatient routine services than beds used for long-term care. Moreover, the case of scattered observation beds that are only intermittently used for furnishing services to persons other than admitted acute care hospital patients is stronger than the use of beds that are dedicated to long term care.

D. Proposed HCFA Policy is Unsupported on Logical Grounds:

The proposed HCFA Policy set forth in the HCFA Memorandum not only requires the exclusion of observation days billed as outpatient services, but also requires the exclusion of observation

days billed as inpatient days. The Provider contends that the "DRG payment window" set forth in 42 U.S.C. § 1395ww(a)(4) clearly requires that all outpatient services furnished within three days of the date of admission must be billed as inpatient services. Since observation services for a Medicare patient who is admitted must be billed as inpatient services, there is no conceivable basis for excluding the bed day from the count of bed days used to calculate a hospital's bed count. The Provider points out that a patient in a "scattered" observation bed is in an inpatient bed, receives the same services as inpatients, and is billed as an inpatient and, yet, HCFA's new policy states that the bed is not an available inpatient bed.

The Provider argues that the exclusion of observation bed days in scattered beds which are billed as inpatient services is impractical as well as unsupportable on logical grounds. The cost report calculation of observation days for admitted inpatients, and the revenue codes on claims forms do not identify those services. Accordingly, the Provider concludes that the lack of a mechanism for identifying such days is evidence, by itself, that it was never HCFA's policy to exclude such days from the count of available bed days.

E. HCFA Administrator's Rationale for the Proposed HCFA Policy is not Reasonable:

The Intermediary cites the HCFA Administrator's decision in 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 ("Commonwealth of Kentucky"), as its authority for relying on the proposed HCFA policy to exclude the Provider's scattered observation beds from the available bed count. While the Administrator's decision in Commonwealth of Kentucky supports the proposed HCFA policy, the Provider contends that its rationale is unsupportable by previous HCFA regulations, manual provisions, policy pronouncements and other Administrator decisions. The Administrator's decision indicates that it has always been HCFA's policy to count as available bed days "only inpatient days to which the prospective payment system applies" and, therefore observation bed days are not counted in the available bed day count, even if the bed is an inpatient bed. The Provider points out that this decision focuses directly on the use of a bed rather than its availability, and is contrary to the law and previous policy promulgated for years by HCFA. According to the Commonwealth of Kentucky decision, bed days not reimbursed under the Medicare PPS System are not counted because the "day was not recognized under PPS as an inpatient operating cost. The Provider counters that one need only look to the bed counting example in HCFA Pub. 15-§ 2405.3.G(2) to see that this is incorrect. Further, a number of observation bed days are actually paid under PPS because of the effect of the "DRG payment window." The Provider asserts that its observation beds were clearly within its inpatient units and should have been counted as part of the unit in which they were located in accordance with HCFA's longstanding policy.

F. HCFA Proposed Policy Eliminates Predictability and Undermines the Principle of Prospectivity:

The Provider advises that, from the outset of PPS, HCFA has focused on the desirability of the

predictability of a prospective payment in contrast to the uncertainty created under retrospective cost reimbursement. As one example, HCFA rejected making retroactive adjustments to correct errors in market basket projections on the grounds that this "would introduce an element of uncertainty incompatible with the very purpose of the prospective payment system." 49 Fed. Reg. 234, 252 (Jan. 3, 1984). However, HCFA's new policy on excluding scattered observation bed days from the count of available bed days introduces a great deal of uncertainty for urban hospitals with 100, or just over 100 beds. Such facilities will not know at the beginning of a cost reporting period whether they will qualify for DSH payments, which defeats the predictability that HCFA has held forth as being the hallmark of prospective payment. The Provider acknowledges that all hospitals have uncertainty as to the precise amount of payment under PPS. However, the uncertainty in this instance for hospitals such as the Provider is altogether different because it is not the amount of a DSH adjustment that is at issue; rather, it is whether there will be any such adjustment at all.

G. Proposed HCFA Policy May Not Be Retroactively Applied:

The Provider contends that it had no notice of the change in policy for observation beds, and has always included in its DSH calculation the bed days for the scattered observation beds. Accordingly, to the extent that the policy for determining available beds will be changed to exclude observation bed days, the policy should not be applied retroactively to the Provider. The Provider believes that the HCFA policy at issue in this case is confusing, and that written instructions to providers have been far from clear in excluding routine beds used intermittently for observation services. Moreover, even the Intermediary's witness testified that policies with respect to observation beds have "led to a lot of confusion."[26] In summary, the Provider states that no objective person could reasonably conclude that this issue has been addressed clearly or unambiguously by HCFA, as reflected in the following recapitulation of previously explained points:

- The regulation text does not mention such scattered observation beds;
- HCFA Pub. 15-1 § 2405.3.G excludes only beds in "outpatient areas" and includes beds "maintained for lodging inpatients;"
- That same manual section gives an example of including "long term care" beds in a hospital's count of inpatient acute care beds when that is how the beds are licensed and certified;
- The cost reporting forms have to be completed backwards for scattered observation bed days to be excluded from the count of available acute care bed days;
- Longstanding policy reflected in a Blue Cross Administrative Bulletin requires including

[26] Tr. at 206.

in the count of available bed days those beds which could be used for inpatients within 24-48 hours:

- The longstanding policy not to attribute costs or days to individual beds, but rather to units or departments;

- The HCFA Administrator has held that beds occupied by physicians, for whom no nursing staff are necessary, are available; and

- Finally, the longstanding prevailing practice, not just for this Provider but all over the country, has been to include scattered observation bed days in the count of available acute care bed days.

In the instant case, the Provider claimed the same scattered observation beds excluded by the Intermediary for several prior years without comment from the Intermediary until the recently proposed adjustment negating the Provider's entire DSH payment. The Provider reasonably relied upon the manual provisions in determining that the scattered observation beds were properly included in its bed count since they were, in fact, licensed acute care beds that were "available" within the meaning of the Medicare program. Accordingly, should the proposed HCFA policy be applied, it should be applied prospectively only, and should not be the basis for huge retroactive adjustments adverse to the Provider.

IV. Provider's Supplement to Post-Hearing Brief and Proposed Decision:

Subsequent to the date on which the Provider submitted its Post-Hearing Brief, the United States District Court for the Eastern District of Kentucky overruled the HCFA Administrator's decision in Commonwealth of Kentucky. Since the Intermediary heavily relied upon the Administrator's decision to support its contentions in this appeal, the Provider filed a supplemental brief to incorporate the court's decision into the record of this appeal.

On March 20, 2001 the district court issued its decision for Clark Regional Medical Center, et al. v. Shalala, 2001 W.L. 332064 (E.D. Ky 2001) ("Clark Regional"),[27] in which the court determined that the Administrator's decision in Commonwealth of Kentucky "was arbitrary and capricious and not supported by the applicable regulations and PRM guidelines." The Provider points out that the court further found the Administrator's construction of the applicable regulations and guidelines relating to the exclusion of scattered observation beds (and swing beds) from the DSH available bed count could not be seen as rational in light of the plain language of the regulations and the Provider Reimbursement Manual ("PRM").

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[27] See Provider Exhibit P-19.

The Provider finds it interesting that the Clark Regional decision also held that the evidentiary burden is on the hospital to exclude beds, not to have them included in the available bed count. The court indicated that the requirements of 42 C.F.R. § 412.106 compel an equal reading of the PRM for IME as well as DSH purposes. The court then stated that, "the burden should have remained on the hospital to exclude beds - necessarily placing the burden on the defendant to include beds - and should not have shifted simply because it would work to the defendant's detriment in this particular case." Thus, the Intermediary's position that the Provider should produce census or other usage statistics in order to prove that the Provider's fourth floor rooms were available is contrary to law. It is the Intermediary's duty to produce evidence that such beds are unavailable under the applicable Medicare definition of "available beds," a duty that the Intermediary has failed to fulfill. The Provider concludes that the Clark Regional decision provides additional support for the Provider's position in this appeal and reverses the only Medicare decision relied upon by the Intermediary to support its contentions.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that it properly determined that the Provider did not meet the minimum criteria of 100 beds or more for the DSH payment adjustment in accordance with the pertinent statutory and regulatory requirements and the relevant instructions issued by HCFA for the determination of available beds.[28] As an urban hospital with less than 100 beds, the Provider was required to meet a minimum disproportionate patient percentage of 45 percent to qualify for DSH payments. Since the Provider's DSH percentage was less than the required amount, adjustments were proposed to remove the Provider's claims for DSH payments for all of the years in contention.[29]

The Intermediary advises that its original determination that the Provider had 101 total beds available (prior to the deduction of five observation beds) was based on documentation supplied by the Provider. In response to a documentation request to support the total number of available beds during its field audit, Provider personnel submitted to the Intermediary auditors a count of available beds based on the annual THA/AHA Survey filed with the Texas Department of Health. The survey data indicated a count of 101 beds with a notation that the count consisted of set up and staffed beds.[30] In addition, the Intermediary toured the Provider's facility on May 19, 1997 as part of the field audit. Based on the tour and notes taken during the tour, the

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[28] Except for citations from the Hospital Manual (HCFA Pub. 10), the statutes, regulations and HCFA instructions cited by the Intermediary have been previously addressed in the Statement of the Case and Procedural History and the Provider's Contentions of this decision.

[29] See Intermediary Exhibit I-6.

[30] See Intermediary Exhibit I-3.

Intermediary counted 102 beds, which was comparable to the THA/AHA Survey.[31] The Intermediary accepted the 101 beds as reported to the Texas Department of Health as the Provider's count of available beds.

The Intermediary notes that the Provider acknowledged that the entire fourth floor was temporarily unoccupied from 1994 through 1996, and that certain rooms were used for office space, storage and outpatient services. While the Provider asserts that at all times all of the beds on the fourth floor could have been shifted into immediate use as inpatient beds should the need arise, no documentation has ever been submitted to the Intermediary to support this assertion. Based on interviews with Provider personnel and a physical tour of the Provider's facility, which included the fourth floor, the Intermediary determined that the Provider was actually using the fourth floor beds for services related to outpatient surgery- an ancillary service excluded from inpatient PPS. This use was in addition to the rooms converted to office and storage space.

[31] See Intermediary Exhibits I-4 and I-5.

Based on its observations, the Intermediary requested detailed census reports to determine whether the fourth floor had been used for routine inpatient care during the fiscal year under review. Instead of supplying the census data requested, the Provider submitted its own schedule of the census report, which indicated that the fourth floor incurred patient census during 1995.[32] However, the Provider failed to submit the actual census reports for the Intermediary's review as requested.[33] Although the Provider had stated earlier that the fourth floor was unoccupied, the Provider's schedule of the census reflected patient days on the fourth floor. When the Intermediary noted that patient days were reported only for Monday through Friday, the Intermediary further questioned the Provider's report of patient days. The Intermediary believes that the lack of patient census on weekends and holidays supports its position that the fourth floor was being used for a purpose other than routine inpatient care. This is further supported by the fact that the Provider's general ledger did not accumulate data for the fourth floor in the departments reported on the cost report as Routine Inpatient, ICU or the Nursery.

In as much as the Provider never supplied the specific documentation requested throughout the settlement process and subsequent meetings, the Intermediary filed a Request for Discovery and a subsequent request with the Board to compel the Provider to respond to the Request for Discovery. The following comments are based on a review of the documentation requested and the Provider's response to the Requests for Discovery

Daily Census Reports:

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[32] See Intermediary Exhibit I-8.

[33] See Intermediary Exhibits I-9 and I-10.

In response to the Intermediary's request for the daily census reports for fiscal year 1995, the Provider submitted the same schedule which had been provided during the settlement process which was rejected because it did not contain auditable and verifiable information. Upon further review of the Provider's census schedule, the Intermediary calculated an unexplained variance of 3,461 days between the census schedule and the days reported by the Provider on its Medicare cost report.[34] The Intermediary believes this discrepancy supports its contention that the Provider's census schedule is unreliable for determining the number of beds available at the Provider's facility.

Outpatient Surgery Services:

As part of the Request for Discovery, the Intermediary also requested a complete listing of outpatient surgery procedures, by patient, which reflected the date of service and the specific location of where the pre- and post-surgery services were rendered. In response, the Provider submitted a listing of the outpatient surgery patients but failed to identify the specific location of the services. Although this documentation is pertinent to the Intermediary's position, the Provider did not fully comply with the Intermediary's Request for Discovery.

Observation Services:

The Provider's listing of observation services by patient and location clearly indicates that the Provider was using beds located on the second, third, fifth and seventh floors for the ancillary observation services.[35] In addition, the volume of observation services was large enough, 1,946 equivalent bed days,[36] to have

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34 See Intermediary Exhibit I-2.

35 See Intermediary Exhibit I-15.

36 See Intermediary Exhibit I-2.

caused five regular routine beds to be occupied for ancillary services throughout the entire cost reporting period.

Availability of Beds Converted to Other Uses Within 24-48 Hours:

The Intermediary argues that the Provider was unable to provide any documentation to support its contentions that the beds used for purposes other than routine inpatient care could be placed into service within 24-48 hours. The Provider could not provide contracts with nurse recruiting agencies, temporary employment agencies or patient bed suppliers that were in effect during fiscal year 1995. Further, no contemporaneous documentation was submitted to support the existence of a formal plan or procedure for placing patient rooms back into routine patient care use within 24-48 hours. According to the Provider's Medical Unit Staffing Pattern,[37] 32 full-time employees would have been required for a nursing unit with 34-40 patients.

Discrepancies in Provider's Documentation Supporting Available Bed Count:

The Intermediary points out that since the filing of the cost report, the audit, final settlement, and the appeal process, the Provider has filed several documents to support the number of available beds at its hospital facility. If you rely on the Provider's census report, the Provider reported 176 beds.[38] Since this number exceeds the Provider's licensed beds by 26 beds, the Intermediary contends that the count based on the census schedule is invalid. If you rely on the beds identified in the Provider's preliminary position paper, the Provider had 148 beds. If you rely on the Provider's count given to the auditor as part of the field audit and final settlement process,[39] the Provider had 101 beds, which is supported by the THA/AHA Survey. If you rely on the cost report, the Provider reported 110 beds.[40] If you rely on the Provider's blue prints, the Provider has either 126 beds or 116 beds.[41]

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37 See Intermediary Exhibit I-16.

38 See Intermediary Exhibits I-14 and I-17.

39 See Intermediary Exhibit I-3.

40 See Intermediary Exhibit I-2

41 See Intermediary Exhibits I-18 and I-19.

Based on the variation and reliability of the evidence furnished by the Provider, it is the Intermediary's position that the most acceptable count is the 101 available beds reported on the THA/AHA Survey. With the exclusion of the five beds used for observation services, the Intermediary concludes that the Provider had less than 100 beds available during the fiscal year ending September 30, 1995.

The Intermediary argues that its determination of available PPS beds used to determine the DSH payment adjustment factor complied with the governing provisions of 42 C.F.R. §§ 412.105 and 412.106, and HCFA Pub. 15-1 §2405.3.G. Pursuant to these controlling provisions, an available bed must be permanently maintained. The Intermediary advises that Webster's Ninth New Collegiate Dictionary defines permanent as; "continuing or enduring without fundamental or marked change." Maintain is defined as; "to keep in an existing state." Accordingly, the Provider would be required to keep beds in their existing state as inpatient routine care beds indefinitely in order for the beds to be considered available. The Intermediary argues that the conversion of rooms to uses other than inpatient routine care, such as office space and storage, would eliminate those rooms from being "permanently maintained" as routine inpatient beds. In addition, the use of the fourth floor beds for outpatient surgery patients would also be excluded, since the beds are no longer permanently maintained for lodging inpatients.

The Intermediary contends that the manual instructions at HCFA Pub. 15-1 § 2405.3.G specifically indicate that beds used for ancillary, outpatient areas, and other areas regularly maintained and utilized for only a portion of the stay by patients are not considered available beds for lodging inpatients. Further support for the exclusion of bed days related to observation services can be found in the Hospital Manual ("HCFA Pub. 10"), which addresses the definitions of "covered inpatient hospital services" and the "counting of inpatient days" as follows:

> An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services.
>
> The number of days of care charged to a beneficiary for inpatient hospital services is always in units of full days.

HCFA Pub. 10 § 210 and § 216.1, respectively (emphasis added).

Pursuant to HCFA Pub. 10, a patient day would only be counted where a patient was admitted for inpatient services. In the case of outpatient observation services, the patient is not admitted as an inpatient. HCFA Pub. 10 offers further guidance by defining "outpatient observation services" as follows:

> 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 necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient.
>
> . . .
>
> 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 overnight. (See § 210 regarding coverage of inpatient admissions.) When a hospital places a patient under observation, but has not formally admitted him or her as an inpatient, the patient initially is treated as an outpatient. The purpose of observation is to determine the need for further treatment or for inpatient admission. Thus, a patient in observation may improve and be released, or be admitted as an inpatient.

HCFA Pub. 10 § 230.6.

The Intermediary also cites the HCFA Memorandum, dated February 27, 1997, which clarified the treatment of observation beds in the count of available bed days for the purpose of the IME and DSH adjustments.[42] The HCFA Memorandum states the following:

> Observation Beds
>
> 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 IME and DSH adjustments. If a patient in an observation bed is later admitted, then the equivalent days before the admission are also excluded. Thus, all observation bed days are excluded from the available bed day count.

The Intermediary also cites the HCFA Administrator's decision in Commonwealth of Kentucky which directly addresses the count of available beds for the determination of the DSH payment.[43] In that decision, the Board found that the Intermediary's adjustment improperly disallowed swing bed days and observation bed days from the count of available days used to determine bed size. However, the HCFA Administrator reversed the Board's decision stating the following:

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[42] See Intermediary Exhibit I-12.

[43] See Intermediary Exhibit I-13.

> As HCFA 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).
>
> . . .
>
> Thus, HCFA's requirement that a bed day under 42 C.F.R. § 412.105(b) only be included in the DSH bed count calculation when the costs of the day are reimbursed as an inpatient service cost is also consistent with the inclusion of only "inpatient days to which the prospective payment system applies" in determining a 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 which are recognized as part of the PPS hospital's inpatient operating costs.
>
> . . .
>
> Consequently, reviewing the applicable law and HCFA's longstanding policy concerning the counting of bed days, the Administrator finds that the Intermediary properly excluded observation bed days and swing bed days from the bed count. HCFA has consistently excluded from the bed day count those bed days not paid as part of the inpatient operating cost of the hospital; that is, in this case the day was not recognized under PPS as an inpatient operating cost. The Administrator finds that the beds at issue were properly excluded from the day bed count for purposes of determining the Providers eligibility for a DSH adjustment.

While the Administrator's decision in Commonwealth of Kentucky only addresses observation and swing beds, the Intermediary argues that the analysis and final decision are equally applicable to the other "available" beds claimed by the Provider (i.e., fourth floor beds being used for office space, storage, and outpatient surgery services). The Intermediary insists that none of these additional "available" beds claimed by the Provider was included in the hospital's PPS inpatient operating costs.

The Intermediary concludes that its exclusion of patient bed days related to beds occupied by patients for observation and outpatient surgery services in the determination of the Provider's

available beds was in compliance with 42 C.F.R. §§ 412.105(b) and 412.106(a)(1)(i). As to its conclusion that the Provider did not meet the minimum criteria of 100 beds or more for a DSH payment adjustment, the Intermediary maintains that its determination was in compliance with 42 C.F.R. § 412.105(c) and (d), the various manual instructions, and the HCFA Memorandum of February 27, 1997. In the instant case, the beds at issue were not permanently maintained for the housing of inpatients, but were taken out of service and fundamentally changed when the rooms were turned over for the provision of outpatient services. The fact that such use continued for a period from 1994 to 1999 demonstrates a permanent change with the result that the beds are no longer providing inpatient services. The beds are no longer under PPS and should not be included in the consideration of an adjustment rate that is intended to compensate for the provision of inpatient routine services.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§1395ww et seq.	-	Payment to Hospitals for Inpatient Hospital Services

2. Law - 5 U.S.C.:

§ 553	-	Administrative Procedure Act - Rule Making

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

§§ 405.1835-.1841	-	Board Jurisdiction
§ 412.105 et seq.	-	Special Treatment: Hospitals that Incur Indirect Costs for Graduate Medical Education Programs
§ 412.106 et seq.	-	Special Treatment: Hospitals that Serve a Disproportionate Share of Low-Income Patients
§ 413.20 et seq.	-	Financial Data and Reports

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

§ 2405.3.G et seq.	-	Adjustment for the Indirect Cost of Medical Education - Bed Size

5. Program Instructions- Hospital Manual (HCFA Pub. 10):

§ 210 et seq. - Covered Inpatient Hospital Services

§ 216 et seq. - Inpatient Hospital Benefit Days

§ 230 et seq. - Outpatient Hospital Services

6. Case Law:

Clark Regional Medical Center, et al. v. Shalala, 2001 W.L. 332064 (E.D. Ky 2001).

Natividad Medical Center v. Blue Cross and Blue Shield Association/ Blue Cross of California, PRRB Dec. No. 91-D58, August 9, 1991, Medicare and Medicaid Guide (CCH) ¶ 39,573, rev'd HCFA Administrator, October 6, 1991 Medicare and Medicaid Guide (CCH) ¶ 39, 611.

Pacific Hospital of Long Beach v. Aetna Life Insurance Company, PRRB Dec. No. 93-D5, December 12, 1992, Medicare and Medicaid Guide (CCH) ¶ 40,987, rev'd in part, HCFA Administrator, February 2, 1993, Medicare and Medicaid Guide (CCH) ¶ 41,355.

United Hospital Medical Center v. Blue Cross and Blue Shield Association/ Blue Cross and Blue Shield of New Jersey, PRRB Dec. No. 2000-D23, March 2, 2000, Medicare and Medicaid Guide (CCH) ¶ 80,399.

Commonwealth of Kentucky 92-96 DSH Group v. Blue Cross and Blue Shield Association/AdminaStar Federal, PRRB Dec. No. No. 99-D66, September 2, 1999, Medicare and Medicaid Guide (CCH) ¶ 80, 322, rev'd HCFA Administrator, November 8, 1999, Medicare and Medicaid Guide (CCH) ¶ 80,389

7. Other:

Pub. L. No. 98-21.

HCFA Memorandum, February 27, 1997.

BCBSA Administrative Bulletin #1841, 88.01.

BCBSA Administrative Bulletin #1830, 87.01.

49 Fed, Reg. 234, 252 (Jan. 3, 1984).

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

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration and analysis of the controlling law, regulations and manual guidelines, the facts of the case, parties' contentions, evidence presented, testimony elicited at the hearing and Provider's post-hearing submissions, the Board finds and concludes that the Intermediary's determination of the number of available beds for DSH eligibility purposes was not proper. Accordingly, the Provider is entitled to receive a DSH payment adjustment for the fiscal years ended December 31, 1994, 1995 and 1996.

The enabling statute at 42 U.S.C. § 1395ww(d)(5)(F) provides for a DSH adjustment to hospitals that serve a significant disproportionate number of low-income patients. Under the statute, a hospital that is located in an urban area and has 100 or more beds qualifies for the DSH adjustment if 15 percent of its patients are low-income patients. The Board finds that this authorizing statute considers three factors in determining a hospital's qualification for a DSH adjustment. These factors include a provider's location (rural or urban), its patient days and its number of beds, which is the factor at issue for the fiscal years under appeal by the Provider. The Board notes that the statute refers only to the singular word "bed," and does not expound upon its meaning with respect to DSH eligibility.

The regulation at 42 C.F.R. § 412.106 implements the statutory provisions and establishes the factors to be considered in determining whether a hospital qualifies for a DSH adjustment. With respect to determining the number of beds for DSH status, the regulation at 42 C.F.R. § 412.106 (a)(1)(i) requires this determination to be made in accordance with 42 C.F.R. §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 beds 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 at 42 C.F.R. § 412.105 establishes the fundamental methodology for determining a hospital's bed size for purposes of DSH eligibility. This regulation requires that all beds and all bed days be included in the calculation unless they are specifically excluded under the categories listed in the regulation.

The Board finds that the word "bed" is specifically 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, 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 puts 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).

Based on the above-cited authorities, the Board finds that the proper application of these governing provisions to either the five scattered observation beds or the fourth floor inpatient beds at issue would have resulted in the Provider meeting the 100-available bed threshold requirement for the calculation of the DSH payment adjustment. The criteria applied by the Intermediary for the exclusion of the beds at issue cannot be supported based on the correct and clear interpretation of the language set forth in the regulations and manual guidelines.

With respect to the observation bed days, the Board finds that the Provider met all of the Medicare program's requirements to be included in the bed size calculation used to determine DSH eligibility. The Board specifically notes that all of the observation beds at issue were licensed acute care beds located in the acute care area of the Provider's hospital facility. Further, these beds were permanently maintained and available for lodging inpatients and were fully staffed for the provision of inpatient services during the cost reporting periods in contention. The fact that the beds were sometimes occupied by observation patients did not alter their availability.

The Board's determination also relies upon the fact that the enabling regulation and manual

instructions identify the specific beds excluded from the bed count, and neither of these authorities provide 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 on at least two occasions to clarify the type of beds excluded from the count, the Board finds that these comprehensive rules are meant to provide an all inclusive listing of the excluded beds. The Board rejects 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 amounts. If this argument was valid, Congress would simply have said that in the enabling statute, and a regulation could have been easily promulgated to accommodate a category for PPS -excluded beds. Instead, the controlling regulation and manual guidelines have been written in a manner which provide great specificity regarding beds that are included and excluded from the count.

The Board finds further support for its decision in HCFA Pub. 15-1 § 2405.3.G(2), which provides an example for determining bed size. 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 Boards 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, identical to the observation beds at issue in this case, are included in the count. Accordingly, the Board agrees with the Provider's argument that the bed count for DSH eligibility is essentially intended to distinguish small and large hospitals, and that the temporary use of acute care beds for outpatient observation purposes does not change the size of a facility as stipulated in HCFA Pub. 15-1 §2405.3.G.

The Board finds the informal instructions set forth in the HCFA Memorandum dated February 27, 1997, which served as the basis for the Intermediary's exclusion of scattered observation beds, are wholly inconsistent with the controlling Medicare regulations, manual instructions and prior HCFA policy regarding the counting of available beds. Moreover, since the cost reporting periods in contention concern the Provider's fiscal years ended December 31, 1994, 1995 and 1996, the Board finds that such instructions cannot be retroactively applied even if their application were legitimate.

As to the sub-issue regarding the Intermediary's exclusion of the 42 medical/surgical beds located on the Provider's fourth floor from the available bed count used to determine DSH eligibility, the Board finds that the Intermediary applied an erroneous standard in making this determination. Rather than applying the standard of "maintained and available beds" as set forth under the controlling regulatory and manual provisions, the Intermediary used a "set up and

staffed beds" standard which resulted in the exclusion of all licensed inpatient beds on the fourth floor of the Provider's hospital facility. The use of the "set up and staffed beds" standard is unsupportable under Medicare policy and ignores the long-standing Medicare definition of "available beds" which is intended to capture changes in the size of a facility rather than day-to-day fluctuations in patient rooms and wards.

The Board finds that the evidence presented at the hearing demonstrates that the beds on the Provider's fourth floor were licensed inpatient beds in routine areas that were maintained to provide inpatient services. During the cost reporting periods under contention, the Provider continued to pay the applicable licensing fee to operate all of its 148 general acute care beds. The Board finds the Provider's license to be a more accurate measure of the number of available beds at the Provider's facility than the number of "set up and staff beds" identified by the Intermediary. The record shows that the Provider's fourth floor inpatient beds were: (1) reasonably ready for immediate inpatient use within 24-48 hours; (2) maintained as depreciable plant assets on the Medicare cost reports; and (3) capable of being adequately covered by the Provider's nursing staff or nurses from a nurse registry if the need arose. It is the Board's conclusion that the inclusion of the fourth floor beds in the available bed count for purposes of the DSH eligibility determination reflects a more accurate application of Medicare policy than the standard devised by the Intermediary.

Finally, the Board notes that the district court's decision in Clark Regional recently upheld the decision rendered by the Board in Commonwealth of Kentucky, wherein the Board found that observation bed days met all of the Medicare program's requirements to be included in the bed size calculation used to determine DSH eligibility. The court found that, under the plain meaning of the regulation at 42 C.F.R. § 412.105(b), the observation bed days should not have been excluded from the count for determining DSH eligibility. The court further stated that HCFA's proposed construction "tortures the plain language of the regulation," and that "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.' " With respect to the manual guidelines, the court found the instructions in HCFA Pub. 15-1 § 2405.3.G also support the inclusion of observation bed days because the beds were permanently maintained and staffed for acute care inpatient lodging, and that their temporary use for other purposes did not change this fact.

The court concluded that the HCFA Administrator's decision in Commonwealth of Kentucky was "arbitrary and capricious and not supported by the applicable regulations and PRM guidelines .... Therefore, it was a clear error of judgment for the HCFA Administrator to ignore the language of the regulations and guidelines and instead construe eligibility based solely upon its own statement of intent hidden in the Federal Register."

DECISION AND ORDER:

The Intermediary's adjustments to the number of available beds for DSH qualification purposes were not proper and are reversed. The Provider meets the DSH eligibility requirement of 100

beds or more and is entitled to DSH payment adjustments for all fiscal years in contention.

BOARD MEMBERS PARTICIPATING:

Irvin W. Kues
Henry C. Wessman, Esquire
Stanley J. Sokolove
Gary B. Blodgett, D.D.S.

Date of Decision: November 21, 2001

FOR THE BOARD

Irvin W. Kues
Chairman