PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
98-D84

PROVIDER -
Los Angeles County NIC Unit Beds
Group Appeal

Provider No. See Attachment

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Blue Cross of California

DATE OF HEARING-
July 29, 1998

Cost Reporting Period Ended -
June 30, 1988 and
June 30, 1989

CASE NO. 96-0066G

INDEX

ISSUE:

Was the Intermediary's inclusion of neonatal intensive care unit (NICU) beds in the indirect medical education (IME) calculation proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Martin Luther King, Jr./Drew Medical Center, Harbor/UCLA Medical Center, Olive View Medical Center, and LAC+USC Medical Center, ("Providers") are public general acute care hospitals in Los Angeles County, which have approved medical education programs. As teaching hospitals, the Providers receive additional payments in the form of an adjustment for the indirect cost of medical education ("IME"), pursuant to 42 U.S.C. § 1395ww(d)(5)(B).

The IME payment is made to reimburse providers for the additional use of ancillary services inherent in the training of interns and residents. Among the elements of the calculation of the IME payment is the bed count. Certain types of beds are not to be included in the calculation. At issue here is whether the NICU beds are included or excluded in the calculation. The difference in opinion centers on whether NICU beds are newborn bassinets or pediatric ICU beds. Blue Cross of California ("Intermediary") contends that the beds are pediatric ICU beds that must be included in the bed count for the IME calculation. The Providers maintain that the inclusion of these neonatal intensive care beds in the IME calculation was improper and violates 42 C.F.R.
§ 412.118.

On October 24, 1995, the Providers appealed the issue to the Provider Reimbursement Review Board ("Board") and have met the jurisdictional requirements of 42 C.F.R.§ 405.1835-.1841. The amount of Medicare reimbursement in dispute is approximately $ 462,789.[1]

The Providers were represented by Jon Neustadter of Hooper, Lundy, & Bookman, Inc. The Intermediary was represented by Bernard Talbert, Esquire, of the Blue Cross and Blue Shield Association.

BACKGROUND:

The formula for determining the IME adjustment includes the ratio of full time equivalent

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[1] Intermediary Exhibit I-1. This amount was taken from the Intermediary's schedule of Providers in the initial group appeal for FYEs June 30, 1988, 1989 and 1990. The Providers subsequently transferred the 1990 year to an existing group appeal with the same providers for the 1991 fiscal year, PRRB Case No. 94-0284G, for the same issue.

("FTE") interns and residents to the number of hospital beds. 42 C.F.R. § 412.118(a)(1).[2]

Prior to 1985, the IME regulation, then codified at 42 C.F.R. § 405.477(d)(2), stated that the IME payment would be based on the ratio of FTE interns and residents to beds, without indicating how the number of beds would be determined and without requiring exclusion of any particular category of beds from the calculation. Effective April 29, 1985, this regulation was redesignated to 42 C.F.R. § 412.118, without any change regarding the calculation of the number of beds. 50 Fed. Reg. 12740, 12759 (Mar. 29, 1985).

Direction as to the bed calculation first appeared in a June 10, 1985 proposed rule concerning changes to the inpatient hospital prospective payment system. See 50 Fed. Reg. 24366 (June 10, 1985).[3] The proposed change to § 412.118(b) was 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 and excluded distinct part hospital units, and dividing that number by the number of days in the cost reporting period.

Id. at Provider Exhibit P-3.

The discussion regarding indirect medical education in the preamble to this proposed rule, found at 50 Fed. Reg. 24381-24383, did not discuss the newborn bed exclusion, either in regard to what was meant by newborn beds or in regard to the policy behind said exclusion. Providers' Exhibit P-3.

The exclusion of newborn beds was included in the final rule, effective October 1, 1985. See 50 Fed. Reg. 35646, 35690 (Sept. 3, 1985).[4] The final rule, quoted above, added custodial care beds to the categories of beds excluded from the IME calculation. In the proposed rule, one commentator requested a more precise definition of the term "available bed day". The response was as follows:

> Comment: One commenter requested a more precise definition of the term "available bed" days.

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[2] This regulation was redesignated to 42 C.F.R. § 412.105 in 1991. See 56 Fed. Reg. 43241 (Aug. 30, 1991).

[3] Provider Exhibit P-3.

[4] Provider Exhibit P-1.

> Response: 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. at 35683 (Sept. 3, 1985) (Providers' Exhibit P-1).

Until 1988, there was nothing in the Provider Reimbursement Manual, Part 1 (HCFA Pub.15-1) which indicated that the term "newborn beds" in 42 C.F.R. § 412.118(b) should be interpreted to exclude newborn intensive care beds in the IME calculation. In 1988, HCFA imposed a qualification on the regulation, by defining beds as follows:

> A bed is defined [for purposes of the IME calculation] 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.

HCFA Pub. 15-1 § 2405.3.G (Provider Exhibit P-2). This manual provision was effective August 25, 1988.

PROVIDERS' CONTENTIONS:

The Providers argue that the issue in this appeal is whether beds designated for neonatal intensive care should be excluded, along with routine beds for newborn infants, from the total number of available bed days used in the calculation of the IME adjustment. The regulation applicable to all the fiscal years at issue in this appeal is 42 C.F.R. § 412.118(b):

> Determination of number of beds. For purposes of this section, the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period, not including beds 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.

Id.

The Providers maintain that the regulation should be read literally, so that the exclusion applying to "beds assigned to newborns" should apply to all newborn beds, both routine and intensive care. (Emphasis in original). The Providers contend that the Intermediary would

read into the term “beds assigned to newborns” the qualifying factor “routine,” and exclude only the routine beds from the IME calculation.[5]

The Providers point out that on August 25, 1988, HCFA imposed a qualification on the regulation at § 412.118(b). A manual provision was adopted at HCFA Pub. 15-1 § 2405.3G to specifically include neonatal intensive care unit beds in the IME calculation. The Providers contend that HCFA cannot, however, modify a clear regulatory requirement by implementing a manual provision which restricts the regulatory language. The Providers argue that if HCFA's manual provision was merely an interpretation of the regulatory language, then it might be permissible. However, the amendment of the term “newborn beds” clearly has a substantive effect. The Providers contend that such a change would be subject to Administrative Procedure Act requirements of notice and opportunity for public comment before such a change can be made. 5 U.S.C. § 553(b) and (c); Flagstaff Medical Ctr. Inc. v. Sullivan, 962 F.2d 879, 885-886 (9th Cir. 1992). Therefore, the adoption of this manual provision cannot be applied to the Providers’ IME calculation.

The Providers argue that if the regulation's meaning is clear on its face, the agency's interpretative manual provision is irrelevant and the court will uphold the clear meaning of the regulation.
See Thomas Jefferson 114 S. Ct. 2381, 2386 (1994) (Court defers to Secretary's interpretation unless contrary to regulation's plain language). The Providers contend that the operative words of the regulation (“not including beds assigned to newborns”) are commonplace terms whose meaning is perfectly clear (all beds assigned to recently born persons, or neonates, must be excluded from the IME calculation) and, consequently, there is absolutely no need to inquire further to determine the meaning of the regulation. Id. Based on the above, the Providers contend that the Secretary's “reasonable interpretation,” is simply not necessary, is clearly inconsistent with a literal reading of the regulation, and is therefore invalid.

The Providers also point out that even if HCFA Pub. 15-1 § 2405.3.G could be applied, the Secretary may not reverse a policy articulated in an existing regulation without complying with the notice-and-comment requirements of the Administrative Procedure Act. See 5 U.S.C.
§ 553(b) and (c); Shalala v. Guernsey Mem. Hosp., 115 S. Ct. 1232 (1995) (“APA rulemaking would be required if [an interpretive rule] . . . adopted a new position inconsistent with any of the Secretary's existing regulations.). The Providers contend that HCFA Pub. 15-1 § 2405.3.G was not promulgated in accordance with those requirements.

It is the Providers’ position that HCFA Pub. 15-1 § 2405.3.G would effect a substantive change in, and effectively add a new requirement to, the IME adjustment calculation as outlined in the regulation. The Providers contend that while the regulation would mandate the exclusion of all newborn beds in the IME bed count, § 2405.3.G of the manual would

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[5] Providers’ Position Paper at 3.

mandate the inclusion of some, but not all, "beds assigned to newborns." The Providers assert that this manual provision has clearly added a new requirement to the regulation at § 412.118(b) that is directly contrary to that regulation, and could not be valid until it was promulgated as a proposed rule with prior publication and opportunity for public comment.[6]

The Providers also argue that even if the manual provision were somehow valid and could apply, despite its inconsistency with the regulation, the manual provision could not apply to the Providers' fiscal years in this case, FYEs 6/30/88 and 6/30/89. The Providers point out that the manual provision was effective on August 25, 1988, which is after the close of the Providers' fiscal year ending 6/30/88 and after the start of the Providers' fiscal year ending 6/30/89.

The Providers argue that the Intermediary's application of this manual provision to its IME reimbursement calculations constitutes an impermissible retroactive application of a cost-limit rule, a practice that the U.S. Supreme Court has held invalid under the Medicare statute. Bowen v. Georgetown Univ. Hosp., 488 U.S. 204, 213-14 (1988) (holding that the Secretary of Health and Human Services may not promulgate cost limits that are retroactive because neither the Medicare Act specifically, nor the Medicare Act's general grant of authority to the Secretary to promulgate cost-limit rules, contained an express authorization for retroactive rulemaking).

Therefore, the Providers contend that the manual provision is completely invalid and inapplicable to its fiscal years ending June 30, 1988 and June 30, 1989 because the manual provision became effective after the start of those two fiscal years. The Providers argue that retroactive application of the manual provision is not permitted. Regardless, as discussed above, the manual provision is invalidly inconsistent with the regulation (prior to the 1994 amendment to the regulation), and cannot apply to the fiscal years at issue in this appeal.

The Providers point out that the Board has recently addressed the issue herein in Kern Medical Center v. Blue Cross & Blue Shield Assn./Blue Cross of California, PRRB Dec. No. 95-D42 (June 13, 1995), Medicare & Medicaid Guide (CCH) ¶ 43,467, ("Kern").[7] In that case, the Board unanimously agreed that it is proper to exclude neonatal intensive care beds from the formula used to compute the IME cost adjustment factor. The Board stated as follows:

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[6] In 1994, HCFA amended 42 C.F.R. § 412.118(b) through notice-and-comment rule making to include newborns in an intensive care unit in the IME bed count. See 59 Fed. Reg. 45,398 (Sept. 1, 1994) (Providers Exhibit P-6).

[7] Providers' Exhibit P-4.

> [t]he recodified regulation at 42 C.F.R. § 412.118 revised the prior regulation to clarify the policy for determining the number of beds used in the IME cost calculation.
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> Whereas the prior regulation at 42 C.F.R. § 405.477(d)(2) was silent as to the inclusion or exclusion of specific types of hospital beds in the IME calculation, paragraph (b) of 42 C.F.R. § 412.118, as amended and recodified September 3, 1985, provides the following specific instructions for determining the number of beds:
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> [f]or 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.

42 C.F.R. § 412.118(b) (emphasis added.)

> The Board finds that this regulation clearly instructs the [i]ntermediary to exclude all beds assigned to newborns whether the newborn beds are located in a routine or an intensive care unit. Since the existing regulation contains specific instructions which relate directly to the computation of the IME cost adjustment factor, the Board views the Intermediary's determination as an improper and arbitrary action which totally ignores the governing regulatory rule.

Providers' Exhibit P-4.

The Providers agree with the Board's decision in Kern. The applicable regulation clearly states that "newborn beds" should be excluded from the IME calculation. Since nothing in the regulation further defines "newborn beds," this term should be given its normal meaning and all beds relating to newborns (both routine and intensive care) should be excluded.

The Providers also reference the HCFA Administrator's reversal of the Board's decision in Kern on July 30, 1995.[8] The Providers note that the Administrator claims in his decision that the inclusion of newborn intensive care beds in the IME calculation is pursuant to a longstanding policy. However, the Administrator fails to provide any support for this position.

The Providers point out that in his decision, the Administrator relies on the characterization of routine and intensive care newborn beds in an unrelated manual provision. The Administrator states:

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[8] Providers' Exhibit P-5.

> As early as 1976, however, a general methodology to determine the bed count had been included in guidelines issued by HCFA. PRM § 2510.5A, issued to establish bed size categories for purposes of applying the cost limits under section 223 of the Social Security Amendments of 1972, excludes newborn beds but specifically includes beds in intensive care units.

HCFA Adm. Dec. in Kern, Medicare & Medicaid Guide (CCH) ¶ 43,682.

The Providers assert that the Administrator's reliance on the definitions found in this manual section is misplaced. As the Administrator points out, a distinction is made between newborn routine beds and newborn beds in ICUs for the purpose of applying the Section 223 cost limits. The Providers contend that the reason for this is that these limits apply to the cost of routine care only, so clearly intensive care beds had to be separated.

The Providers contend that the Administrator provides no explanation as to why this same distinction between newborn routine beds and newborn ICU beds must be made for the IME calculation. The Providers further contend that if there were policy reasons for including newborn intensive care days while excluding newborn routine days from the IME calculation, these reasons would be different from the reasons for separating those costs for the purposes of cost apportionment or determining Section 223 cost limits. However, the Providers are unaware of any policy reasons which have been expressed for the separation of these costs in the IME calculation.

The Providers also note that the Board has expressly rejected HCFA's reliance on a pre-PPS manual provision to support the notion of a “longstanding” policy to include intensive care unit beds for IME calculation purposes. See Providers Exhibit P-4. In Kern, the Board stated:

> [t]he Board does not accept the Administrator's premise that the IME regulation is based on longstanding policy. HCFA Pub. 15-1 2510.A . . . do[es] not relate to the [IME] regulation which clearly excludes beds assigned to newborns.

Id.

In summary, the Providers request the Board to defer to its earlier decision in Kern and find that the Providers’ neonatal intensive care beds should be excluded from the IME evaluation for fiscal years ending June 30, 1988 and June 30, 1989.

INTERMEDIARY’S CONTENTIONS:

The Intermediary contends that nursery beds which meet the criteria for a special care unit should be included in the bed count used in the indirect medical education formula.

The Intermediary refers to the regulations in effect at the start of the 1988 year end which rule indirect medical education. 42 C.F.R. § 412.118(b) defines beds as follows:

> [D]etermination 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.

42 C.F.R. § 412.118(b).

The Intermediary points out that this definition was originally published in the September 3, 1985 Federal Register. One commentor to the proposed rule requested a more precise definition of the term "available bed days". The response was as follows:

> Response: 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 other 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 at 35683 (Sept. 3, 1985)

The Intermediary contends that the policy consideration for including NICU beds in the IME calculation is that interns and residents receive extensive training on the treatment of infants who need special care (and will usually stay in the hospital for a considerable length of time) versus infants who are in the nursery (and usually will go home shortly after birth).

The Intermediary notes that this was further clarified in the Federal Register dated Sept. 1, 1994 (Exhibit 1-3), which reiterated this policy, in part as follows:

> As explained in the proposed rule and repeated above, we are only clarifying our long-standing policy position regarding neonatal intensive care beds and are not making a change in policy. We note that the United States Court of Appeals for the Eighth Circuit recently upheld this longstanding policy Sioux Valley Hospital v. Shalala, No. 933741 SD (8th Cir. July 20, 1994).

59 Fed. Reg. at 45374 (Sept. 1, 1994).

The Intermediary refers to the the HCFA Administrator's decision in Sioux Valley Hospital v. Blue Cross and Blue Shield of Iowa, PRRB Dec. No. 92-D53, Medicare & Medicaid Guide (CCH) ¶ 40,747, August 26, 1992, rev'd HCFA Administrator, October 26, 1992, Medicare & Medicaid Guide (CCH) ¶ 41,044 ("Sioux Valley"), in which the Administrator reversed the Board and upheld the Intermediary on the position that NICU beds are to be included in the IME calculation. The Administrator found that the Program instructions were consistent with the regulations in including these beds based on a long-standing policy of the Medicare Program of including all ICU beds in the bed count. The Intermediary points out that the Administrator also found that HCFA's method of counting beds was not modified by regulation 42 C.F.R.
§ 412.118(b). The Administrator stated:

> [t]he reference to "newborns" in the regulation can reasonably be interpreted to exclude only newborn bassinets receiving routine care. Further, the language of the regulation permits an interpretation that neonatal intensive care beds are properly counted as ICU beds. Accordingly, the Intermediary's adjustment in this case, which included the Provider's ICU beds in the determination of the resident-to bed ratio of the IME cost calculation, was proper.

HCFA Administrator's Decision in Sioux Valley, CCH ¶ 41,044.

In the instant case, the Intermediary believes that the same interpretation of what constitutes newborn days should be made. The NICU beds in question are not considered bassinets and refer to special care unit type of care at the Providers. As a result, these beds should be considered beds to be included in the Providers' IME calculation.

The Intermediary also notes that the HCFA Administrator's interpretation has also been upheld in Hahnemann University Hospital v. Shalala, No. 94-2457 (D.D.C. April 17, 1996) (unpublished).[9] This decision stated that the Administrator's interpretation of the regulation to allow the inclusion of NICU beds in the bed count used to calculate the IME adjustment was reasonable and based on long standing agency policy and practice.

The Intermediary notes that the exclusion of newborn days had been applied by the Medicare Program as early as 1976 through the inpatient cost limits (Section 223 of the Social Security Amendments of 1972).[10] Also, various Program instructions from 1977 onward (i.e., HCFA Pub. 15-1, § 2202.7A on Special Care Units) included NICU days as special care unit days rather than nursery days. The Intermediary asserts that the program instructions found in

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[9] Intermediary Exhibit 1-6.

[10] Intermediary Position Paper at 4.

HCFA-Pub. 15-1, Section 2405.3G incorporated into a single section existing policy setting forth the method of counting beds which had previously been expressed in several sections.[11]

The Intermediary notes that Transmittal No. 345[12] to HCFA Pub. 15-1, was issued in August 1988, with an effective date of August 25, 1988. This transmittal revised various parts of Section 2405.3, Adjustments for the Indirect Cost of Medical Education. The Intermediary believes that this section was revised to clarify the definition of beds to be used for IME. This clarification further supports the Intermediary's treatment of including NICU beds in the IME calculation.

The Intermediary contends that the [California] Department of Health includes NICU beds in a provider's license because these beds are regarded as another type of pediatric bed, i.e., Special Pediatric Beds.[13] The Intermediary believes the reason the Department includes these as licensed beds is because the neonatal patients generally have long-term stays in the hospital compared to nursery patients. In a monthly printout from the Department called "Summary of Report for Hospitals", both Neonatal Intensive Care Unit and Special Care Nursing Unit beds are listed as Special Pediatric beds under the licensed beds for hospitals. As indicated in the Department's Certificate of Need standards, these beds are intended for the care of all seriously ill or risk newborn infants who require complex services.[14]

To distinguish neonatal beds from newborn bassinets, the Department of Public Health defined these bassinets as unlicensed bassinets operated as part of the obstetrical services of a hospital.

The Intermediary contends that the above regulations and Program instructions show that NICU patients were merely another type of intensive care patient required to be included in the bed count. The Intermediary asserts that these patients were regarded by the Medicare Program as not newborn but as another type of intensive care unit patient.

Therefore, it was appropriate for the Intermediary to include these beds in the bed count for the IME calculation.

The Intermediary's maintains that its calculation of the IME payment, by including NICU beds in the bed count, is based on the Program regulations and instructions and has been

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11 Id.

12 Intermediary Exhibit 1-5.

13 Intermediary Position Paper at 5.

14 Id.

upheld by the Administrator and the courts. The Intermediary requests that the Board uphold the audit adjustments.

CITATION OF LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS:

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

§ 1395ww(d)(5)(B)	-	Payment to Hospitals for Inpatient Hospital Services - Indirect Medical Education Costs

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

§ 553(b) & (c)	-	Administrative Procedures Act

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

§ 405.1835-.1841	-	Board Jurisdiction
§ 412.118 (Redesignated 412.105) et.seq. (previously § 405.477(d)(2))	-	Determination of Indirect Medical Education Costs

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

§ 2202.7A	-	Special Care Units
§ 2405.3 et seq	-	Adjustment for the Indirect Cost of Medical Education

5. Cases:

Flagstaff Medical Ctr. Inc. v. Sullivan, 962 F.2d 879 (9th Cir. 1992).

Thomas Jefferson 114 S. Ct. 2381, 2386 (1994).

Shalala v. Guernsey Mem. Hosp., 115 S. Ct. 1232 (1995).

Bowen v. Georgetown Univ. Hosp., 488 U.S. 204 (1988).

Kern Medical Center v Blue Cross & Blue Shield Assn./Blue Cross of California, PRRB Dec. No. 95-D42 (June 13, 1995), Medicare & Medicaid Guide (CCH) ¶ 43,467, rev'd HCFA Administrator, July 30, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,682.

Sioux Valley Hospital v. Shalala, 29 F.3d 628 (8th Cir. July 20, 1994).

Sioux Valley Hospital v. Blue Cross and Blue Shield of Iowa, PRRB Dec. No. 92-D53, Medicare & Medicaid Guide (CCH) ¶ 40,747, August 26, 1992, rev'd HCFA Administrator, October 26, 1992, Medicare & Medicaid Guide (CCH) ¶ 41,044.

Hahnemann University Hospital v. Shalala, No. 94-2457 (D.D.C. April 17, 1996) (unpublished).

Little Company of Mary Hospital and Health Care Centers v. BC/BS of Illinois, PRRB Dec. No. 98-D1, (October 21, 1997), Medicare & Medicaid Guide (CCH) ¶ 45,739, rev'd in part, HCFA Adm. Dec. (December 22, 1997), Medicare & Medicaid Guide (CCH) ¶ 46,053.

Hahnemann University Hospital v. Shalala, No. 96-5191, 1997 WL 362672, at *1 (D.C. Cir. May 5) (per curiam).

Grant Medical Center v. Community Mutual Insurance Company/BSBCA, PRRB Dec. No. 97-D67, (June 18, 1997), Medicare & Medicaid Guide (CCH) ¶ 45,453, HCFA Adm. declined rev.

5. Other:

HCFA Transmittal No. 345 (August, 1988)

56 Fed. Reg. 43241 (Aug. 30, 1991).

50 Fed. Reg. 12740, 12759 (Mar. 29, 1985) .

50 Fed. Reg. 24366, 24381-24383 (June 10, 1985)

50 Fed. Reg. 35646, 35683, 35690 (Sept. 3, 1985).

59 Fed. Reg. 45374 (Sept. 1, 1994).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties contentions, and evidence presented, finds and concludes that the Intermediary's inclusion of neonatal intensive care unit (NICU) beds in the indirect medical education (IME) calculation was proper.

The Board notes that the issue in this case has been brought before it many times in the past. The Board finds that its original position opposing the inclusion of NICU beds in the IME

adjustment calculation was predicated on the Board's literal interpretation of 42 C.F.R. § 412.118(b). See Kern. This subsection, states in part:

> [d]etermination 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.

42 C.F.R. § 412.118(b). (emphasis added).

The Board further notes that the Board majority modified the above position for cases with fiscal years beginning after the manual revision to HCFA Pub. 15-1, § 2405.3G on August 25, 1988. See Grant Medical Center v. Community Mutual Insurance Company/BSBCA, PRRB Dec. No. 97-D67, (June 18, 1997), Medicare & Medicaid Guide (CCH) ¶ 45, 453, HCFA Adm. declined rev. July 30, 1997. HCFA Pub. 15-1, § 2405.3G defines beds as follows:

> [a] bed is defined [for purposes of the IME calculation] 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.

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

The Board takes judicial notice of two U. S. circuit court decisions on the same issue as presented in the instant case. See Sioux Valley Hospital v. Shalala, 29 F.3d 628 (8th Cir. July 20, 1994) and Hahnemann University Hospital v. Shalala, No. 96-5191, 1997 WL 362672, at *1 (D.C. Cir. May 5) (per curiam). These two circuit court decisions put forth an interpretation of the issue in this case different from earlier Board decisions and different from the Board majority's most recent decision in Little Company of Mary Hospital and Health Care Centers v. BC/BS of Illinois, PRRB Dec. No. 98-D1, (October 21, 1997), Medicare & Medicaid Guide (CCH) ¶ 45,739, rev'd in part, HCFA Adm. Dec. (December 22, 1997), Medicare & Medicaid Guide (CCH) ¶ 46,053.

The Board finds the circuit courts' decisions persuasive, and therefore gives deference to the circuit courts' decisions in their interpretation of the regulations regarding the inclusion of NICU beds in the IME calculation.

DECISION AND ORDER:

The Intermediary properly included NICU beds in the IME calculation. The Intermediary's action is affirmed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire
Martin G. Hoover, Jr.

Date of Decision: August 28, 1997

FOR THE BOARD:

Irvin W. Kues
Chairman