PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2006-D10

PROVIDER -
Highland Medical Center
Lubbock, Texas

Provider No.: 45-0162

vs.

INTERMEDIARY -
Mutual of Omaha Insurance Company

DATE OF HEARING -
August 10, 2005

Cost Reporting Periods Ended -
September 30, 1999 and September 30, 2000

CASE NOs.: 03-1555 and 04-0387

INDEX

ISSUE:

Whether or not Highland Medical Center has 100 or more available beds for Medicare disproportionate share adjustment qualification and payment purposes.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This dispute arises under the Federal Medicare program administered by the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA). The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395(c). CMS is the agency of the Department of Health and Human Services responsible for administering the Medicare program. CMSs' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law, regulations and interpretive guidelines published by CMS. *See* 42 U.S.C. §1395(h), 42 C.F.R. §§413.20-413.24.

In 1983, Congress changed hospital reimbursement under the Medicare program by enacting Pub. L. No. 98-21, which created the Prospective Payment System ("PPS"). Under PPS, hospitals and other health care providers are reimbursed for 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:

> 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 subchapter.

The statutory provision at 42 U.S.C. §1395ww(d)(5)(F)(i) further directs the Secretary to provide "for an additional payment amount for each subsection (d) hospital" serving "a significantly 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 the version of 42 U.S.C. §1395ww(d)(5)(F)(v) in effect during Provider's fiscal years 1999 and 2000, a hospital located in an urban area with 100 or more beds was eligible for the additional disproportionate share hospital ("DSH") payment if its disproportionate patient percentage was 15 percent or greater. To the extent an urban hospital had fewer than 100 beds, the threshold disproportionate share patient percentage to qualify for Medicare DSH payment was 40 percent. In addition, the amount of DSH payments varied based upon whether a hospital qualified for DSH payments at the 15 percent or at the 40 percent disproportionate patient threshold.

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 qualification status during the relevant time period of this

appeal, the regulation at 42 C.F.R. §412.106(a)(1)(i) stated that "[t]he 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) (1999 & 2000). This bed counting regulation, along with additional guidance published by CMS, establish specific governing rules adopted by CMS for determining the size of a hospital facility for DSH payment qualification under the statutory provisions of 42 U.S.C. §1395ww(5)(F)(v). This case involves the method by which the number of beds is determined.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Highland Medical Center (the "Provider") is an acute care facility located in Lubbock, Texas in an urban area of Lubbock County, Texas. During its fiscal year 1999 ("FY 1999") and fiscal year 2000 ("FY 2000"), Provider was licensed by the State of Texas for 123 total beds.[1] In addition, Provider holds itself out to the community as having a capacity of 123 beds.[2]

Provider's Facility During FY 1999

Provider submitted its license application with the following array of beds on or about August 28, 1998, over a month before the beginning of its fiscal year 1999 (October 1, 1998).[3]

Medical/Surgical	81
Skilled Nursing	12
OB/GYN	12
ICU/CCU	7
Rehabilitation	11
Total	123

Shortly after submitting its license application, Provider requested a change in licensure status for certain rehabilitation beds based on its desire to increase the number of general medical/surgical beds.[4] Provider requested the immediate conversion on its license of five rehabilitation beds into five medical/surgical beds (all on Provider's first floor). Provider's

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[1] *See* Provider Exhibit 3 (FY 99); Provider Exhibit 5 (FY 00).
[2] *See* Provider Exhibit 4 (FY 99); Provider Exhibit 7 (FY 00).
[3] *See* Provider Exhibit 5 (FY 99).
[4] *See* Provider Exhibit 6 (FY 99).

request was granted by the Texas Department of Health ("TDH") on September 16, 1998, two weeks before the start of Provider's FY 1999.[5] As a result, at the beginning of Provider's FY 1999 cost reporting period, Provider's licensed beds were arrayed as follows:

Medical/Surgical	85
Skilled Nursing	12
OB/GYN	13
ICU/CCU	7
Rehabilitation	6
Total	123

In addition, Provider made a request to TDH on November 2, 1998 to immediately convert four skilled nursing beds into four medical/surgical beds.[6] This request was granted by TDH in a letter dated November 9, 1998, resulting in the following array of licensed beds for 326 out of the 365 days in Provider's FY 1999:[7]

Medical/Surgical	89
Skilled Nursing	8
OB/GYN	13
ICU/CCU	7
Rehabilitation	6
Total	123

Thus, during its FY 1999, Provider was licensed to provide general acute care services in at least 105 beds for the entire fiscal year, and for the vast majority of FY 1999 was licensed to provide general acute care services in 109 beds. [8]

Provider submitted floor plans to the Intermediary evidencing the layout of its licensed beds.[9] According to the floor plans, the Provider's facility contains the following array of rooms and beds:

First Floor:	43 Patient Rooms (46 Beds)
Second Floor:	34 Patient Rooms (38 Beds)
Third Floor:	29 Patient Rooms (32 Beds)
Total:	106 Patient Rooms (116 Beds)

One set of the floor plans submitted as an exhibit by the Provider included certain annotations written in the corridors of each floor's room layout. For example, on the first floor, the southeast section of patient rooms included an annotation in the corridor stating "labor/delivery," the

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[5] *See* Provider Exhibit 7 (FY 99).
[6] *See* Provider Exhibit 8 (FY 99).
[7] *See* Provider Exhibit 9 (FY 99).
[8] The weighted average of the beds licensed for acute care for FY 1999 was 108.59, which rounds to 109 licensed acute care beds.
[9] *See* Provider Exhibit 10 (FY 99); *See also*, Provider Exhibit 8 (FY 00).

southwest section of patient rooms included the annotation "med./surg.," the northwest section of patient rooms included the annotation "medworks," and the northeast section of patient rooms included the annotation "SNF" and "rehab."[10] On the second floor, the corridor included the annotations "outpatient surgery" and "outpatient chemo."[11] On the third floor, the corridor included the annotation "med/surg." The floor plans also include some annotations of "office" for certain specific rooms.[12]

Provider's FY 1999 Cost Report and Appeal

Prior to FY 1999, the Provider's facility was toured by the Intermediary, and the Intermediary instructed the facility that it did not believe the Provider had 100 beds. Based on the Intermediary's prior findings, Provider reported fewer than 100 available beds on its FY 1999 Worksheet S-3 attachment to its cost report and claimed DSH payments as a protested amount on its FY 1999 cost report based upon the Provider's belief that it had more than 100 available beds.[13]

Upon receipt of its Notice of Program Reimbursement ("NPR") for FY 1999, Provider filed a timely hearing request with the Provider Reimbursement Review Board ("Board") pursuant to 42 CFR §405.1835 *et seq*. and has met the jurisdictional requirements of those regulations.

Provider's Facility During FY 2000

As of the beginning of its FY 2000, Provider ceased operating any rehabilitation beds.[14] As of April 1, 2000 Provider decertified its SNF program.[15] During its FY 2000, Provider's facility continued to include the following array of rooms and beds:[16]

First Floor:	43 Patient Rooms (46 Beds)
Second Floor:	34 Patient Rooms (38 Beds)
Third Floor:	29 Patient Rooms (32 Beds)
Total:	106 Patient Rooms (116 Beds)

On June 5, 2000 the Intermediary conducted a walk-through of the Provider's facility to establish a count of Provider's "beds in service." The Intermediary identified 113 "beds in service" in the following categories: Routine Beds–105; Pediatric Isolation/NICU–1; ICU–7.[17]

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[10] *Id.*
[11] *Id.*
[12] *Id.*
[13] *See* Provider Exhibits 35 and 36 (FY 99); Transcript (Tr.) at 150 – 151. *See also,* Intermediary Exhibit 16 (FY 00); Tr. at 39 – 59.
[14] *See* Provider Exhibits 6 and 10 (FY 00).
[15] *See* Provider Exhibit 10 (FY 00); Intermediary Exhibit 10 (FY 00).
[16] *See* Provider Exhibits 8 & 9 (FY00).
[17] *See* Provider Exhibit 10 (FY00).

Provider's FY 2000 Cost Report and Appeal

Provider filed its FY 2000 cost report utilizing the 113 beds from the Intermediary's June 5, 2000 walk-through on its worksheet S-3 and claimed a Medicare DSH payment as an urban hospital with 100 or more beds. Nevertheless, based on its review of the facility, the floor plans, and the nursing staff of Provider, the Intermediary determined that Provider did not have at least 100 available beds for DSH payment purposes.[18]

Upon receipt of its NPR for FY 2000, Provider filed timely hearing requests with the Board pursuant to 42 CFR §405.1835 *et seq* and has met the jurisdictional requirements of those regulations.

Consolidation for Hearing

Since the facts, issues, and legal analysis for both of the appeals are nearly identical, the cases were consolidated for a single hearing before the Board.

The Provider was represented by Gregory Etzel, Esq. and Scott McBride, Esq., of Vinson & Elkins LLP. The Intermediary's representatives were Terry Gouger, C.P.A. and Richard Lee, of Mutual of Omaha Insurance Company.

PROVIDER'S CONTENTIONS:

The DSH Statute and Regulation Require Counting all Licensed Beds

Provider argues that the statutory provisions at 42 U.S.C. §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 15 percent if the hospital is located in an urban area and has 100 or more beds." (emphasis added). The statute contains no reference to any reimbursement methodology or hospital usage requirement for purposes of determining the 100-bed threshold for DSH eligibility. Patient bed days, or patient days, are mentioned specifically by Congress in establishing the actual DSH patient percentage calculation. Provider contends that Congress could have easily added a reference to bed days in establishing the 100-bed size eligibility requirements, but it did not. Instead, Congress used the simple term "beds," a term that is uniformly interpreted by hospitals as meaning a hospital's licensed and certified beds. This industry definition of "bed" is consistent with the manner in which the Provider held its facility out to the public and to its peer institutions in reports to the American Hospital Association.[19] The Provider's witness, who had approximately 30 years of experience in hospital administration, indicated that this definition and manner of reporting to the AHA was typical.[20]

Provider further notes that the DSH regulation at 42 C.F.R. § 412.106 states that the bed-counting methodology for determining the number of beds for DSH status shall be the same as

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[18] *See* Intermediary Exhibit 16 (FY 00); Tr. at 39 – 59.
[19] *See* Provider Exhibit 37 (FY 99); Provider Exhibit 40 (FY 00).
[20] Tr. at 103 and 111.

the indirect medical education ("IME") bed count rules. Provider asserts, however, that CMS does not have the statutory authority to narrow the meaning of the term "beds" in the DSH statute as it does to establish the IME definition of "available beds." For purposes of counting IME "available beds," Congress gave the Secretary express authority to establish a definition of available beds for purposes of determining the intern and resident-to-bed ratio. *See* 42 U.S.C. §1395ww)(5)(B)(vi)(I) ("'r' may not exceed the ratio of the number of interns . . . to the hospital's available beds (as defined by the Secretary) during that cost reporting period") (emphasis added). In contrast, the DSH statute simply refers to the number of "beds" for purposes of establishing the size of a facility in determining DSH eligibility. Provider argues that it is well-established as a matter of statutory construction that each word and clause in a statute should be given effect and none should be presumed to be superfluous. So, when Congress uses different language in different sections of the statute, or mentions one thing in part of a statute and omits it from another part of the same statue, it is presumed that Congress acted intentionally. Thus, Provider contends it should be presumed that Congress did not intend to apply an "available bed" requirement with respect to the count of beds for DSH eligibility purposes, but rather, that the industry meaning of the term "beds" (i.e., licensed beds) is the proper measure. Accordingly, Provider contends that it has at least 100 beds based on its licensed bed count.

Provider has at least 100 available beds

Provider also contends that it has at least 100 available beds for DSH eligibility and payment purposes even under the IME bed-counting regulation that was in place during the relevant time period. Under the bed-counting provision of the IME regulation, there is no reference to the exclusion of licensed inpatient beds that are not used for inpatient services, nor does the regulation require excluding licensed inpatient beds associated with outpatient services. *See* 42 C.F.R. § 412.105(b). As the regulation at 42 C.F.R. § 412.105(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.

Provider argues that the Intermediary grossly undercounted Provider's available bed total for DSH eligibility and payment purposes because it improperly focused upon a perceived inability to staff the beds and on the perceived use of the room or bed in question, rather than upon the availability of the bed (*i.e.*, its status as a licensed inpatient bed capable of being put into use for inpatient services within 24–48 hours). While Provider did not actually utilize all of its licensed beds for inpatient care, Provider contends that the rooms were available for use, as needed, to house acute care beds up to the Provider's complement of 116 beds. Provider's witness testified to the availability of all the beds, using the floor plans as a guide, and based on his personal familiarity with the capabilities of each room.[21] Provider also notes that the Intermediary conducted a walk-through of the Provider's facility to establish a count of Provider's "beds in service" and determined that Provider had 113 available beds.[22] Hence, Provider argues that the size of Provider's facility was clearly large enough to fully treat well over 100 inpatients as required for DSH eligibility. The Provider further notes that it has the ability to staff the full complement of beds claimed by Provider if necessary.

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[21] Tr. at 61 – 100.

[22] *See* Provider Exhibit 10 (FY00).

The Provider contends that the Intermediary used the wrong standard in determining the number of available beds at the facility for DSH eligibility purposes. The Intermediary argued that it excluded observation beds from the bed count because a patient in an observation bed is not admitted into the hospital (*i.e.*, the bed is not used for inpatient services). The Intermediary also found that licensed inpatient beds used for day surgery services should be excluded because such beds are not being utilized for inpatient lodging. In addition, licensed inpatient rooms used for labor and delivery services were improperly excluded by the Intermediary. According to Provider, the reliance by the Intermediary on this "usage" standard to calculate available beds contravenes the applicable statutes, regulations, program instructions, Board and CMS Administrator decisions, and federal case law from other jurisdictions regarding the appropriate counting of available beds.

The PRM provides further clarification of the available beds determination process set forth in the regulations and includes and expands upon the definition contained in the preamble to the final rule discussed above. Provider contends that the PRM clearly states that "available bed days" include all routine beds, regardless of usage. *See* PRM §2405.3G. In addition, the manual provision expressly indicates that the available bed count should not take into consideration "the day-to-day fluctuations in patient rooms and wards being used," such as the use of a licensed inpatient room for day surgery services, office space, storage, or the temporary stay of an observation patient. 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." *Id.* The size of Provider's facility remained constant during the relevant time period.

Provider notes that when the PRM is read together with the regulation, it is clear that the PRM's references to beds in "labor rooms" and "outpatient areas" are limited to unlicensed beds only (*e.g.*, unlicensed beds in interior rooms used as treatment rooms), and does not include licensed beds capable of providing inpatient care. The list of beds excluded in the controlling regulation at 42 C.F.R. § 412.105(b) does not refer to ancillary, outpatient, or labor room beds. Presumably, the reason for that omission is that such beds do not fall within the accepted industry definition of "beds" (*i.e.*, licensed and certified), and would not need to be included in the first instance, and thus need not be expressly excluded. Accordingly, the PRM's exclusion of unlicensed outpatient beds is not inconsistent with the regulation.

Provider contends, however, that the Intermediary has attempted to interpret the PRM as excluding licensed beds from the available bed count, which is an impermissible extension of the regulatory language. Since the PRM cannot contradict a regulation, or go beyond the bounds of what is an acceptable interpretation of a regulation, Provider argues that the PRM reference to labor rooms and outpatient areas must be read as a reference to unlicensed beds only. Accordingly, Provider argues that all of the Provider's licensed inpatient acute care beds must be counted as available beds, including any labor and delivery room beds and other beds occasionally used for observation or outpatient services.

Provider further argues that CMS itself acknowledges this result in the PRM. The Provider referred the Board to the example presented under Section 2405.3G2 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, licensed inpatient beds that may have been used for observation and other outpatient services must be counted because they remained

licensed as acute care beds throughout the relevant time period and were available for use as inpatient beds. Hence, Provider contends that a hospital's temporary use of a licensed and certified inpatient routine bed to furnish observation or outpatient services does not reduce a hospital's bed size under standard and accepted definitions of bed size.

Provider also contends that it has been longstanding CMS policy (which is consistent with the statutory and regulatory framework) 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/CMS Administrator decisions.

In *Natividad Medical Center v. Blue Cross & Blue Shield Association/Blue Cross of California*, PRRB Dec. No. 91-D58, August 9, 1991, Medicare and Medicaid Guide (CCH) ¶39,573, rev'd CMS Administrator, October 6, 1991, Medicare and Medicaid Guide (CCH) ¶39,611, 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. The annual survey used in *Natividad* carried no weight as evidence of the number of available beds at the facility, and the CMS Administrator ruled that the intermediary's use of the licensed bed count was appropriate.

In *Edinburgh Hospital v. Blue Cross & Blue Shield Assoc./TrailBlazer Health Enterprises, LLC*, PRRB Dec. No. 2003-D23, April 29, 2003, Medicare and Medicaid Guide (CCH) ¶80,891, the Board held that all of the observation beds at issue were licensed acute care beds and should be included in the bed size calculation for determining DSH eligibility. The Board based its holding on the fact that both the enabling regulation and manual provision exclude specific beds from the bed count, and neither of the authorities provides for the exclusion of observation beds. The Board's finding is supported by the fact that the manual instructions are written with a great degree of specificity, and the regulation has been modified multiple times to clarify the types of beds excluded from the count, which does not include licensed inpatient beds used for outpatient services such as observation. There is no logical distinction for other available licensed inpatient beds used for other types of outpatient services.

The Provider also referred the Board to the CMS Administrator's decision in *Pacific Hospital of Long Beach v. Aetna Life Insurance Company*, PRRB Dec. No. 93-D5, December 16, 1992, Medicare and Medicaid Guide (CCH) ¶40,987, rev'd in part, CMS Administrator, February 2, 1993, Medicare and Medicaid Guide (CCH) ¶41,355. 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 CMS 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 into 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. In this case, the Provider contends that all of the beds which were used to provide observation and outpatient services were licensed and capable of use as

inpatient beds for immediate occupancy.[23] 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. *See Clark Regional Medical Center v. U.S. Dept. of Health & Human Services*, 314 F.3d 241 (6th Cir. 2002) ("*Clark Regional*").

The CMS Administrator addressed the issue of available bed days in *Santa Clara Valley Med. Ctr. v. Blue Cross and Blue Shield Association/Blue Cross of California*, CMS Adm'r Dec., Medicaid and Medicare Guide (CCH) ¶45,230, rev'g in part PRRB Dec. Nos. 97-D25 and 97-D26, Medicare and Medicaid Guide (CCH) ¶45,064. In that case, the provider claimed that 18 beds were unavailable and were not included in the IME bed count because they were utilized for physician sleeping quarters. The Administrator held that the beds were deemed "available for inpatient lodging" as described in Provider Reimbursement Manual §2405.3G, despite the fact that they were temporarily occupied by physicians. Therefore, the Provider contends that, if actual use of a bed as a physician sleeping bed (which requires no nurse staffing) does not render the bed unavailable, then the use of a bed for a few hours by an outpatient or an observation patient also should not render the bed unavailable.

The Provider further notes that the Board has upheld the broad definition of "available beds" that has been promulgated by the CMS 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.[24]

In further support of its contentions, the Provider cites to *Clark Regional Medical Center v. Shalala*, in which a Federal District Court in the Eastern District of Kentucky determined that the CMS Administrator's attempt to exclude swing-bed and observation bed days from the available bed count for DSH eligibility purposes was arbitrary and capricious and not supported by the applicable regulations in PRM guidelines. 136 F. Supp. 2d 667 (E.D. Ky 2001). The Court agreed with the Board's original decision in the case and found the Administrator's construction of the applicable regulations and guidelines could not be seen as rational in light of the plain language of the regulations and the PRM. *Id*. In *Clark Regional*, the Sixth Circuit affirmed the Eastern District of Kentucky's finding that the plain language of 42 C.F.R. §412.105(b) and the Department's interpretation of an "available bed" as described in PRM § 2405.3G clearly demonstrate that observation beds shall be considered available beds for DSH purposes. 314 F.3d 241 (6th Cir. 2002). The Sixth Circuit also clarified that CMS may not shift the burden of proof for determining the number of available beds "so as to always disadvantage the subject hospital" (*i.e.*, the agency should stand behind the PRM's language that the burden is on the provider to exclude beds).

In addition, Provider notes that the Ninth Circuit Court of Appeals has held that sub-acute care beds must be included in the bed-size calculation used to determine DSH adjustments, reversing a separate Administrator decision. *Alhambra Hospital & Memorial Hospital of Gardena v.*

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[23] *See* Provider Exhibits 5-8.

[24] *See* Provider Exhibit 27 (FY99).

Thompson, 259 F.3d 1071 (9th Cir. 2001). The Court stressed that 42 C.F.R. § 412.106 is plain on its face and requires the inclusion of sub-acute patient days as part of the DSH reimbursement. *Id*. at 1076. The sub-acute beds met all the necessary requirements as available beds and were not specifically identified as beds excluded from the DSH calculation. *Id*. at 1075.

Provider notes that, unlike the CMS Administrator, the Board has consistently held that days such as observation bed days should be included in the available bed count. The federal court decisions reversing the CMS Administrator in both *Clark Regional* and *Alhambra* were consistent with the Board's findings in those cases (i.e., that subacute bed days and observation bed days were not excluded from the DSH available bed count). The Board has further reiterated that observation beds are to be included in the calculation of the 100-available bed threshold requirement for the calculation of the DSH payment adjustment in *Presbyterian Hospital of Greeneville v. Blue Cross and Blue Shield Association/TrailBlazer Health Enterprises, LLC*, 2002-D1, (November 21, 2001). In *Presbyterian*, the Provider operated a portion of its licensed inpatient bed capacity as a pre- and post-surgery triage area, and the Board included such beds in the Provider's count noting the example contained in the PRM instructing the inclusion of acute care beds utilized for long term care but not certified as such. *Id*. at 24.

The Board held similarly in *Central Texas Medical Center v. Blue Cross and Blue Shield Assoc./TrailBlazer Health Enterprises, LLC*, 2003-D2, (October 16, 2002). In both *Presbyterian* and *Central Texas*, Provider contends that the Board continued to correctly apply the plain language of the bed counting regulation, noting that the *Clark Regional* 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 [CMS'] 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.'"

Central Texas, at 25. Provider contends that the "observation" and other "outpatient" beds alleged by the Intermediary in this case are the same as those involved in the cases addressed above and must be included in the bed count for determining DSH eligibility for the same reasons as the beds in the cases discussed above.

Provider also notes that the instructions set forth in Administrative Bulletins published by the Blue Cross and Blue Shield Association provide clarification to CMS' longstanding policy relating to available bed determinations. Administrative Bulletin #1830, 87.01 (January 28, 1987)[25] 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.

[25] *See* Provider Exhibit 26 (FY 99)

Administrative Bulletin #1830, 87.01.

Similarly, Administrative Bulletin #1841, 88.01 (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." 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. Accordingly, the Provider contends that the occasional use of licensed inpatient beds as observation beds or to provide outpatient services is not sufficient to overcome their status as available beds. The beds were included in the Provider's depreciable assets and were clearly capable of being set-up and staffed within 24–48 hours.

Provider contends that, as its witnesses testified, its facility contained well over 100 licensed acute care beds that were actually maintained for housing inpatients. There were no dedicated outpatient areas supplanting the Provider's available licensed inpatient beds as implied by the Intermediary's position paper and exhibits.[26] Moreover, given the uncontested evidence presented by the Provider at the hearing concerning the ability of the Provider to obtain nursing staff from its own staff, staff from related party entities, and staff from multiple nurse registries to cover Provider's full complement of 100 or more beds, Provider contends that it must be considered an "urban hospital with 100 or more beds" under the applicable statute, regulations, and CMS policy.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider does not have at least 100 available beds for DSH payment purposes for FY 1999 and FY 2000. The Provider claimed and documented in its position paper and at the hearing a total of 116 hospital beds. The Intermediary argues that policy, as stated in HCFA Pub. 15-1, §2405.3.G, specifically excludes from the available bed count hospital-based skilled nursing beds, PPS excluded rehabilitation unit beds, labor room beds and beds in outpatient areas and areas that are maintained and utilized for only a portion of the stay or for purposes other than inpatient lodging. The Intermediary contends that policy requires the removal of the 8 SNF beds, 6 Rehab beds, 6 Labor/Delivery beds and 1.5 observation beds from the 116 hospital beds and as a result, the Provider does not qualify for a DSH payment.

The Intermediary also argues that a significant number of beds located on the second floor are utilized for outpatient surgery and outpatient chemo and should also be removed from the available bed count. The Provider's witness testified that the hospital's second floor was used

[26] *See* Tr. at 139-141.

for outpatient and inpatient services.[27] Through discovery the Intermediary requested but did not receive outpatient or inpatient utilization for beds on the second floor.[28] As the Provider could not provide such documentation, the Intermediary contends that all 31 beds on the second floor should be removed from the available bed count.

The Intermediary did complete a physical count of the number of beds located at the facility as of June 5, 2000. The count identified a total of 113 patient beds from which the Intermediary contends that SNF, Rehab, Labor/Delivery beds, and outpatient usage must be removed. This results in less than 100 available beds for purposes of DSH payment. As stated in the Intermediary's letter to the Provider dated July 11, 2000:

> As we agreed during the tour, you are to maintain support for the amount of time Routine Beds are used for Outpatient or Ancillary services such as Day Surgery. This time will then be converted into days resulting in a reduction in the number of available beds used in the calculation of disproportionate share payments. This is consistent with the treatment of Observation Bed Days, another outpatient service.

The Intermediary contends that there were a significant number of beds that were out of service or unstaffed, and that the Condition of Participation for nursing services, 42 CFR §482.23(b)(1), requires hospitals to provide 24-hour nursing services furnished or supervised by a registered nurse. In order for these beds to be considered eligible, the hospital must be able to provide staffing within 24-48 hours. The Provider identified various sources for obtaining nurses within 24-48 hours but could only speculate as to the availability of the nurses. The two contracts documented by the Provider contained a clause stating that staffing was subject to availability. During cross-examination the Provider's witness testified that they did not know how many nurses the agencies had on staff and did not ask how many nurses the agencies could provide to the hospital.[29]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of the relevant Medicare law, regulations, and manual provisions, the facts of the case, the parties' contentions, and the evidence and testimony presented in the case, the Board finds and concludes that the Intermediary's determination of the number of available beds for DSH eligibility purposes was not proper. The Board concludes that the Provider had at least 109 available beds for DSH eligibility and payment purposes for FY 1999 and FY 2000. Therefore, the Provider is entitled to receive additional reimbursement for DSH payment purposes.

The statute at 42 U.S.C. §1395ww(d)(5)(F) provides for a DSH adjustment to hospitals that serve a significantly 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

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[27] Tr. at 180.

[28] *See* Intermediary Exhibit 30 (FY00).

[29] Tr. at 166-168.

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 the number of its beds, which is the only factor in dispute in the present case. The Board notes that the statute itself does not expound upon the meaning of "bed" with respect to DSH qualification.

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) (1999 & 2000).

The Board finds that the 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 §2405.3G for the purpose of calculating the adjustment for indirect medical education and DSH eligibility. In part, the manual states:

> G. Bed Size. — A bed is defined for this purpose as an adult or pediatric bed (exclusive of beds assigned to newborns which are not in intensive care areas, custodial beds, and beds in excluded units) maintained for lodging inpatients, including beds in intensive care units, coronary care units, neonatal intensive care units, and other special care inpatient hospital units. Beds in the following locations are excluded from the definition: hospital based skilled nursing facilities or in any inpatient area(s) of the facility not certified as an acute care hospital, labor rooms, PPS excluded units such as psychiatric or rehabilitation units, postanesthesia or postoperative recovery rooms, outpatient areas, emergency rooms, ancillary departments, nurses' and other staff residences, and other such areas as are regularly maintained and utilized for only a portion of the stay of patients or for purposes other than inpatient lodging.
>
> To be considered an available bed, a bed must be permanently maintained for lodging inpatients. It must be available for use and housed in patient rooms or wards (i.e., not in corridors or temporary beds). Thus, beds in a completely or partially closed wing of the facility are considered available only if the hospital 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.*
>
> *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 §2405.3G (emphasis added).

The Board concludes that the criteria applied by the Intermediary for the exclusion of certain beds cannot be supported based on the correct and clear interpretation of the language set forth in the regulations and manual guidelines.

The Board notes that during the relevant time periods, Provider was licensed by the State of Texas for 123 total beds.[30] In addition, Provider held itself out to the community as having a capacity of 123 beds.[31]

Provider presented two witnesses. The Provider's first witness, the current Plant Operation Director who is responsible for ensuring the patient care capabilities of all licensed beds, testified that there have been no material structural changes to the physical plant facilities that would change the number of beds or the availability of the beds for inpatient use between 1999 and 2005.[32] Provider presented exhibits and its Plant Operations Director testified in support of a patient bed count of 116 available beds for the three floors of the Provider's facility. Evidence and testimony was also presented that each of the 116 beds included the necessary oxygen hook-up, nurse call service, medical vacuum/suction, nursing service stations, and other Texas licensing requirements for inpatient use.[33] The Plant Operations Director also testified that the beds currently "out of service" could be prepared for inpatient use within a short period of time:

Q: [W]hat would be the total time we're talking about here to go through all these rooms and all these beds that need to be put into place?

A: I think we could do it in probably 10 hours, certainly within 24.[34]

The Provider's second witness, the CEO of the facility during most of the relevant time period, confirmed the Plant Operation Director's testimony regarding the layout and inpatient care capabilities of the facility during FY 1999 and FY 2000, and testified that the Provider's bed count of 116 beds was based on available beds for inpatient care.[35] The former CEO confirmed the available bed count and testified that the beds were available and used for inpatient care as

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[30] *See* Provider Exhibit 3 (FY 99); Provider Exhibit 5 (FY 00).
[31] *See* Provider Exhibit 4 (FY 99); Provider Exhibit 7 (FY 00).
[32] Tr. at 97 –98.
[33] *See* Provider Exhibits 10 –13, and 34 (FY 99); Provider Exhibits 8, 9, 11, 12, and 38 (FY 00); Tr. at 61 – 100.
[34] Tr. at 95 – 96.
[35] Tr. 130 – 132.

necessary to meet patient care needs.[36] When questioned regarding the annotations on the facility floor plans submitted to the Intermediary and the use of the patient beds, the former CEO testified that the annotations were not an accurate reflection of the use of the rooms and were misleading.[37] The Board finds the Provider's witness testimony to be credible and convincing. The Board notes, however, that even if the floor plan annotations accurately reflected the usage of the applicable rooms, it would not alter the Board's decision.

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 applicable to the relevant time periods provides for the exclusion of unstaffed beds or licensed acute care beds used for other purposes, such as storage or office space.

The Board finds that the example in HCFA Pub-15-1 §2405.3G2 to be compelling evidence supporting this finding. The example specifically requires the inclusion of licensed acute care beds in the available bed count even though they are set up and used as long-term care beds:

> [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 §2405.3G (emphasis added). Thus, the Board finds that, regardless of the usage of the beds as alleged by the Intermediary (which relied upon the annotations reflected on the floor plans), the Provider maintained greater than 100 beds for inpatient care, and its DSH qualification and payment must reflect that count.

In furtherance of its findings, the Board observes that the district court's decision in *Clark Regional* upheld the decision rendered by the Board in *Commonwealth of Kentucky 92-96 DSH Group* 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 *Clark* Court found the instructions in Section 2405.3G of the PRM 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.

With respect to the exclusion of beds being used for alternative (*i.e.*, non-patient care) purposes, such as office space or storage, the Board finds that such beds must be included in the bed count determination. The controlling regulatory and manual provisions provide that "maintained and available beds" are to be included in the bed count. The evidence and testimony presented demonstrated that the beds were licensed inpatient beds in routine areas that were maintained to provide inpatient services even though some were used for other purposes.

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[36] Tr. at 135 – 143.
[37] Tr. at 169, 198 – 202.

With respect to the Intermediary's exclusion of beds in the "labor and delivery" area of the first floor, the Board finds that the PRM exclusion of "labor rooms" is limited to unlicensed beds only and does not include licensed beds capable of providing inpatient care. The evidence indicates that these beds were not used solely as labor rooms and that the beds were capable of, and, in fact, were used to provide inpatient care.[38] The Board finds that such beds were licensed beds for inpatient use and must be included in the available bed count.

The Board also finds it compelling that the Intermediary itself determined that the Provider had 113 beds in service. On June 5, 2000, the Intermediary conducted a walk-through of the Provider's facility to establish a count of Provider's "beds in service." The Intermediary identified 113 "beds in service" in the following categories: Routine Beds – 105; Pediatric Isolation/NICU – 1; ICU – 7.[39] The Board finds the Intermediary's own bed count to be additional evidence in support of the Board's decision that the Provider has greater than 100 beds for DSH purposes.

With respect to the ability of the Provider to staff the full complement of available beds, the Board notes that there are no regulatory provisions addressing the staffing issues. However, certain administrative guidance has been published regarding those issues. The instructions set forth in Administrative Bulletins published by the Blue Cross and Blue Shield Association provide clarification to CMS' longstanding policy relating to available bed determinations. Administrative Bulletin #1830, 87.01, (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.

Similarly, Administrative Bulletin #1841, 88.01, (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." 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).

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[38] Tr. at 133 – 134.

[39] *See* Provider Exhibit 10 (FY 00).

The Board notes that it is unrealistic to expect all the available beds to become immediately needed at the same time, except perhaps in a disaster management situation. Nevertheless, the Provider presented testimony that the full complement of beds was capable of being set up and staffed within 24–48 hours. The Provider's CEO testified that any increased need of nursing staff would first be filled by the Provider's own nursing staff. If the demand was greater than the Provider's own staff capabilities, the Provider would seek additional nursing staff from its nearby related-party hospital. If the demand for additional staff was still unmet, the Provider testified that it would obtain the necessary nursing staff through the various nurse registries with which it had agreements or other business relationships.[40]

Q: . . . as chief executive officer in 1999 and 2000 and your familiarity with the ability to staff Highland Medical Center, do you feel that you could have provided the full complement of nurses to over a hundred inpatient beds?

A: Yes, we could have.

Q: Could you have done that within 24 to 48 hours?

A: Yes, we could have.[41]

Again, the Board finds the Provider's witness testimony relating to its ability to staff beds to be credible and convincing. The Intermediary did not provide any evidence to contradict the Provider's contentions. Accordingly, the Board concludes that the Provider was capable of staffing its full complement of beds if the need arose.

The record shows that the beds in dispute were licensed beds and 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, the nursing staff of a nearby related-party hospital, or nurses from a nurse registry if the need arose. Based on the evidence and testimony presented, the Board finds that the beds in dispute were permanently maintained and available for lodging inpatients. Therefore, the Board concludes that Provider had at least 109 available beds for FY 1999 and FY 2000 for DSH eligibility and payment purposes.

Because the Board finds that Provider had at least 109 available beds for DSH eligibility and payment purposes for FY 1999 and FY 2000 under the plain terms of the applicable regulations, manual provisions, and policy pronouncements during the relevant time period, the Board will not address the Provider's contention that CMS does not have the statutory authority to narrow the meaning of the term "beds" in the DSH statute to the IME definition of "available beds." Accordingly, the Board makes no findings or conclusions with respect to this argument set forth by Provider.

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[40] Tr. at 143 – 149; 204 – 207. *See also*, Provider Exhibits 28 – 31 (FY 99) and 33 – 36 (FY 00).

[41] Tr. at 149.

DECISION AND ORDER:

The Intermediary's determination of the number of available beds for DSH eligibility purposes was not proper. The Provider had at least 109 available beds for Medicare DSH adjustment qualification and payment purposes for Provider's fiscal years ended 9/30/99 and 9/30/00. Accordingly, Provider is entitled to additional DSH payment adjustments to reflect an available bed count of at least 109 beds for these fiscal years.

Board Members Participating

Suzanne Cochran, Esq., Chairperson
Gary B. Blodgett, D.D.S.
Anjali Mulchandi-West

FOR THE BOARD

DATE: December 22, 2005

Suzanne Cochran
Chairperson