PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2004-D16

PROVIDER –
Odessa Regional Hospital

Provider No. 45-0661

vs.

INTERMEDIARY –
Mutual of Omaha Insurance Company

DATE OF HEARING -
January 27, 2004

Cost Reporting Periods Ended
December 31, 1996
December 31, 1997

CASE NOs. 00-2594
00-0411

INDEX

ISSUE:

Was the Intermediary's adjustment excluding observation bed days from the determination of the Provider's disproportionate share hospital adjustment proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Odessa Regional Hospital (Provider) is a Medicare certified acute care facility located in Odessa, Texas. During its Medicare cost reporting periods ending December 31, 1996 and December 31, 1997, the Provider claimed a disproportionate share hospital (DSH) adjustment based upon its being an urban hospital with at least 100 beds as determined in accordance with 42 C.F.R. §412.105(b).

Governing Statues and Regulations:

This is a dispute over the amount of Medicare payments to a hospital.

The Medicare program provides health insurance to the aged and disabled. 42 U.S.C. §§1395 – 1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services charged with administering the Medicare program.

The Secretary of Health and Human Service's (Secretary) 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 the Medicare law and interpretative guidelines published by CMS. Id.

At the close of its fiscal year, a Medicare provider of services must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and what portion of those costs are to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost reports, determines the total amount of Medicare reimbursement due the provider, and informs the provider in a notice of program reimbursement (NPR). 42 C.F.R §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

In 1983, Congress changed the former cost based payment system and created a Prospective Payment System (PPS) to pay hospitals for services to Medicare patients. Under PPS, inpatient-operating costs are reimbursed based on a prospectively determined formula taking into account national and regional operating costs.

Congress also provided for adjustments to the PPS rates for certain hospitals that met specific criteria with respect to their inpatient population. The statutory provision at 42 U.S.C. §1395ww(d)(5)(F)(i) directs the Secretary to provide for an additional

payment for hospitals that serve "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 the exception relevant to this case, 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. The instant case involves the method by which the number of beds is determined.

Mutual of Omaha Insurance Company (Intermediary) reviewed each of the Provider's cost reports and removed observation bed days from the calculation of the Provider's bed count. As a result of these adjustments, the Provider's bed size fell below 100 beds, and the Provider's DSH adjustment was limited to 5 percent of its Federal Part A Medicare payments as opposed to a much greater percentage.

The Intermediary issued NPRs reflecting its adjustment to the Provider's DSH calculation for the 1996 and 1997cost reporting periods. The Provider appealed the Intermediary's adjustments to the Board pursuant to 42 C.F.R. §§405.1835-405.1841 and met the jurisdictional requirements of those regulations. The amount of Medicare funds in controversy is approximately $1,000,000 in each of the subject cost reporting periods.[1]

The Provider was represented by Byron J. Gross, Esq. and Hope R. Levy-Biehl, Esq., of Hooper, Lundy & Bookman, Inc. The Intermediary was represented by Marshall Treat, Senior Appeals Consultant, Mutual of Omaha Insurance Company.

Stipulation of Facts

The Provider and Intermediary entered into a joint stipulation which included the following:

1. During its cost reporting periods ended 12/31/96 and 12/31/97 the Provider had 100 licensed beds, all maintained and otherwise available for inpatient care.

2. Patients receiving observation care were temporarily treated in beds otherwise maintained for inpatient care and located throughout the hospital. At no time did the Provider have a dedicated observation unit or any one bed dedicated to observation care.

3. In both cost reporting periods, the Intermediary further concluded that, as a hospital with fewer than 100 beds (after excluding observation bed days from the available bed count), that the Provider was not eligible to receive Capital DSH reimbursement.

[1] Provider Position Papers at 2 and 3.

4. To the extent the Board finds that the Intermediary improperly excluded observation bed days from the available bed count, the Provider will be treated as a 100-bed hospital for both DSH and Capital DSH purposes.

PROVIDER'S CONTENTIONS:

The Provider contends that neither the statute nor the regulation governing DSH payments and outlining how to count beds excludes observation beds from a hospital's bed count. The plain language of the statute, 42 U.S.C. §1395ww(d)(5)(F)(iv)(I), indicates that all of a provider's beds should be included in the bed count. The applicable regulation for counting beds, 42 C.F.R. §412.105(b), provides that all beds except certain specifically enumerated types of beds be included in the bed count. The regulation does not exclude observation beds. Accordingly, the DSH statute, as interpreted by the DSH regulation and applicable bed counting regulation, mandates that observation beds be included in the bed count.[2]

The Provider contends that the CMS' current policy to exclude observation beds from the available bed count is inconsistent with Medicare's Provider Reimbursement Manual, Part I HCFA Pub. 15-1 §2405.3G, the only authoritative manual provision in effect during the subject cost reporting periods. It indicates that beds regularly maintained for lodging inpatients should be included in the bed count, and that the occasional or temporary use of a bed for other purposes does not eliminate the bed from the count. The Provider asserts that the beds it used for observation services were regularly maintained to lodge inpatients, and their occasional use for observation services does not affect their status as inpatient beds. The Provider believes that by excluding the equivalent number of observation beds, the Intermediary has inappropriately modified the Provider's available bed count based upon day-to-day fluctuations in bed utilization, instead of actual changes in the size of the facility as discussed in HCFA Pub. 15-1 §2405.3G. Moreover, the Provider asserts that according to HCFA Pub. 15-1 §2405.3G, a hospital bears the burden of excluding beds from its available bed count. The Provider maintains that it never intended to exclude observation beds from its available bed count and, as a result, such beds cannot be excluded pursuant to PRM-I §2405.3G.

The Provider contends that CMS did not establish its policy of excluding observation beds from the inpatient hospital bed count until after the start of its fiscal year ending December 31, 1997.[3] The Provider believes that the Intermediary based its audit adjustment on either one or both of the following documents:

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[2] Provider Position Paper for Case No. 00-2594 at 8. Note: The Provider's position papers for each of the subject cases consolidated herein are essentially identical. Therefore, for ease of reference, all references made to the Provider's Position Paper will be directed to Case No. 00-2594.

[3] Provider Position Paper at 4 and 17.

- A Region IV Intermediary Letter (RIL) dated March 11, 1997, [4] or

- Revised cost reporting instructions published on October 1, 1996 and effective for cost reporting periods beginning on or after September 30, 1996 (HCFA Pub. 15-2 §3630.1)

The Provider contends that neither the RIL nor the revised cost reporting instructions are applicable to the fiscal periods at issue. Moreover, the Provider asserts that the RIL and the cost reporting instructions are both invalid to the extent they exclude beds temporarily used for observation purposes from the Provider's available bed count. The reduction in the number of available beds because of their temporary use for observation purposes violates both the Medicare Act and applicable regulations. Furthermore, any policy requiring the exclusion of observation days is a substantive rule that must be promulgated in accordance with the Administrative Procedure Act's (APA) notice and comment requirements. CMS' current policy of excluding observation days from the available bed count was not adopted in accordance with the APA, and the Provider contends it is therefore invalid.

In addition, the Provider asserts that neither the revised cost reporting instructions in HCFA Pub. 15-2 §3630.1 nor the HCFA Region IV's letter to its intermediaries can be applied retroactively. See Bowen v. Georgetown University Hospital., 488 U.S. 204, 208, 109, S. Ct. 468,471 (1988). Also, the manual sections in Part II of the Provider Reimbursement Manual are instructions for completing the cost report forms and are not intended to promulgate new policies. See National Medical Enterprises v. Bowen, 851 F.2d 291, 293 (9th Cir. 1988).

The Provider believes that the Board's decision favorable to the providers 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 & Medicaid Guide (CCH) ¶ 80,332, rev'd, CMS Administrator, Nov. 8, 1999, Medicare & Medicaid Guide (CCH) ¶ 80,389, rev'd, Clark Regional Medical Center, 136 F. Supp. 2d 667 (E.D. KY 2001) (Commonwealth of Kentucky) supports its claim in the instant appeals, i.e., that the exclusion of observation days from the count of a provider's available beds was improper.

The Provider also cites Edinburg Hospital v. Blue Cross Blue Shield Association/TrailBlazer Health Enterprises, PRRB Dec. No. 2003-D23, April 29, 2003, Medicare & Medicaid Guide (CCH) ¶ 80,981, aff'd, CMS Administrator, July 3, 2003, where the Board found that an intermediary improperly excluded observation bed days from a hospital's available beds for DSH purposes, and, District Memorial Hospital v. Thompson, F. Supp. 2d, 2:01CV259-C (W.D.N.C. May 12, 2003), where the court concluded, with reasoning similar to that in Alhambra Hospital v. Thompson, 259 F.3d 1071 (9th. Cir. 2001), that days during which inpatient beds are

[4] Exhibit P-5. Note: This exhibit is incorrectly dated March 1977 although it was actually issued in March of 1997.

used as swing-beds[5] should not, based upon the plain language of the governing regulation, be excluded from the DSH bed count.[6]

The Provider also addresses the proposed changes to the hospital prospective payment system rule for FY 2004 (See Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2004 Rates, 68 Fed. Reg. 27154 (May 19, 2003)) wherein CMS outlined its policies for counting beds for both DSH and indirect medical education (IME) purposes. Although this rule excluded from the bed count beds used for observation services when determining DSH and IME Medicare reimbursement, the language in the Federal Register reflects that it is new policy. It, therefore, cannot be retroactively applied to the subject cost reporting periods.[7]

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that Congress implemented the DSH adjustment to reimburse hospitals for costs that are not reflected in Medicare's PPS rate for inpatient services. As such, the Intermediary asserts that observation bed days should be excluded from the available bed count used to determine a hospital's DSH adjustment because such services are considered outpatient care that is not reimbursed under PPS.[8]

The Intermediary contends that the governing regulation, 42 C.F.R. §412.106, explains that the number of beds used in the DSH calculation is determined in accordance with 42 C.F.R. §412.105 (b). The Intermediary asserts that observation bed days must be excluded from the DSH determination based upon this rule, which states:

> *Determination of number of beds.* For purposes of this section, the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period, not including beds or bassinets in the healthy newborn nursery, custodial care beds, or beds in 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 Intermediary contends that in order for a bed to be included in the available bed days determination, it must be permanently maintained for lodging hospital inpatients pursuant to HCFA Pub. 15-1 §2405.3G. The Intermediary asserts that this cannot be

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[5] Swing beds are similar to observation beds in that they are acute care beds permanently maintained and staffed to house inpatients that are, at times, used for another purpose. Swing beds are specifically used to provide skilled nursing care.

[6] Admitted into the record as Exhibit P-10, Case No. 00-2594, and Exhibit P-9, case No. 00-0411.

[7] Id.

[8] Intermediary Position Papers at 6.

the case for beds that are going to be occupied at times by hospital outpatients for observation.

The Intermediary disagrees with the Provider's argument that a letter issued by CMS' Atlanta Regional Office on March 11, 1997, is a change in policy that is being applied retroactively. The Intermediary contends that the letter, which specifies that all observation bed days are excluded from the available bed day count, is a pronouncement of long-standing policy.

Finally, the Intermediary relies on the Administrator's decision reversing the Board in Commonwealth of Kentucky. CMS stated:

> Based on a reading of the language in section 1886(d)(5)(F) of the Act, which implements the disproportionate share provision, we are in fact required to consider only those inpatient days to which the prospective payment system applies in determining a prospective payment hospital's eligibility for a disproportionate share adjustment.
>
> Congress clearly intended that a disproportionate share hospital be defined in terms of a subsection (d) hospital, which is the only type of hospital subject to the prospective payment system. . .

Commonwealth of Kentucky, Medicare & Medicaid Guide (CCH) ¶ 80,389 at 201,236.

The Intermediary concludes, therefore, that CMS' requirement that a bed day under 42 C.F.R. §412.105(b) only be included in the DSH bed count when the costs of the day are reimbursed as an inpatient service cost is consistent with the Administrators interpretation in Commonwealth of Kentucky of including only "inpatient days to which the prospective payment system applies in determining a prospective payment hospital's eligibility for a disproportionate share adjustment."

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, and evidence presented, finds and concludes as follows:

The Intermediary excluded observation bed days from the calculation of the Provider's available bed days used to determine the Provider's eligibility for a DSH adjustment. In general, the Intermediary argues that only beds reimbursed under PPS should be included in the total bed count, since the purpose of DSH is to adjust PPS payment amounts; observation bed days must be excluded from the count because they are reimbursed as an outpatient service.

The Intermediary asserts that observation beds do not meet the program's definition of "bed size" as that term applies to DSH eligibility, as observation beds by their very

nature are not permanently maintained and available for lodging inpatients as required by 42 C.F.R. §412.105 and HCFA Pub. 15-1 §2405.3.G.

The Board finds that the pertinent statute, 42 U.S.C. §1395ww(d)(5)(F), considers three factors in determining whether or not a hospital qualifies 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 in this case. 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 controlling regulation, 42 C.F.R. §412.105, requires a hospital's bed size to be determined by dividing its "available bed days" by the number of days in the cost reporting period. Moreover, the regulation excludes nursery beds assigned to newborns that are not in intensive care areas from the determination of available bed days, as well as custodial care beds and beds in excluded units.

The Board finds that the word "bed" is more specifically defined in 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 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.

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

Based upon these authorities, the Board finds that the Provider's observation bed days meet all of the program's requirements to be included in the bed size calculation used to

determine DSH eligibility. In particular, all of the beds at issue in this case are licensed acute care beds located in the inpatient area of the Provider's facility. Moreover, these beds were permanently maintained and available for lodging inpatients. As discussed below, the fact that these beds were sometimes occupied by observation patients does not affect their availability.

The Board's decision also relies upon the fact that the aforementioned regulation and manual instructions identify the specific beds excluded from the bed count and that neither of these authorities excludes observation beds. The Board finds that these rules are meant to provide an all-inclusive listing of the excluded beds, considering the great specificity with which they address this issue.[9] The Board also finds, as it did in Commonwealth of Kentucky, that CMS had modified the enabling regulation on at least two occasions to clarify the types of beds excluded from the count and chose not to address observation beds.

Additionally, the Board finds support for its decision in the example provided by CMS for determining bed size at HCFA Pub. 15-1 §2405.3.G.2. In this example, a hospital has 185 acute care beds, including 35 beds that were used to provide long-term care. CMS 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, CMS 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 Board 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, just as the observation beds at issue in this case, are included in the count.

The Board rejects the Intermediary's argument that only beds reimbursed under PPS should be included in the count of available bed days because the purpose of DSH is to adjust PPS amounts. The Board finds that if this argument were true, Congress would simply have stated that in the statute. Furthermore, if only days reimbursed under PPS were to be included in the bed count, there would be no reason for the controlling regulation and manual guidelines to be written in the manner that they are, i.e., with great specificity regarding beds that are included and excluded from the count.

The Board also believes as it did in Commonwealth of Kentucky, that the bed count for DSH eligibility is essentially intended to distinguish small and large hospitals, and as discussed in HCFA Pub. 15-1 § 2405.3.G that the temporary use of acute care beds for observation does not change the size of a facility. As illustrated by the providers in Commonwealth of Kentucky, a hospital with 100 acute care beds could arguably lose its DSH eligibility if it used one bed for just one day for observation, based upon the

[9] The Board notes that a listing of specific items in the manner employed by the regulations and manual instructions restricts the class to the items listed under the principle of *ejusdem generis.*

Intermediary's interpretation of the rules. The Board does not believe this was the intent of Congress.

The Board notes that the Intermediary, in part, relied upon the Administrator's decision reversing the Board in Commonwealth of Kentucky. The Board further notes, however, that the providers in that case ultimately prevailed in District Court. The Board further finds the March 11, 1997, CMS regional office letter directing intermediaries to exclude observation bed days from the bed count to be inconsistent with the pertinent regulations and manual guidelines discussed above.

Finally, the Board acknowledges that CMS issued a Final Rule on Friday, August 1, 2003, entitled Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2004 Rates (Fed. Reg. Vol. 68, No. 148). Within this rule, CMS does in fact modify 42 C.F.R. §412.105 to stipulate that beds used for observation outpatient services are excluded from the bed count used for both indirect medical education and DSH determinations. The Board finds, however, that this rule, effective October 1, 2003, is not applicable to the subject cost reporting periods.

DECISION AND ORDER:

The Intermediary's adjustments disallowing observation bed days from the count of available days in the Provider's 1996 and 1997 cost reporting periods were improper. The Intermediary's adjustments are reversed.

Board Members Participating:

Dr. Gary B. Blodgett
Martin W. Hoover, Jr., Esq.
Elaine Crews Powell, C.P.A
Anjali Mulchandani

Suzanne Cochran, Esq. (Recused)

Date: April 29, 2004

FOR THE BOARD:

Martin W. Hoover, Jr., Esq.