# *CENTERS FOR MEDICARE & MEDICAID SERVICES*

*Decision of the Administrator*

| In the case of: | Claim for: |
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| **District of Columbia General Hospital**<br><br>**Provider**<br><br>**vs.**<br><br>**Blue Cross/ Blue Shield Association**<br>**Carefirst of Maryland**<br><br>**Intermediary** | **Provider Cost Reimbursement Determination For Cost Reporting Periods Ending: 09/30/94; 09/30/05; 09/30/96; 09/30/98; 09/30/99; 09/30/2000 and 07/15/2001**<br><br>**Review of:**<br>**PRRB Decision 2006-D51**<br>**Dated: September 12, 2006** |

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

## BACKGROUND

The Provider was an acute care hospital located in Washington, DC. For fiscal years 1994 through 1996 and 1998 through 2001, the Provider used its internal "available bed" reports, also referred to as the "operating bed "reports, as the basis for the number of available beds reported on the cost reports to calculate the Provider's

indirect medical education (IME) payment.[1] The Intermediary performed an audit of the various cost reports and increased the number of available beds to calculate the Provider's IME payment.[2] For FYs 1994 through 1996, the Intermediary adjusted the Provider's bed count to 380 beds. For FYs 1998 through 2001, the Intermediary based the available bed count on the Provider's licensed bed capacity of 449 beds. The Provider timely filed an appeal with the Board, challenging the Intermediary's adjustments to its IME bed count. The Provider terminated participation in the Medicare program effective July 15, 2001. Accordingly, the Provider's fiscal year ended on that dated.

## ISSUE AND BOARD'S DECISION

The issue is whether the Intermediary's determination of "available bed days" for the purpose of calculating the Provider's IME payment was accurate. The Board held that the Intermediary's adjustments increasing the number of available beds were improper. The Board held that the Provider's available bed/operating bed reports accurately reflected the Provider's available bed count and, therefore, should be used to calculate the Provider's IME payment for the various cost periods in dispute.

## SUMMARY OF COMMENTS

The Intermediary submitted comments requesting that the Administrator reverse the Board's decision. The Intermediary argued that the Provider has not provided sufficient documentation of its available bed count. The Intermediary argued that, while units or wings of the Provider were closed during the cost years under appeal, their closure did not mean that the beds were permanently taken out of service. To support this position, the Intermediary pointed to internal memoranda by the Provider which stated that units were being closed due to underutilization, but could be place back into service if utilization changes.

Furthermore, the Intermediary argued that the Board mistakenly relied on the Provider's available bed reports in determining the correct number of beds for IME

[1] Intermediary Exhibit I-31, column 3. FY 1994—358; FY 1995—285; FY 1996—265; FY 1998—265; FY -1999—265; FY 2000—256; and FY 2001—185.
[2] Intermediary Exhibit I-31, column 2.

purposes. The Intermediary contends that the Provider's available bed reports reflect nothing more than occupied beds. Therefore, since sufficient documentations does not exist to support that the beds in question were permanently removed from service, or that units were permanently closed, or that it would be unreasonable to expect that these closed units could not be reopened if needed, the Intermediary's adjustments were correct. The Administrator should reverse the Board's decision in this case.

CMM commented, requesting that the Administrator modify the Board's decision. CMM agreed with the Board's determination that beds in a closed unit should be removed from the available bed count. However, CMM argued that beds should be counted as an available bed in those units where the unit was not closed but beds were taken out as part of a reduction of the unit.

The Provider commented requesting that the Administrator affirm the Board's decision. The Provider disagreed with the Intermediary's suggestion that the available bed reports represented only occupied or staffed beds. The Provider maintained that sufficient evidence was presented to distinguish between available beds and occupied beds.

The Provider also disagreed with the standard the Intermediary used to determine whether beds were available for purposes of the IME bed count. The Provider asserted that the standard for determining whether a bed is available is not whether the beds were intended to be permanently taken out of service, or whether a provider intended to reopen a bed or unit, because of increase patient care demands, but whether or not the bed could be made ready for inpatient use in a relatively short period. In this case, the Board correctly determined that beds could not be made available in a reasonably short period of time.

## DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

Section 1886(d)(5)(B) of the Act provides that teaching hospitals subject to the prospective payment system (PPS) shall receive an additional payment for the indirect cost of medical educations. This payment is designed to cover the increased operating or patient care costs that are associated with approved intern and resident programs and which are not separately identifiable on the cost report or accounting statement. These increased costs may reflect a number of factors such as an increase in the number of tests and procedures ordered by the intern or resident as compared to a more experienced physician, higher staffing ratios, the need of hospitals with teaching programs to maintain more detailed medical records than other hospitals, and the presence of a more severely ill patient population.[3]

The amount of payment is based on a hospital's ratio of full-time equivalent interns and residents to bed size.[4] The regulation governing this provision is set forth at 42 C.F.R. §412.105 (1998) and that to determine the IME adjustment CMS uses the following procedures:

> (a) *Basis data*. CMS determines the following for each hospital:
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> (1) The hospital's ratio of full-time equivalent residents, except as limited under paragraph (f) of this section, to the number of beds (as determined under paragraph (b) of this section)….
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> ****
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> (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 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.

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[3] See 51 Fed. Reg. 16772, 16775 (1986). See also Committee of Conference Report on the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), No. 99-453, 99the Congress, 1st Session, p. 455 (December 19, 1985).

[4] See 50 Fed. Reg. 35646, 35678 (1985). See also Report of the Senate Budget Committee on COBRA 1985, No. 99-146, 99th Congress, 1st Session, p. 291 (September 30, 1985) which, in summarizing the current law, states that: "In addition to the DRG payment, teaching hospitals are paid amounts designed to compensate them for certain costs that are indirectly attributable to their teaching activities. The amount of this indirect teaching adjustment is based on the ratio of the hospital's residents and interns to the number of its beds." (Emphasis added.)

Further, the preamble to the final rule for "Changes to the Inpatient Hospital Prospective Payment System" for 1986[5] states, regarding the definition of available beds, that:

> 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 lodgings, 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.

Consistent with the regulation and preamble, §2405.3(G) of the Provider Reimbursement Manual (PRM) clarified that:

> To be considered an available bed, a bed must be permanently maintained for lodging inpatients. It must be available for use and housed in patients 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 bed" as used for the purposes 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 the facility as beds are added or taken out of service.
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> 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.

In response to CMS correspondence regarding §2405.3 of the PRM, Blue Cross and Blue Shield Association (BCBSA), issued Administrative Bulletin (AB) 1841, 88.01, on November 18, 1988.[6] The Bulletin stated that:

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[5] 50 Fed. Reg. 35646, 35683 (September 3, 1985)

[6] Administrative Bulletin (AB) No. 1841, 88.01, November 18, 1988.

> Section 2405.3G also states that "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." [CMS] makes a distinction here between a temporarily closed wing and a permanently closed wing. A wing is considered permanently closed if the area in which the beds are contained is not included in a hospital's depreciable plant assets subject to capital-related cost reimbursement during a cost reporting period, and no available bed days for these beds should be counted. In 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 nurse 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.
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> Where 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…

Finally, AB 1841, 88.01 states that: "Depending upon circumstances, it may not be appropriate to use all licensed beds in determining total available bed days."[7]

The policy for determining available beds in effect during the relevant cost reporting periods was reiterated in the final rule published on August 11, 2004 in the Federal Register. The preamble language states:

> Currently, if a bed can be staffed for inpatient care either by nurses on staff or from a nurse registry within 24 hours to 48 hours, the unoccupied beds is determined available. In most cases, it is straightforward matter to determine whether unoccupied beds can be staffed within this time frame because they are located in a unit that is otherwise staffed and occupied…[8]

[7] Id.
[8] 69 Fed. Reg. 49094 (August 11, 2004).

In this case, the Provider contends that its available bed reports should be used to calculate the IME payments for the cost reporting periods in dispute. The Provider disagrees with the Intermediary's characterization that the available bed reports represent staffed beds, i.e., patient census reports. The Provider maintains that it had separate patient census reports that differ from that of its available bed reports. The Provider also disagrees with the Intermediary's standard for determining whether a bed is available for purposes of the IME bed count. The Provider argues that the Intermediary's reliance of AB 1841, 88.01 is contrary to the standard set by CMS which is whether a bed can be placed into services immediately not put into service within 24-48 hours. However, not withstanding the Intermediary's definition of available beds the Provider argues that it could not have put the beds in question into service within 24-48 hours.

After a review of the record and the applicable regulations and policy guidelines, the Administrator disagrees with the Board's determination that the Provider's available bed/operating bed reports accurately reflected the Provider's available bed count and, therefore, should be used to calculate the Provider's IME payment for the various cost periods in dispute. The Administrator finds the Provider's available bed/operating bed reports show what appear to be day-to-day fluctuations in the units as shown by the monthly fluctuations in the number of beds. Such fluctuations, showing both monthly increases and decreases in the bed count, indicates a standard other than that set forth in the Manual and policy statements used for determining the beds to be included in this count. As noted in the Manual, the available bed count is not intended to capture the day-to-day fluctuations in patient rooms and wards. In addition, the record shows instances in the available bed/operating bed report where the Provider was showing more patients in beds than the beds claimed as available.[9] Hence, the record does not support the use of the available bed/operating bed reports for purposes of determining the Provider's available beds under 42 CFR 412.105.

However, the Administrator finds that evidence other than the Provider's available bed/operating bed report indicates that the Provider's available bed count for the fiscal periods in dispute was less than the Provider's available licensed bed capacity. Specially, the record does support a finding that the Provider closed units, which remained closed over multiple years. The Administrator holds that beds in these closed units should not be included in the Provider's available bed count for IME

[9] Transcript of Oral Hearing (Tr.) at 254-256. The Intermediary found several instances where the hospital was showing more patients in beds than the beds claimed as available.

purposes.[10] The Administrator finds that these closed units could not have been put back into service within 24 to 48 hours.[11]

However, in those units where beds were "reduced" and the unit remained open, the Administrator finds that these "reduced" beds should be included in the Provider's available bed count for IME purposes.[12] The Administrator finds that the Provider was not able to demonstrate that these beds could not have been put back into service within 24 to 48 hours.[13]

[10] For example, Provider's Post-Hearing Brief pp 5-19 identifying closed units: for FYE 9/30/93-closure of unit OB1; FYE 9/30/95-closure of units 33S, 62, 53C, 32N 2E; FYE 9/30/00-closure of unit 63; FYE 7/15/01-closure of various units throughout the period.

[11] For example, various testimony of Leyland Grant, Director of Facilities Development, regarding protocol for closing units (e.g., Tr. 47-53, Tr. 89-91, Tr. 100-101) and Internal memorandums at Provider Exhibits 22, 23, 24, 26, 27, 28.

[12] For example, for FYE 9/30/95-reduction of beds in Units MICU, OB2; FYE 9/30/96—reduction of beds in Units 23S, 22N and S; FYE 9/30/00-reduction/consolidations of beds 42 and 52 N and 52S. FYE 7/15/01 showed various reductions of units before the hospital itself was closed.

[13] The record shows that while certain units were closed, despite the Provider's financial hardships, the Provider still had the capacity to expand other units. The evidence does not demonstrate that the Provider could not have staffed and occupied beds in units where there was a partial reduction of beds in the unit. See, e.g., Provider's Post-Hearing Brief pp. 14 showing that the pediatrics unit was moved from 2 West to the closed OB1 space and added 5 beds to the already existing 21 beds. See also Provider's Post-Hearing Brief regarding expansion of beds in Units 52N and 63 for FYE 9/30/95. Even for FYE 07/15/01, while the Provider was reducing and closing certain units, it expanded other units.

## DECISION

The decision of the Board is modified consistent with the foregoing opinion.

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

Date: 11/9/06 /s/

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