CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Central Texas Medical Center **Provider** **vs.** **Blue Cross/ Blue Shield Association** **Trailblazer Health Enterprises, LLC** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Years Ending: 12/31/92, 12/31/93, 12/31/95, and 12/31/97** **Review of:** **PRRB Dec. No. 2005-D56, 2005-D57, 2005-D58 and 2005-D59** **Dated: August 30, 2005**

These cases are before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decisions of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in §1878(f)(1) of the Social Security Act (Act), as amended (42 USC 1395oo(f)). The parties were notified of the Administrator's intention to review the Board's decisions. The Provider submitted comments, requesting that the Administrator affirm the Board's decisions. Accordingly, these cases are now before the Administrator for final agency review.

BACKGROUND

The Provider is an acute-care hospital which is certified by the Texas Department of Health for 109 beds. In 1991, the Provider opened a nine-bed distinct part skilled nursing facility (SNF), leaving 100 of the State-certified beds for use in other areas of the facility. For its FYE 1991, the Provider requested a Board hearing regarding the exclusion of various types of bed days for purposes of determining the number of available bed days, under inpatient prospective payment system (IPPS), for the Medicare disproportionate share adjustment (DSH) bed size calculation. For that cost year, the Board held that the observation and swing bed days should be included

in the available bed day count and found that the Provider had at least 100 beds. On review, the Administrator disagreed as to the inclusion of the observation and swing bed days in the available bed day count, but affirmed the finding that the Provider had at least 100 beds based upon the inclusion of certain bed days not at issue in these cases.[1]

For the cost years at issue, FYEs 1992, 1993, 1995, and 1997, the parties have entered into stipulations agreeing to the number of available beds prior to removing the observation bed days and swing bed days; the number of observation bed days and swing bed days in each of the respective cost year and the number of available bed days to be included in the DSH calculation based on each of the respective parties' positions.[2]

ISSUE AND BOARD'S DECISION

The issue before the Board was whether the observation days and swing bed days should reduce the number of available beds for purposes of calculating the Provider's eligibility for DSH payments.

The Board held that the Intermediary's exclusion of the observation bed and swing bed days was not proper. The Board observed that §1886(d)(5)(F) of the Act considers three factors in determining a hospital's qualifications for the DSH adjustment: whether the Provider's location is urban or rural; the number of patient days; and the number of beds. The Board noted that there was no dispute that the Provider in these cases was located in an urban area and that the only issue under dispute was the number of available bed days. However, the statute does not define the meaning of "bed" in the DSH context; rather, the regulation at 42 CFR 412.106(a)(1)(i), by reference to §412.105(b), lists the beds to be included in the calculation.

---

[1] *See* PRRB Dec. No. 2003-D2, *aff'd on other grounds*, Admr. Dec. 12/29/02.

[2] For FYE 12/31/92, the parties stipulated that inclusion of 1.54 observation bed days and 0.44 swing bed days would result in 101 available beds, and exclusion would result in 99.02 available beds. For FYE 12/31/93, the parties stipulated that inclusion of 3.71 observation bed days and 0.48 swing bed days would result in 101 available beds, and exclusion would result in 96.81 available beds. For FYE 12/31/95, the parties stipulated that inclusion of 3.25 observation bed days and 0.27 swing bed days would result in 102.795 available beds, and exclusion would result in 99.275 available bed days. For FYE 12/31/97, the parties stipulated that inclusion of 3.26 observation bed days and 0.32 swing bed days would result in 99.989 available bed days, and exclusion would result in 96.409 available bed days.

The Board also noted that the Secretary has stated in various decisions reversing the Board's interpretation of "available beds" that CMS has had a long-standing policy of using inpatient prospective payment system (IPPS) days to determine the number of available bed days for DSH purposes. However, the Board stated that this claim was inconsistent with §2405.3.G of the PRM. Specifically, an example in that section of the PRM states that a hospital which has beds used to provide long-term care beds, would include those beds with its acute care beds to determine available bed days because the long term care beds were certified for acute care.

Based on the above-cited regulatory and PRM criteria, the Board found that the Intermediary's exclusion of the observation and swing bed days was not supportable. The Board observed that all of the observation and swing beds at issue were licensed acute care beds located in the acute care areas of the Provider's facility. The beds were permanently maintained, available, and staffed for lodging inpatients. Moreover, the regulations and PRM required the inclusion of all beds in the calculation, unless they were specifically excluded. The Board noted the degree of specificity with which the manual addresses this issue and the fact that the enabling regulation has been modified at least twice to clarify the type of beds excluded from the count. The Board thus concluded that these comprehensive rules were meant to provide an all-inclusive listing of the excluded beds.

The Board rejected the Intermediary's argument that only beds reimbursed under IPPS should be included in the count since the purpose of DSH is to adjust IPPS payment amounts. If that were the policy driving the counting of bed days, the Board maintained, Congress would have said as much in the enabling statute, and regulations would have been promulgated to accommodate a category for IPPS-excluded beds. However, the Board found that the regulations and PRM have been written to identify which beds are to be excluded and which are to be included in the count, and disagreed with the Secretary's decisions to the contrary as inconsistent with this policy.

The Board further found that the 1997 CMS Memorandum, which the Intermediary used as its basis for the exclusion of observation beds, sets forth instructions which are inconsistent with the above-cited Medicare law and policy. In addition, the Board stated that such instructions cannot be retroactively applied to the Provider's pre-1997 cost years. Finally, the Board noted that the U.S. Court of Appeals for the Sixth Circuit[3] upheld the Board's decision[4] in a case involving the DSH available bed days

---

[3] *Clark Regional Medical Center v. Shalala*, 314 F.3d 241 (6th Cir. 2002).

issue. Thus, the Board reversed the Intermediary's adjustments in these cases.

SUMMARY OF COMMENTS

The Provider observed that the relevant facts in the cases are not in dispute. Rather, the parties have stipulated to the number of available beds prior to removing observation bed days and swing bed days and the number of observation bed days and swing bed days in dispute. The Provider stated that it was relying on the position as established in its position papers, and did not know which aspects of the Board's decisions was under review by the Administrator. Finally, the Provider maintained that the Board's decisions were consistent with the law and conformed to the courts' interpretations of the law, and should be affirmed.

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.

The Social Security Amendments of 1965,[5] established Title XVIII of the Social Security Act, which authorized the establishment of the Medicare program to pay part of the costs of the health care services furnished to entitled beneficiaries. The Medicare program primarily provides medical services to aged and disabled persons and consists of two Parts: Part A, which provides reimbursement for inpatient hospital and related post-hospital, home health, and hospice care, and Part B, which is supplemental voluntary insurance program for hospital outpatient services, physician services and other services not covered under Part A. At its inception in 1965, Medicare paid for the reasonable cost of furnishing covered services to beneficiaries.

From the beginning of the program, under reasonable cost hospital inpatient reimbursement, the average cost per day for reimbursement purposes was calculated by dividing the total costs in the inpatient routine cost center by the “total number of inpatient days.”[6] Generally, Medicare reimbursement for routine inpatient services

---

[4] *See Commonwealth of Kentucky 92-96 DSH Group Appeal*, PRRB Dec. No. 99-D66, *rev'd Admr.* Nov. 8, 1999.

[5] Pub. Law No. 89-97.

[6] *See e.g.* 42 CFR 413.53(b); 42 CFR 413.53(e)(1) ("Departmental Method: Cost reporting periods beginning on or after October 1, 1982.")

was based on an average cost per day as reflected in the inpatient routine cost center multiplied by the total number of Medicare inpatient days.[7] Consequently, the inclusion or exclusion of a bed day in the per diem calculation would impact the Medicare per diem payment.

However, concerned with increasing costs, Congress enacted Title VI of the Social Security Amendments of 1983.[8] This provision added §1886(d) to the Act and established the inpatient prospective payment system for reimbursement of inpatient hospital operating costs for all items and services provided to Medicare beneficiaries, other than physician's services, associated with each discharge. The purpose of PPS was to reform the financial incentives hospitals face, promoting efficiency by rewarding cost effective hospital practices.[9]

These amendments changed the method of payment for inpatient hospital services for most hospitals under Medicare. Under IPPS, hospitals and other health care providers are reimbursed their inpatient operating costs on the basis of prospectively determined national and regional rates for each discharge rather than reasonable operating costs. Thus, hospitals are paid based on a predetermined amount depending on the patient's diagnosis at the time of discharge. Hospitals are paid a fixed amount for each patient based a diagnosis-related groups (DRG) subject to certain payment adjustments. Notably, while IPPS was implemented to replace the reasonable cost method of reimbursing hospitals for the operating costs of inpatient hospital services, it continues to require cost reporting consistent with that required under the reasonable cost methodology including the principles guiding the inpatient routine per diem methodology.

Concerned with possible payment inequities for IPPS hospitals that treat a disproportionate share of low-income patients, pursuant to §1886(d)(5)(F)(i) of the Act, Congress directed the Secretary to provide, for discharges occurring after May 1, 1986, an additional payment per patient discharge, "for hospitals serving a significantly disproportionate number of low-income patients…."[10] The legislative history of Consolidated Omnibus Budget Reconciliation Act (COBRA) 1985 shows that, with respect to hospitals that serve a disproportionate share of low-income patients,

---

[7] *Id. See also* Section 2815 PRM-Part II, "Worksheet D-1 Computation of Inpatient Operating costs" sets forth definitions to apply to days used on Worksheet D-1 which has been in place since 1975. 60 Fed. Reg. 45778, 45810 (1995).

[8] Pub. L. No. 98-21.

[9] H.R. Rep. No. 25, 98th Cong., 1st Sess. 132 (1983).

[10] Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. Law No. 99-272). *See also* 51 Fed. Reg. 16772, 16773-16776 (1986).

Congress found that these hospitals have "a higher Medicare cost per case."[11] Congress noted that:

> There are two categories for these increased costs: a) low-income Medicare patients are in poorer health within a given DRG (that is, they are more severely ill than average), tend to have more complications, secondary diagnoses and fewer alternatives for out of hospital convalescence than other patients: b) hospitals having a large share of lowincome patients (Medicare and non-Medicare) have extra overhead costs and higher staffing ratios which reflect the special need for such personnel such as medical social workers, translators, nutritionists and health education workers. These hospitals are frequently located in central city areas and have higher security costs. They often serve as regional centers and have high standby costs….[12]

To be eligible for the additional payment, a hospital must meet certain criteria, concerning, *inter alia*, its disproportionate patient percentage. Generally, the location and bed size of a hospital determines the threshold patient percentage amount to qualify for a DSH payment. For the cost years at issue, under §1886(d)(5)(F)(v) of the Act, a hospital that is located in an urban area and has 100 or more beds is eligible for the additional DSH payment, if its disproportionate patient percentage is 15 percent. However, if the urban hospital has less than 100 beds, it must have a disproportionate patient percentage of 40 percent to be eligible for the DSH adjustment. With respect to the bed size, the H.R. Report explained:

> Based on the comprehensive analysis of cost data, the committee determined that the only hospitals that demonstrated a higher Medicare cost per case associated with disproportionate share low-income patients were urban hospitals with over 100 beds…. Since the rationale for making the disproportionate share adjustment is related directly to *higher Medicare costs per case*, the committee concluded that, based on available data, there was no justification for making these payments to … urban hospitals with fewer than 100 beds.[13] (Emphasis added.)

Finally, the legislative history shows, with respect to Congress, that:

---

[11] H.R. Report No. 99-241 at 16 (1986); *reprinted* in 1896 U.C.C.A.N. 594

[12] *Id.*

[13] H.R. Report No. 99-241 at 17 (1986) *reprinted* in 1986 U.C.C.A.N. 595.

> The Committee believes that the Secretary should interpret the 100 bed threshold *narrowly*, that is, that the beds that should be counted should be staffed and available beds. The bed count would reflect beds staffed and available in the cost reporting period immediately prior to the costreporting period for which the adjustment would be made. (Emphasis added.)

Consistent with the statute, the governing regulation at §412.106 (1992), which addresses the DSH payment states that:

> (a) *General considerations.* (1) The factors considered in determining whether a hospital qualifies for a payment adjustment include the number of beds, the number of patient days, and the hospital's location.
>
> (i) The number of beds in a hospital is determined in accordance with §412.105(b).
>
> (ii) The number of patient days includes only those days attributable to areas of the hospital that are subject to the prospective payment system and excludes all others.

The regulation at §412.105(b)(1992), cross-referenced at 42 CFR 412.106(a)(1)(ii), addresses the indirect medical education (IME) payment and explains that:

For purposes of this section, the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period, not including beds assigned to newborns, custodial care, and excluded distinct part hospital units, and dividing that number by the number of days in the cost reporting period.

The preamble to the final rule for the Federal Fiscal Year (FFY) 1986 IPPS rates[14] gave further explanation as to the definition of available beds, stating that:

> For purposes of the prospective payment system, "available beds" are generally defined as adult or pediatric (exclusive of newborn bassinets,

[14] 50 Fed. Reg. 35683.

> 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 wings or rooms on the floor are temporarily unoccupied, the beds in these areas are counted if they can be immediately opened and occupied. (Emphasis added.)[15]

Since the establishment of the DSH and IME payment provisions, the Secretary has taken the opportunity to clarify the types of beds days to be included in the bed count and discuss the general principle guiding such clarifications. For example, the Secretary stated in discussing the counting of bed days in the FFY 1995 IPPS rule, that:

> Our current position regarding the treatment of these beds is unchanged from the time when cost limits established under section 1861(v)(1)(A) of the Act were in effect and is consistent with the way we treat beds in other hospital areas. *That is, if the bed days are allowable in the calculation of Medicare's share of inpatient costs, the beds within the unit are included as well.*[16] (Emphasis added.)

The Secretary has consistently applied the policy for both DSH and IME payment provisions mindful of the fact that, as a general matter, the same bed counting policy

---

[15] *Id.* Similarly, Section 2405.3.G of the Provider Reimbursement Manual (PRM) states that: "A bed is defined for this purpose as an adult or pediatric bed (exclusive of beds assigned to newborns which are not 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 areas(s) of the facility not certified as an acute care hospital, labor rooms, PPS excluded units … , *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.*" (Emphasis added.) (Trans. No. 345, July 1988)

[16] 59 Fed. Reg. 45330, 45373 (1994). *See also Id.* at 45374 (where the Secretary stated that with respect to the inclusion of neonatal beds in the count: "We disagree with the position that neonatal intensive care beds should be excluded based on the degree of Medicare utilization. Rather, we believe it is appropriate to include these beds because the costs and the days of these beds are recognized in the determination of Medicare costs (nursery costs and days, on the other hand, are excluded from this determination)….")

will favorably affect one payment, while adversely affecting the other payment. Generally, the inclusion of bed days will increase DSH payments and decrease IME payments, while the exclusion of beds days increases IME payments and decreases DSH payments. In particular, the Secretary, observed that:

> We believe we have a responsibility to apply this policy consistently over time and across providers. Excluding these beds from the determination of bed size would have an adverse impact on some hospitals. Several prospective payment system special adjustments are based on bed size: for example the threshold and adjustment for the disproportionate share (DSH) adjustment for urban hospitals with 100 or more beds. If we no longer considered neonatal intensive care beds in determining bed size, DSH adjustments to some hospitals would be sharply reduced….[17]

This principle guiding the counting of bed days for purposes of determining a hospital's bed size is also the same as that guiding the determination of the DSH patient percentage calculation, under 42 CFR 412.106(b)(1)(ii). The Secretary explained in the preamble promulgating that regulatory provision that:

> [W] e believe that, 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 subsection (d) hospital, which is the only type of hospital subject to the prospective payment system….*
>
> Moreover, this reading of section 1886(d)(5)(F) of the Act produces the most consistent application of the disproportionate share adjustment, since only data from prospective payment hospitals or from hospital units subject to the prospective payment system are used in determining both the qualifications for and the amount of additional payment to hospitals that are eligible for a disproportionate share adjustment.[18] (Emphasis added.)

---

[17] 59 Fed. Reg. 45374.

[18] 53 Fed. Reg. 38480 (Sept. 30, 1988); *See also* 53 Fed. Reg. 9337 (March 22, 1988).

Relevant to these cases, the bed days at issue in these cases involve observation and SNF level swing bed days.[19] An observation bed day is a day when the bed is used for "outpatient observation services." Observation services are those services "furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and to evaluate an outpatient's condition or to determine the need for a possible admission to the hospital as an inpatient…."[20] In addition, generally, a person is considered a hospital inpatient if formally admitted as an inpatient with the expectation that he or she will remain at least over night. However, when a hospital places a patient under observation, but has not formally admitted him or her as an inpatient, the patient initially is treated as an outpatient.[21]

Because, under these circumstances, the observation services are paid as outpatient services, the costs of observation bed patients are to be carved out of the inpatient hospital costs as they are not recognized and paid under inpatient hospital PPS as part of a hospital's inpatient operating costs.[22] This is done by the counting of observation bed days. Observation bed days only need to be computed if the observation bed patients are placed in a routine patient care area. The bed days are needed to calculate the costs of observation bed days since it cannot be separately costed when the routine patient care area is used.[23]

In addition, certain hospitals are allowed to use inpatient beds for skilled nursing services.[24] Generally, acute level inpatient hospital care and skilled nursing level care are provided in distinct and separate parts of a facility. However, the Secretary recognized that maintaining separate facilities for different types of care was particularly difficult for small rural hospitals with the limited resources. Thus, the original swing bed hospital provisions were put into place to allow rural hospitals with less than 100 beds to use their inpatient acute care beds for services of the type that would be provided at a skilled nursing facility. Hence, the term "swing beds."[25]

---

[19] *See e.g* Provider Exhibit P97-2 (FYE 1997 Cost Report, Worksheet S-2 showing Swing bed-SNF, Worksheet S-3 showing bed days statistical data for swing bed SNF (line 4) and total adults and pediatric exclusive of observatin bed days (line 5).

[20] Section 230.6.A of the Hospital Manual.

[21] Section 230.6.B of the Hospital Manual.

[22] Section 3605 of the PRM-Part II.

[23] Section 3605.1, line 26.

[24] *See also District Memorial Hospital of Southwest North Carolina v. Thompson*, 346 F.2d 513 (2004) for discussion of swing bed hospital provisions.

[25] *See* Administrator's Decision, *District Memorial Hospital of Southwestern North Carolina*, PRRB Dec. No. 2001-D37. (August 27, 2001) pp 7-8 for a general discussion of the swing bed provisions.

When a patient is admitted to a swing bed hospital as an inpatient requiring a hospital level of care and subsequently requires a reduced level of care at a SNF or NF level, the situation is treated as a discharge from the hospital and an admission to a SNF or ICF (or NF). This occurs despite the fact that the change in the level of care may not involve a physical move of the patient. The day on which the patient begins to receive a lower level of care is considered to be the day of discharge from the hospital and the day of admission to a SNF or ICF (or NF) bed.[26] The swing-bed hospital provisions reflect that these swing bed days are not recognized as inpatient operating costs of an IPPS hospital.[27] Payment to these hospitals for post-hospital SNF care furnished in general routine inpatient beds are based on the reasonable cost of post hospital SNF care.[28] Hospitals and distinct part hospital units excluded from IPPS and paid on a reasonable cost or other basis *include* routine SNF-level services furnished in swing beds.[29] Thus, the swing bed days are not recognized under IPPS as inpatient operating costs of the hospital.

CMS specifically addressed observation bed days in a 1997 Memorandum to the CMS Regional Offices[30] stating that: "[I]f a hospital provides observation services in beds that are generally used to provide hospital inpatient services, the equivalent days that those beds are used for observation services should be excluded from the count of available bed days for purposes of the IME and DSH adjustments."

While the Secretary had stated the underlying principle for counting bed days under the DSH and IME provision, the Secretary first specifically discussed observation and swing bed days in the final rule for the FFY 2004 IPPS rates in response to an adverse Court of Appeals case.[31] The court in *Clark Regional Medical Center v. Shalala*, 314 F.3d 241 (6th Cir. 2002), found that the regulatory listing of beds to be excluded from the count restricts the class of excluded beds only to those specifically listed. Because observation beds and swing beds are not currently specifically mentioned in 412.105(b) as being excluded from the bed count, the *Clark* court ruled that these beds must be included.

---

[26] Section 2230.2 of the PRM.
[27] 42 CFR 413.114; 42 CFR 482.66
[28] 42 CFR 413.114(a).
[29] Section 415.B of the Hospital Manual
[30] *See* CMS Memorandum, dated Feb. 27, 1997, from Acting Deputy Director/Bureau of Policy Development to Associate Regional Administrator/Division of Medicare/All Regional Offices, Subject: Counting Beds and Days for Purposes of the Medicare Hospital Inpatient Disproportionate Share and Indirect Medical Education Adjustments.
[31] 68 Fed Reg. 45346, 45418-45419 (Aug 1, 2003)

In the FFY 2004 IPPS rule preamble, the Secretary took this opportunity to point out that, contrary to the court's findings, the listing at 42 CFR 412.105(b) was not intended to be all-inclusive list and, in fact, specific bed types had been added to the list as clarifications of the type of beds to be included and excluded.[32] The Secretary also observed that the *Clark* court found that observation and swing bed days were included under the plain meaning of the regulatory text at 412.106(a)(1)(ii). However, the Secretary noted that the court failed to address the preamble language that promulgated the regulatory provisions at 42 CFR 412.106(a)(1)(ii) and clarified its meaning.[33] That language specifically stated that based on the statute the Secretary is "in fact required to consider only those inpatient days to which the prospective payment system applies in determining a hospital's eligibility for a disproportionate share adjustment." The policy of excluding observation and swing bed days is also consistent with this regulatory interpretation of days to be counted under 42 CFR 412.106(a)(1)(ii). The Secretary concluded that this general policy had also been reviewed and upheld previously by several courts. Consequently, the Secretary clarified the regulation to state that observation and swing bed days were to be excluded from the determination of number of beds under 42 CFR 412.105(b) and the determination of the DSH patient percentage under 42 CFR 412.106.[34]

Subsequently, the Fourth Circuit Court of Appeals in *District Memorial Hospital of Southwest North Carolina v. Thompson*, 346 F.2d 513 (2004), ruled favorably on the Secretary's interpretation of the 42 CFR 412.106 as requiring the exclusion of swing bed days. The *District Memorial* court, *inter alia*, deferred to the Secretary's assertion that the term "areas" in the phrase 42 CFR 412.106 refers to the scope or sphere of operation or action as opposed to the more narrow "geographical"

---

[32] Citing to 59 Fed. Reg. 45373 (Sept.1, 1994) and 60 Fed Reg. 45810 (Sept. 1, 1995).

[33] Citing to 53 Fed. Reg. 38480 (Sept. 30, 1988).

[34] The regulation at 42 CFR 412.105 was clarified, *inter alia*, to state that: "(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 days in the cost reporting period. The count of available beds excludes bed days associated with—…(4) Beds otherwise countable under this section used for outpatient observation services, skilled nursing swing bed services; or ancillary labor/delivery services." Similarly, the regulation at 42 CFR 412.106(a)(1)(ii) was clarified, *inter alia*, to state read, that: "(ii) For purposes of this section, the number of patient days in a hospital includes only those days attributable to units or wards of the hospital providing acute care services generally payable under the prospective payment system and excludes patient days associated with—….(B) Beds otherwise countable under this section used for outpatient observation services, skilled nursing swing bed services; or ancillary labor /delivery services…."*See* 68 Fed. Reg. 45470 (2003).

definition of "areas" argued by the provider in that case. The court also found that even if one were to insist that the word "areas", as used in the regulation at 42 CFR 412.106, be read to carry geographical connotations, the Secretary's interpretation would remain a reasonable construction of the regulatory language. The word "areas" would then refer to the location of any bed used to provide acute care when such services were being provided and the disproportionate share adjustment would apply to that calculation at that time. Similarly, the word "areas" would not refer to the location of a bed when skilled nursing services were being provided at that bed because such services were not subject to the prospective payment system. Under this interpretation, the word "areas" in a geographical sense would be referring to the locations of individual beds, as opposed to wings or units of the hospital.[35]

Finally, the Secretary again restated his longstanding policy of excluding observation bed days and swing bed days from the available bed day count for DSH purposes in the final rule for the FFY 2005 IPPS rates.[36] In that rule, the Secretary also specifically promulgated in the regulation under 42 CFR 412.105(b) and 412.106(a)1)(ii), that observation and swing-bed days are to be excluded from the counts of both available beds and patient days, unless a patient, who receives outpatient observation services is ultimately admitted for acute inpatient care, in which case the beds and days would be included in those counts.[37] Applicable to both observation bed days and swing bed days, the Secretary stated that:

---

[35] *District Memorial Hospital of Southwest North Carolina v. Thompson*, 346 F.2d 513, 519-520 (2004).

[36] 69 Fed. Reg. 48916, 49096-49097 (Aug. 11, 2004).

[37] 69 Fed. Reg. 49097, 49245, 49246. The regulation at 42 CFR 412.106(a)(1)(ii) was clarified, *inter alia*, to state that: "(B) Beds otherwise countable under this section used for outpatient observation services, skilled nursing swing bed services; or ancillary labor /delivery services. This exclusion would not apply if a patient treated in an observation bed is ultimately admitted for acute inpatient care, in which case the beds and days would be included in those counts." The regulation at 42 CFR 412.105(b) was clarified *inter alia*, to state that: (4) Beds otherwise countable under this section used for outpatient observation services, skilled nursing swing bed services; or ancillary labor /delivery services. This exclusion would not apply if a patient treated in an observation bed is ultimately admitted for acute inpatient care, in which case the beds and days would be included in those counts. 69 Fed. Reg. 49245, 49246 (2004).

> Observation services and swing-bed skilled nursing services are both special, frequently temporary, alternative use of acute inpatient care beds. Thus the days a bed in an (otherwise occupied) acute inpatient care unit or ward is used to provide outpatient observation services are to be deducted from the available bed count under 42 CFR 412.105(b) and the patient day count under 412.106(b). Otherwise, the bed would be considered available for IPPS-level acute care services (as long as it meets the other criteria to be considered available.) This same policy applies to any bed days the bed is used to provide SNF level care. The policies to exclude observation days and SNF-level swing-bed days from the count of available bed days and patient days, as described above stem from the fact that although the services are provided in beds that would otherwise be available to provide an IPPS level of services, these days are not payable under the IPPS, except in the case of observation days when the patient is ultimately admitted as an inpatient.[38]

In these cases, the parties stipulated that the issue is whether observation and swing bed days should be excluded from the number of available beds for the purpose of calculating the Provider's eligibility for DSH payments in FYs 1992, 1993, 1995, and 1997. The parties agreed that adoption of the Intermediary's position, i.e., excluding observation bed days and swing bed days, would result in the available bed counts below the 100 bed threshold. The parties agreed that adoption of the Provider's position, including the observation bed days and swing bed days, would result in more than 100 available beds for FFYs 1992, 1993, and 1995. For the Provider's FY 1997, the parties stipulated that the addition of the subject bed days would result in 99.989 available bed days.[39] The Provider contended, *inter alia*, that observation/swing beds should be included in the bed count for purposes of determining DSH eligibility because the beds are licensed acute care beds located in the acute care area of the hospital and maintained for inpatient lodging.

The Administrator recognizes that, under the statute, the DSH adjustment is intended to be an additional payment to account for a “higher Medicare payment per case” for IPPS hospitals that serve a disproportionate number of low-income patients. The Administrator finds that the policy to only include bed days that are recognized as part of hospital's inpatient operating costs is consistent with that overarching statutory intent.

---

[38] 69 Fed Reg. 49096-49097. *See also* 68 Fed. Reg. 45418-45419.

[39] The Provider has argued that there is precedent for "rounding up" to 100 beds.

Further, with respect to the regulation at 42 CFR 412.105(b) and the PRM, the Administrator finds that the listing of beds to be excluded is general in nature and not all-inclusive. A review of the beds listed to be excluded from the count of bed days shows as a general matter that these beds are not allowable in the calculation of Medicare's share of inpatient costs. The Administrator finds that SNF swing and observation bed days are treated for purposes of inpatient costs like the SNF-excluded unit beds and outpatient beds and are not treated like inpatient adult and pediatric acute care beds. Notably, most courts have found that 42 CFR 412.105(b) is not an all-inclusive list. Rather, the courts have found that the list is not confined to the literal terms of 42 CFR 412.105(b) in assessing its meaning.[40] Thus, the Administrator finds that the exclusion of these bed days is a reasonable interpretation of the regulatory language set forth at 42 CFR 412.105(b).[41]

Moreover, the exclusion of observation and swing bed days is proper under the language set out in the preamble of the final rule for the FFY 1986 IPPS rates and §2405.3.G of the PRM. Specifically, both the preamble and the PRM explains that: "a bed must be permanently maintained for lodging inpatients" to be considered an available bed. The beds must be "immediately opened and occupiable" to be countable.[42] The beds used for other than inpatient lodging, are not counted. Therefore, if a bed is being utilized for another purpose, i.e., lodging a skilled nursing patient or for patient observation, it is not available for inpatient lodging. In this

---

[40] *See*, e.g., *AMISUB d/b/a/ St. Joseph's Hospital v. Shalala*, No. 94-1883(TFH) (D.D.C. 1995); *Grant Medical Center v. Shalala*, 905 F. Supp. 460, 1995 U.S. Dist. Lexis 17398; *Sioux Valley Hospital v. Shalala*, 29 F.3d 628,1994, U.S. App. Lexis 26519. In these cases, the Secretary was faced with similar arguments concerning neonatal intensive care beds and was successful in arguing that the regulation as written at that time did not clearly exclude all beds assigned to newborns, but could reasonably be interpreted to apply only to newborns in bassinets. The neonatal intensive care beds at issue in those cases were more like intensive care beds, which were listed as beds to be counted, and less like newborn bassinets, which were listed as beds to be excluded. The courts' held that the language of 42 CFR 412.105(b) with respect to neonatal intensive care beds was ambiguous and, thus, the Secretary's interpretation was entitled to deference.

[41] The exclusion of observation and swing bed days is also consistent with the definition of "patient day" under 42 CFR 412.106(b) in that the bed day is not "attributable to the areas of the hospital subject to the prospective payment system."*See also District Memorial Hospital of Southwest North Carolina v. Thompson*, 346 F.2d 513, 519-520 (2004).

[42] 50 Fed. Reg. at 35683.

instance, the bed days at issue were used and paid for another purpose than inpatient services and should similarly be excluded from the bed count.[43]

Applying the relevant law and program policy to the foregoing facts, the Administrator finds that the Intermediary properly excluded observation and swing bed days from the bed count. As established by the above law and manual instructions, CMS has consistently excluded from the bed day count those bed days not paid as part of the inpatient operating cost of the hospital, that is, days not recognized as an inpatient operating cost under IPPS. The observation and swing bed days at issue are not recognized under IPPS as part of the inpatient operating costs of a hospital and must be excluded from the available bed count. Accordingly, based upon the foregoing reasoning, the Board's decisions in these cases are reversed.

[43] The Administrator also disagrees with the Board's conclusion that the PRM example at §2405.3.G.2, which includes long-term bed days in the count if the beds are not certified as long-term beds, is evidence that certification determines whether a bed is counted. The Administrator finds that this example does not rebut or address the principle that a bed day is included if the day was used in the calculation of the inpatient operating costs.

DECISION

The decisions of the Board are reversed in accordance with the foregoing opinion.

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

Date: 10/24/05 /s/

Leslie V. Norwalk, Esq.
Deputy Administrator
Centers For Medicare & Medicaid Services