CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Health Alliance Hospital **Provider** **vs.** **BlueCross/BlueShield Association/ NHIC Corp., c/o National Government Services, Inc.** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 09/30/03** **Review of: PRRB Dec. No. 2013-D42 Dated: September 24, 2013**

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 §1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). Accordingly, the parties were notified of the Administrator's intention to review the Board's decision. The Center for Medicare (CM) submitted timely comments requesting that the Administrator reverse the Board's. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue is whether the observation bed days for the Provider's fiscal year ending September 30, 2003 ("FY 2003") were properly netted from the calculation of the bed count for purposes of qualifying for a disproportionate share hospital ("DSH") payment, the DSH calculation.

The Board found that the Intermediary's determination of the number of available beds for DSH eligibility purposes was not proper pursuant to the regulations and manual instructions. The Board stated that the determination should have included

the Provider's observation bed days for FY 2003. As such, the Provider had 103 available beds for Medicare DSH adjustment qualification and payment purposes.

SUMMARY OF COMMENTS

CM commented requesting that the Administrator remand the case to the Board so that it can be determined whether the beds in question could have been available for inpatient care use as described in *Clark Regional*. CM also stated that CMS' long standing policy has been that when beds are used to provide outpatient observation services, those bed days are excluded from the count of available bed days.

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.

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,[1] 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.

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

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."[2] Generally, Medicare reimbursement for routine inpatient services 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.[3] 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.[4] This provision added §1886(d) to the Act and established the inpatient prospective payment system, or IPPS, 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 IPPS was to reform the financial incentives hospitals face, promoting efficiency by rewarding cost effective hospital practices.[5]

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…."[6]

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.

Consistent with the statute, the governing regulation at §412.106 (2002), which addresses the DSH payment states that:

---

[2] *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.")

[3] *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).

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

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

[6] 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).

> (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 IME adjustment attempts to measure teaching intensity based on the ratio of the hospital's full-time equivalent interns and residents to beds. The DSH and IME calculations share a common element. The Medicare regulations provide that the number of beds for purposes of DSH payment must be determined in accordance with the IME bed count rules set forth in 42 CFR 412.105(b). The regulation at §412.105(b)(2003), which is cross-referenced at 42 CFR 412.106(a)(1), 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 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.

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…, o*utpatient 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)

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. 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.[7] (Emphasis added.)

Since the establishment of the DSH and IME payment provisions, the Secretary has taken the opportunity to clarify the types of bed 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.*[8] (Emphasis added.)

---

[7] 53 Fed. Reg. 38480 (Sept. 30, 1988); *See also* 53 Fed. Reg. 9337 (March 22, 1988).

[8] 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

The CMS' guidance on bed counting demonstrate that the long-standing policy had been to exclude bed days from the count of available bed days when the beds are used to provide outpatient observation services. This policy also applied to beds located in inpatient acute care units. In a March 7, 1997 letter to fiscal intermediaries, CMS informed fiscal intermediaries that:

> Observation beds that are generally used to provide hospital services, the equivalent days that those beds are used from observation services are excluded from the count of available bed days for purposes of IME and DSH… Thus all observation bed days are excluded from the bed day count.

Relevant to this case, the bed days at issue involve observation bed days. 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…."[9] 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 overnight. 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.[10]

Because, under these circumstances, the observation services are paid as outpatient services, the costs of observation bed patients are to be removed from the inpatient hospital costs as they are not recognized and paid as part of a hospital's inpatient operating costs.[11] 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.[12]

While the Secretary had stated the underlying principle for counting bed days under the DSH and IME provision, in early IPPS rules, the Secretary also specifically

---

Medicare costs (nursery costs and days, on the other hand, are excluded from this determination)….")

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

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

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

[12] Section 3605.1, line 26.

discussed observation bed days in the final rule for the FFY 2004 IPPS rates in response to an adverse Court of Appeals case.[13] 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.

Notable for this case, the Secretary took the opportunity to point out that, contrary to the court's findings in *Clark Regional*, the listing at 42 CFR §412.105(b) was not intended to be all-inclusive list and that this application has been recognized and accepted by the courts under the IME payment.[14] 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.[15] 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 bed days is also consistent with this regulatory interpretation of days to be counted under 42 CFR §412.106(a)(1)(ii). The Secretary stated that:

> Observation services may be provided in a distinct observation area, but they may also be provided in a routine inpatient care unit or ward. In either case, our policy is the bed days attributable to beds used for observation services are excluded from the counts of available bed days and patient days at §§ 412.105(b) and 412.106(a)(1)(ii). This policy was clarified in a memorandum that was sent to all CMS Regional Offices (for distribution to fiscal intermediaries) dated February 27, 1997, which stated that if a hospital provides observation services in beds that are generally used to provide hospital inpatient services, the days that those beds are used for observation services should be excluded from the available bed day count (even if the patient is ultimately admitted as an acute inpatient).
>
> ….
>
> Observation beds and swing-beds are both special, frequently temporary, alternative uses of acute inpatient care beds. That is, only

[13] 68 Fed Reg. 45346, 45418-45419 (Aug 1, 2003)

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

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

the days an acute inpatient care unit or ward bed is used to provide outpatient observation services are to be deducted from the available bed count under §412.105(b). Otherwise, the bed is considered available for acute care services (as long as it otherwise meets the criteria to be considered available).

Although the Court in *Clark* found that Congress had not explicitly "addressed the question of whether swing and observation beds should be included in the count of beds in determining whether a hospital qualifies for the DSH adjustment," *Clark*, 314 F.3d at 245, the Court found that observation and swing-bed days were included under the "plain meaning" of the regulation text at §412.106(a)(1)(ii), which reads: "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." However, the preamble language of the rule that promulgated the regulatory provision at § 412.106(a)(1)(ii) clarified its meaning (53 Fed. Reg.. 38480, September 30, 1988):

"Although previously the Medicare regulations did not specifically define the inpatient days for use in the computation of a hospital's disproportionate share patient percentage, we 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."

Our policy excluding outpatient observation and swing-bed days is consistent with this regulatory interpretation of days to be counted under §412.106(a)(1)(ii). That is, the services provided in these beds are not payable under the IPPS (unless the patient is admitted, in the case of observation bed days).

As outlined previously, our consistent and longstanding policy, which has been reviewed and upheld previously by several courts, including the United States District Court for the District of Columbia in *Amisub v. Shalala*, is based on the principle of counting beds in generally the same manner as the patient days and costs are counted. Our policy to exclude observation and swing-bed days under the regulations at §412.105(b) and §412.106(a)(1) stems from this policy.

> In the May 19, 2003 proposed rule, although we reiterated our longstanding policy that observation beds and swing bed days generally are excluded, we proposed to amend our policy with respect to observation bed days of patients who ultimately are admitted. We are still in the process of reviewing the comments and defer action until a later rule with respect this issue—for example, patients in observation beds who are ultimately admitted to the hospital.[16]

Further in response to commenters, the Secretary explained the basis for this longstanding policy, that:

> *Comment*: Some commenters objected to the general exclusion of observation bed days from the available bed day count on the grounds that it is a flawed premise that the size of a hospital's bed complement should be impacted by the payment policy classification of the services provided to the patient. That is, the commenter believed a bed should not be excluded from the available bed day count because it is used to provide services not payable under the IPPS on a particular day.
>
> *Response:* When the application of IPPS payment policy hinges on a determination of a hospital's bed size, it seems reasonable to determine bed size based on the portion of the hospital that generates the costs that those IPPS payments are designed to compensate. In addition, we use available bed days as the basis to determine a hospital's bed count for purposes of the IME adjustment. Therefore, we believe it is appropriate to consider how a bed is used on a given day. For example, if a bed is used for observation services on a given day, it is not available for inpatient services. As stated above, our bed counting policies start with the premise that the treatment of beds should be generally consistent with the treatment of the patient days and the costs of those days on the Medicare cost report. Therefore, we continue to believe it is appropriate to exclude outpatient observation days, even when the beds used to provide that service are located in an otherwise available routine inpatient care unit or ward.
>
> In determining whether a bed should be considered available, our policy has been to treat the bed in the same manner as we treat the patient days and costs associated with the bed. For example, we

[16] 68 Fed. Reg. 45346, 45419-45420 (August 1, 2003). *See also* at 68 Fed. Reg. 27154, 27205-06 (May 19, 2003) (proposed rule).

> include intensive care unit beds in the available bed count because patient days in these units are included in total patient days and the costs are included in the calculation of allowable costs under the IPPS. If a patient is placed for observation in a bed generally used to provide inpatient services, and is then admitted to the hospital, the patient days that occurred before the inpatient admission are included in the inpatient stay, the costs prior to the admission are included in allowable inpatient costs, and the bed days are included in the available bed day count. However, if the patient placed for observation is released from the hospital without being admitted, then the observation days and costs are excluded from the calculation of inpatient days and costs, and the bed days are excluded from the available bed day count.[17]

Consequently, pursuant to the FFY 2004 IPPS rule, the Secretary clarified the regulation to specifically state in the regulation that observation 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.[18]
The Secretary again restated CMS' longstanding policy of excluding observation bed days from the available bed day count for DSH purposes in the final rule for the FFY 2005 IPPS rates.[19] In the FFY 2005 IPPS rule,[20] CMS again explained this policy stating that:

---

[17] 69 Fed. Reg. 48916, 49096 (Aug 11, 2004).

[18] 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, 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). This regulatory change is the subject of this Provider's appeal for later cost years. (Case Nos. 07-1255, 08-2853) *See* Board Decision n. 1.

[19] 69 Fed. Reg. 48916, 49096-49097 (Aug. 11, 2004).

[20] 69 Fed. Reg. 48916, 49096 (Aug 11, 2004)).

> However, we note that whether the observation services are provided in a separate outpatient observation area or in a bed within an inpatient acute care unit or ward, our general policy is that the days attributable to beds used for observation services are excluded from the counts of available bed days and patient days at (§§412.105(b) and 412.106(a)(1)(ii)). This policy was clarified in a memorandum that was sent to all CMS Regional Offices (for distribution to fiscal intermediaries) dated February 27, 1997. This memorandum stated that if a hospital provides observation services in beds that are generally used to provide hospital inpatient services, the days that those beds are used for observation services are to be excluded from the available bed day count (even if the patient is ultimately admitted as an acute inpatient).[21]

In that rule, the Secretary further clarified in the regulation under 42 CFR §412.105(b) and §412.106(a)1)(ii), that observation 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.[22]

CMS also issued a Joint Signature Memorandum, dated August 25, 2004, in response to the *Clark Regional* decision, addressing the counting of beds and patient days.[23] The JSM-109 clarified how the Sixth Circuit Court of Appeals decision would affect CMS policy on the counting of beds and patient days on the Medicare cost report for hospitals located within the Sixth Circuit. The JSM-109 explicitly stated that the *Clark* decision and the instructions were applicable only to hospitals located within the Sixth Circuit (Michigan, Ohio, Kentucky, and Tennessee) for discharges

---

[21] 69 Fed. Reg. 48916, 49096 (Aug 11, 2004).

[22] 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).

[23] *See* Joint Signature Memorandum (JSM)-109.

occurring before October 1, 2003, and had no impact on hospitals located outside that circuit. The instructions clearly stated that for providers located in all other Circuits (and for all providers including the Sixth Circuit for all discharges beginning on or after October 1, 2003) the longstanding policy of excluding all bed days during which acute care beds are used to provide outpatient observation services or skilled nursing swing-bed services from the count of available days should be applied.

As indicated in the 2003 and 2004 IPPS Rules, CMS' longstanding policy is that observation bed days are excluded from the available bed day and patient day counts. Therefore, the Board improperly determined that the Provider's observation patient days for FYE September 30, 2003, should be included in the available bed count. The inclusion of such days is contrary to CMS' long-standing policy to exclude observation patient days in the Medicare DSH adjustment. The Board also improperly applied the *Clark Regional* decision to facts of this case. The Administrator finds that the Court's decision in *Clark Regional* is not controlling in this case. The *Clark Regional* decision is applicable to States within the Sixth circuit which does not include the State of Massachusetts, where the Provider in this case is located.

However, even assuming, *arguendo*, that the *Clark Regional* standard could be applied to this case, the Administrator finds that the Board's application of *Clark Regional* cannot be squarely applied in this case to include such beds since the beds in question can only be included if they "could be made available for inpatient care use that resulted in an observation patient being displaced." Absent such facts, the Board's application of the *Clark Regional* standard is flawed.

In *Clark Regional*, the Court held that PRM 15-1, Section 2405.3(G) indicated that if a bed could be made available for inpatient care use, even if that resulted in an observation or SNF patient being displaced, then it may be counted as an available bed, and the Court also stated that:

> [T]here is no evidence in this record to suggest that the swing beds and observation beds in this case were not immediately available for use should an acute care patient need them. As a consequence, the PRM creates a presumption that the beds at issue are to be included in the count of available beds" (314 F.3d 241).

The Provider is an acute care hospital located in Leominster, Massachusetts. The Provider is an urban hospital with a disproportionate patient percentage (DPP) exceeding 15 percent. On its as-filed cost report for FY 2003, the Provider reported 103 total beds on line 12 of Worksheet S–3, Part I. In determining the Provider's eligibility for DSH reimbursement, the Intermediary removed "observation bed days"

from the Provider's available bed day count which reduced the bed count to 98.30 beds. [24] Because this reduction brought the bed count to below 100 beds, it reduced the DSH payment for FY 2003. There is no dispute that the hospital meets the other criteria for DSH (i.e., is located in an urban setting and exceeding the 15 percent disproportionate patient percentage threshold).

In this case, the Provider states that the observation services were typically provided using inpatient routine beds that were unoccupied. The Administrator supports the longstanding CMS policy regarding the exclusion of observation beds from the determination of available beds under 42 CFR 412.105, when determining the DSH payment.

As indicated in the 2003 and 2004 IPPS Rules policy guidance and prior Administrator decisions,[25] CMS' reasoned and longstanding policy is that observation bed days are excluded from the available bed day and patient day counts. Therefore, the Board improperly determined that the Provider's observation patient days for FY 2003 should be included in calculating the available bed day count. The inclusion of such days is contrary to CMS' long-standing policy to exclude observation patient days in the Medicare DSH adjustment. The Board also improperly applied the *Clark Regional* decision to facts of this case. The Administrator finds that the Court's decision in *Clark Regional* is not controlling in this case. The *Clark Regional* decision is applicable to States within the Sixth circuit which does not include the State of Massachusetts, where the Provider in this case is located.

However, even assuming *arguendo*, that the *Clark Regional* standard could be applied to this case, the Administrator finds that the Board's use of the *Clark Regional* holding cannot be squarely applied in this case to include such beds since the beds in question can only be included if they "could be made available for inpatient care use that resulted in an observation patient being displaced." Absent such facts, the Board's application of the *Clark Regional* standard is incorrect.

---

[24] In this case, the Provider's DSH payment was capped at 5.25 percent as the Intermediary determined that the Provider had less than 100 beds and, therefore, qualified under 42 CFR 413.106(b)(2)(iii)(B)(2). The Provider's "FY 2003 Settled Cost Report Worksheets", Worksheet E--Part A, Line 3 (Exhibit P-16), shows that the Provider had 98.30 beds (bed days available divided no. of days in cost reporting period).

[25] For example the Clark Regional decision was issued as *Commonwealth of Kentucky 92-96 DSH Group*, Admin. Dec. 99-D66 (Sept 2, 1999).

In *Clark Regional*, the Court held that PRM 15-1, Section 2405.3(G) indicated that if a bed could be made available for inpatient care use, even if that resulted in an observation or SNF patient being displaced, then it may be counted as an available bed, and the Court also stated that:

> there is no evidence in this record to suggest that the swing beds and observation beds in this case were not immediately available for use should an acute care patient need them. As a consequence, the PRM creates a presumption that the beds at issue are to be included in the count of available beds" (314 F.3d 241).

In this case, the Provider states that the observation services were typically provided using inpatient routine beds that were unoccupied. The Administrator finds that there are no facts contained within the record that support the Provider's claim that such beds could have been made available for inpatient use. The Provider also never demonstrates that the observation patient could have been placed in a bed outside of the IPPS area. Under 42 C.F.R. §§ 413.20 and 413.24, a provider has the burden of maintaining adequate documentation to support its claimed costs and enable the Intermediary to determine the amount payable. Since the record does not contain any substantiating documentation to support the Provider's claim, the *Clark Regional* standard would not prevail even if it could be applied in this particular Provider's jurisdiction.

When beds are used to provide outpatient observation services, those bed days are excluded from the count of available bed days. As noted above the longstanding policy The Administrator finds that there are no facts contained within the record that support the Provider's claim that such beds could have been made available for inpatient use (e.g., that the observation outpatient patient could have been placed in a bed outside of the IPPS area). Under 42 C.F.R. §§ 413.20 and 413.24, a provider has the burden of maintaining adequate documentation to support its claimed costs and enable the Intermediary to determine the amount payable. Since the record does not contain any substantiating documentation to support the Provider's claim, the Clark Regional standard would not prevail even if it could be applied in this particular Provider's jurisdiction.

DECISION

The decision of the Board is reversed in accordance with the foregoing opinion.

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

Date: 12/6/13

/s/
Marilynn Tavenner
Administrator
Centers for Medicare & Medicaid Services