COVID-19 Update: Cost-report reimbursement impact of expanding hospital inpatient bed capacity

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Amid the ongoing COVID-19 (coronavirus) outbreak, many hospitals are seeking to increase available intensive care unit (ICU) and other inpatient hospital beds to treat an influx of patients. This may mean bringing new inpatient beds into service from outpatient units, opening new inpatient units both on- and off-site, or converting other types of beds into inpatient beds.

Bed count

A hospital's inpatient bed count is an important factor in determining the reimbursement of indirect medical education (IME) payments and disproportionate share hospital (DSH) payment adjustments. Because IME and DSH bed calculations only include inpatient beds, the following categories of beds are excluded from the calculation of a hospital's total bed count ("non-counted beds"):

- Outpatient beds (including observation beds)
- Emergency department beds
- Inpatient hospice beds
- Postanesthesia or postoperative recovery room beds
- Skilled nursing swing-beds

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- Beds in excluded distinct part hospital units, such as psychiatric or rehabilitation units

IME impact

Hospitals that move non-counted beds to the ICU or other inpatient areas could inadvertently impact their IME or DSH reimbursement. The Centers for Medicare and Medicaid Services uses a hospital's ratio of full-time equivalent residents to the number of inpatient hospital beds in its calculation of a hospital's IME payments. Increases to the number of beds result in lower IME payments. Hospitals that increase their bed counts by converting non-counted beds to inpatient beds would have their IME payments reduced.

DSH impact

Hospitals qualify for a DSH payment adjustment based on their disproportionate patient percentages. One of the inputs to the disproportionate patient percentage is the total number of Medicare inpatient days, which increases when a hospital adds inpatient beds that are utilized by Medicare patients. Hospitals that convert non-counted beds to inpatient status may increase their disproportionate patient percentage and increase their chances of qualifying for a DSH payment adjustment. Urban hospitals with more than one hundred beds may also qualify for a DSH payment adjustment through an alternative special exception.

Other qualifications or statuses that depend on bed count and could be affected as hospitals increase inpatient bed capacity include:

- Sole community hospitals that qualify by having less than 50 beds
- Hospitals classified as referral centers
- Medicare-dependent, small rural hospitals
- Treatment of hospital-associated rural health clinics

As hospitals continue responding to the COVID-19 crisis, they should consider the secondary reimbursement and cost-report impacts of any long-term movement of beds. Proper use of waivers and/or timing of the bed changes may be used to minimize or control for these impacts.

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