PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2015-D1

PROVIDER –
OhioHealth 2004 Clark Bed Days Group, Bricker & Eckler 2002 Bed Days Group, Bricker & Eckler 2003 Bed Days Group, SRI 2002 Clark Decision Group, SRI 2003 Available Bed Days for IME Group, SRI 2003 Patient Days for DSH Group, SRI 2004 Available Bed Days for IME Group, and SRI 2004 Patient Days for DSH Group

PROVIDER NOs.: Various (see Attachment A)

vs.

INTERMEDIARY –
CGS Administrators/
BlueCross BlueShield Association

DATE OF HEARING -
April 22, 2014

Cost Reporting Periods Ended -
2002-2004

CASE NOs. 10-0302GC
06-0662G
06-2036G
06-0740G
07-0271G
07-0273G
06-0872G
06-0873G

INDEX

ISSUE

Whether the Intermediary's application of the Sixth Circuit Court of Appeals' holding in *Clark Regional Med. Ctr. v. United States Dep't of Health and Human Servs.*, 314 F.3d. 241 (6th Cir. 2002) ("*Clark"*) to the determination of the number of available bed days for purposes of calculating the appealing Providers' indirect medical education or disproportionate share payments, as applicable to each such provider, was proper.[1]

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services. The Medicare program was established under Title XVIII of the Social Security Act, as amended, ("Act") to provide health insurance to eligible individuals. Title XVIII of the Act was codified at 42 U.S.C. Chapter 7, Subchapter XVIII. The Centers for Medicare & Medicaid Services ("CMS"), formerly the Health Care Financing Administration ("HCFA"), is the operating component of the Department of Health and Human Services ("DHHS") charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries ("FIs") and Medicare administrative contractors ("MACs"). FIs and MACs[2] determine payment amounts due the providers under Medicare law, regulation and interpretative guidelines published by CMS.[3]

Providers are required to submit cost reports annually, with reporting periods based on the provider's accounting period. A cost report shows the costs incurred during the relevant accounting period and the portion of those costs allocated to the Medicare Program.[4] Each intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider, and issues the provider a Notice of Program Reimbursement ("NPR").[5] A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board ("Board") within 180 days of the receipt of the NPR.[6]

Part A of the Medicare program covers inpatient hospital services. Since 1983, the Medicare program has paid most hospitals for Medicare-covered inpatient hospital services using predetermined, standardized amounts per discharge, subject to certain payment adjustments, under the inpatient prospective payment system ("IPPS").[7] The statutory provisions addressing the IPPS are located in 42 U.S.C. § 1395ww and they contain a number of provisions that adjust payment based on hospital-specific factors.[8] This case involves two of these provisions.

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[1] Stipulations at ¶1 (Jan. 17, 2014) (copy included at Provider Exhibit P-2).
[2] FIs and MACs are hereinafter referred to as intermediaries.
[3] *See* 42 U.S.C. §§ 1395h, 1395kk-1; 42C.F.R. §§ 413.20, 413.24.
[4] *See* 42 C.F.R. § 413.20.
[5] *See* 42 C.F.R. § 405.1803.
[6] *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835.
[7] *See* 42 U.S.C. § 1395ww(d); 42 C.F.R. Part 412.
[8] *See* 42 U.S.C. § 1395ww(d)(5).

The first provision is located at 42 U.S.C. § 1395ww(d)(5)(F)(i) and it requires that the Secretary provide an additional payment for hospitals that serve "a significant disproportionate number of low income patients." Whether a hospital qualifies for the disproportionate share hospital ("DSH") adjustment, and how large an adjustment it receives, depends on the hospital's "disproportionate patient percentage."[9] A hospital that is located in an urban area and has 100 or more beds is eligible for DSH payments, if its disproportionate patient percentage is at least 15 percent. However, if the urban hospital has less than 100 beds it must have a disproportionate patient percentage of at least 40 percent (or 15 percent, for discharges occurring on or after April 1, 2001) to be eligible to receive DSH payments.[10]

A second provision is located at 42 U.S.C. § 1395ww(d)(5)(B) and it recognizes that teaching hospitals have indirect operating costs that would not be reimbursed under the prospective payment system or by the Direct Graduate Medical Education ("DGME") payment methodologies and authorizes an additional payment known as the Indirect Medical Education ("IME") payment, to hospitals with graduate medical education programs. Specifically, the IME payment compensates teaching hospitals for higher than average operating costs that are associated with the presence and intensity of residents' training in an institution but which cannot be specifically attributed to, and does not include, the costs of residents' instruction. The IME adjustment measures teaching intensity based on "the ratio of the hospital's full-time equivalent interns and residents to beds."[11]

Both the DSH and IME calculations require counting the number of beds in accordance with the IME bed count rules set forth in 42 C.F.R. §412.105(b).[12] Under the IME regulation:

> 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. (Emphasis added.)[13]

The Provider Reimbursement Manual, CMS Pub. No. 15-1 ("PRM 15-1"), provides further clarification of the available beds determination process set forth in the regulations. PRM 15-1 § 2405.3.G states:

> A bed is defined for this purpose as an adult or pediatric bed (exclusive of beds assigned to newborns which are not in intensive care areas, custodial beds, and beds in excluded units) maintained

[9] 42 U.S.C. § 1395ww(d)(5)(F)(v).
[10] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(v)(I), 1395ww(d)(5)(F)(v)(III).
[11] 42 U.S.C.§ 1395ww(d)(5)(B)(ii).
[12] *See* 42 C.F.R. § 412.106(a)(1)(i). The DSH regulation, refers back to the IME regulation at 42 C.F.R. § 412.105(b).
[13] 42 C.F.R. § 412.105(b) (2001).

> for lodging inpatients, including beds in intensive care units, coronary care units, neonatal intensive care units, and other special care inpatient hospital units. Beds in the following locations are excluded from the definition: hospital-based skilled nursing facilities or in any inpatient area(s) of the facility not certified as an acute care hospital, labor rooms, PPS-excluded units such as psychiatric or rehabilitation units, post-anesthesia or post-operative recovery rooms, outpatient areas, emergency rooms, ancillary departments, nurses' and other staff residences, and other such areas as are regularly maintained and utilized for only a portion of the stay of patients or for purposes other than inpatient lodging.
>
> To be considered an available bed, a bed must be permanently maintained for lodging inpatients. It must be available for use and housed in patient rooms or wards (i.e., not in corridors or temporary beds). Thus, beds in a completely or partially closed wing of the facility are considered available only if the hospital put the beds into use when they are needed. The term "available beds" as used for the purpose of counting beds is not intended to capture the day-to-day fluctuations in patient rooms and wards being used. Rather, the count is intended to capture changes in the size of a facility as beds are added to or taken out of service.
>
> 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.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY

Each of the providers in these group appeals ("Providers")[14] is an acute care, urban hospital located in Ohio and is located within the geographic boundaries of the Sixth Circuit. The Providers operate approved graduate medical education programs for interns and residents and, therefore, are eligible to receive an IME payment. Most, but not all, of the Providers were eligible to receive a DSH payment in one or more of the fiscal years at issue.

The Intermediary adjusted each of the Providers' cost reports at issue to include all observation bed days and swing bed days in the IME calculations based upon 2002 decision of the Sixth Circuit in *Clark*. The Providers challenged the Intermediary's application of *Clark* and appealed the inclusion of observation bed days and swing bed days in both the IME and DSH calculations.

The Providers' appeal meets the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841. The Provider was represented by James F. Flynn, Esq., of Bricker & Eckler LLP. The

[14] *See* Schedule A for a list of the providers by group case number.

Intermediary was represented by Brendan G. Stuhan, Esq., of the Blue Cross and Blue Shield Association.

PARTIES' STIPULATIONS

The parties agreed to a set of stipulations[15] and they read in pertinent part:

2. CMS' longstanding policy has been that observation bed days and swing bed days are excluded from the counts of available bed days and patient days at 42 C.F.R. §§ 412.105(b) and 412.106(a)(1)(ii) (the "Policy Position").

3. As a result of the United States Court of Appeals for the Sixth Circuit decision in *Clark Regional Medical Center v. Shalala*, 314 F.3d 241 (6th Cir. 2002) ("*Clark*"), CMS' fiscal intermediaries treated observation and swing bed days in accordance with the decision in *Clark* for providers located within the geographic boundaries of the Sixth Circuit.

4. As a result of the decision in Clark, CMS issued Joint Signature Memorandum 109 ("JSM-109") on August 25, 2004, a copy of which is attached hereto as Stipulated Joint Exhibit 1.

5. The providers that are the members of these Group Appeals are located within the geographic boundaries of the Sixth Circuit.

6. The providers that are the members of these Group Appeals received adjustments to their Medicare reimbursement based on the application of JSM-109

7. CMS' fiscal intermediaries consistently applied the Policy Position to applicable cost reports of providers located outside of the geographic boundaries of the Sixth Circuit.

8. For discharges occurring on and after October 1, 2003, CMS' fiscal intermediaries treated observation and swing bed days in accordance with 42 C.F.R. §§ 412.105(b) (2003) and 412.106(A)(1)(ii) (2003) and as discussed in 68 Fed. Reg. 45346, 45,415-45,422 (Aug. 1, 2003).

PROVIDERS' CONTENTIONS:

The Providers believe that the Intermediary erred by including observation beds and swing bed days in the bed day calculations based on *Clark* and JSM-109. The Providers argue that the exclusion of the disputed bed days is supported by the regulatory framework as established and applied by CMS and that the Intermediary erred in relying upon the *Clark* decision to make adjustments to the Providers' cost reports.

[15] *See* Stipulations (Jan. 17, 2014) (copy included at Provider Exhibit P-2).

The Provider notes that Congress' implementation of the IPPS in 1983 did not reimburse hospitals for swing beds or observation beds as they were reimbursed separately by Medicare under other payment systems.[16] The Providers argue that the applicable regulation, 42 C.F.R. § 412.105(b), and PRM guidance remained the same throughout the time period pertinent to these appeals and neither specifically included, nor excluded, observation beds or swing beds. As a result, CMS and fiscal intermediaries consistently interpreted the regulatory and policy language to exclude observation beds and swing beds throughout the period at issue in this appeal.[17]

The Providers argue that this interpretation was "longstanding policy" and that even the 2003 changes to the regulations did not reflect a change in CMS policy in response to *Clark*, but merely "a codification" of longstanding policy.[18] The agency, in the August 1, 2003 preamble to the IME rule changes, reaffirmed that the wording of the former regulation, § 412.105(b), was never meant to create an exhaustive list of excluded categories of beds.[19]

For these reasons, Providers argue that *Clark* should be limited to the facts and circumstances of that case. Providers emphasize the contradictory positions that CMS representatives took about the applicability of the *Clark* case to the Providers. First, in August 2003, CMS promulgated changes to the applicable regulation with preamble commentary specifically denouncing the decision in *Clark*. Then, more than a year later in the Joint Signature Memorandum dated August 25, 2004 ("JSM"), CMS' Director of Hospital and Ambulatory Policy Group directed intermediaries to apply *Clark*'s holding under certain circumstances.[20] Notably, the JSM acknowledges CMS' continuing disagreement with the *Clark* holding. Then again, almost two months later on October 27, 2004, CMS ostensibly contradicted this position when the Administrator issued his decision in the second round of *Clark* litigation that expressly limited the decision to "the facts and circumstances of this case."[21]

The *Clark* decision, Providers argue, was focused solely on determining the number of beds in a hospital to establish eligibility for the DSH payment and which DSH eligibility threshold applied, focusing on sub-paragraph (a)(1)(i) of 42 C.F.R. § 412.106 and merely cross-referencing sub-paragraph (b) of 42 C.F.R. § 412.105, the IME regulation. The *Clark* decision was focused solely on DSH payment and had nothing to do with IME payment adjustments. As this case focuses primarily on bed count for IME purposes, the *Clark* decision should not have been applied to the Providers' cost reports.[22]

The Providers also dispute the Intermediary's argument that the legal principles of *res judicata, collateral estoppel* and *issue preclusion* apply, giving the Intermediary no choice but to follow the *Clark* decision. The Providers argue that these legal principles only apply to the named

[16] Providers' Revised Final Position Paper at 9.
[17] *Id.* at 6.
[18] 68 Fed.Reg. 45346, 45417-18 (Aug. 1, 2003) (copy included at Provider Exhibit P-6).
[19] *Id.* at 45419.
[20] *See* Provider Exhibit P-2 at 3-5 (copy of the JSM).
[21] Provider Exhibit P-11.
[22] Providers' Revised Final Position Paper at 16

parties in the case and because they were not parties in the case are not precluded from a different outcome in this case. Additionally, the legal principle of *stare decisis*, i.e. that the same issue litigated in the same jurisdiction will have judicial precedent, only points to a likely outcome, but does not require it. *Stare decisis* does not mandate that a litigant apply its litigation loss to all other parties in the same jurisdiction.[23]

The Providers assert that the effect of applying *Clark* to hospitals in only four states (within the jurisdiction of the Sixth Circuit) while applying contradictory Medicare policy in the other 46 states is arbitrary, capricious and an abuse of discretion. As stipulated and agreed by the Intermediary, CMS only made the adjustment to the Providers' bed day counts because the Providers were located in Ohio. In the other 46 states, CMS followed its longstanding policy excluding observation or swing bed days to calculate IME and/or DSH payments. It is arbitrary, capricious and an abuse of discretion for the Intermediary to treat these Providers differently than all other providers in the country, merely because they happened to be located in a jurisdiction where one hospital successfully challenged CMS' policy position.[24]

The Providers also contend that there is no reason for CMS to apply the Sixth Circuit decision to providers within the Sixth Circuit. CMS should not be proactively following a decision which it considers aberrant. Additionally, the Providers cite several examples[25] in which CMS ignores unfavorable rulings issued by a federal court because it disagrees with the Courts' decision. Based on this history, there is no reason for CMS to be bound by the *Clark* decision in the present case.

The Providers also point out that the exclusion of observation and swing beds from the IME and DSH bed count has been CMS' longstanding view, iterated throughout the litigation in the various *Clark* proceedings, and articulated in a variety of policy memorandum and language in IPPS final rules. This policy has remained the same both before, during and after the *Clark* decision and culminated in the October 1, 2003 rule change which specifically excluded observation and swing bed days from the bed count.

These amendments to § 412.105(b)(4) explicitly excluded observation and SNF swing beds from the bed count, adding the following clarifying language:

> (b) This count of available bed days excludes bed days associated with –

[23] *Id*. at 16-17.
[24] *Id*. at 17.
[25] *Jewish Hosp., Inc. v. Sec'y of Health & Human Servs.*, 19 F.3d 270 (6th Cir. 1994); *Deaconess Health Servs. Corp. v. Shalala*, 83 F.3d 1041 (8th Cir. 1996); *Legacy Emmanuel Hosp. & Health Ctr. V. Shalala*, 97 F.3d 1261(9th Cir. 1996); *Cabell Huntington Hosp., Inc. v. Shalala*, 101 F.3d 984 (4th Cir. 1996); *Riverside Methodist Hosp. v. Thompson*, No. C2-02-94, U.S. Dist. LEXIS 15163 (S.D. Ohio 2003); *Alhambra Hosp. v. Thompson*, 259 F.3d 1071 (9th Cir. 2001),

> (4) Beds otherwise countable under this section used for outpatient observation services, skilled nursing swing-bed services, or ancillary labor/delivery services;

The comments to the final rule change are very clear why this change is being made:

> Specifically, we proposed to clarify that beds and patient days that are counted for these purposes should be limited to beds or patient days in hospital units or wards that would be directly included in determining the allowable costs of inpatient hospital care payable under the IPPS on the Medicare cost reports. As a preliminary matter, beds, and patient days associated with these beds, that are located in units or wards that are excluded from the IPPS . . . are not to be counted for purposes of §§ 412.105(b) and 412.106(a)(1).[26]

The Providers contend that this regulatory change is both evidence of CMS' continued commitment to a consistent policy and a regulatory action which can be applied both prospectively and retroactively.[27] While courts generally disfavor a retroactive application of a regulation, this case meets the criterion for retroactive application and as an "interpretive" or clarifying regulation, it can be applied retroactively.

There can be little doubt that the Intermediary's adjustments to the Providers' cost reports are contrary to CMS' long-standing policy and its own interpretation of its regulations. In the absence of some legal mandate that requires CMS to apply the aberrant *Clark* decision to the Providers, the Intermediary's adjustments should be reversed.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the issue in these appeals is whether observation and swing bed days were included within the definition of "beds" set forth by 42 C.F.R. §§ 412.105 and 412.106 which were in effect during the fiscal years at issue. Swing beds are acute care beds that can be used to provide post-hospital skilled nursing facility care on a temporary basis, while observation beds are beds used to observe patients to determine whether those patients should be admitted to the hospital.[28] The Intermediary agrees with the Provider that CMS' longstanding policy has been that observation bed days and swing bed days are excluded from the counts of available bed days and patient days at 42 C.F.R. §§ 412.105(b) and 412.106(a)(1)(ii).[29] The Intermediary maintains, however, that it was required to follow the decision in *Clark* because the Providers are located within the geographic boundaries of the Sixth Circuit. Despite CMS' longstanding policy to the contrary, the *Clark* plaintiffs successfully challenged CMS' policy as arbitrary and capricious and the Sixth Circuit determined that CMS's policy "cannot be squared

[26] 68 *Fed. Reg.* at 45415-16.
[27] Providers' Revised Final Position Paper at 25.
[28] *See Clark*, 314 F.3d at 242 (6th Cir. 2002).
[29] *See* Stipulations at ¶ 2.

with either the plain meaning of the regulations or with the Department's definition of 'available bed' set forth in PRM 15-1 § 2405.3(G)."[30]

The Intermediary points out that the Sixth Circuit based its decision on the fact that the regulation specifically listed certain types of beds (*i.e.*, beds and bassinets in the healthy newborn nursery, custodial care beds and beds in excluded distinct part hospital units) that were excluded from the bed count, but did not include swing or observation beds on the excluded list. Thus, the plain meaning of the regulation suggests that it is permissible to count swing and observation beds.[31] The Intermediary is bound to follow the Sixth Circuit's decision in this case.

The Intermediary further points out that the issue raised by the Providers has already been addressed multiple times by the Board and the Administrator. In *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n* ("*St. Vincent*"),[32] the provider appealed the same issue that the Providers appealed here and that provider, like the Providers here, was located within the geographic boundaries of the Sixth Circuit. In its 2008 decision for this case, the Board found that observation bed days should be included in the IME bed count computation but excluded from the Medicare fraction used to compute the Provider's DSH reimbursement.

The Administrator agreed with the Board that observation bed days should be included in the IME bed count computation, but reversed the Board's determination that observation bed days should be excluded from the Medicare fraction stating that "the separation of powers doctrine requires administrative agencies to follow the law of the circuit whose courts have jurisdiction over the cause of action. [33] In the absence of a controlling decision by the Supreme Court, the respective courts of appeals express the law of the circuit."[34] The Intermediary states that the situation is the same here. As there has not been a controlling decision by the Supreme Court, it is obligated to follow the decision of the Sixth Circuit in which the Providers are located.

The Board addressed this issue again in 2010 in *Clinton Mem. Hosp. v. Blue Cross Blue Shield Ass'n, Inc.* ("*Clinton*").[35] In *Clinton*, the provider was again located within the geographic boundaries of the Sixth Circuit and made the same arguments as the Providers in this case: 1) observation bed days should be excluded in the IME bed count citing the CMS policy of excluding observation bed days; and 2) that the *Clark* decision was limited to the question of whether observation bed days should be included for DSH adjustment purposes. The Intermediary states that Board rejected these arguments noting that CMS published policy has consistently interpreted the statutory bed count to apply equally to IME and DSH and that this principle of applying the bed count consistently for DSH and IME mitigates the concern the Provider raises that providers outside the Sixth Circuit may be treated differently than those in

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[30] 314 F.3d at 247.
[31] *Id.*
[32] *See St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008) (copy included at Intermediary Exhibit I-8).
[33] *See St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm. Dec. (Nov. 17, 2008) (copy included at Intermediary Exhibit I-9), *rev'g*, PRRB Dec. No. 2008-D35 (Sept. 14, 2008).
[34] *Id.* at 13 (quoting *Hyatt v. Heckler*, 807 F.2d 376, 379 (4th Cir. 1986)).
[35] *See Clinton Mem. Hosp. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2010-D32 (May 26, 2010) (copy included as Intermediary Exhibit I-10).

the Sixth Circuit. That is, those Providers outside the Circuit have beds *excluded* for the IME and DSH calculation; those Providers within the Sixth Circuit have these beds *included* for the IME and DSH calculation. Consequently, there is typically a beneficial as well as a detrimental effect, albeit the reverse effect in the Sixth Circuit.[36]

The Administrator affirmed the Board's decision, based on the same reasoning that it used when it reviewed the Board's decision in *St. Vincent* and held that observation bed days must be included in the bed count for both DSH and IME purposes.[37]

The Intermediary maintains that the Providers here are situated similarly to Clinton Memorial Hospital and St. Vincent Mercy Medical Center and that the Board should rule consistently with its decision in *Clinton* and the Administrator's decisions in *St. Vincent.* The Board should affirm the Intermediary's adjustments including observation and swing bed days in the bed counts for DSH and IME purposes for the Providers.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law and guidelines, the Parties' contentions, and evidence presented and contained in the record, finds that the observation bed days and swing bed days should be included in the available bed count and used in determining the Providers' IME payments and eligibility for DSH reimbursement, if applicable, for these Providers in the Sixth Circuit.

The Board agrees that the Intermediary was bound by the U.S. Court of Appeals for the Sixth Circuit *Clark* decision that concluded the Department's interpretation of the regulation to exclude swing and observation beds from the count of available beds is arbitrary and capricious and otherwise not in accordance with the law[38]. The Board does not agree with the Providers' contention that the decision in *Clark* is limited to its litigants and is not applicable to the facts and circumstances of these cases. Nor does the Board agree with Providers' argument that the regulation change effective October 1, 2003 should apply retrospectively to the cost reporting periods in these subject appeals as the parties agree the Intermediary treated all discharges related to observation and swing bed days occurring on and after October 1, 2003 in accordance with 42 C.F.R. §§ 412.105(b) (2003).[39]

The Board disagrees that the effect of applying *Clark* to hospitals in only four states (within the jurisdiction of the Sixth Circuit) while applying contradictory Medicare policy in the other 46 states is arbitrary, capricious and an abuse of discretion. The Board concurs with the Administrator in *St. Vincent* that "the separation of powers doctrine requires administrative agencies to follow the law of the circuit whose courts have jurisdiction over the cause of action.

[36] *Id.* at 7.
[37] *See id.*
[38] *See* Intermediary Final Position paper I-9 at 9.
[39] *See* Stipulations at ¶ 8.

In the absence of a controlling decision by the Supreme Court, the respective courts of appeals express the law of the circuit."[40] As there is no controlling decision by the Supreme Court addressing the issue in this case, the Board finds that the Intermediary is obligated to follow the relevant decisions of the Sixth Circuit in which the Providers are located.

The Board concludes that the rationale applied by the Intermediary for the inclusion of observation and swing beds is consistent with the Sixth Circuit's interpretation of the regulation and manual guidelines, specifically the Sixth Circuit Court of Appeal's decision in the *Clark* case. Therefore, the Board concludes the Intermediary's inclusion of observation bed days and swing bed days, for discharges occurring prior to the October 1, 2003, was correct in this case, as all the providers are located within the Sixth Circuit and the *Clark* decision is controlling legal precedent.

DECISION AND ORDER:

The Intermediary's adjustment to include outpatient observation bed days and swing bed days in the bed count for purposes of calculating the Providers' Indirect Medical Education ("IME") and where applicable, Disproportionate Share Hospital ("DSH"), reimbursement was proper.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson

FOR THE BOARD:

/s/
Michael W. Harty
Chairman

DATE: JAN 29 2015

[40] Intermediary Final Position Paper at I- 9 at 13 (quoting *Hyatt v. Heckler*, 807 F.2d 376, 379 (4th Cir. 1986)).

ATTACHMENT A

SCHEDULE OF PROVIDERS

Schedule A

Schedule of Providers in Group

Group Name: **OhioHealth 2004 Clark Bed Days Group**

Date Prepared: **February 25, 2011**

Representative: **James F. Flynn, Esq.**

Case No.: **10-0302GC**

Issue: ***Clark* Decision Bed Count**

	Provider Number	Provider Name	FYE	Inter-mediary	A Date of Final Deter-mination	B Date of Hearing Request	C Number of Days Elapsed	D Audit Adj. No.	E Amount of Reimburse-ment	F Original Case No.	G Date of Add/ Transfer
1	36-0017	Grant Medical Center	2004	National Government Services ("NGS")	9/22/06	3/12/07	171	4, 54	$184,010	07-1579	12/18/09
2	36-0006	Riverside Methodist Hospital	2004	NGS	9/28/06	3/12/07	165	4, 50	$428,236	07-1575	12/18/09

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PROVIDER REIMBURSEMENT
REVIEW BOARD

Schedule A

Schedule of Providers in Group

Group Name: **Bricker & Eckler 2002 Bed Days Issue Appeal**

Representative: **James F. Flynn, Esq.**

Date Prepared: May 1, 2007

Case No.: **06-0662G**

Issue: **2002 Bed Days Appeal**

Provider Number	Provider Name	FYE	Intermediary	Date of Final Determination	Date of Hearing Request	Number of Days Elapsed	Audit Adj. Number	Amount of Reimbursement	Original Case No.	Date of Add/ Transf
36-0006	Riverside Methodist Hospital 3535 Olentangy River Road Columbus, OH 43214 (Franklin County)	2002	AdminaStar Federal	Dec. 30, 2004	June 13, 2005	165	4	$262,004	05-1703	Feb. 7, 2006
36-0017	Grant Medical Center 111 South Grant Ave Columbus, OH 43215 (Franklin County)	2002	AdminaStar Federal	Dec. 17, 2004	June 13, 2005	177	4, 71 and 76	$578,651 (IME) $36,648 (DSH)	05-1683	Feb. 7, 2006
36-0152	Doctors Hospital 5100 West Broad Street Columbus, OH	2002	AdminaStar Federal	Dec. 29, 2004	June 13, 2005	166	4 and 39	$273,472 (IME) $166,478 (DSH)	05-1704	Feb. 7, 2006

	43228 (Franklin County)										
36-0141	Western Reserve Care System 500 Gypsy Lane Youngstown, OH 44501 (Mahoning County)	2002	AdminaStar Federal	July 20, 2005	Dec. 19, 2005	151	45, 46 and 47	$48,660	05-2133	July 19, 2006	

Schedule A

Schedule of Providers in Group

Group Name: **Bricker & Eckler 2003 Bed Days Issue Appeal**

Representative: **James F. Flynn, Esq.** Date Prepared: **February 29, 2008**

Case No.: **06-2036G** Issue: **Bed Days Appeal**

Provider Number	Provider Name	FYE	Intermediary	Date of Final Determination	Date of Hearing Request	Number of Days Elapsed	Audit Adj. Numbers	Amount of Reimbursement	Original Case No.	Date of Add/ Transf
36-0006	Riverside Methodist Hospital 3535 Olentangy River Road Columbus, OH 43214 (Franklin County)	2003	AdminaStar Federal	NPR dated Sept. 30, 2005 (attached)	Feb. 27, 2006	150	4, 46	$307,976 (2003) plus rolling average effect in 2004 of $505,498	06-0913	July 25, 2006
36-0141	Western Reserve Care System 500 Gypsy Lane Youngstown, OH 44501 (Mahoning County)	2003	AdminaStar Federal	NPR dated Sept. 28, 2005 (attached)	March 23, 2006	176	10, 45, 46, 48	$141,974 (IME) and $36,213 (DSH)	06-1419	July 25, 2006
36-0017	Grant Medical Center 111 South Grant Ave Columbus, OH	2003	AdminaStar Federal	NPR dated Sept. 27, 2005 (attached)	Feb. 20, 2006	146	4,65	$350,593 (IME) and $3,118 (DSH)	06-0751	July 25, 2006

SCHEDULE A

Schedule of Providers in Group

Group Name: SRI 2002 Clark Decision Group Appeal

Group Representative: James F. Flynn, Esq.

Case No.: 06-0740G

					A	B	C	D	E	F	G
	Provider Number	Provider Name	FYE	Intermediary[1]	Date of Final Determination	Date of Hearing Request	Number of Days Elapsed	Audit Adj. No.	Amount of Reimbursement[2]	Original Case No.	Date of Add/ Transfer
1.	36-0064	St. Elizabeth Health Center	12/31/01	AdminaStar (now NGS)	3/4/05	8/5/05	154	4, 17, 60	$107,216	05-1940	2/10/06
2.	36-0161	St. Joseph Health Center	12/31/01	NGS	3/11/05	8/5/05	147	4, 38, 41	16,882	05-1941	2/10/06
3.	36-0079	Kettering Memorial Hospital	12/31/01	NGS	12/30/04	6/17/05	169	4	214,546	05-1765	7/9/09
4.	36-0133	Grandview Hospital	12/31/01	NGS	1/12/05	6/17/05	156	4, 7, 33, 38	129,051	05-1769	7/9/09

Note: Supporting documentation attached is referenced by the line number (e.g., 1, 2, or 3) and the column letter (i.e., A, B, C, etc.)

[1] While the Fiscal Intermediary assigned to the group is now CGS Administrators, LLC, the Intermediary was previously National Government Services, Inc. and prior to that Administar Federal.

[2] The Group representative has not separately calculated the amount in controversy, but has referenced the amounts shown in each provider's request for hearing. In some cases, the provider may not have had all of the information necessary to precisely calculate the reimbursement effect. In each case, it appears certain that the jurisdictional threshold is met.

SCHEDULE A

Schedule of Providers in Group

Group Name: SRI 2003 Available Bed Days for IME Group Appeal

Group Representative: James F. Flynn, Esq.

Case No.: 07-0271G

					A	B	C	D	E	F	G
	Provider Number	Provider Name	FYE	Intermediary[1]	Date of Final Determination	Date of Hearing Request	Number of Days Elapsed	Audit Adj. No.	Amount of Reimbursement[2]	Original Case No.	Date of Add/ Transfer
1.	36-0020	Summa Health	12/31/02	National Government Services (NGS)	8/31/05	2/17/06 Add issue 7/26/07	170	4, 51	$345,005	06-0862	7/26/07
2.	36-0133	Grandview Hospital	12/31/02	NGS	9/30/05	3/23/06	174	8, 10, 39	$150,000	06-0359	1/30/07
3.	36-0239	Sycamore Hospital	12/31/02	NGS	1/11/05	6/17/05	157	4, 10	$73,000		7/9/09
4.	36-0064	St. Elizabeth- Health Center	12/31/02	NGS	5/2/05	10/10/05	161	4, 48	$124,820	06-0039	7/16/09

Note: Supporting documentation attached is referenced by the line number (e.g., 1, 2, or 3) and the column letter (i.e., A, B, C, etc.)

[1] While the Fiscal Intermediary assigned to the group is now CGS Administrators, LLC, the Intermediary was previously National Government Services, Inc. and prior to that Administar Federal.

[2] The Group representative has not separately calculated the amount in controversy, but has referenced the amounts shown in each provider's request for hearing. In some cases, the provider may not have had all of the information necessary to precisely calculate the reimbursement effect. In each case, it appears certain that the jurisdictional threshold is met.

SCHEDULE A

Schedule of Providers in Group

Group Name: SRI 2003 Patient Days for DSH Group Appeal

Group Representative: James F. Flynn, Esq.

Case No.: 07-0273G

					A	B	C	D	E	F	G
	Provider Number	Provider Name	FYE	Intermediary[1]	Date of Final Deter-mination	Date of Hearing Request	Number of Days Elapsed	Audit Adj. No.	Amount of Reimburse-ment[2]	Original Case No.	Date of Add/ Transfer
1.	36-0020	Summa Health	12/31/02	National Government Services (NGS)	8/31/05	2/17/06	170	4, 46, 51	$345,005	06-0862	7/26/07
2.	36-0133	Grandview Hospital	12/31/02	NGS	9/30/05	3/23/06	174	4, 40, 48	$126,000	06-1359	1/30/07
3.	36-0064	St. Elizabeth's Health Center	12/31/02	NGS	5/2/05	10/10/05	161	8	$5,455	06-0039	7/16/09

Note: Supporting documentation attached is referenced by the line number (e.g., 1, 2, or 3) and the column letter (i.e., A, B, C, etc.)

[1] While the Fiscal Intermediary assigned to the group is now CGS Administrators, LLC, the Intermediary was previously National Government Services, Inc. and prior to that Administar Federal.

[2] The Group representative has not separately calculated the amount in controversy, but has referenced the amounts shown in each provider's request for hearing. In some cases, the provider may not have had all of the information necessary to precisely calculate the reimbursement effect. In each case, it appears certain that the jurisdictional threshold is met.

SCHEDULE A

Schedule of Providers in Group

Group Name: SRI Available Bed Days for IME Group Appeal: FFY 2004 [Clark Decision]

Representative: James F. Flynn, Esq.

Case No.: 06-0872G

					A	B	C	D	E	F	G
	Provider Number	Provider Name	FYE	Inter-mediary	Date of Final Deter-mination	Date of Hearing Request	Number of Days Elapsed	Audit Adj. No.	Amount of Reimburse-ment	Original Case No.	Date of Add/ Transfer
1.	36-0079	Kettering Memorial Hospital	12/31/03	National Government Services (NGS)	6/23/05	12/16/05	176	4,34	$54,514	06-0414	2/20/05 Lead
2.	36-0239	Sycamore Hospital	12/31/03	NGS	5/9/05	11/02/05	177	4,18	52,992	06-0212	2/20/05 Lead
3.	36-0020	Summa Health	12/31/03	NGS	9/29/05	3/17/06	169	4,33,38	98,298	06-1186	2/28/07
4.	36-0133	Grandview Hospital	12/31/03	NGS	3/30/06	9/20/06	174	4,29,37	263,087	06-2407	2/28/07

SCHEDULE A

Schedule of Providers in Group

Group Name: SRI Available Bed Days for DSH Group Appeal: FFY 2004 [Clark Decision]

Representative: James F. Flynn, Esq.

Case No.: 06-0873G

	Provider Number	Provider Name	FYE	Inter-mediary	A Date of Final Deter-mination	B Date of Hearing Request	C Number of Days Elapsed	D Audit Adj. No.	E Amount of Reimburse-ment	F Original Case No.	G Date of Add/ Transfer
1.	36-0020	Summa Health	12/31/03	National Government Services, Inc.	9/29/05	3/17/06	169	4,33,38	$269,057	06-1186	2/28/07
2.	36-0133	Grandview Hospital	12/31/03	NGS	3/30/06	9/20/06	184	4,29,37	168,987	06-2407	2/28/07

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