CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Clinton Memorial Hospital **Provider** **vs.** **Blue Cross Blue Shield Association/ National Government Services, Inc.** **Intermediary**	**Provider Reimbursement Determination for Cost Reporting Period Ended: December 31, 2001 and 2002** **Review of:** **PRRB Dec. No. 2010-D32** **Dated: May 26, 2010**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in Section 1878(f)(1) of the Social Security Act (Act), as amended (42 U.S.C. 1395oo(f)). The parties were notified of the Administrator's intention to review the Board's decision. The Provider submitted comments requesting that the Administrator reverse the Board's decision. Accordingly, this case is now before the Administrator for final administrative review.

BACKGROUND

For the cost years at issue, the Provider excluded from its available bed day count those days where beds were used for observation services. The exclusion affected the Provider's calculation of its indirect medical education (IME) reimbursement. as well as the calculation of its disproportionate share hospital (DSH) eligibility and payment. Applying the adverse case law controlling in the judicial circuit in which the Provider is located, and consistent with CMS instructions set forth in the Joint Signature Memorandum (JSM-109), the Intermediary adjusted the cost report settlement data to include all observation bed days in both calculations.

ISSUE AND BOARD DECISION

The issue concerns whether outpatient observation bed days should be included in the bed count for the purpose of calculating the Provider's indirect medical education or IME reimbursement.

The Board found that the beds used for observation services should be included in the computation of the full time equivalent (FTE) resident-to-bed ratio that is used to compute the Provider's IME reimbursement. The Board relied on the controlling regulation at 42 CFR §412.105(b), which established the fundamental methodology for determining a hospital's bed size for purposes of calculating IME reimbursement. The Board also relied upon the definition of "available bed" in the Provider Reimbursement Manual (PRM) §2405.3G. The Board found that the beds used by the Provider to furnish observation services were licensed acute care beds that were located in the acute care area of the Provider's hospital. The Board further found that these beds were permanently maintained and available for the lodging of inpatients and were fully staffed to provide inpatient services during the cost reporting period at issue.

The Board relied on the fact that the controlling regulation and the manual instructions identify the specific beds to be excluded from the bed count and neither of the authorities provide for the exclusion of observation beds. The Board reasoned that these comprehensive rules were meant to provide an all-inclusive listing of the excluded beds. The Board noted that, in various decisions reversing the Board's interpretation of available beds, the Administrator stated that CMS has a longstanding policy of using Inpatient Prospective Payment System (IPPS) reimbursed days to determine the number of available beds used to determine whether a provider qualifies for a DSH adjustment. However, the Board found that this statement is inconsistent with the program instructions at PRM §2404.3G regarding IME reimbursement.

Finally, the Board observed that the Sixth Circuit decision in *Clark Regional vs. United States DHHS* (314 F.3d 241 (6th Cir. 2002)) (*Clark Regional*), upheld the Board's decision that observation bed days meet the Medicare program requirements to be included in the bed size calculation used to determine DSH eligibility.

SUMMARY OF COMMENTS

The Provider commented requesting that the Administrator reverse the Board's decision. The Provider noted that the Administrator has made clear that the decision in *Clark Regional* was inconsistent with CMS' longstanding policy. The Provider argued that *Clark Regional* should not be binding.

The Provider also argued that, in any judicial review of this matter, the Provider would bring the case in the District Court for the District of Columbia, where *Clark Regional* is not binding and where the Administrator could not argue that *Clark Regional* should be applied. The Provider noted that the decision in *District Memorial Hospital of Southwest North Carolina v. Thompson,* 346 F.2d 513(4th Cir. 2004) concerned the same bed counting issue as *Clark Regional*, however, the Administrator prevailed in that case. The Provider argued that the Administrator has commented that *District Memorial Hospital* represented the correct interpretation of the law. The Provider reasoned that this conflict would go against the Administrator's comments on this matter, and likely be barred under the doctrines of judicial estoppel and related doctrine of preclusion of inconsistent positions.

Finally, the Provider contended that the general rule is that the law must be applied as it reads today unless doing so creates an injustice. *Bradley v. School Board of Richmond*, 416 U.S. 696 (1974). The Provider argued that there can be no doubt that in this instance applying the Administrator's own regulation, that by the Administrator's own repeated claims and applications reflects longstanding CMS policy, results in an injustice.

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 (2001), which addresses the DSH payment states that:

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[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 ahs 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.
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> (i) The number of beds in a hospital is determined in accordance with § 412.105(b).
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> (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 "disproportionate patient percentage" is the sum of two fractions, the "Medicare and Medicaid fractions," expressed as a percentage for a hospital's cost reporting period. The Medicare fraction numerator is the number of hospital patient days for patients entitled to both Medicare Part A and Supplemental Security Income, excluding patients receiving State supplementation only, and the denominator is the number of hospital patient days for patients entitled to Medicare Part A. The Medicaid fraction's numerator is the number of hospital patient days for patients who were eligible for medical assistance under a State plan approved under Title XIX for such period but not entitled to benefits under Medicare Part A, and the denominator is the total number of the hospital's patient days for such period.[7]

The regulation at §412.106(b) (2001), provides for the calculation of a hospitals disproportionate patient percentage. Relevant to this case, is the Medicaid patient percentage set forth in §412.106(b)(4), stating that:

> The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.

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)(2001), which is cross-referenced at 42 CFR 412.106(a)(1), addresses the indirect medical education (IME) payment and explains that:

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[7] 42 CFR §412.106(b)(5).

> 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.[8] (Emphasis added.)

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*.[9] (Emphasis added.)

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…."[10] 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.[11]

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

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[8] 53 Fed. Reg. 38480 (Sept. 30, 1988); *See also* 53 Fed. Reg. 9337 (March 22, 1988).

[9] 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)….")

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

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

operating costs.[12] 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.[13]

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 discussed observation bed days in the final rule for the FFY 2004 IPPS rates in response to an adverse Court of Appeals case.[14] 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, in fact, specific bed types had been added to the list as clarifications of the type of beds to be included and excluded.[15] 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.[16] 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 concluded that this general policy had also been reviewed and upheld previously by several courts. Consequently, pursuant to the FFY 2004 IPPS rule, the Secretary clarified the regulation to specifically state that observation bed days were to be excluded from the determination of number of beds

[12] Section 3605 of the PRM-Part II.
[13] Section 3605.1, line 26.
[14] 68 Fed Reg. 45346, 45418-45419 (Aug 1, 2003)
[15] Citing to 59 Fed. Reg. 45373 (Sept.1, 1994) and 60 Fed Reg. 45810 (Sept. 1, 1995).
[16] Citing to 53 Fed. Reg. 38480 (Sept. 30, 1988).

under 42 CFR §412.105(b) and the determination of the DSH patient percentage under 42 CFR §412.106.[17]

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.[18] 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.[19]

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.[20] The JSM-109 clarified how the Sixth Circuit Court of Appeals decision would affect

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[17] 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).

[18] 69 Fed. Reg. 48916, 49096-49097 (Aug. 11, 2004).

[19] 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).

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

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 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.

The JSM-109 instructions stated that for providers located within the Sixth Circuit, for all discharges occurring before October 1, 2003, when hospitals provide outpatient observation or skilled nursing swing-bed services in beds that are located within areas, units, or wards that are generally used to provide inpatient acute care services, the days associated with the use of the beds to provide outpatient observation or skilled nursing swing-bed services should be included in the count of available bed days for purposes of both the DSH and IME adjustments. CMS further explained that, although the regulation addressing the number of hospital beds is separate from the regulation on counting patient days, (and the latter regulation was not considered by the Sixth Circuit in *Clark*), for purposes of implementing the court's decision, it would be appropriate to treat patient days in the same manner as the beds in which they occur. Specifically, this policy should be applied to discharges occurring before October 1, 2003, if one of the following circumstances is present:

1. The fiscal intermediary (FI) has not yet issued an initial notice of program reimbursement (NPR) with respect to the cost report containing the discharges.
2. The provider has filed, or files within the period allowed under §405.1841, a jurisdictionally proper appeal for the cost report in which the discharges are reported, and that appeal has not been dismissed; and,
    a. The provider identifies as a basis for that appeal the FI's exclusion under §412.105(b) or §412.106(a)(1)(i) of available bed days associated with outpatient observation or swing-bed days when such services are provided in beds that are located within areas, units, or wards that are generally used to provide inpatient acute care services; or,
    b. The provider identifies as a basis for that appeal the FI's exclusion under §412.106(a)(1)(ii) of patient days associated with the provision of outpatient observation

> or swing-bed services when such services are provided in beds that are located within areas, units, or wards that are generally used to provide inpatient acute care services.

In this case, the issue involves whether the Intermediary's adjustment to include outpatient observation bed days in the bed count for purposes of calculating the Provider's IME and DSH reimbursement was proper. The Administrator supports the longstanding CMS policy regarding how beds are counted when determining the IME and DSH payments. When beds are used to provide outpatient observation services, those bed days are excluded from the count of available bed days. However, the Administrator also recognizes that the U.S. Court of Appeals for the Sixth Circuit has ruled that CMS policy based on the regulatory language in effect prior to 2003, was not consistent with the plain meaning of the regulation under 42 CFR 412.105(b). Many courts have indicated 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.[21] In the absence of a controlling decision by the Supreme Court, the respective courts of appeals express the law of the circuit.[22] Generally, when a court determines that an agency's interpretation is inconsistent with the language of the regulation, an agency may recognize that court's interpretation and apply the court's interpretation uniformly, thereafter, within the jurisdictional bounds of the interpreting court.

This principle is more problematic when an agency is faced with venue uncertainty under the review provisions of its statute.[23] Under the Medicare statute at section 1878 of the Act, a provider may file suit in the district court of the United States for the judicial district in which the provider is located or in the District Court for the District of Columbia. In this case, through the issuance of JSM-109, CMS has provided for the orderly administration of the Medicare program, in a circuit where there is case law, contrary to its national policy, that is controlling for cost years prior to 2003.

The Intermediary's action is consistent with the JSM-109, dated August 25, 2004, that was issued by CMS in response to the *Clark* court decision. The facts of this case fall within the scope of the instruction set forth in the JSM-109. In the instant case, the Provider is an acute care hospital located in Wilmington, Ohio, which is in

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[21] *See*, e.g, *Johnson v. Railroad Retirement Board,*969 F.2d 1082, 1092 (D.C. Cir. 1992), citing to cases addressing true intra-circuit refusal of an agency to recognize adverse controlling case law when an agency knows which court of appeals will review.

[22] *Hyatt v. Heckler,* 807 F.2d 376, 379 (4th Cir. 1986).

[23] *See*, e.g, *Rosendo-Ramirez vs. INS,*32 F.3d 1085, 1092 (7th Cir. 1994).

the Sixth Circuit. The Provider disputed discharges occurring on its December 31, 2001 and 2002 cost reports. The NPR was issued by the Intermediary on February 24, 2005. Thus, the Administrator finds that the Intermediary properly applied the JSM instructions to the Provider's December 31, 2001 and 2002 cost reporting periods. Due to the fact that the Provider is located within the Sixth Circuit, and the discharges at issue occurred before October 1, 2003, the outpatient observation bed services in beds that were located within areas, units, or wards that are generally used to provide inpatient acute care services, and the days associated with the use of the beds to provide outpatient observation should be included in the count of available bed days for purposes of both the DSH and IME adjustments. Accordingly, the Administrator finds that the observation bed days were properly counted in the bed count for purposes of calculating the Provider's IME and DSH payment in this case.

Notably, the JSM-109 Memorandum recognizes that the regulation addressing the number of hospital beds is separate from the regulation on counting patient days. However, for the purposes of implementing the court's decision, CMS determined that it would be appropriate to treat patient days for DSH purposes in the same manner as the beds in which they occur. The Administrator also notes that to include the observation beds in the IME adjustment, but to exclude such days for those beds in the DSH calculation would go against CMS' policy, which is that beds and patient days associated with those beds, must be counted in the same manner. CMS has repeatedly stated that these days are counted similarly for IME and DSH purposes, although usually with opposite reimbursement effects. Therefore, the JSM-109 instructs intermediaries to include patient days associated with the provision of outpatient observation for purposes of the IME provision at 42 CFR §412.105 and the count of patient days under the DSH provision of §412.106(a)(1)(ii) when hospitals provide outpatient observation services in beds that are located within areas, units or wards that are generally used to provide inpatient acute care services.

The Administrator notes the Provider's argument that the judicial review of this matter is not limited to the Sixth Circuit where *Clark Regional* is binding. The Provider alleges that it has the option of initiating judicial review in the United States District Court where the Provider resides or in the District Court for the District of Columbia, where *Clark Regional* would not be binding precedent. CMS has decided to apply to all providers located in the Sixth Circuit the same policy, consistently, for counting days for purposes of the IME and DSH computations. Under this policy, all similarly situated providers are treated the same for the applicable cost reporting periods. CMS has decided to apply the JSM to ensure the orderly administration of a complex and time sensitive program and despite the venue uncertainty in PRRB cases.

The Administrator recognizes that the D.C. Circuit would not be bound by the *Clark Regional* decision, were the Provider to file in that venue. Nor would CMS' desire to litigate against CMS' longstanding position on the merits, which would otherwise allow for the exclusion of these days. Rather, should a court not bound by *Clark* review this case, the issue would only be limited to whether the policy applied by CMS, to Providers located in the States of Michigan, Ohio, Kentucky, and Tennessee, equally and regardless of whether it benefits or disadvantages an individual provider, is reasonable in order to ensure the orderly administration of the program under these unique facts.

If a court were to find the application of JSM unreasonable under the unique facts of this case, i.e., that CMS was not reasonable to consistently apply the policy regardless of whether it benefits or disadvantages a provider located in the Sixth Circuit, the Administrator concedes that its longstanding national policy would exclude these days for the purposes of both the IME and the DSH, calculation. However, the Administrator again emphasizes that whether applying the *Clark* rationale or its own longstanding policy, observation bed days need to be treated in the same manner for both IME and DSH. That is, it will never be acceptable to apply a *Clark* rationale to include observation days to increase payment under one provision, and apply CMS national policy to exclude observation bed days to increase payment under another provision. The same policy to include or exclude days must be applied consistently to both IME and DSH payments.

Thus, applying the relevant law and program policy to the foregoing facts, the Administrator finds that the Intermediary properly included observation bed days in calculating both the Provider's IME payment and DSH payment in accordance with JSM-109. Accordingly, based upon the foregoing reasoning, the Board's decision is affirmed, in accordance with the foregoing opinion.

DECISION

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

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

Date: 7/26/2010 /s/

Marilyn Tavenner
Principal Deputy Administrator and Chief Operating Officer
Centers for Medicare & Medicaid Services