PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2013-D13

PROVIDER –
UMDNJ – University Hospital
Newark, New Jersey

Provider No.: 31-0119

vs.

INTERMEDIARY –
Blue Cross Blue Shield Association/
Cahaba Safeguard Administrators, LLC

DATE OF HEARING –
April 27, 2011

Cost Reporting Periods Ended –
June 30, 2000; June 30, 2001;
June 30, 2002; June 30, 2003;
June 30, 2004

CASE NOs: 03-0262, 04-1461,
05-0450, 06-1449, and 09-0710

INDEX

ISSUE:

Whether the Medicare administrative contractor properly determined that the Provider was not entitled to reimbursement for medical education pass-through costs related to the university's nursing education and allied health program because the Provider did not meet the requirement of operating the program.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper amount of Medicare reimbursement due to 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 the aged and disabled. Title XVIII of the Act was codified at 42 U.S.C. Chapter 7, Subchapter XVIII. The Centers for Medicare and 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[1] determine payment amounts due the providers under Medicare law, regulations and under interpretive guidelines published by CMS.[2]

Cost reports are required from providers on an annual basis with reporting periods based on the provider's accounting period. A cost report shows the costs incurred during the relevant reporting period and the portion of those costs to be allocated to the Medicare program.[3] The 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").[4] A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board ("Board" or "PRRB") within 180 days of the receipt of the NPR.[5]

From the inception of the Medicare program in 1965, certain educational expenses have been reimbursed on a reasonable cost basis.[6] Both the House and Senate Committee reports accompanying the 1965 legislation[7] suggest that Congress favored including a part of educational expenses as allowable costs under the Medicare program as demonstrated by the inclusion in both of these reports of the following statements:

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[1] FIs and MACs are hereinafter referred to as intermediaries.

[2] *See* 42 U.S.C. §§ 1395h and 1395kk-1; 42 C.F.R. §§ 413.20 and 413.24 (2000). All citations to the C.F.R. are to the edition dated October 1, 2000 unless otherwise noted.

[3] *See* 42 C.F.R. § 413.20.

[4] 42 C.F.R. § 405.1803.

[5] *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835-1837.

[6] *See* 57 Fed. Reg. 43659, 43661 (Sept. 22, 1992); 42 U.S.C. § 1395x(v)(1)(A).

[7] Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965).

> Many hospitals engage in substantial educational activities, including the training of medical students, internship and residency programs, the training of nurses, and the training of various paramedical personnel. Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education cost in some other way, that a part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program.[8]

On November 22, 1966, CMS published a final rule promulgating regulations at 20 C.F.R. § 405.421 addressing when the costs of educational activities are allowable under the Medicare program.[9] The regulation repeated the 1965 congressional committee report language that Medicare would share in the costs of educational activities until communities bore them in some other way. In particular, as part of this final rule, CMS established the following regulatory guidance at § 405.421(c):

> (c) *Educational activities.* Many providers engage in educational activities including training programs for nurses, medical students, interns and residents, and various paramedical specialties. These programs contribute to the quality of patient care within an institution and are necessary to meet the community's needs for medical and paramedical personnel. It is recognized that the costs of such educational activities should be borne by the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these costs, the program will participate appropriately in the support of these activities. Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.[10]

While the regulation did not include any criteria to use in determining whether responsibility for a program had been assumed by a community, it clearly stated "it is not intended that this program [*i.e.*, the Medicare program] should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units."

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[8] S. Rep. No. 89-404, at 36 (1965); H.R. Rep. No. 89-213, at 32 (1965).
[9] 31 Fed. Reg. 14808 (Nov. 22, 1966).
[10] *Id.* at 14814.

In 1977, CMS redesignated the regulation as 42 C.F.R. § 405.421 without altering or amending subsection (c) of that regulation.[11]

In 1983, Congress enacted the Medicare inpatient prospective payment system ("IPPS") under which the Medicare program reimburses hospitals for the "operating costs of inpatient hospital services" at a fixed, predetermined rate[12] per discharge. Significantly, Congress excluded payment for "approved educational activities" such as nursing and paramedical education activities from the IPPS.[13] On September 1, 1983, CMS issued an interim final rule ("September 1983 Interim Final Rule") to implement IPPS.[14] Consistent with the statute, the September 1983 Interim Final Rule excluded certain approved education activities such as nursing and allied education activities from hospital operating costs under IPPS, and continued to pay these costs on a reasonable cost or "pass through" basis.[15]

In addition, as part of the final rule dated January 3, 1984 ("January 1984 Final Rule"), CMS amended subsection (d)(6) of 42 C.F.R. § 405.421 to clarify that "the costs of clinical training for students enrolled in programs, *other than at the hospital*, are normal operating costs."[16] In connection with this clarification, CMS stated the following in the preamble to the January 1984 Final Rule:

> We believe that only the costs of those approved medical education programs operated directly by a hospital [should] be excluded from the prospective payment system. If a program is operated by another institution, such as a nearby college or university, if [*sic* it] must be noted that by far the majority of the costs of that program are borne by that other institution, and not by the hospital. While it is true that the hospital may incur some of the costs associated with its provision of clinical training to students enrolled in a nearby institution, the hospital also gains in return. For example, it obtains the services of the trainee (often at no direct cost to itself). We do not believe that this type of relationship was what Congress intended when it provided for a pass through of the costs of approved medical education programs. Rather, we believe that Congress was concerned with those programs that a hospital operates itself, and for which it incurs substantial direct costs.[17]

On September 30, 1986, CMS redesignated 42 C.F.R. § 405.421 as 42 C.F.R. § 413.85 without altering or amending subsection (c) of that regulation.[18]

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[11] 42 Fed. Reg. 52826 (Sept. 30, 1977).
[12] *See* Social Security Amendments of 1983, Pub. L. No. 98-21, § 601(e), 97 Stat. 65, 152-162 (1983) (codified at 42 U.S.C. § 1395ww(d)).
[13] 97 Stat. at 149 (codifying 42 U.S.C. § 1395ww(a)(4) which excluded "approved education activities" from the definition of "operating costs of inpatient hospital services").
[14] 48 Fed. Reg. 39752 (Sept. 1, 1983).
[15] *See id.* at 39797, 39811, 39844 (amending 42 C.F.R. § 405.421).
[16] 49 Fed. Reg. 234, 267 (Jan. 3, 1984) (emphasis added). *See also id.* at 313.
[17] *Id.* at 267.
[18] 51 Fed. Reg. 34790, 34790-34791, 34813-34814 (Sept. 30, 1986).

In both the Omnibus Budget Reconciliation Act of 1989 ("OBRA-89")[19] and the Omnibus Budget Reconciliation Act of 1990 ("OBRA-90"),[20] Congress revised the education cost rules as applied to nursing and allied health education expenses. In OBRA-89 § 6205(a), Congress created a temporary category of "hospital-based nursing schools" and allowed a hospital to claim the costs incurred in training students in a hospital-based nursing school as pass-through costs (reimbursed as reasonable costs under the Medicare program). This category was effective for cost reporting periods beginning on or after December 19, 1989 and on or before the date the Secretary issued a final rule for the payment of costs of approved nursing and allied health education programs. Congress directed CMS to issue regulations by July 1, 1990 and to clarify the criteria for reasonable cost reimbursement of nursing education costs to include:

> (i) the relationship required between an approved nursing or allied health education program and a hospital for the program's costs to be attributed to the hospital;
> (ii) the types of costs related to nursing or allied health education programs that are allowable by medicare;
> (iii) the distinction between costs of approved educational activities as recognized under section 1886(a)(3) of the Social Security Act [i.e., which are eligible for pass-through reimbursement] and educational costs treated as operating costs of inpatient hospital services; and
> (iv) the treatment of other funding sources for the program.[21]

Congress mandated that these regulations "shall not be effective prior to October 1, 1990, or 30 days after publication of the final rule in the Federal Register, whichever is later."[22]

In OBRA-90 § 4004(b), Congress established the methodology for payment of certain costs of approved nursing and allied health education activities conducted on the premises of the hospital when the program for such activities is *not* operated by the hospital. In particular, Congress specified that such activities were reimbursable during a cost reporting period subsequent to October 1, 1989 only if the hospital had "claimed and was reimbursed for such costs during the most recent cost reporting period that ended on or before October 1, 1989."[23]

On September 22, 1992, CMS published a proposed rule to implement the OBRA-89 and OBRA-90 amendments.[24] In this proposed rule, CMS defined the term "redistribution of costs" and proposed five criteria that a provider would have to meet to be considered "the operator of an approved nursing or allied health program."[25] On January 12, 2001, CMS issued the final rule ("January 2001 Final Rule") which was substantially the same as the proposed rule.[26]

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[19] Pub. Law No. 101-239, 103 Stat. 2106, 2243 (1989).
[20] Pub. Law No. 101-508, 104 Stat. 1388, 1388-39 – 1388-40 (1990).
[21] OBRA-89 § 6205(b)(2)(C).
[22] OBRA-89 § 6205(b)(2)(B)(iii).
[23] OBRA-90 § 4004(b)(2)(A).
[24] 57 Fed. Reg. 43659 (Sept. 22, 1992).
[25] *See id.* at 43672.
[26] 66 Fed. Reg. 3358 (Jan. 12, 2001).

Specifically, the January 2001 Final Rule added the following definitions at 42 C.F.R. § 413.85(c):

> *Approved educational activities* means formally organized or planned programs of study of the type that:
> (1) Are operated by providers as specified in paragraph (f) of this section;
> (2) Enhanced the quality of inpatient care at the provider; and
> (3) Meet the requirements of paragraph (e) of this section for State licensure or accreditation. . . . .
> *Community support* means funding that is provided by the community and generally includes all non-Medicare sources of funding (other than payments made for furnishing services to individual patients), including State and local government appropriations. Community support does not include grants, gifts, and endowments of the kind that are not to be offset in accordance with section 1134 of the Act.
> *Redistribution of costs* means an attempt by a provider to increase the amount, or to expand the types, of the costs of educational activities that are allowed for Medicare payment purposes by claiming costs that previously were not claimed by the provider and were considered costs of an educational institution. For example, costs for a school of nursing or allied health education or a medical school that were incurred by an educational institution and were not allowable to the provider in its prospective payment or rate-of-increase limit base year cost report, or graduate medical education per resident amount calculated under § 413.86, are not allowable costs in subsequent fiscal years.[27]

Further, the January 2001 Final Rule amended 42 C.F.R. § 413.85(f) to add the following criteria for identifying programs operated by a provider:

> (f) *Criteria for identifying programs operated by a provider.*
> (1) Except as provided in paragraph (f)(2) of this section, for cost reporting periods beginning on or after October 1, 1983, in order to be considered the operator of an approved nursing or allied health education program, a provider must meet *all* of the following requirements:
> (i) Directly incur the training costs.
> (ii) Have direct control of the program curriculum. (A provider may enter into an agreement with an educational institution to furnish basic academic courses required for completion of the program, but the provider must provide all of the courses relating to the theory and practice of the nursing or allied health profession

[27] *Id.* at 3374.

> involved that are required for the degree, diploma, or certificate awarded at the completion of the program.)
> (iii) Control the administration of the program, including collection of tuition (where applicable), control the maintenance of payroll records of teaching staff or students, or both (where applicable), and be responsible for day-to-day program operation. (A provider may contract with another entity to perform some administrative functions, but the provider must maintain control over all aspects of the contracted functions.)
> (iv) Employ the teaching staff.
> (v) Provide and control both classroom instruction and clinical training (where classroom instruction is a requirement for program completion), subject to the parenthetical sentence in paragraph (f)(1)(ii) of this section.
>
> (2) Absent evidence to the contrary, the provider that issues the degree, diploma or other certificate upon successful completion of an approved education program is assumed to meet all of the criteria set forth in paragraph (f)(1) of this section and to be the operator of the program.[28]

The issue in this case relates to whether the entity or unit participating in the Medicare program for UMDNJ ("Provider") operates the nursing and allied health programs at issue and/or whether there was a prohibited redistribution of costs from an educational institution as defined in the regulations at 42 C.F.R. § 413.85.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The University of Medicine and Dentistry of New Jersey ("UMDNJ" or the "University") is a body corporate and politic of the State of New Jersey.[29] UMDNJ consists of eight schools, five health care units, and one managed care network. The cost reporting treatment of two of the schools, UMDNJ-School of Nursing ("SON") and UMDNJ-School of Health Related Professions ("SHRP"), and one health care unit, UMDNJ-University Hospital are at issue in this case.

The Provider's fiscal year ends on June 30th and this case concerns the cost reports for the five fiscal years ("FYs") 2000 through 2004. Each of these cost reports were originally filed including UMDNJ-University Hospital costs and excluding SON and SHRP costs. The Provider appealed multiple issues in each of the FYs. On May 2, 2006, pursuant to 42 U.S.C. § 1395oo(a), the Board denied jurisdiction over this case because the costs at issue for FYs 2000 through 2004 were unclaimed or self-disallowed costs (*i.e.*, the Provider never sought Medicare reimbursement for these program costs).

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[28] *Id.* at 3375 (emphasis added).
[29] A description of the organization is located in Provider Exhibit P-6 (Notes to Consolidated Financial Statements, June 30, 2000).

The Provider appealed to the U.S. District Court for the District of Columbia ("D.C. Court").[30] On March 7, 2008, the D.C. Court found that "a provider may invoke the Board's jurisdiction under [42 U.S.C. §] 1395oo(a) by claiming dissatisfaction with the *total* amount of reimbursement determined in an NPR, and the Board has the power under 1395oo(d) to modify the total amount based on evidence not considered by the fiscal intermediary."[31] As a result, in connection with the Provider, the D.C. Court found that the Board had "jurisdiction over the costs related to the clinical education programs for fiscal years 2000-2003" and that "[t]he Board must now decide again whether it will hear these claims as a matter of discretion [under § 1395oo(d)] not statutory jurisdiction."[32] In particular, the D.C. Court rejected the Provider's request for an order directing the Board to review and rule upon the issue on the merits. The D.C. Court concluded that, pursuant to its "power and authority" under § 1395oo(d), "the Board may adopt a policy of hearing claims not initially presented to the Intermediary or of refusing to hear them, or it may decide them on a case-by-case basis."[33]

On February 17, 2009, the parties requested dismissal of their appeals then pending before the Court of Appeals for the D.C. Circuit and entered into a "Stipulation of Settlement and Order of Dismissal" ("Settlement Agreement"). [34] As part of the Settlement Agreement, the parties agreed that the Board "shall have, and . . . shall exercise, jurisdiction over the matter at issue . . . : whether UMDNJ is entitled to reimbursement for costs related to UMDNJ's clinical medical education programs for the 2000-2003 fiscal years."[35]

Based upon the Settlement Agreement, the Administrator remanded these cases to the Board.[36] The Board reopened the FYs 2000-2003 cases through a letter dated April 3, 2009.

On January 22, 2009, the Provider appealed its NPR for FY 2004 and requested that this new appeal be consolidated with the reopened cases for administrative efficiency. The Board granted this request for consolidation.

The Provider was represented by Steven B. Roosa, Esq. of Reed Smith LLP. The Intermediary was represented by James R. Grimes, Esq. of BlueCross BlueShield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that UMDNJ is not a healthcare "system." Rather, UMDNJ is a healthcare provider and a hospital unto itself. The Provider points out UMDNJ's consolidated financial statements speak in the first person when addressing the issue of Medicare and Medicaid reimbursement.[37] UMDNJ, *i.e.*, the Medicare provider, both legally and in practice,

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[30] *See UMDNJ-University Hosp. v. Leavitt*, 539 F. Supp. 2d 70 (D.D.C. 2008), *appeal dismissed*, 2009 WL 412888 (D.C. Cir. Feb. 5, 2009).
[31] *Id.* at 78.
[32] *Id.* at 78-79.
[33] *Id.* at 79.
[34] *See* Provider Exhibit P-2 at 1-2 (Stipulation of Settlement and Order of Dismissal).
[35] *Id.* at ¶ 1.
[36] *See* Provider Exhibit P-3 (Order of the Administrator).
[37] *See* Provider Exhibit P-6 at 15 (Notes to Consolidated Financial Statements, "5. Healthcare Reimbursement System").

operates and controls the SON and SHRP. The Provider finds it significant that there is only one tax identification number between the three facilities and one Medicare number belonging to UMDNJ. The Provider asserts CMS issues its NPRs to UMDNJ. The Provider concludes that UMDNJ, therefore, easily meets the requirement of operation and control of the SON and SHRP under 42 C.F.R. §413.85(f) because it is the "provider" in fact.[38]

The Provider next contends that UMDNJ as the "provider" operates and controls the SON and SHRP and, thereby, meets the requirements of 42 C.F.R. § 413.85(f) governing provider-operated nursing and allied health programs. In particular, the nursing and allied health programs qualify as provider- operated under § 413.85(f)(1) as UMDNJ incurs all costs and controls all administration of the educational programs at issue and under § 413.85(f)(2) as UMDNJ awards and issues the degrees for these programs.[39]

The Provider acknowledges that, in order to receive pass through treatment of these costs, the costs may not constitute a redistribution of costs. The Provider argues that reimbursement of the costs at issue does not result in a prohibited redistribution of costs because UMDNJ is a single legal entity. [40] In particular, the Provider maintains that the U.S. Supreme Court's decision in *Thomas Jefferson University v. Shalala* ("*Thomas Jefferson*")[41] is not controlling in this case because the findings in *Thomas Jefferson* were based upon differences in both fact and law. First, Thomas Jefferson Hospital and the University were separate legal entities with separate tax identification numbers. Second, the regulation at issue in *Thomas Jefferson* prohibited the redistribution of costs between "entities *or units*."[42] The Provider points out the "or units" language was subsequently removed from the regulation as part of the January 2001 Final Rule. The Provider argues that the *Thomas Jefferson* case, which did not consider whether the old regulation could even be applied to a facility such as UMDNJ to begin with (because UMDNJ consists of a single legal entity), certainly cannot apply by way of analogy to UMDNJ now because the operative language that supposedly would apply to UMDNJ (as a facility consisting of various "units") has been removed from the regulation.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends UMDNJ-University Hospital does not operate approved educational activities. The SON and the SHRP are part of the University, not the hospital. The Intermediary asserts that students apply for enrollment and pay tuition to the University and that the hospital did not incur any costs of classroom education programs. The Intermediary emphasizes that, while the hospital and the University may operate as one corporate entity under one federal tax identification number, the Medicare regulations pay only those hospitals that directly incur costs of approved nursing and allied health education programs.[43]

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[38] *See* Provider's Final Position Paper at 5-9.
[39] *See id.* at 9-11.
[40] *See* Provider's post-hearing letter dated July 6, 2011 from the Provider's representative to the Board.
[41] 512 U.S. 504 (1994).
[42] *Id.* at 508 (citing 42 C.F.R. § 413.85(c)) (emphasis added).
[43] *See* MAC Final Consolidated Position Paper at 9-10.

The Intermediary notes that UMDNJ-University Hospital did not claim the cost of the SON and SHRP education programs for the fiscal years 2000 through 2004 and had not claimed such costs in preceding years' cost reports.[44] The Intermediary argues that the Secretary has repeatedly stated the policy position that the cost of training health care professionals should be borne by the community and education programs for such training are not patient care costs. However, until the community assumed that education and training cost, the Medicare program would consider it an allowable Medicare cost only if provided directly by the hospital. The Intermediary believes that the Medicare regulations specifically prohibit the redistribution of costs from educational institutions to patient care institutions, and states that the Medicare program will not assume the cost of educational activities previously borne by the community.[45] The Intermediary asserts that it is clear that UMDNJ is claiming education and training costs that have historically been borne by the University, and were never before claimed as medical education pass-through costs by the hospital. This action, it believes, amounts to an impermissible redistribution of costs from an education institution to a patient care institution under the regulations.[46] The Intermediary believes the U.S. Supreme Court addressed this same redistribution issue in *Thomas Jefferson* finding:

> The circumstance addressed by the anti-redistribution clause is a hospital's submission of "increased costs" arising from approved educational activities. The regulation provides, in unambiguous terms, that the "costs" of these educational activities will not be reimbursed when they are the result of a "redistribution," or shift, of costs from an "educational" facility to a "patient care" facility.[47]

Finally, the Intermediary asserts the Provider has never filed a home office cost statement, which would be required, to allocate managerial and administrative costs of UMDNJ to the hospital.[48] The Intermediary argues that, even if UMDNJ were to file a home office cost statement, it could not be used to allocate administrative and managerial costs of the SON or SHRP to the hospital as those are education costs to be shared with the University.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board has considered Medicare law and guidelines, the parties' contentions, and the evidence presented. The parties have entered into the Settlement Agreement stating that "[t]he PRRB shall have, and the PRRB shall exercise, jurisdiction over the matter at issue" for FYs 2000 through 2003.[49] This case also includes FY 2004 which was not addressed by the

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[44] *See id.* at 13. *See also, e.g.,* Provider's Response to Intermediary's Jurisdictional Challenge dated Oct. 13, 2006 at 2 (PRRB Case No. 06-1449) ("the Provider has not, for any cost report year, been reimbursed by Medicare for the costs associated with the School of Nursing, School of Health Related Professions, or School of Biomedical Sciences").

[45] *See* 42 C.F.R. § 413.85(c).

[46] *Id.*

[47] *Thomas Jefferson*, 512 U.S. at 514.

[48] *See* Provider Reimbursement Manual, CMS Pub. No. 15-1 ("PRM 15-1"), § 2150 for the discussion of chain organizations which "may also include business organizations which are engaged in other activities not directly related to health care" and the need for home office cost statements.

[49] *See* Provider Exhibit P-2 at ¶ 1 (Stipulation of Settlement and Order of Dismissal).

Settlement Agreement. Therefore, the Board will address the jurisdiction and the merits of the issue. Set forth below are the Boards findings and conclusions.

STATUTORY JURISDICTION AND DISCRETIONARY POWERS UNDER 42 U.S.C. §§ 1395oo(a) AND (d) RESPECTIVELY:

As previously noted, on March 7, 2008, the D.C. Court found that 42 U.S.C. § 1395oo(a) requires only dissatisfaction with the *total* amount of program reimbursement in order to obtain a hearing before the Board and that the Provider demonstrated this dissatisfaction with regard to FYs 2000 through 2003. Notwithstanding, the D.C. Court rejected the Provider's request for an order directing the Board to review and rule on the merits of the issue for FYs 2000 through 2003 and found that § 1395oo(d) allows the Board to consider evidence not put before the Intermediary and make modifications based upon that evidence. The Board further notes that FY 2004 was consolidated with this hearing and was not addressed in either the D.C. Court's remand or the settlement agreement.[50] Therefore, the Board will address jurisdiction for FY 2004. Further, the Board will address its discretionary power under § 1395oo(d) for FY 2004 as well as for FY 2000 through 2003 as required by the D.C. Court's remand.

At the outset, the Board recognizes that the Settlement Agreement states that "the PRRB shall have, and the PRRB shall exercise, *jurisdiction* over the matter at issue in [these] proceedings"[51] and that, similarly, the Administrator's Order states that "[t]he Board shall have and shall exercise *jurisdiction* pertaining to the matter at issue in the above cited proceedings."[52] However, the Board finds that these statements address only the Board's jurisdiction under 42 U.S.C. § 1395oo(a) and do not address the Board's discretionary powers under § 1395oo(d). In that regard, the D.C. Court stated:

> The statutory provisions at issue in this case are subsections (a) and (d) of 42 U.S.C. 1395oo. Subsection (a) establishes the jurisdiction of the Board . . . . Subsection (d) establishes the powers of the Board *once it has jurisdiction* . . . .[53]

The Board's finding is further supported by the D.C. Court's refusal to issue an order directing the Board to review and rule upon the issue on the merits. In refusing to grant such an order, the D.C. Court stated that:

> The Board must now decide again whether it will hear these claims as a matter of discretion, not statutory jurisdiction. *See MaineGeneral*, 205 F.3d at 501. "Congress specifically granted the Board 'full power and authority' to make rules 'necessary or appropriate' to carry out its statutory tasks." *Id.* (quoting 42 U.S.C. § 1395oo(e). Accordingly, the Board may adopt a policy of

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[50] The Board granted a January 28, 2009 joint request by the parties to consolidate case number 09-0710 into the previous years' hearing for administrative economy.
[51] Provider Exhibit P-2 at ¶ 1 (emphasis added).
[52] (Emphasis added.)
[53] *UMDNJ-University Hosp.*, 539 F. Supp. 2d at 73 (emphasis added).

> hearing claims not initially presented to the fiscal intermediary or of refusing to hear them, or it may decide on a case by case basis. *Id.* This conclusion comports with the plain language of subsection (d) . . . . Congress empowered the Board to make such modifications and allowed it to consider evidence not put before the fiscal intermediary, but did not require it to do so. *See Loma Linda*, 492 F.3d at 1073; *MaineGeneral*, 205 F.3d at 501; *St. Luke's Hosp. v. Secretary of Health and Human Servs.*, 810 F.2d 325, 332-33 (1st Cir. 1987) (Breyer, J.).
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> This conclusion not only flows directly from the statutory language, but addresses many of the policy concerns articulated by the Secretary in his brief . . . . If the Board shares these concerns, it may address them pursuant to its rulemaking authority.[54]

As a result, the Board addresses its discretionary powers under § 1395oo(d) separately from statutory jurisdiction under § 1395oo(a).[55]

A. STATUTORY JURISDICTION UNDER § 1395oo(a) FOR FY 2004.

On January 22, 2009, the Provider filed its appeal request for FY 2004 from an NPR dated August 20, 2008. Four issues including the issue in this decision were appealed in the original the appeal request. Consistent with the D.C. Court's holding in the earlier case, the Board finds that it has jurisdiction over this Provider's FY 2004 cost report under 42 U.S.C. § 1395oo(a) based on dissatisfaction shown through items appealed exclusive of the issue in this appeal.[56]

B. EXERCISING DISCRETIONARY POWERS UNDER § 1395oo(d) FOR FYS 2000 THROUGH 2004.

Consistent with the D.C. Court's remand of FYs 2000 through 2003, the Board finds that, if it were to review the medical education pass-through costs related to the SON and SHRP in the appeal of the cost reports for FYs 2000 through 2004, its authority to do such a review would fall under 42 U.S.C. § 1395oo(d) which gives the Board discretionary power to "make revisions on matters covered by such cost report . . . even though such matters were not considered by the intermediary in making such final determination." It is uncontested that the Provider failed to claim the cost of the SON and SHRP education programs for the FYs 2000 through 2004[57] and that the Provider had not claimed such costs on any prior cost report.[58]

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[54] *Id.* at 79 (underline emphasis added.)

[55] Further, the Board notes that this is consistent with the U.S. Supreme Court's finding in *Bethesda Hosp. Ass'n, v. Bowen*, 485 U.S. 399, 406 (1988) that 42. U.S.C. § 1395oo(d) "allows the Board, *once it obtains jurisdiction pursuant to subsection (a)*, to review and revise a cost report with respect to matters not contested before the fiscal intermediary." (Emphasis added.) The Board notes that, as reflected in prior Board decisions, the Board historically has interpreted jurisdiction under § 1395oo(a) on an issue specific basis. In issuing this decision, the Board is not deciding to deviate from this historical policy, but rather it is simply applying the D.C. Court's decision to this case.

[56] *See supra* note 55.

[57] *See* Provider's Final Position Paper at 2.

[58] *See supra* note 44 and accompanying text.

As previously discussed, the D.C. Court concluded that the Board may adopt a policy of hearing claims not initially presented to the Intermediary or a policy of refusing to hear them, or that the Board may decide jurisdiction on such claims on a case-by-case basis. Historically, the Board has decided to exercise its discretionary power under 42 U.S.C. § 1395oo(d) on a case-by-case basis. The Board declines to change its policy at this time.

The Board finds that it will not exercise its discretionary power over this issue for FYs 2000 through 2003. Similarly, in the FY 2004 appeal, the Board finds that it will not exercise its discretionary power over this issue.

The Provider's failure to claim the cost of the SON and SHRP education programs for the FYs 2000 through 2004 was due solely to the Provider's negligence.[59] Only in hindsight after filing its cost reports did the Provider determine that it was entitled to claim the educational programs for FYs 2000 through 2004. The Board finds that these costs were not considered by the Intermediary in making its final determination for these FYs. The Board has consistently declined to use its discretionary power to remedy a provider's failure to claim all costs on the cost reports.

C. Reimbursement of Medical Education Pass-Through Costs.

Even if the Board had not declined to exercise its § 1395oo(d) discretionary powers for FYs 2000 through 2004 and addressed the merits of this case, it would have upheld the Intermediary finding that the medical education-pass-through costs at issue were a prohibited redistribution of costs.

For FYs 2000 and 2001, consistent with the U.S. Supreme Court's holdings in *Thomas Jefferson*, the Provider would be barred from claiming the costs of the SON and SHRP programs under the anti-redistribution principle found in 42 C.F.R. § 413.85 as it existed prior to the January 2001 Final Rule. Within the definition of the term "educational activities" located in subsection (c) of that regulation, CMS makes the following policy statement: "it is not intended that this program should participate in increased costs resulting from redistribution of costs from *educational* institutions or *units to patient care* institutions or *units*."[60] The Provider's consolidated financial statements,[61] cost report filings,[62] and state licensure[63] that are in the record before the Board

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[59] It is not clear whether the Provider negligently or deliberately failed to claim these educational costs on the cost reports at issue or any other prior cost report. It is possible that the reason the Provider failed to claim these costs was that even it did not believe that these costs were actually costs that could be claimed by the hospital prior to 42 C.F.R. § 412.85 being amended by the January 2001 Final Rule. In addition, the Board notes that the Provider did not seek to correct its alleged error by filing either an amended cost report or a request for reopening for the FYs at issue.

[60] (Emphasis added.)

[61] The Provider's "Notes to Consolidated Financial Statements" for 2000 lists the "units" governed by UMDNJ. The SON and SHRP are listed as "units" under the "Schools of the University" and UMDNJ-University is listed as a "unit" under the "University Health Care Units." *See* Provider Exhibit P-6 at 7-8.

[62] As reflected in the Provider's income statements and their reconciliation to costs claimed on Worksheet A of the Medicare cost report, the SON and SHRP educational costs at issue were not claimed in the as filed Medicare cost reports nor on any Medicare costs reports from previous years and, as a result, the SON and SHRP educational costs at issue remained a cost of the educational unit. *See* Provider's post hearing submission dated July 6, 2011, Exhibits A and B; Intermediary's Post Hearing Brief at 3.

demonstrate that UMDNJ is primarily an educational institution with various operating "units" and that the University Hospital, SON, and SHRP are each a separate operating "unit." Since it is undisputed that UMDNJ is a part of the State of New Jersey and that these educational costs had not previously been claimed by the Provider on any prior cost report, these educational costs were being supported by the community through non-Medicare sources of funding (other than payments made for furnishing services to individual patients), including State and local government appropriations. The SON and SHRP educational costs at issue were costs of educational units for which the community was bearing the costs.

Similarly, for FYs 2002, 2003 and 2004, the Provider would be barred from claiming the costs of the SON and SHRP programs under the anti-redistribution principle found in 42 C.F.R. § 413.85(c) as amended by the January 2001 Final Rule. In the January 2001 Final Rule, CMS moved its policy statement regarding redistribution of costs into the newly-added definition of the term "redistribution of costs" located in the amended 42 C.F.R. § 413.85(c). While CMS dropped the "institution or units" language from the new regulatory provision, CMS inserted an "example" into the definitions and this example confirms that, if educational costs were incurred in a provider's prospective payment or rate-of-increase limit base year and such costs were not allowable to such provider in that base year cost report or the graduate medical education per resident amount calculated under § 413.86, then educational costs in subsequent fiscal years are not allowable costs. As previously noted, the costs at issue for FYs 2000 and 2001 were part of the educational unit and the costs for this educational unit had never been previously claimed on the Medicare costs report, including the base year referenced in the example.

DECISION AND ORDER:

Consistent with the Court's decision and remand, the Board finds that it has statutory jurisdiction under 42 U.S.C. § 1395oo(a). However, pursuant to the Court's instruction, the Board has reviewed the case and declines to exercise its discretionary powers under 42 U.S.C. § 1395oo(d) to review the Intermediary's adjustments relating to medical education-pass-through costs for FYs 2000, 2001, 2002, 2003, and 2004.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
Keith E. Braganza, CPA
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

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[63] *See* Provider's post-hearing submission dated July 6, 2011, Exhibit D (various licensure issued to "UMDNJ University Hospital"). The Board notes that Exhibits C and E pertaining to revalidation of Medicare enrollment information and Exhibit F pertaining to federal taxes are not relevant as they are dated subsequent to the time period at issue.

FOR THE BOARD:

Michael W. Harty
Chairman

DATE: APR 25 2013