PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2022-D12

PROVIDER –
Kettering Memorial Hospital

PROVIDER NO. –
36-0079

vs.

MEDICARE CONTRACTOR –
CGS Administrators, LLC/
Federal Specialized Services, Inc.

DATE OF HEARING –
October 8, 2019

Cost Reporting Period Ended–
12/31/2009

CASE NO. 14-0032

INDEX

ISSUE STATEMENT:

Did the Medicare Contractor err when it made an adjustment for fiscal year ("FY") 2009 to remove the Provider's protested item for the addition of Allied Health Program revenue to the accumulated cost allocation statistic, Audit Adjustment No. 26?[1]

DECISION:

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor's adjustment for FY 2009 to remove the Provider's protested item for the addition of Allied Health Program revenue to the accumulated cost allocation statistic was proper.

INTRODUCTION:

Kettering Memorial Hospital ("Kettering" or "Provider") is an acute care hospital located in Kettering, Ohio which operates an approved School of Nursing and other schools of Allied Health.[2] Kettering's assigned Medicare contractor[3] for fiscal year 2009 was CGS Administrators, LLC ("Medicare Contractor"). Kettering is appealing the Medicare Contractor's audit adjustment Number 26 which removed Kettering's protested item for the addition of Allied Health Program revenue to the accumulated cost allocation statistic.[4] Kettering timely appealed the Medicare Contractor's adjustment to the Board, and met the jurisdictional requirements for a hearing.

On October 8, 2019, the Board held a live hearing. Kettering was represented by David Johnston, Esq. and Joshua Gilbert, Esq, both of Bricker & Eckler, LLP. The Medicare Contractor was represented by Edward Lau, Esq. and Joseph Bauers, Esq., both of Federal Specialized Services.

STATEMENT OF FACTS AND RELEVANT LAW:

This dispute centers on how Kettering reported various Allied Health Education Programs' revenue on its cost report and the resultant allocation of overhead costs to the same Allied Health Education Programs.

A. Allied Health Education Programs

From the inception of the Medicare program in 1965, certain medical education expenses have been reimbursed on a reasonable cost basis.[5] Both the House and Senate Committee reports

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[1] Hearing Transcript ("Tr.") at 6.
[2] Provider's Post-Hearing Brief at 2 (Nov. 22, 2019) ("Provider's PHB").
[3] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate.
[4] Provider's Final Position Paper at 1 (June 1, 2018) ("Provider's FPP").
[5] *See* 42 U.S.C. § 1395x(v)(1)(A); 42 C.F.R. § 405.421 (1966); 57 Fed. Reg. 43659, 43661 (Sept. 22, 1992).

accompanying the 1965 legislation[6] suggest that Congress favored including medical educational expenses as allowable medical education costs under the Medicare program. The following Congressional statements address the reimbursement of medical education costs as allowable expenses under the Medicare program and reflect Congressional inclination regarding reimbursement of medical education expenses:

> 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 costs 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.[7]

Significantly, these reports specifically list nursing and paramedical (*i.e.*, allied health) education expenses as a type of medical education activity that "should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program [*i.e.*, the Medicare program]."[8]

On November 22, 1966, the Secretary 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] In 1975, the Secretary clarified that an approved nursing or allied health education program had to be operated by a provider for its costs to be allowable as the costs of approved educational activities.[10] In 1977, the Secretary 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] Significantly, Congress excluded "approved educational activities" such as nursing and allied health education activities from IPPS.[13] On September 1, 1983, the Secretary issued an interim final rule ("September 1983 Interim Final Rule") to implement the IPPS.[14] Consistent with the statute, the September 1983 Interim Final Rule excluded certain approved medical education activities such as nursing and allied health

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[6] Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965).
[7] S. Rep. No. 89-404, at 36 (1965); H.R. Rep. No. 89-213, at 32 (1965).
[8] *Id.*
[9] 31 Fed. Reg. 14808 (Nov. 22, 1966).
[10] Provider Reimbursement Manual, CMS Pub. No. 15-1, § 404.2. *See also* 66 Fed. Reg. 3357, 3359 (Jan. 12, 2001).
[11] 42 Fed. Reg. 52826 (Sept. 30, 1977).
[12] *See* Social Security Amendments of 1983, Pub. L. No. 98-21, 97 Stat. 65, 152 § 601(e) (1983); 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).

education activities from hospital operating costs under IPPS, and continued to pay these costs on a reasonable cost or "pass-through" basis.[15] On September 30, 1986, the Secretary redesignated 42 C.F.R. § 405.421 as 42 C.F.R. § 413.85 without altering or amending subsection (c) of that regulation.[16]

Through the Omnibus Budget Reconciliation Act of 1989 ("OBRA-89")[17] and the Omnibus Budget Reconciliation Act of 1990 ("OBRA-90"),[18] Congress revised the education cost rules as they applied to nursing and allied health education expenses. In OBRA-89 § 6205(a), Congress created a *temporary* category of certain "hospital-based nursing schools" and allowed such hospitals to claim the costs incurred in training nursing students in a hospital-based nursing school as pass-through costs. This *temporary* 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 that addressed the payment of costs of approved nursing and allied health education programs.[19] In particular, Congress directed the Secretary to issue regulations to clarify the criteria for reasonable cost reimbursement of nursing education costs to include:

> (i) the relationship required between an approved nursing . . . education program and a hospital for the program's costs to be attributed to the hospital;
>
> (ii) the types of costs related to nursing . . . education programs that are allowable by medicare;
>
> (iii) the distinction between costs of approved educational activities [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.[20]

Congress mandated that the Secretary issue regulations reflecting these statutory requirements by July 1, 1990 and 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."[21]

On January 12, 2001, the Secretary issued a final rule ("2001 Final Rule")[22] promulgating regulations at 42 C.F.R. § 413.85 to implement the OBRA-89 and OBRA-90 revisions to the education cost rules.[23] The Secretary subsequently revised these regulations during the time at issue in this appeal through final rules published on August 1, 2003 and August 11, 2004 ("2003

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[15] *See id.* at 39797, 39811, 39844 (amending 42 C.F.R. § 405.421). *See also* 42 U.S.C. § 1395ww(a)(4).
[16] 51 Fed. Reg. 34790, 34790-34791, 34813-34814 (Sept. 30, 1986).
[17] Pub. L. No. 101-239, 103 Stat. 2106, 2243 (1989).
[18] Pub. L. No. 101-508, 104 Stat. 1388, 1388-39 – 1388-40 (1990).
[19] OBRA-89 § 6205(a)(2).
[20] OBRA-89 § 6205(b)(2)(C).
[21] OBRA-89 § 6205(b)(2)(B)(iii).
[22] 66 Fed. Reg. 3358 (Jan. 12, 2001).
[23] 57 Fed. Reg. 43659 (Sept. 22, 1992).

Final Rule" and "2004 Final Rule" respectively).[24] As a result of those final rules, the regulations at 42 C.F.R. § 413.85(d) (2009) set forth the applicable standards for reimbursing the reasonable cost of nursing and allied health educational activities under the Medicare program, stating in relevant part:

> (d) *General payment rules.* (1) Payment for a provider's **net cost** of nursing and allied health education activities is determined on a reasonable cost basis, subject to the following conditions and limitations:
>
> (i) An approved educational activity —
>
> (A) Is recognized by a national approving body or State licensing authority as specified in paragraph (e) of this section;
>
> (B) Meets the criteria specified in paragraph (f) of this section for identification as an operator of an approved education program.
>
> (C) Enhances the quality of inpatient care at the provider.
>
> (ii) The cost for certain nonprovider-operated programs are reimbursable on a reasonable cost basis if the programs meet the criteria specified in paragraph (g)(2) of this section.
>
> (iii) The costs of certain nonprovider-operated programs at wholly owned subsidiary educational institutions are reimbursable on a reasonable cost basis if the provisions of paragraph (g)(3) of this section are met.
>
> (2) *Determination of net cost.* (i) Subject to the provisions of paragraph (d)(2)(iii) of this section, the net cost of approved educational activities is determined by **deducting the revenues that a provider receives from tuition and student fees from the provider's total allowable educational costs that are directly related to approved educational activities.**
>
> (ii) A provider's total allowable educational costs are those costs incurred by the provider for trainee stipends, compensation of teachers, and other costs of the activities as determined under the Medicare cost-finding principles in §413.24. **These costs do not include** patient care costs, **costs incurred by a related organization**, or costs that constitute a redistribution of costs from an educational institution to a provider or costs that have been or are currently being provided through community support.

[24] The 2003 and 2004 Final Rules are located at 68 Fed. Reg. 45346 (Aug. 1, 2003) and 69 Fed. Reg. 48916 (Aug. 11, 2004), respectively.

* * * *

> (iv) Net costs are subject to apportionment for Medicare utilization as described in §413.50.[25]

B. Cost Report Data and Cost Finding

Providers are required to furnish cost data to medicare contractors in order to receive program payments.[26] Medicare contractors must be allowed to examine "records and documents as are necessary to ascertain information pertinent to the determination of the proper amount of program payments due."[27]

The cost data that providers furnish when seeking reimbursement must be according to one of several approved cost-finding methods as explained at 42 C.F.R. § 413.24 (2009):

> (a) *Principle.* Providers receiving payment on the basis of reimbursable cost must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting.

The Provider Reimbursement Manual, Part II ("CMS Pub 15-2"), § 3610 provides instructions for reporting the costs of Allied Health Education Programs on Schedule A of the cost report, stating, in relevant part:

> Line 24— this line is used for a hospital or subprovider which operates an approved paramedical education program that meets the criteria of 42 CFR 413.85 and 412.113(b). Establish a separate cost center for each paramedical education program (e.g., one for medical records or hospital administration). If additional lines are needed, subscript line 24. If the direct costs are included in the costs of an ancillary cost center, reclassify them on Worksheet A-6 to line 24. Appropriate statistics are required on Worksheet B-1 to ensure that overhead expenses are properly allocated to this cost center.

Prior to allocating overhead costs to the revenue producing cost centers, a provider must make appropriate reclassifications and adjustments to its costs. While cost report Worksheet A-6 is used to reclassify costs between cost centers, cost report Worksheet A-8 is used to make adjustments to the provider's revenue and non-revenue producing cost centers. The instructions for completing Worksheet A-8 of the cost report are found at CMS Pub 15-2, § 3613 which states, in relevant part:

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[25] (Italics emphasis in original and bold and italics emphasis added.)
[26] 42 C.F.R. § 413.20(d)(1).
[27] 42 C.F.R. § 413.20(d)(2).

> Types of adjustments entered on this worksheet include (1) those needed to adjust expenses to reflect actual expenses incurred; (2) ***those items which constitute recovery of expenses through sales, charges, fees, etc.;*** (3) those items needed to adjust expenses in accordance with the Medicare principles of reimbursement; and (4) those items which are provided for separately in the cost apportionment process.[28]

Cost report Worksheet B-1 is used to allocate General Services costs and is designed to accommodate the step-down method of cost finding.[29] The regulation at 42 C.F.R. § 413.24(d)(1) (2009) describes the step-down method of cost finding as:

> (1) *Step-down method*. This method recognizes that services rendered by certain nonrevenue-producing departments or centers are utilized by certain other nonrevenue-producing centers as well as by the revenue-producing centers. All costs of nonrevenue-producing centers are allocated to all centers that they serve, regardless of whether or not these centers produce revenue. The cost of the nonrevenue-producing center serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first. Following the apportionment of the cost of the nonrevenue-producing center, that center will be considered "closed" and no further costs are apportioned to that center. This applies even though it may have received some service from a center whose cost is apportioned later. Generally, if two centers furnish services to an equal number of centers while receiving benefits from an equal number, that center which has the greatest amount of expense should be allocated first.

The cost report instructions for Worksheet B-1 state "the provider can elect to change the order of allocation and/or allocation statistics, as appropriate, for the current cost reporting period if a request is received by the intermediary, in writing, 90 days prior to the end of that reporting period."[30] The request to change allocation methodology must include supporting documentation and an explanation of why the alternative methodology should be used.[31] Additionally, the "change must be shown to more accurately allocate the overhead or should demonstrate simplification in maintaining the changed statistics."[32]

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[28] (Emphasis added)
[29] CMS Pub. 15-2, § 3617. *See* Provider Exhibit P-4.
[30] *Id.*
[31] *Id.*
[32] *Id.*

C. Provider's Treatment of Nursing and Allied Education Program Costs on its Cost Report

Kettering filed its FY 2009 cost report with the costs related to its paramedical programs reported on Worksheet A, Lines 24 through 24.06.[33] On Line 24, Kettering included indirect Administrative and General ("A&G") costs associated with the paramedical education programs, and on Lines 24.01 through 24.06 included the direct and indirect education costs associated with each specific paramedical program.[34] These included programs for Nursing (24.01), Radiology (24.02), Sonography (24.03), Physician's Assistant (24.04), Respiratory Therapy (24.05), and Chaplain (24.06).[35]

On the cost report, Kettering made some reclassifications through Worksheet A-6 and made certain adjustments to the nursing and allied health programs through Worksheet A-8. Specifically, on Lines 39.07 to 39.11 of Worksheet A-8, Kettering made miscellaneous revenue offsets for tuition and room and board.[36] This resulted in Lines 24.01 - Nursing, 24.02 - Radiology, 24.03 - Sonography and 24.05 - Respiratory on Worksheet A having negative balances.[37] Even after these lines received indirect allocations on Worksheet B, Part I of Building and Depreciation, Moveable Equipment, and Employee Benefits, before the A&G allocation, they still had negative balances.[38] Since the A&G costs are allocated on an accumulated cost statistic, these allied health programs received no indirect allocation of A&G cost.[39] Kettering estimated the impact of reversing the revenue offset on Worksheet B-1 column 6a to be $423,610 and included this amount as a protested amount on the filed cost report.[40] The Medicare Contractor, through Audit Adjustment No. 26, reversed this protested amount. Kettering later revised this estimate to $726,761 but never provided a calculation.[41] As a result, in order to provide a calculation of the reimbursement impact, the Medicare Contractor reversed the tuition and the room and board offset on Worksheet B-1, Column 6a and estimated the reimbursement impact to be 708,348.[42]

In prior years, Kettering alleges that it used a similar methodology (that is currently under appeal) to be reimbursed for their nursing and allied health programs.[43] In the year under appeal, the Compu Max software package did not allow Kettering to reverse the revenue on Schedule B-1, Column 6a of the cost report.[44] As a result, Kettering estimated the reimbursement impact and included it as a protested amount on Worksheet E, Part A, line 30 of the cost report.[45] This appeal is related to Audit Adjustment No. 26 that removed the protested amount from the cost report.

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[33] Exhibit C-2 at 1.
[34] *Id.*
[35] *Id.*
[36] *Id.* at 8. Medicare Contractor's Post Hearing Brief at 5 (Nov. 21, 2019) ("Medicare Contractor's PHB").
[37] Exhibit C-2 at 3.
[38] Exhibit C-3 at 12.
[39] Exhibit C-2 at 11 (note heading at the top of Column 6.01).
[40] *Id.* at 12.
[41] Provider's FPP at 1.
[42] Exhibit C-5 at 1.
[43] Tr. at 24-25.
[44] *Id.*.
[45] Exhibit C-2 at 12.

DISCUSSION, FINDINGS OF FACT AND CONCLUSIONS OF LAW:

Kettering has made numerous arguments in support of its proposed methodology for reimbursement of its nursing and allied health programs, which requires the alteration of the accumulated cost statistic used for the allocation of A&G costs on Worksheet B-1. The Medicare Contractor asserts that "this type of add-on revenue by the Provider is not allowable per 42 C.F.R. § 413.85(d)(2), 42 C.F.R. § 413.24(d)(1), and the Provider Reimbursement Manual[.]"[46] In particular, the Medicare Contractor contends that the regulation at 42 C.F.R. 413.85(d) makes clear two important issues:

1. The payment will be made for "net cost"; and
2. "[N]et cost" requires the deduction of revenues "from tuition and student fees."

Kettering's witness, Mr. Pugh, indicated that the revenue offsets were comprised of "all of the Allied Health revenue, tuition, room and board, books . . . anything else."[47] In view of the regulation and the witness' testimony, there can be no doubt that an offset for these items was required on Worksheet A-8. Both parties to the appeal agree on this point.[48]

Under the step-down method of cost finding, as stated in 42 C.F.R. § 413.24(d)(1) (2009):

> All costs of nonrevenue-producing centers are allocated to all centers that they serve, regardless of whether or not these centers produce revenue. The cost of the nonrevenue-producing center serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first.

In this appeal, Kettering added revenue to the accumulated cost allocation statistic (Administration and General) on Worksheet B-1 of its cost report, which resulted in additional allocation of overhead costs to the Allied Health/Paramedical Education Program cost centers. The cost report instructions in the Provider Reimbursement Manual ("PRM") 15-2, § 3617 state, in part:

> The following statistical bases *must* be used for purposes of allocating overhead cost centers. *There can be* ***no*** *deviation* of the prescribed statistics and it must be utilized for all the following cost centers . . . Administrative and General – Accumulated Costs.[49]

Significantly, the term "Accumulated Costs," as used above, is not "Total Costs" but rather only reflects costs accumulated to this point inclusive of reclassed adjustments. To this end, cost report software, which must be approved by CMS, automatically reports this accumulated cost

[46] Medicare Contractor's PHB at 5.
[47] Tr. at 103.
[48] Provider's PHB at 3.
[49] Exhibit P-4 at 1 (emphasis added).

statistic in Column 6 of Worksheet B-1. In fact, the cost report instructions continue with detailed instruction for Column 6 (Administrative and General), stating:

> Worksheet B-1, Column 6--The administrative and general expenses are allocated on the basis of accumulated costs. Therefore, the amount entered on Worksheet B-l, column 6, line 6, is the difference between the amounts entered on Worksheet B, Part I, column 5A and Worksheet B-1, column 6A. A negative cost center balance in the statistics for allocating administrative and general expenses causes an improper distribution of this overhead cost center. Exclude negative balances from the allocation statistics.[50]

These instructions clearly explain that negative balances at the time of allocation must be excluded. Further, the automatic "Accumulated Costs" statistic developed by the cost reporting software is based upon the net cost from Worksheet A (after any revenue offsets) plus any costs allocated from cost centers prior to the A&G cost center. For all cost centers, this means any revenue offsets would be included in that statistic. The Board finds that nothing in the Provider Reimbursement Manual or the controlling regulations permitting Kettering to add back the Allied Health Program revenue to the accumulated cost allocation statistic on Worksheet B-1 of the cost report. While Kettering argues that cost reporting software issues caused the need to make these alternative adjustments,[51] no regulation or instruction is referenced indicating this alternative handling is reasonable.

Kettering states that, in 2017, they were told that they could add back the revenue to B-1 of the cost report and that the Medicare Contractor did not change Kettering's adjustment to Worksheet B-1.[52] The Board notes that CMS instructions in CMS-2552-10 for Worksheet B-2 are even more explicit for the 2017 cost report, stating:

> NOTE: Do not use this worksheet to reduce the total allowable costs that are directly related to the [Nursing Allied Health Education] programs by the revenue received from tuition and student fees. Use Worksheet A-8 to offset NAHE program costs by tuition and student fees (42 CFR 413.85(d)(2)(i)). Do not use a post step-down adjustment.[53]

Worksheet B-2 allows a provider to make post step-down adjustments on Worksheet B, Part I and II; D Part III and IV; and L-1, Part I. The amounts reported on B-2 are to be transferred to the appropriate lines on Worksheets B, Part I and II, or L-1, Part I, Column 25. Although CMS allows, in certain circumstances, revenue to be offset after Worksheet B, Part I indirect allocations, CMS specifically states this does not apply to Nursing Allied Health Education ("NAHE") programs and the offset for NAHE revenue must be made on A-8. CMS does not

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[50] *Id*. at 7.
[51] Provider's PHB at 7-11.
[52] *Id.* at 18 (quoting Tr. at 31).
[53] CMS 2010-10, PRM 15-2 § 4022 instruction for cost reports beginning on or after May 1, 2010.

allow for a revenue offset to be made after the indirect stepdown process. Kettering, in this appeal, offsets tuition and room revenue on Worksheet A-8 and then adds it back on Worksheet B-1, Column 6a.01, so they can increase their accumulated cost statistic and receive a greater allocation of A&G costs.[54] What CMS has prohibited, Kettering has done, but with a different approach. The B-2 instructions are clear that the A-8 adjustments are to be made for NAHE programs before the stepdown of indirect costs on Worksheets B Part I and II. From this, the Board can surmise that CMS does not allow providers to reverse the impact of revenue offsets on Worksheet B-1 in order to increase the A&G indirect costs for their NAHE programs.

In addition, the Board finds that the methodology Kettering used to allocate A&G costs to the Allied Health programs is not in compliance with the regulation at 42 C.F.R. § 413.85(d)(2)(ii) (2009), which states:

> A provider's total allowable educational costs are those costs incurred by the provider for trainee stipends, compensation of teachers, and other costs of the activities as determined under the Medicare cost-finding principles in § 413.24. These costs do not include patient care costs, costs incurred by a related organization, or costs that constitute a redistribution of costs from an educational institution to a provider or costs that have been or are currently being provided through community support.

The allowable costs do not include related party, or any costs, that cannot be directly related to the support of the allied health program. This excludes several the costs that are grouped to the A&G cost areas that Kettering attempts to include in Allied Health through the Worksheet B step down process on the cost report.

In this regard, the Board notes that on schedule A-8-1[55] Kettering has included $27.9 million of home office costs in A&G.[56] At the hearing, and in the post-hearing brief, Kettering argues that "the Provider and the home office are 'the same party' because the home office and the Provider 'are all one legal entity, so technically it's *the* party, not a related party.'"[57] Therefore, Kettering maintains that the $27.9 million does not meet the definition of "costs incurred by a related organization."[58] Kettering contends that a "related organization" is not defined in the Medicare regulations and that "no reasonable interpretation would find that the same legal entity could be a related party to itself."[59]

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[54] Worksheet B-1 contains the statistic to allocate the costs on Worksheet B Part I and II. When Kettering adds back the tuition and room and board revenue offset on Worksheet B-1 they are increasing the accumulated cost statistic used to allocate the A&G expenses on Worksheet B, Parts I and II.
[55] *See* Exhibit C-2 at 10.
[56] The home office costs on Schedule A-8-1 flow to A-8 and to Worksheet A, Column 6. Of the total $56,778,931 in A&G costs reported on Worksheet A (*id.* at 3, Line 6.01), the home office is 49.21 percent of the total.
[57] Provider's PHB at 6 (quoting Tr. at 81 (emphasis in quote)).
[58] 42 C.F.R. § 413.85(d)(2)(ii).
[59] Provider's PHB at 7.

The Board disagrees. First, the regulations do define organizations related *to the provider* as follows at 42 C.F.R. § 413.17(b):

> (b) *Definitions*—(1) *Related to the* ***provider***. Related to the provider means that **the provider** to a significant extent is associated or affiliated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.[60]

Here, Kettering (*i.e.*, the hospital organization participating in the Medicare program) is the "provider" and it is apparently housed within the same corporate entity as Kettering's home office whose costs must be apportioned between multiple Medicare-participating providers and/or other health care-related organizations (whether in the same entity or not). For Medicare program purposes, the costs associated with the Kettering hospital are treated separately and distinct from the home office (*e.g.*, costs are reported separately) and the related organization rules apply.[61] This is borne out in the cost report at issue. Review of the filed cost report at Exhibit C-2 describes Part A of Worksheet A-8-1 as "Costs Incurred and Adjustments Required as a Result of Transactions with Related Organizations or the Claiming of Home Office Costs."[62] This worksheet, as filed, indicates that $27.9 million of A&G expenses are being added to the cost report. These expenses are not on Kettering's trial balance of expense, as there is $0 amount in Column 5.[63] Thus, this is additional expense. Further, Part B of the worksheet states "Interrelationship to Related Organization(s) and/or Home Office: The Secretary, by virtue of authority granted under Section 1814(b)(1) of the Social Security Act, ***requires*** *that you furnish the information requested under Part B of this Worksheet.*"[64] A symbol must be reported for each related organization(s) and/or home office, accordingly. The worksheet states "Use the following symbols to indicate interrelationship to related organizations."[65] Descriptions are given for each symbol. Kettering indicated that Kettering Adventist had 100 percent ownership of Kettering and was in the business of "Healthcare." Kettering also assigned this organization a symbol of "B." The filed cost report form describes symbol "B" as "Corporation, Partnership or other organization has financial interest in provider."[66] Kettering filed this cost report using Worksheet A-8-1, which is specifically for related organizations or home office allocations. It identified the costs as coming from Kettering Adventist which Kettering identified on its filed cost report as a 100 percent owner of the hospital provider (*i.e.*, the part of the organization enrolled in the Medicare program as a hospital and to which a provider number is assigned), and filed the symbol which indicates that Kettering Adventist had a financial interest in the hospital provider. All of this information, as filed by Kettering, indicates this is a related organization. It is not possible to then argue that the costs are not related organization costs in order to allow additional allocation to the Allied Health programs.

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[60] *See also* PRM 15-1, Ch. 10 (entitled "Cost to Related Organizations") (bold and underline emphasis added).
[61] Other scenarios where this occurs includes situations where more than one hospital (whether a subsection (d) IPPS hospital or specialty hospital such an LTCH or IRF) are housed in the same corporate entity as the home office which serves multiple hospitals. The accounting for each of entities participating in the Medicare program have to be tracked separately notwithstanding the fact they may be in the same corporate entity.
[62] Exhibit C-2 at 10.
[63] *Id.*
[64] *Id.* (emphasis added).
[65] *Id.*
[66] *Id.*

In addition, Kettering argues that A&G costs other than related parties as contained in the A&G cost center are directly related to the Allied Health programs. In support, Kettering quotes the following excerpt from the final rule published on September 22, 1992 which is entitled "Medicare Program; Payment for Nursing and Allied Health Education" ("1992 Final Rule"):

> We are also clarifying the definition of net costs in the proposed regulations to indicate that "total costs" was intended to include only direct *and indirect costs* incurred by the provider that are *directly attributable to the operation of an approved education activity*. Such costs do not include usual patient costs that would be incurred in the absence of the education activity, such as the salary costs for nursing supervisor who oversee the floor nurses and student nurses. Moreover, we believe that such costs do not include costs incurred by a related organization.[67]

Kettering states that "[t]he Secretary's rulemaking is clear whether or not a cost is 'directly related to an approved education activity' is not determined by whether the cost was directly or indirectly incurred by the Provider but rather whether it is directly attributable to an approved educational activity."[68] Kettering goes on to state "the costs at issue are [A&G] costs that were indirectly incurred by [Kettering] but which were utilized and directly attributable to [Kettering's] approved educational activities. These [A&G] costs were directly utilized by [Kettering] in order to benefit, facilitate, and enrich its Allied Health Programs."[69] Kettering's definition of direct costs is very broad and appears to argue that ***any*** department with the remotest connection to Allied Health can be included in the A&G allocation.

The Board disagrees with Kettering's definition of direct costs and, in support, notes that the 1992 Final Rule states that:

> . . . [T]otal costs was intended to include only direct and indirect costs incurred by a provider that are ***directly*** *attributable* to the operation of an approved educational activity. Such costs do not include usual patient care costs that would be incurred in the absence of the educational activity[.][70]

At the hearing, the Board questioned Kettering's witness on a number of cost centers to determine how they were related to patient care versus the Allied Health Programs. One such cost center was Infection Control and Kettering stated they are setting up policies and procedures for the entire hospital, such as hand washing, and which would benefit every department of the hospital.[71] The test to determine whether a cost is "directly attributable" to the operation of the Allied Health Programs is not that the policies relate somewhat to the Allied Health Programs,

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[67] Provider's PHB at 5 (quoting 57 Fed. Reg. 43659, 43668 (Sept. 22, 1992) (emphasis in quote)).
[68] *Id.*
[69] *Id.*
[70] 57 Fed. Reg. at 43668 (emphasis added.)
[71] Tr. at 78.

but would the Infection Control department be impacted (costs decrease) if the Allied Health Programs did not exist. The general policies related to the hospital such as hand washing would exist with or without the Allied Health Programs. However, the enforcement of the policies may require more employees and cost as it relates to the Allied Health Programs. As a result, in this instance, it is difficult to know, without additional information, if Infection Control is directly related to the Allied Health Program.

Patient Access is another cost center on which the Board questioned Kettering's witness.[72] Patient Access is involved with front-end admissions and, as a result, the admitting of a patient would not appear to be directly related to the Allied Health Programs. Patients would need to be admitted with or without the Allied Health Program.

In addition, at the hearing, Kettering's witness explained that hospital A&G costs "would include administration costs, billings, malpractice insurance, purchasing, information technology, patient accounting, business development."[73] Based solely on this description, there are several items that are not directly related to the operation of an Allied Health Program such as patient accounting which would still occur whether or not the hospital trained allied health students. Similarly, billings and malpractice insurance are related to physicians and patient care, not educational goals. Business development relates to the business of patient care, not the Allied Health Programs. All of these costs would be contrary to the Secretary's intent of requiring allowable costs be "***directly*** *attributable* to the operation of an approved education activity."[74] The Board also notes that, at the hearing, Kettering was not able to provide concrete answers related to the Board's inquiry into the function of several departments grouped to the A&G cost center.[75] In order to allocate any A&G costs to the Allied Health Program the Board finds that Kettering would need to have a complete understanding of how the department directly impacts the operation of the Allied Health Program in accordance with 42 C.F.R. § 413.85. The Board finds that Kettering has failed to meet its burden of proof and Kettering's overly broad definition of what A&G costs can be allocated to Allied Health does not conform to the regulations.

Kettering also argues that the Medicare Contractor's handling was "arbitrary and . . . did not meet notice and comment rulemaking."[76] However, the Medicare Contractor's arguments are a reasonable interpretation of 42 C.F.R. § 413.85(d), which is also cited by Kettering as the governing regulation. Similarly, Kettering argued that "there are other types of hospitals making similar types of adjustments as those at issue in this appeal."[77] However, the fact that a Medicare Contractor may have previously accepted a different handling, or moreover, that other Medicare Contractors may accept a different handling does not make that CMS policy. The Board notes that the D.C. Circuit has confirmed that substantive Medicare reimbursement policy can be adopted by case-by-case adjudication.[78] This is different than the situation discussed by the Supreme Court in *Allina*, where a *new* substantive reimbursement policy was announced and

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[72] *Id.* at 79-80.
[73] *Id.* at 51.
[74] 57 Fed. Reg. at 43668 (emphasis added).
[75] Tr. at 78-81.
[76] Provider's PHB at 16.
[77] *Id.* at 17.
[78] *See, e.g., Catholic Health Initiatives Iowa Corp. v. Sebelius*, 718 F.3d 914 (D.C. Cir. 2013).

published on the CMS website and was applied nationwide to all hospitals at one time.[79] The fact that CMS may have directed the Medicare Contractor to handle Allied Health costs *in this particular case* (or even on a case-by-case basis, as presented to CMS) is not inconsistent with adopting a substantive policy through adjudication, and is different than the *Allina* situation where CMS posted publicly on its website a "nationwide" adoption of the new substantive policy. Accordingly, the Board rejects Kettering's *Allina* argument.

The Board finds that the method of cost finding used by Kettering is not described in cost report instructions or regulations, and is alternative to the step-down method required in the cost report instructions for Worksheet B-1.[80] Further, the Board finds that a large number of costs that are contained in the A&G cost center on the cost report are not *directly* related to the Allied Health Programs. The methodology used by Kettering allocates a greater portion of A&G costs to the Allied Health/Paramedical Education programs than the regulation allows, and there are no cost report instructions or regulations that permit reversing Worksheet A-8 offsets prior to the step-down method of cost finding. Accordingly, the Board finds that the Medicare Contractor's Audit Adjustment No. 26 to remove the protested amount at issue for FY 2009 was proper.

DECISION AND ORDER:

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor's adjustment for FY 2009 to remove Kettering's protested item for the addition of Allied Health Program revenue to the accumulated cost allocation statistic was proper.

BOARD MEMBERS PARTICIPATING:

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FOR THE BOARD:

3/2/2022

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

[79] 139 S. Ct. 1804, 1808, 1810 (2019).
[80] CMS Pub. 15-2, § 3617. *See* Provider Exhibit P-4. *See also* 42 C.F.R. § 413.85(d)(2)(ii) (specifying that a provider's total allowable education costs "do not include costs that constitute a redistribution of costs from an education institution to a provider ***or*** costs that have been or are currently being provided through *community support*" as defined in subsection (c) (emphasis added)).