PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2024-D07

PROVIDER –
William Beaumont Hospital – Royal Oak

HEARING DATE –
August 25 - 27, 2021

Provider No. –
23-0130

Fiscal Year –
2013

vs.

MEDICARE CONTRACTOR –
WPS Government Health Administrators

Case No. –
18-1014

INDEX

ISSUE STATEMENTS

This case involves the following three issues for the fiscal year ending December 31, 2013 ("FY 2013"):

1. Whether the Medicare Contractor should have adjusted William Beaumont Hospital, Royal Oak's (hereinafter "Provider" or "Beaumont") nursing school passthrough costs, specifically Cohort Clinical Training.

2. Whether the Medicare Contractor should have adjusted the Provider's square footage attributable to nursing and allied health ("NAH") programs.

3. Whether the Medicare Contractor should have adjusted Beaumont's kidney acquisition costs.[1]

DECISIONS

After considering Medicare law, regulations and program guidance, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds as follows:

1. The Medicare Contractor properly disallowed all of Beaumont's pass-through costs reported for the cohort clinical nurse training program for FY 2013.

2. The Medicare Contractor properly removed square footage from the cost centers for the nursing allied health programs of Radiology, Nuclear Medicine, Radiation, Lab, and Pharmacy.

3. The Medicare Contractor's reclassification of conference and seminar expenses from the Kidney Acquisition cost center into the Administrative & General cost center was proper.

INTRODUCTION

Beaumont is a 1,070-bed acute care hospital located in Royal Oak, Michigan.[2] Beaumont is the site of clinical nurse training programs for several college and university nursing schools in the area that are not operated by Beaumont.[3] Beaumont's designated Medicare contractor[4] is WPS Government Health Administrators ("Medicare Contractor").

Federal regulations allow certain providers, like Beaumont, to claim pass-through reimbursement for training costs incurred for nurse training programs that they do not operate or sponsor.[5] Beaumont claimed pass-through reimbursement on its cost report for nurse training costs

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[1] Hearing Transcript ("Tr.") at 6 (Day 1, Aug. 25, 2021) (hereinafter "Tr. Day 1").
[2] Provider's Preliminary Position Paper at 3 (Oct. 30, 2018).
[3] *Id.* at 4.
[4] 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.
[5] 42 C.F.R. § 413.85(g).

incurred for FY 2013. The Medicare Contractor adjusted the nursing school pass-through costs, based on an audit finding of inadequate time studies, consistent with 42 C.F.R. § 413.85(h) and the Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1"), § 2313.2.[6] Specifically, the Medicare Contractor "reclassified the cost of 'Cohort Clinical Training' . . . from the Nursing School to the Adults & Pediatrics cost center, eliminating the pass-through cost reimbursement for this expense."[7] Beaumont contends that the Medicare Contractor "determined that the time studies should be performed by the nurses who provide the training and the time studies should be kept in accordance with guidance in [PRM 15-1, § 2313.2(E)]."[8] Beaumont appealed the reclassification and adjustment to the Board, which is described herein as Issue 1.[9]

In addition, the Medicare Contractor adjusted the square footage statistical allocation for several nursing allied health programs based on audit findings "[p]er 42 C.F.R. § 413.85(d)(2) and [the] January 12, 2001 Federal Register."[10] Specifically, the Medicare Contractor reclassified square footage that Beaumont had "allocated to the following [nursing and] allied health ("NAH") programs: Radiology, Nuclear Medicine, Radiation, Lab, and Pharmacy."[11] The Medicare Contractor's auditor, "after investigating an increase in indirect costs from the prior period, determined the Provider claimed square footage statistics for the first time in the [NAH cost centers] based on a percentage of training time the students spent in ancillary areas."[12] The Medicare Contractor's Final Position Paper notes that "[t]he auditor removed the square footage from the NAH Radiology, NAH Nuclear Medicine, NAH Radiation, NAH Lab, and NAH Pharmacy cost centers because the square feet statistics were calculated on an percent to total cost method and were not dedicated to the specific NAH cost centers."[13] Beaumont appealed this removal and asserted that "[t]here were employees and space within Beaumont Royal Oak hospital designated to these programs, . . . space for the instructors, students, classrooms, [and] equipment needed for training."[14] This issue is described herein as Issue 2.

Finally, the Medicare Contractor reclassified what were determined to be non-allowable organ expenses, out of the Kidney Acquisition cost center and into the Administrative and General ("A&G") cost center based on audit findings per 42 C.F.R. § 413.24.[15] Beaumont described these expenses as "conference and seminar expenses related to the kidney acquisition cost

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[6] Exhibit C-1 at 11.
[7] Provider's Preliminary Position Paper at 5.
[8] Provider's Appeal Request – Issue Statement (Issue A).
[9] The Provider initially included arguments regarding the $50,000 amount that Beaumont claimed per year as incremental costs for administrative and clerical support staff whose function it was to coordinate rotations with the nursing schools and to schedule the clinical rotation for each nursing student. *See* Provider's Final Position Paper at 8-9 (May 26, 2021). However, Beaumont *accepted* the Medicare Contractor's representation that it, in fact, received this amount in reimbursement and therefore, this amount is ***not*** at issue in this appeal. *See* Provider's Post-Hearing Brief at 23-24 (Nov. 29, 2021).
[10] Provider's Appeal Request at Issue Statement (Issue B); *id*. at Audit Adjustment Report, Audit Adjustment No. 27/Ref. No. 29.
[11] Provider's Preliminary Position Paper at 7.
[12] Medicare Contractor's Final Position Paper at 13 (June 25, 2021).
[13] *Id.* Exhibit C-4.
[14] Provider's Appeal Request at Issue Statement (Issue B).
[15] *Id.* at Audit Adjustment Report, Audit Adjustment No. 24/Ref. No. 38.

centers"[16] and maintains they should be reported in the Kidney Acquisition cost center pursuant to PRM 15-1 § 2307.[17] This issue is described herein as Issue 3.

The Board held a video hearing on August 25-27, 2021. Thomas Schehr, Esq. of Dykema Gossett, PLLC, represented Beaumont. Joseph Bauers, Esq. of Federal Specialized Services ("FSS") represented the Medicare Contractor. On November 29, 2021, both parties submitted post-hearing briefs, and the record is now closed.

STATEMENTS OF FACTS AND RELEVANT LAW

A. Issue 1: Cohort Clinical Nurse Training Program

This is not the first time that Beaumont has appeared before the Board on the issue of pass-through costs reported for clinical nurse training programs. On June 3, 2016, the Board issued a decision involving FYs 2005 and 2006 (significantly 7 years *prior to* the year at issue here) and found that "[t]he Medicare Contractor improperly disallowed all of Beaumont's pass-through reimbursement for the incremental clinical nurses training costs . . . for FYs 2005 and 2006 [the audit was in 2010]."[18] Those costs were for "both cohort and preceptor clinical training, [which was provided] to more than a thousand nursing students per year."[19] The "cohort" training was described as clinical training at the junior level where the nursing school has an instructor on site and in the nursing unit to assist with the clinical training process. The "preceptor" training was described as clinical training at the senior level where individual nursing students are paired with nursing staff for one-on-one training while the nurse is performing rounds on the unit.[20]

In that decision, the Board emphasized that there was no regulatory "requirement that a provider document allowable clinical training costs *through time studies* . . . [and that] the first time the Medicare Contractor requested *time studies* from Beaumont was in 2010, well after the close of [FYs 2005 and 2006]."[21] For these reasons, the Board found it "unreasonable for the Medicare Contractor to require Beaumont to have time studies for [FYs] 2005 and 2006 and not accept *alternative* documentation [of that training time] in support of its clinical training costs."[22] Through testimony and other evidence in the record, the Board found that Beaumont "submitted adequate documentation that [was] auditable to support the incremental clinical training costs that it incurred for FYs 2005 and 2006."[23] The Board used this alternative documentation of

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[16] Provider's Final Position Paper at 14.
[17] Provider's Appeal Request at Issue Statement (Issue C).
[18] Exhibit P-1 at 2 (copy of PRRB Dec. 2016-D12 (June 3, 2016)). The Board's decision was reversed by the Administrator, and then the United States District Court for the Eastern District of Michigan upheld the Board's decision. The parties agreed to a reimbursement amount of $3 million for not only these two FYs, but also FYs 2007-2009 (i.e., the years prior to the Medicare Contractor requesting time studies from Beaumont). *See* Provider's Final Position Paper at 1-2.
[19] Provider's Final Position Paper at 3. The instant case for FY 2013 involves only cohort clinical training. The Medicare Contractor approved Beaumont's claimed reimbursement for preceptor clinical training in FY 2013.
[20] Hearing Transcript at 45-46 (August 25, 2021).
[21] Exhibit P-1 at 4 (emphasis added).
[22] *Id.* (emphasis added).
[23] *Id* at 4-5.

training time in conjunction with documentation of the other factors needed to determine the incremental clinical training costs.[24]

That documentation of the other factors included student roster schedules that established the number of students during FYs 2005 and 2006, as well as the hours that those students spent at Beaumont for clinical training during those FYs; testimony of the employee responsible for maintaining those student roster schedules to confirm that they were a routine business record contemporaneously created and maintained by Beaumont during the ordinary course of business, and that Beaumont established this practice prior to FY 2005; pay scales from the Human Resources Department for nurses with 3 to 5 years of experience who train cohorts and nurses with 10 or more years of experience who train preceptors. In addition, Beaumont established through testimony and affidavits that 1.5 hours was the average time per 8-hour day that the nurse instructor spent providing clinical training to each nursing student during FYs 2005 and 2006, and that the record reflected that these figures were conservative.[25] The Board found that these figures (number of students, nurse salary, and number of hours per day nurses spent training) could be used to calculate Beaumont's incremental clinical training costs during FYs 2005 and 2006, and directed the Medicare Contractor to pay these calculated costs.[26]

The Board also held two consolidated hearings on the issue of whether Beaumont was entitled to pass-through clinical nurse training costs for FYs 2007, 2008 and 2009.[27] Because Beaumont was not yet aware of the requirement for time studies *during this period of time*, these cases were considered together with the cases involving FYs 2005 and 2006, and the parties agreed to a reimbursement amount to resolve the pass-through reimbursement claims related to nurse clinical training costs for all five FYs (2005-2009).[28] Accordingly, while the Board held a hearing for FYs 2007, 2008 and 2009, the Board never issued a decision and never made any findings for FYs 2007, 2008, and 2009. Rather, on August 17, 2020, the parties entered into the Settlement Agreement that is marked Exhibit P-3, and Beaumont withdrew its appeals for FYs 2007, 2008, and 2009.

During calendar year 2010, Beaumont started maintaining time studies, as a result of the Medicare Contractor's request for them during the FY 2005-2006 audit which was performed during 2010, and has continued to maintain them through the fiscal year at issue, FY 2013. For FYs 2011 and 2012, the Medicare Contractor provided full reimbursement to Beaumont, with FY 2012 having been audited by the Medicare Contractor.[29] Then, during 2017, following an audit, the Medicare Contractor informed Beaumont that its time studies for FY 2013 were inadequate and denied Beaumont its claimed reimbursement amount of $887,204 for its incremental cohort clinical nurse training costs in FY 2013.[30]

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[24] *Id.*
[25] *Id.* at 5. For example, *id.* at 5 n.18 (citations omitted) notes that "[t]he 1.5 hours of clinical training by nurses during a student day for FYs 2005 and 2006 is conservative as supported by the testimony of Barbara Juliano and demonstrated by the fact that 1.5 hours of the 8 hour day (19%) is below the percentage of time (22 to 25 percent) reported based on time studies for 2010, 2011 and 2012."
[26] *Id.*at 5.
[27] *See* Exhibits P-16, P-17 (hearing transcripts dated June 2, 2017 and August 1, 2017).
[28] Exhibit P-3 (copy of Settlement Agreement dated August 17, 2020).
[29] Provider's Final Position Paper at 2.
[30] *Id.*

The instant case involves the pass-through, incremental cohort clinical nurse training costs for FY 2013. The Medicare Contractor "agrees that the Provider qualifies for pass-through treatment for its *documented* incremental cohort clinical training costs under 42 C.F.R. § 413.85(g)."[31] However, the Medicare Contractor "asserts that the Provider has not *documented* the ***incremental*** cohort clinical training cost as claimed on the [Provider's] as-filed cost report,"[32] and contends that the time studies performed during FY 2013 to support the amount being claimed for those costs did not meet program requirements, are inadequate and unreliable, and that the information submitted is not capable of being audited.[33]

As noted in the Federal Fiscal Year ("FFY") 2011 Inpatient Prospective Payment System ("IPPS") Final Rule:

> Medicare has historically paid providers for the program's share of the costs that providers incur in connection with approved educational activities, which can be divided into three categories: (1) The costs of approved GME programs in medicine, osteopathy, dentistry and podiatry; (2) approved nursing and allied health education activities operated by a provider; and (3) all other costs that can be categorized as educational programs and activities that are considered to be part of normal operating costs.[34]

Federal law authorizes *limited* payment for nonprovider-operated nurses' training programs, provided that: (1) the hospital claimed and was reimbursed for these costs "during the most recent cost reporting period that ended on or before October 1, 1989"; and (2) "the percentage of total allowable provider cost attributable to allowable clinical training cost does not exceed the percentage of total cost for clinical training in the provider's most recent cost reporting period ending on or before October 1, 1989."[35]

The definition of *allowable* clinical training costs was discussed in the 2001 Federal Rule on Medicare Payment for Nursing and Allied Health Education, as follows:

> Section 4004(b)(1) of Public Law 101-508 also required that we define allowable clinical training costs under this provision for payment for certain nonprovider-operated programs. At 57 FR 43667 in the September 22, 1992 proposed rule, we proposed to define these costs *as the* ***incremental costs*** *that,* ***in the absence of the students,*** *would* ***not*** *be incurred by the provider.* These incremental costs would include the costs of clinical instructors and administrative and clerical support staff whose function is

[31] Medicare Contractor's Post-Hearing Brief at 3 (Nov. 29, 2021).
[32] *Id.* (emphasis added).
[33] *Id.* at 4-15.
[34] 75 Fed. Reg. 50042, 50299 (Aug. 16, 2010).
[35] 42 C.F.R. § 413.85(g)(2)(ii)-(iii). *See also* Omnibus Budget Reconciliation Act of 1990, P.L. 101-508, § 4004(b), 104 Stat. 1388, 1388-39 (1990).

> to coordinate rotations with a nursing school and to schedule clinical rotation for each student nurse. They would not, however, include the costs of a charge or floor supervisor nurse who may spend a portion of his or her time supervising student nurses but who, in the absence of the students, would still have to be employed by the provider. In general, these costs are payroll and related salary costs. Although some provider-incurred overhead costs directly related to the cost of the students would be allowable, overhead costs incurred by the related organization generally would not be considered allowable.[36]

The FFY 2011 IPPS Final Rule clarified that:

> Costs of approved nursing and allied health education programs that are operated by a provider are excluded from the definition of inpatient hospital operating costs and are not included in the calculation of the payment rates for hospitals paid under the IPPS or in the calculation of the payments to hospitals and hospital units excluded from the IPPS. These costs are separately identified and "passed through" (that is, paid separately on a reasonable cost basis) . . . . [B]oth inpatient and outpatient training costs are allowable for pass-through payment. . . . However, costs of training activities occurring in areas of the hospital other than the IPPS or OPPS areas or in nonprovider settings are not allowed for pass-through payment.[37]

The regulation pertaining to nursing and allied health education program costs are located at 42 C.F.R. § 413.85 (2013) which provides, in pertinent part, as follows:

> **§ 413.85 Cost of approved nursing and allied health education activities.**
>
> (a) *Statutory basis.* This section implements section 1861(v)(1)(A) of the Act and section 4004(b) of the Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) by establishing the methodology for Medicare payment of the costs of approved nursing and allied health education activities.
>
> (b) *Scope.* (1) This section sets forth the rules for determining Medicare payments to hospitals for the costs of nursing and allied health education activities.
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> ****

[36] 66 Fed. Reg. at 3368-3369 (Jan. 12, 2001) (emphasis added).
[37] 75 Fed. Reg. at 50299.

(3) The rules under this section do not apply to activities that are specified in paragraph (h) of this section and identified as normal operating costs.

(c) *Definitions*. For purposes of this section, the following definitions apply:

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Classroom instruction costs are those costs associated with formal, didactic instruction on a specific topic or subject in a class that meets at regular, scheduled intervals over a specific time period (for example, semester or quarter), and for which a student receives a grade.

Clinical training costs means costs of training for the acquisition and use of the skills of a nursing or allied health profession or trade in the actual environment in which these skills will be used by the student upon graduation. Clinical training may involve occasional or periodic meetings to discuss or analyze cases, critique performance, or discuss specific skills or techniques; it involves no classroom instruction.

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 §§413.75 through 413.83, are not allowable costs in subsequent fiscal years.

(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) Enhance the quality of health 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.

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(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.

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

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(g) *Payment for certain nonprovider-operated programs*—(1) *Payment rule.* Costs incurred by a provider, or by an educational institution that is related to the provider by common ownership or control (that is, a related organization as defined in § 413.17(b)), for the clinical training of students enrolled in an approved nursing or allied health education program that is not operated by the provider, are paid on a reasonable cost basis if the conditions specified in paragraph (g)(2) of this section are met.

(2) *Criteria for identification of nonprovider-operated education programs.* Payment for the incurred costs of educational activities identified in paragraph (g)(1) of this section will be made if the following conditions are met:

(i) The clinical training must occur on the premises of the provider, that is, in the hospital itself or in the physical area immediately adjacent to the provider's main buildings, or in other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings.

(ii) The provider must have claimed and been paid for clinical training costs on a reasonable cost basis during the most recent cost reporting period that ended on or before October 1, 1989. This condition is met if a notice of program reimbursement (NPR) was issued for that cost reporting period by November 5, 1990, and the clinical training costs were included as pass-through costs. If an NPR was not issued by that date, or an NPR was issued but did not treat the clinical training costs as pass-through costs, the condition is met if –

(A) The contractor included the clinical training costs in the allowable costs used to determine the interim rate for the most recent cost reporting period ending on or before October 1, 1989; or

(B) The provider claimed the clinical training costs as pass-through costs when the cost report for the most recent cost reporting period ending on or before October 1, 1989, was initially submitted.

(iii) In any cost reporting period, the percentage of total allowable provider cost attributable to allowable clinical training cost does not exceed the percentage of total cost for clinical training in the provider's most recent cost reporting period ending on or before October 1, 1989.

(iv) The students in the educational program must provide a benefit to the provider through the provision of clinical services to patients of the provider.

(v) The clinical training costs must be incurred by the provider or by an educational institution related to the provider by common control or ownership as defined in § 413.17(b) ("*Cost to related organizations.*") Costs incurred by a third-party, regardless of its relationship to either the provider or the educational institution, are not allowed.

(vi) The costs incurred by a provider does not exceed the costs the provider would have incurred if it was the sole operator of the program.

****

(h) *Cost of educational activities treated as normal operating costs.* The costs of the following educational activities incurred by a provider but not operated by that provider are recognized only as normal operating costs and paid in accordance with the reimbursement principles specified in Part 412 of this subchapter. They include:

(1) Orientation and on-the-job training.

(2) Part-time education for bona fide full-time employees at properly accredited academic or technical institutions (including other providers) devoted to undergraduate or graduate work.

(3) Educational seminars, workshops, and continuing education programs in which the employees or trainees participate that enhance the quality of medical care or operating efficiency of the provider and, effective October 1, 2003, do not lead to the ability to practice and begin employment in a nursing or allied health specialty.

(4) Maintenance of a medical library.

(5) Training of a patient or patient's family in the use of medical appliances or other treatments.

(6) Except as provided in paragraph (g) of this section, clinical training and classroom instruction of students enrolled in an educational program that is not operated by the provider. The following are clinical training and classroom instruction costs that are allowable as normal operating costs:

(i) Costs incurred in the clinical training of students, including the clinical training or clerkship of undergraduate medical school students that takes place in a provider.

(ii) Classroom instruction costs incurred by a provider that meet the following criteria:

(A) The provider's support does not constitute a redistribution of nonprovider costs to the provider. The support must be in addition to the costs already being incurred by the nonprovider-operated program. If the nonprovider entity reduces its costs due to receiving provider support, this reduction constitutes a redistribution of costs from an educational institution to a patient care institution and is a nonallowable provider cost.

(B) The provider receives a benefit for the support it furnishes.

(C) The cost of the provider's support is less than the cost the provider would incur were it to operate the program.

> (7) Other activities that do not involve the actual operation of an approved educational program.[38]

As stated above, only the pass-through costs that Beaumont reported for the cohort clinical nurse training is at issue in this appeal. Significantly, subsection (c) of this regulation defines the term "[c]*linical training costs*" as "costs of training for the acquisition and use of the skills of a nursing or allied health profession or trade *in the actual environment* in which these skills will be used by the student upon graduation. Clinical training may involve *occasional* ***or*** *periodic* meetings to discuss or analyze cases, critique performance, or discuss specific skills or techniques; ***it involves no classroom instruction***."[39] Consistent with this definition, PRM 15-2, § 4013 defines clinical training as "involving the acquisition and use of the skills of a nursing or allied health profession or trade in the actual environment in which these skills will be used by the student upon graduation. While it may involve occasional or periodic meetings to discuss or analyze cases, critique performance, or discuss specific skills or techniques, *it involves no classroom instruction*."[40]

Beaumont describes its cohort clinical training as follows:

> Cohort training is for lower level undergraduate nursing students. In the cohort program, a university-based faculty member brings approximately eight to nine students to Beaumont for clinical rotation on a unit, and the faculty member remains on the unit with the students. . . . the nursing school faculty member works with the students intermittently throughout the day, but the students spend the vast majority of the time with Beaumont's hospital-based instructors . . . . the nursing student "shadows" the Beaumont nurse. *The nurse attends to and treats patients while <u>simultaneously</u> explaining to the student the duties being performed and how to perform them*. . . . there is indisputably ***an incremental cost*** *in <u>simultaneously</u> providing patient care and teaching*, *because everything takes longer* when the nurse is providing clinical training."[41]

To support the *incremental* costs claimed on its as-filed FY 2013 cost report for the cohort clinical training program, Beaumont submitted to the Medicare Contractor 46 time studies for FY 2013.[42] The time studies consist of pre-printed forms on which students fill in the following information:

- the date;
- the hospital unit on which they were trained;

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[38] (Bold and italics emphasis in original and underline emphasis added.)
[39] (Emphasis added.)
[40] PRM 15-2 § 4013 (emphasis added) (addressing Worksheet A, lines 20 and 23 and the instructions also refer to 42 C.F.R. § 413.85(c)).
[41] Provider's Final Position Paper at 5 (May 26, 2021) (emphasis added).
[42] Exhibit P-11B.

- start and end times of their shift, the pre-conference, lunch, and post-conference sections of the day;
- the Beaumont training nurse's name;
- the school instructor's name;
- the college or university at which the nursing student is attending;
- their year in school; and
- the period of time that they categorize as observation and/or teaching.[43]

In addition to time studies, Beaumont submitted what it described as the student rosters for *all* students who trained at Beaumont during the winter, summer, and fall terms of FY 2013 (497, 128, and 490 students respectively) which reflected that the students came from 13 different universities/college campuses.[44] Significantly, the 46 time studies submitted were only from 8 individual students for multiple dates and all of the 8 students who filled them out attended Wayne State University (only 1 of the 13 university/college campuses covered by the student rosters). However, even more important is the fact that, during the first day of the hearing, it came to light that ***none*** of the names of these 8 students associated with the 46 time studies is listed on the student roster for the relevant semester for FY 2013 for that university.[45]

However, on the second day of the hearing, August 26, 2021, Beaumont suddenly *supplemented the record* by submitting 7 ***newly-found*** time studies for students attending Madonna University and who were trained on a single day, April 6, 2013, in one unit of the hospital, the Mother-Baby unit.[46] The names of these 7 students are listed on the FY 2013 roster for that school. The Board allowed admission of these 7 newly-found time studies with the *caveat* that, based on the record before it, the Board would determine what weight/evidentiary value they are due (if any).[47]

On the second day of the hearing, Beaumont further suggested that it had been unable to find all of the FY 2013 time studies because the data tech employee responsible for maintaining them was unhappy with the organization and left Beaumont in unfavorable circumstances:

> MR. SCHEHR: Okay and to the best of your understanding, what happened in 2013 with respect to the collection and maintenance of the time studies?
>
> THE WITNESS: The data tech whose position was responsible for collecting, scanning, storing the time studies, we assume that maybe that didn't happen, or an error happened in scanning and storing, but we have been looking through years and years of documents, of scan

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[43] *Id.*
[44] Exhibit P-4B to P-4D; Tr. Day 1 at 199; Tr. at 158 (Day 2, Aug. 26, 2021) (hereinafter "Tr. Day 2"). The 13 university/college campuses listed in these Beaumont exhibits are: Baker College-Clinton Township; Baker-AH; Davenport University; Henry Ford Community College; Macomb Community College; Michigan State University; Madonna University; Oakland Community College; Oakland University; Rochester College; University of Detroit Mercy; Washtenaw Community College; and Wayne State University. *See also* Tr. Day 1 at 55.
[45] Exhibit P-4A to P-4D; Tr. Day 1 at 228-30.
[46] Exhibit P-19.
[47] Tr. Day 2 at 5-8.

> drives, of files, looking to see what happened to the 2013 time studies.
>
> MR. SCHEHR: Okay, and this data tech is no longer with the organization?
>
> THE WITNESS: He is no longer with Beaumont.
>
> MR. SCHEHR: Okay, and in fact the case that he left in 2013 or 2014.
>
> THE WITNESS: Yes, he did.
>
> MR. SCHEHR: Okay and was it under good or bad circumstances that he left.
>
> THE WITNESS: It was not favorable circumstances.
>
> MR. SCHEHR: Okay, and so to the best of your ability, have you searched for the time studies that were gathered in 2013?
>
> THE WITNESS: My office and it's specially challenging since last year and this year and COVID and the working from home and things like that, but my people, we've been pulling every folder, going through file cabinets, looking for either paper or going through the nurse step drive that looking for the scanned files to try to find anything we can related to 2000, dated in 2013. But that also entails going through 14's, 15's. I mean, we're looking to see if files could have been misplaced, or whatever, so it's taking us a long long time.
>
> MR. SCHEHR: Okay, in Exhibits [P-]11B and Exhibit [P-]19, are the universe of 2013 time studies that you've been able to locate?
>
> THE WITNESS: Yes.[48]

Thus, on the second day of the hearing, Beaumont now represented that Exhibit P-11B (the 46 time studies) plus Exhibit P-19 (the 7 then newly-found time studies) contains "the universe of [FY] 2013 time studies" that they had been able to locate after scouring company records.

Beaumont contends that, for FY 2013, it used the ***same*** methodology for calculating incremental cohort clinical training costs that was approved by the Board for FYs 2005-06 and approved by the Medicare Contractor for FY 2010-12.[49] Beaumont describes its methodology as follows:

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[48] Tr. Day 2 at 167-169.
[49] Provider's Final Position Paper at 5.

> To calculate reimbursement, Beaumont has calculated the incremental cost of its clinical instructors, which are allowed "payroll and related salary costs" per the Federal Register. The nursing school cost is calculated as follows:
>
> 1. Nursing students completed time studies when they were at Beaumont for clinical training. The time studies established that 44.37% of the nursing student's time at Beaumont was spent in training with Beaumont clinical nurses.
>
> 2. The nursing students spent 111,291 hours at Beaumont in 2013, which was computed based on the number of classes, number of students, and number of hours the students spent at Beaumont.
>
> 3. Based on items #1 and #2, Beaumont clinical nurses spent 49,379.86 hours on training the student nurses in 2013, multiplied by the average hourly rate of $31.71, for a total salary expense of $1,565,835.[50]

Beaumont further argues that the cohort clinical nursing trainer spent no less than 2 hours per day (per 8-hour shift) training nursing students: "The two-hour minimum time commitment is an *incremental* time commitment for a registered nurse when he or she acts as a clinical nurse trainer, [and it] did not change for 2013."[51] Tasks included "time spent by the registered nurse educating the student, answering the student's questions, and providing hands-on training such as changing dressings and applying feeding tubes."[52]

Beaumont further explained that cohort clinical training frequently causes registered nurses to work overtime (thereby causing Beaumont to pay these nurses overtime) in order to complete their regular responsibilities in addition to clinical training, and other registered nurses have to take on extra patients and tasks to assist the nurse providing the training. Beaumont asserts that the contemporaneous time studies from FYs 2010 to 2012 confirm the 2-hour per day calculation. The Medicare Contractor audited the time studies for FY 2012, and approved Beaumont's nursing school education costs for FY 2012.[53] Beaumont argues that "[n]othing has changed for [FY] 2013. Beaumont provided identical cohort training and used the same time studies that were approved following an audit in [FY] 2012."[54]

The Medicare Contractor argues that the 46 time studies submitted fail to meet *numerous* Medicare requirements for time studies detailed as follows at PRM 15-1, § 2313.2(E):

> E. Periodic Time Studies.—Periodic time studies, in lieu of ongoing time reports, may be used to allocate direct salary and

[50] *Id.* at 5-6 (citing to Exhibits P-4 (calculation) and P-5 (payroll)).
[51] *Id.* at 6.
[52] *Id.* at 6-7.
[53] *Id.* at 7.
[54] *Id.* at 8.

> wage costs. However, *the time studies used **must** meet the following criteria*:
>
> 1. The time records to be maintained must be specified in a written plan submitted to the intermediary no later than 90 days prior to the end of the cost reporting period to which the plan is to apply. The intermediary must respond in writing to the plan within 60 days from the date of receipt of the request, whether approving, modifying, or denying the plan.
>
> 2. *A **minimally acceptable** time study must encompass at least one full week per month of the cost reporting period*.
>
> 3. Each week selected must be a full work week (Monday to Friday, Monday to Saturday, or Sunday to Saturday).
>
> 4. The weeks selected must be equally distributed among the months in the cost reporting period, e.g., for a 12 month period, 3 of the 12 weeks in the study must be the first week beginning in the month, 3 weeks the 2nd week beginning in the month, 3 weeks the 3rd, and 3 weeks the fourth.
>
> 5. No two consecutive months may use the same week for the study, e.g., if the second week beginning in April is the study week for April, the weeks selected for March and May may not be the second week beginning in those months.
>
> 6. *The time study must be **contemporaneous** with the costs to be allocated. Thus, a time study conducted in the current cost reporting year may **not** be used to allocate the costs of prior or subsequent cost reporting years*.
>
> 7. The time study must be provider specific. Thus, chain organizations may not use a time study from one provider to allocate the costs of another provider or a time study of a sample group of providers to allocate the costs of all providers within the chain.
>
> The intermediary may require the use of different, or additional, weeks in the study in its response to the provider's request for approval and may prospectively require changes in the provider's request as applied to subsequent cost reporting periods.[55]

Specifically, the Medicare Contractor contends that the time sheets submitted are not compliant with these PRM requirements for the following reasons:

[55] (Underline emphasis in original and bold and italics emphasis added.)

> First, there is no evidence in the record that the provider submitted a detailed plan or that the [Medicare Contractor] approved the plan. Second, *the time studies do **not** encompass **at least one full week per month** of the cost reporting period*. In fact, none of the support indicates that even a single complete calendar week was included in the time study. Third, *the Provider did **not** include any time studies for the winter 2013 or summer 2013 semesters*. Fourth, the teaching percentage applied by the provider (67.40%) did not agree with the underlying time study detail.[56]

The Medicare contractor observed and communicated, in its management letter for FY 2013, dated July 18, 2017, that the nurses should complete the time studies rather than the students.[57] Specifically, the FY 2013 management letter communicated this observation as follows:

> **Observation #4:** The time studies used for the "Nursing School Cohort Teaching Costs" the provider is claiming is inappropriate, inadequate and unreasonable to meet the utilization of periodic time studies for cost finding purposes and therefore, these are not deemed acceptable time studies to allocate costs to determine the RN's direct teaching and supervision time spent with the School of Nursing Students (Cohort time), as they do not meet the requirements.
>
> **Recommendation:** The purpose of the time study is to determine an allocation percentage to apply to the salary and wage related costs for the RNs who are the ones actually engaged in both direct teaching and supervision activities for the Nursing School (Nursing School Cohort activities) and regular patient care activities throughout their work weeks. As such, *it would be the RNs who should be completing the time study form for the week*, as opposed to the Nursing School students completing the time study form for their week. An appropriate time study form for the RNs would show both the number of hours spent in their Nursing School Cohort activities and the number of hours spent in other regular patient care activities for each day of the work week. The time study form should be completed daily and then signed and dated by the RNs at the conclusion of their work week.
>
> Per [PRM] CMS 15-1 Section 2313.2[58]

The Medicare Contractor argues that, "[a]lthough the Provider maintains that a Beaumont data technician collects and analyzes the time data for accuracy and promptness, the [Medicare Contractor] doubts this occurred considering that 2 of the 46 records submitted included dates that

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[56] Medicare Contractor's Final Position Paper at 7-8 (emphasis added). *See also* Exhibit C-6.
[57] Medicare Contractor's Final Position Paper at 8. *See also* Exhibit C-2 (copy of the Medicare Contractor's July 18, 2017 management letter issued to Beaumont in connection the FY 2017 audit).
[58] Exhibit C-2, at 2 (emphasis added).

were not within the cost reporting period [at issue]."[59] Additionally, the Medicare Contractor notes that "observation and teaching times were ***not*** filled out in a *consistent* manner. For example, some students listed time in minutes, others in hours, and others listed the time of day spent completing the activity. Some students did not utilize the appropriate columns to report observation or direct teaching time."[60]

In addition, the Medicare Contractor points out that Beaumont has revised its claim for incremental costs at three different times, including in its final position paper. However, notwithstanding these changes, the claimed incremental costs still fail to agree with the time study detail submitted by Beaumont as exhibits with its position papers:

> The provider filed its cost report utilizing a Cohort teaching percentage of 67.40 [percent]. With the filing of the provider's preliminary position paper, the teaching percentage was revised to 43.74 [percent]. The provider's final paper revised the percentage again to 44.37 [percent]. Interestingly, the latest calculation still does not agree to the underlying time study source documents and does not apply a 50 [percent] reduction for observation time, as in prior calculations. Based on the time study detail, the [Medicare Contractor] contends the teaching percentage, if the time studies would have been otherwise acceptable, [which the Medicare Contractor contends they are not] calculated to 20.62 [percent]. After removing time studies [with] dates identified as being outside of the cost reporting period, the teaching percentage calculates to 20.08 [percent]."[61] In summary, the Medicare Contractor argues that the time study deficiencies noted above render a lack of auditable documentation and result in unreliable estimates, as illustrated here.[62]

The Medicare Contractor clarifies that the issue in this case is not whether the Provider has met the requirements to receive pass-through costs (since it is undisputed that the Provider is eligible to receive the pass-through costs at issue in accordance with the applicable regulatory authorities). Rather, the issue in this appeal is whether the Provider can support its claimed pass-through costs, and the Medicare Contractor asserts that the Provider did not submit adequate cost data, capable of being audited, for the reasons discussed above.[63]

The Medicare Contractor explains that the principle of adequate cost data and cost finding is defined at 42 C.F.R. § 413.24(a), which states "[p]roviders 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 Medicare Contractor further notes that the importance of submitting adequate data to support allowable costs is stated at 42 C.F.R.

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[59] Medicare Contractor's Final Position Paper at 8 (citing to Exhibit P-11B).
[60] *Id.* (emphasis added).
[61] *Id. See also* Exhibit C-6.
[62] *Id.* at 9.
[63] *Id.* at 10.

§ 413.24(c), as follows: "Adequate data capable of being audited is consistent with good business concepts and effective and efficient management of any organization. . . . It is a reasonable expectation on the part of any agency paying for services on a cost-reimbursement basis."[64]

B. Issue 2: Square Footage – Allied Health Programs

The Medicare statute at 42 U.S.C. § 1395x(v)(1)(A) defines the term "reasonable cost," in pertinent part, as:

> [T]he cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs . . . .

Reasonable costs of approved nursing and allied health educational activities are codified at 42 C.F.R. § 413.85. The determination of net cost for approved nursing and allied health programs is codified at 42 C.F.R. § 413.85(d)(2). Section 413.85(d)(2)(i) provides that "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." Section 413.85(d)(2) states in pertinent part:

> (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.[65]

During FY 2013, the Medicare Contractor recognized the Radiology, Nuclear Medicine, Radiation, Lab and Pharmacy programs as provider-operated nursing and allied health ("NAH") programs. Such programs are entitled to costs related to classroom training and clinical training.

The allied health programs (Radiology, Nuclear Medicine, Radiation, Lab and Pharmacy) "are contained organizationally within the ancillary departments bearing the same names."[66] The

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[64] *Id.* at 11.
[65] (Emphasis added.)
[66] Provider's Final Position Paper at 13.

faculty training the students are not teaching full time, as they are also performing patient care themselves. As a result, Beaumont contends that it may "allocate[] a portion of the departmental *square footage* using a ratio of the Allied Health program direct cost to the total direct cost of the department."[67] Beaumont maintains that it is appropriate that it be reimbursed for both the direct and *indirect* cost of the Allied Health training program. In support, Beaumont contends that "[s]pace cost, represented by *square footag*e, is a reasonable ***indirect*** cost *of that activity*"[68] and, in support, notes that the concept of "indirect costs" is generally recognized in 42 C.F.R. §§ 413.24(b)(1) and 413.24(d)(1).[69]

The regulation at 42 C.F.R. § 413.24(b)(1) defines "cost finding":

> Cost finding is the process of recasting the data derived from the accounts ordinarily kept by a provider to ascertain the costs of the various types of services furnished. It is the determination of these costs by the allocation of the direct costs, and *proration of the* ***indirect*** *costs*.[70]

The regulation at 42 C.F.R. § 413.24(d)(1) describes the "step down" method of cost allocation:

> This method recognizes that services furnished 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.

Beaumont argues that it complied with the relevant regulations, and requests that the Board reverse the Medicare Contractor's adjustment of the square footage.[71]

The Medicare Contractor asserts that Beaumont's "reclassification of square footage from ancillary areas to the NAH programs is incorrect *as these are normal operating costs*. The intent of allowing

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[67] *Id.* (emphasis added).
[68] *Id.*
[69] *Id.*
[70] (Emphasis added.)
[71] *Id.* at 14.

pass-through cost for training is only for the costs of operating these programs."[72] The Medicare Contractor argues that "[s]imply training students in the ancillary area does not, in and of itself, make a percentage of the area or any of the equipment used an allowable pass-through cost. *These areas would exist* ***regardless*** *of whether the provider had NAH programs* and nothing suggests the areas are larger because of additional equipment purchased specifically for the allied health programs."[73]

The Medicare Contractor explains that, "[a]s outlined in PRM 15-1, § 404.2, Costs of Approved Nursing and Paramedical Education Programs, provider-operated programs' allowable cost includes costs of classroom training and costs of clinical training."[74] The Medicare Contractor further notes that "[s]quare footage for classrooms and any dedicated administrative staff is allowed; however, space from the ancillary areas is not reclassified to the NAH cost centers because nursing students perform rotations through these areas."[75] The Medicare Contractor concludes that "the provider's method of using a percentage [of] total cost to allocate square feet from the ancillary areas is not allowed because it is placing normal operating costs in a pass-through cost center."[76]

C. Issue 3: Conference and Seminar Expenses - Kidney Acquisition Cost Center

For FY 2013, the Medicare Contractor notes that "[t]he auditor reviewed other expenses claimed in the kidney acquisition cost center. The reclassification of $7,455 related to seminars and conferences from the kidney acquisition cost center to the [Administrative and General ("A&G")] cost center is the subject of this issue."[77]

Beaumont maintains that it has met each of the relevant requirements of PRM 15-1, § 2307(A)[78] and, in support, notes that § 2307(A) states the following, in pertinent part:

> Direct assignment of cost is the process of assigning directly allocable costs of a general service cost center (see §2302.9) to all cost centers receiving service from that cost center based upon actual auditable usage. Hours worked by hourly wage or metered utility consumption are examples of measures of actual usage.
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> ****
>
> The direct assignment of costs must be made as part of the provider's accounting system with costs recorded in the ongoing normal accounting process. This means costs are to be recorded on a regular basis throughout the accounting period, not only as period ending adjusting entries. For example, if the costs being directly assigned are an element of payroll costs, the direct assignment should be recorded as often as all payroll costs are recorded (usually each pay period).

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[72] Medicare Contractor's Final Position Paper at 14.
[73] *Id*. (emphasis added).
[74] *Id.*
[75] *Id.* at 15.
[76] *Id.* at 14.
[77] Medicare Contractor's Final Position Paper at 19.
[78] Provider's Post-Hearing Brief at 28.

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>
> The following conditions ***must*** *be met* before Medicare will accept direct assignment for cost reporting purposes:
>
> 1. All costs within the general service cost center which can be directly allocated must be assigned to the benefiting cost centers as part of the provider's routine accounting process.
>
> 2. Any indirect supervision and residual costs remaining in the cost center together with any previously allocated overhead must be allocated through cost finding to all remaining benefiting cost centers.

Beaumont contends that the seminar and conference expenses at issue were properly assigned to the Kidney Acquisition cost center, and the other applicable hospital cost centers for which those seminars and conferences related. In support of its position, Beaumont explains its allocation process as follows:

> [S]eminar and conference expenses are direct costs of the employee's department, as opposed to "general service costs," [and] [i]t has been Beaumont's long-standing practice to directly assign seminar and conference expenses to the cost center of the employee(s) who attended. This is done through Beaumont's routine accounting process . . . . [a]ccount 82821 is used to record seminar and conference expenses. This account exists for each hospital department, as evidenced by the working trial balance…. Approval is required at both the departmental level and through Beaumont's accounting department to ensure that expenses are charged correctly . . . . if kidney acquisition seminar and conference expenses are reclassified to A&G, then seminars and conferences for all hospital cost centers must be reclassified to A&G for consistency.[79]

In disagreeing with Beaumont, the Medicare Contractor asserts that it appropriately reclassified the seminar and conference costs to the A&G cost center. The Medicare Contractor explains that the Kidney Acquisition cost center is a "special purpose cost center" for which only the types of costs identified at 42 C.F.R. § 412.100(b) are included and treated separately from the prospective payment rate for inpatient operating costs. This regulation states: "[e]xpenses recognized under this section include costs of acquiring a kidney, from a live donor or a cadaver, irrespective of whether the kidney was obtained by the hospital or through an organ procurement agency."

The Medicare Contractor emphasizes the phrase "costs of acquiring a kidney" and asserts that the regulation lists "eleven specific types of acquisition costs which qualify for this special treatment."[80] Seminar and conference expenses are *not* listed as one of them, and the Provider has not presented any evidence that would suggest that these costs fall within the regulation.

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[79] Provider's Final Position Paper at 14-15. *See also,* Provider's Post-Hearing Brief at 26-28 (Oct. 21, 2021).
[80] Medicare Contractor's Post-Hearing Brief at 17.

Therefore, the Medicare Contractor argues that the seminar and conference costs do not relate to *kidney acquisition costs* but rather to general transplant cost and were correctly reclassified from the Kidney Acquisition cost center to the A&G cost center.[81]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

As in all proceedings before the Board, Beaumont carries the "burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that [it] is entitled to relief on the merits of the matter at issue."[82] These burdens of proof and evidence are consistent with the Medicare statute at 42 U.S.C. § 1395g(a) which requires providers to submit information to support reimbursement requests and explicitly states that "no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider." Further, the regulations at 42 C.F.R. § 413.24(a), (c) explain that "[p]roviders receiving payment on the basis of reimbursable cost [the method at issue here], must provide adequate cost data" and that this cost data "must be based on [a provider's] financial and statistical records which must be capable of verification by qualified auditors" and be "capable of being audited."

A. Issue 1: Cohort Clinical Nurse Training Program

As discussed above, the Medicare Contractor contends that the primary issue with the *incremental* costs claimed for the cohort clinical training program is two-fold: (1) whether Beaumont has appropriately documented and supported these costs by a preponderance of the evidence, and (2) whether the cost data provided was adequate and capable of being audited. As stated above, pass-through treatment is available only for the *incremental* costs incurred because of the cohort clinical training. On review of the record, the Board finds that Beaumont has not met its burdens of proof and evidence and that the cost data, information, and documentation submitted by Beaumont are *not* adequate for determining the *incremental* costs associated with the cohort clinical training at Beaumont in FY 2013, and that the submitted evidence is *not* auditable as described below.

For FY 2013, on its as-filed cost report submitted on or about May 31, 2014,[83] Beaumont claimed incremental time for the cohort clinical nursing training of 67.4 percent of the total training time. Thereafter, in its preliminary position paper filed on October 30, 2018, Beaumont's position shifted *materially downward* by over 20 percentage points as it claimed only a percentage of 43.74 percent. In its final position paper filed on May 26, 2021, Beaumont once again adjusted its position slightly *upward* to a percentage of 44.37 percent.[84] Beaumont explains that the 44.37 percent of cohort clinical training time claimed for FY 2013 was based on the time studies kept by the nursing students.[85]

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[81] *Id.* at 17-18.
[82] 42 C.F.R. § 405.1871(a)(3).
[83] Cost reports are due 5 months after the close of the fiscal year unless an extension is granted by the Medicare contractor. 42 C.F.R. § 413.24(f)(2).
[84] Medicare Contractor's Final Position Paper at 9.
[85] Provider's Final Position Paper at 5.

In support of the amount claimed in its as-filed FY 2013 cost report, Beaumont included, with its final position paper, 46 time studies at Exhibit P-11B and the student rosters for FY 2013 at Exhibits P-4B, P-4C, and P-4D which covered 3 semesters – the winter, summer and fall semesters. Significantly, the 46 times studies only pertained to 7 students from one college/university (Wayne State University) during one semester (the fall semester). Comparison of the 7 students who completed the 46 time studies to the student rosters submitted reveals that ***none*** of them are listed on the FY 2013 student rosters.[86] This discrepancy raises immediate concerns about the accuracy and reliability of the FY 2013 student rosters and those concerns were not resolved at the hearing. At the hearing, Beaumont's witnesses did ***not*** have an explanation for this discrepancy and maintained that the rosters submitted were the "official" rosters of nursing students that trained at Beaumont.[87] The 7 students from these 46 time studies are purported to be from the 2013 fall semester, but are ***not*** listed on the "official" 2013 fall semester student roster.[88] However, rather than resolving the discrepancy, Beaumont's witnesses only raised further concerns[89] about the accuracy of the FY 2013 student rosters at Exhibits P-4B, P-4C, and P-4D as illustrated by the following testimony at the hearing:

1. The FY 2013 student rosters are data extracted from ACEMAPP[90] which "was not created to be a database" but rather to "maximize places by allowing efficiency in request and placement [of nursing students]."[91]

2. Beaumont did not enter the FY 2013 data extracted from ACEMAPP since Beaumont does not have any ACEMAPP editorial rights.[92] Rather, the FY 2013 extracted data was input in ACEMAPP by the relevant colleges and universities[93] and "the accuracy of that is completely dependent upon them and their students and the information they put it [*sic* in]."[94]

3. Unlike its current practice (*i.e.*, the practice it uses now), Beaumont did ***not*** *audit or reconcile* the FY 2013 ACEMAPP extraction to any Beaumont records.[95] In particular, the

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[86] *See* Exhibits P-4, P-11.
[87] Tr. Day 2 at 158.
[88] Exhibit P-4D.
[89] These concerns highlight why the Board is declining to accept the FY 2013 student roster.
[90] Tr. Day 2 at 146, 180, 231-36.
[91] Tr. Day 2 at 144-45. *See also id.* at 182 (the witness stating "[a]nd when I was saying before, the ACEMAPP *isn't technically a database collection system*. ACEMAPP's interest in having the capability to have any reports is to be able to say, in the state of Michigan, we had 1,000 ped's rotations available across the state in 2013. In 2014, 23 had 1,200, so – but *it's a very* ***rudimentary, elementary*** *type of data purpose*. Does that make -- so, so, this is absolutely all the university's information, but no, this is after the fact, after the rotation is completed. So, it is their information, but we have a communication between the request, and this being the final roster of the days, the hours, the start and end dates." (emphasis added)).
[92] Tr. Day 2 at 179, 231.
[93] Beaumont's witness acknowledged that FY 2013 student rosters is "data that is input by the colleges and universities" and claims that this entry is "done contemporaneous to the time of the students are in the program." Tr. Day 2 at 157-58. *See also id.* at 145-46.
[94] Tr. Day 2 at 179-80.
[95] Tr. Day 2 at 283-84. *See also id.* at 291 (the witness stating: "When we process the classes, we go through in – in this rudimentary way and we just add the number of classes at the end of the semester. We weren't doing the type of database we are now."); *id.* at 279 (In response to being asked whether the "raw data entered by the universities [is] audited by you or your department, the witness stated: "***Not*** *audited*, but it is seen as individual classes come to Beaumont." (emphasis added)); *id.* at 231 (In response to being asked whether the information on students and hours

hours listed on the FY 2013 student rosters appear to have been extracted from ACEMAPP (as entered by the college/university) and largely assumed to be correct.[96]

4. The FY 2013 student rosters are "incomplete."[97]

5. Beaumont's witness suggests that the FY 2013 student rosters were not created or maintained by Beaumont *during FY 2013* but rather Beaumont did not "pull[]" the FY 2013 student rosters from ACEMAPP until "years later than [20]13."[98]

6. The FY 2013 student rosters are the "source documents" for the full year summary at Exhibit P-4A.[99]

7. The departed data technician who Beaumont implies may have been responsible for Beaumont's inability to locate FY 2013 time studies also appears to have had the responsibility of "create[ing] and maintain[ing]" the FY 2013 student roster.[100]

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entered by the universities into ACEMAPP was being audited for FY 2013, the witness replied: "*We do **now***. We, what we do is compare anything that we have in our data base now, cause our data base is more robust, it's bigger, and – and ace map has advanced a lot, so it's easier to do, you know, like, audits of what they input." (emphasis added)).

[96] Beaumont's witness stated that "[t]he modification, the only modification that we really did, was we would take and double check the hours, which we even did back then, and then the number of students. . . . So what we did make sure is that every time the university requests a class, they always request eight. They never requests six or seven, because they never know what attrition is going to be. So they always request eight when they place a student. They may be actually only be seven, so what we did is, we always make sure we're recording the actual number of students that come, but *we **assume** the university is fulfilling the exact hours they're requesting*." Tr. Day 2 at 191-92 (emphasis added).

[97] In response to a question asking why none of the students who completed the 46 time studies for Wayne State University "are not captured on the [FY 2013 student] rosters," Beaumont's witness stated "I sure wish I could. I cannot explain it, *I just know that they're **incomplete***." Tr. Day 2 at 279. *See also id.* at 292 (stating "[s]o I know it's incomplete"). The Board recognizes that Beaumont's witness is asserting that she "believed" the student roster to represent the minimum number of students (*e.g.,* Tr. Day 2 at 300) but, given the totality of the concerns raised and conflicting testimony, it is unclear on what foundation that belief is based.

[98] Tr. Day 2 at 283-84 (the witness stating: "Back then we knew *approximately* the classes and, you know, it was all real time, *but we weren't looking to collect the data for the semesters, except at the end of, like, the year, and send them to Sue* [Liu, Beaumont's Director of Reimbursement]. This is how many classes we had, this is how many students, et cetera. ***The roster for ACEMAPP was pulled years later than '13***. And so when we look at -- when I'm looking at the roster and comparing it to the time studies, there's obviously more time studies that are -- that are -- time studies that are not reflected on the roster, and I can't account for that. But I would say since the time study -- study is there with the student's name and an accounting of time and a date, I would think that the time study and those -- those -- the time from these reflects students who actually were there. Do you know what I mean? But it's not reflected on the ACEMAPP report, and so we don't have a way to find these other students unless we find more time studies." (emphasis added)). *See also* Tr. Day 2 at 144 (the witness stating: "This particular 2013 ACE Cohort report [at Exhibit P-4B], we wanted to ACEMAPP the program and there's a reporting mechanism where you can pull information, and *so we had to go back*, ***this was not back in 2013***, *but we went into ACEMAPP* and pulled out what they showed as the data for our classes and rotations for those -- those three semesters for 2013." (emphasis added)).

[99] Tr. Day 2 at 143-44.

[100] Exhibit P-6 at 5-6 (The job description for the "Data Technician" states: "Affiliation Schools of Nursing Data Technician *will create and maintain* spreadsheets, graphs, reports, ***databases of students** from a variety of nursing schools **through ACE** and Beaumont systems* for undergraduate and graduate level nursing students for the Health System, and NP/PA students for Royal Oak.").

Thus, based on the record before it, the Board finds that it is not possible to know the exact number of students from these schools or the number of days the students were being trained at Beaumont, or even to verify the time studies completed. Accordingly, the record cannot support a Board finding that it reflects even the minimum number of students trained for FY 2013.[101] Consequently, the accuracy of both the student roster *and* the time studies submitted are suspect and have not been established as reliable. It is unclear if one, or both, of the documents is inaccurate, *i.e*., the time studies, and/or the student rosters. For these reasons, consistent with PRM 15-1, § 2313.2(E), the 46 time studies submitted for FY 2013 cannot be used to determine the *incremental* cost incurred for the cohort clinical training performed in FY 2013. Further, the student rosters, which are also used in the determination of student hours (number of students on roster x average hours per student) are also questionable and cannot be relied upon, resulting in multiple factors of the entire teaching time calculation being unconfirmed and questionable.[102] As this is the methodology accepted as part of the FY 2005 and 2006 appeals, it is also not possible for the Board to recommend again using that method in the current year. The methodology and associated data, which was represented as accurate and reasonable at that time, is now being called into question on several layers as a result of testimony from the Provider's own witness, as discussed above.[103]

Beaumont argues that the time study ***process*** was consistent with prior years. The Board disagrees and finds that it was not. Exhibit P-9 (also included as Exhibit C-7) indicates that there were only 5,235 minutes of "Total time student spent on the clinical unit" in their FY 2013 time studies (all from the Fall Semester of 2013).[104] However, on the same Exhibit, FY 2012 reflects 26,875 minutes of "Total time students spent on the clinical unit", reflecting 12,280 minutes in the Winter Semester of 2012 and 14,595 minutes in the Fall Semester of 2012. In FY 2011, there were time studies from all three semesters (Winter, Summer, and Fall), totaling 45,873 minutes.[105] The Board also notes that the "Percent of Time on Unit" in Exhibit C-7 ranges from 6 to 29 percent in various semesters from the Fall of 2009 through the Fall of 2012. Yet, for the single Fall semester in FY 2013, the provider is reporting a materially higher rate of 49 percent.[106] Clearly, the time studies provided for FY 2013 were ***not*** representative of all 3 semesters (as in 2011), nor did they cover a similar amount of time (FY 2013's 5,235 minutes is 19.5 percent of FY 2012's total time and only 11.4 percent of FY 2011's total time).

The FY 2013 time studies are also materially inconsistent with prior years in terms of the percentage of time calculated to be spent on the unit. While the time studies in prior years may have been similar, they appear to have been more representative than those provided for FY 2013. Indeed, the time study totals for FY 2010 on the same Exhibit reflected 138,525 minutes

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[101] Exhibits P-11B, P-4B/C/D.
[102] *See* Exhibits P-4A, P-4B.
[103] The Board further notes that *merits* of its decision for FYs 2005 and 2006 was never fully affirmed. Rather, the Administrator reversed the Board and, following remand from the District Court, the parties entered into the Settlement Agreement at Exhibit P-3 wherein the parties agreed that "[t]his Agreement does not constitute an admission of fact or law by either party and has no precedential effect." This is discussed *infra* in more detail in the section of the decision relating to the inapplicability of res judicata and collateral estoppel. *See also infra* note 151.
[104] Exhibit C-7.
[105] *Id.*
[106] *Id.*

in FY 2010, in 2 semesters.[107] FY 2013's total 5,235 minutes are less than 4 percent of the student time reported in FY 2010. It appears that each year's time studies are fewer than the preceding year, and are, thus, less likely to fully represent the full year's teaching time.

During the second day of the hearing, the Provider submitted 7 additional time studies.[108] On the third day of the hearing, the Provider submitted revised data that was originally submitted for the 46 time studies that was now updated to include six of the seven additional time studies, and explained that it decided to exclude one of the seven time studies on which the student reported 5.5 hours for observation time and 4.5 hours of teaching time, because it "obviously has an error because they show total teaching minutes greater than they were on campus"[109] and, thus, it "appears to be an outlier."[110] Considering the additional six time studies (together with the 46 time studies originally submitted), Beaumont recalculated the cohort clinical training time percentage to be 36.77 percent (down from 44 percent).[111]

Because the Board will not consider the 46 time studies originally submitted (as explained above), this recalculation could now only include the 6 additional time studies, and these 6 time studies only add up to a cohort clinical nurse training percentage of about 10 percent.[112] However, consistent with PRM 15-1, § 2313.2(E), the Board also finds that it cannot use only these 6 time studies because they are an inadequate sample of the cohort clinical training time spent with the 1,123 students alleged to have been trained that year.[113] Specifically, all 6 time studies are for the ***same*** date and the ***same*** nurse trainer in *only* ***one*** unit of the hospital (the Mother Baby hospital unit).[114] However, training during FY 2013 was supposedly provided to 1,123 students from 13 different college/university campuses and took place over three terms in multiple and varied units of the hospital. Thus, these six time studies are clearly too small of a sample size to accurately reflect the data needed to determine incremental time for the entire FY 2013 cohort clinical training program. Indeed, these same concerns would exist even if the Board were to consider using the original 46 time sheets because these time sheets similarly reflect a flawed and/or inadequate sample as highlighted by the following observations:

- The 46 time studies only reflected seven named students (some with multiple days).
- At least 10 of the 46 sheets had no observation or teaching time.

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[107] *Id.*
[108] Exhibit P-19; Tr. Day 2 at 5.
[109] Tr. at 44 (Day 3, Aug. 27, 2023) (hereinafter "Tr. Day 3") (in response to being asked why is Jennifer's time study highlighted on Exhibit C-19, Beaumont's witness stated: "Because it obviously has an error because they show total teaching minutes greater than they were on campus so it doesn't really -- it needs to be removed from consideration.").
[110] Tr. Day 3 at 6; Exhibit P-20. The witness stated: "This Exhibit 20 is a supplement of Exhibit 11-A which summarizes the data on the time studies with the addition at the bottom of the time studies that were part of Exhibit 19 which was admitted into evidence yesterday. Exhibit 19 contains 7 time studies. We've only included 6 in the proposed Exhibit 20. We eliminated Jennifer, her cohort time study from April 6, 2013. She is the person who listed 5-1/2 hours of observation time and 4-1/2 hours of teaching time. And so that appears to be an outlier and so we removed that from calculations."
[111] Exhibit P-20. The calculation method was the same as for Exhibit P-4A, except it is now results in a ratio of 36 percent instead of 44 percent. *See* Tr. Day 3 at 129.
[112] Exhibit C-10.
[113] Exhibit P-4A at 2; Tr. Day 2 at 148.
[114] *See* Exhibit P-19.

  - 3 of these had no student or observation/teaching time listed even though the date and schedule are listed[115] and only 1 of these 3 even had the nurse for the shift listed.[116]
  - 7 of these had no observation ***or*** teaching time, even though the student appears to have been present for the shift.[117]
- One sheet was dated "7/16/1991," which is clearly an error if the time sheet pertains to FY 2013.[118]
- One sheet does not appear to be a shift with a nurse on the patient floor because instead of listing a nurse, the student wrote "PNC Meeting"[119] which stands for Professional Nurse Council meeting.[120]

For these reasons, it is not reasonable to use the data from only these 6 time studies (much less the 46 time studies) to drive the entire FY 2013 reimbursement for cohort clinical nurse training, as this data is *grossly* inadequate.[121]

Further, the Board has unresolved concerns about the adequacy of Beaumont's training of students on how to *properly* fill out the time studies. At the hearing, Beaumont's witness explained that the students are trained at orientation.[122] Beaumont created information to impart to the students and the faculty that included what the time study was about, why they conduct the time study, how to complete the time-study form, and an example of a filled-out time-study form.[123] To fill out the time study, the students were asked to write down the patient initials, the nurse's name, and "we tried to give them the difference between at that time, what was being called direct and indirect, or active and passive – teaching, learning. It was very complicated to try to explain the concept, but [] we gave them instructions and showed [them] how to [write it] down in minutes."[124] With regard to teaching time and observation time, Beaumont indicated

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[115] Exhibit P-11B at 15 (form is dated Oct. 13, 2013 for 3 East but no student or nurse is listed), 31 (form is dated Sept. 10, 2013 with rotation to 3 East SICU but no student or nurse is listed).
[116] Exhibit P-11B at 46 (form is dated Sept. 24, 2013 with rotation to "2 5ICU").
[117] Exhibit P-11B at 7 (student Maria Barron for Nov. 12, 2013 but no nurse listed), 18-21 (various students and dates with a nurse listed only on 2), 24-25 (student Jeffrey Chen, both pages for the same date 10/8/2013, thus, also a duplicate but a nurse is listed).
[118] Exhibit P-11B at 29 (student Amy Timcoe).
[119] Exhibit P-11B at 38 (student Cristina Miclea with nurse name as "PNC Meeting").
[120] Tr. Day 2 at 104-05 (After being asked to explain what PNC meant when it was written where the nurse's name should be on the time sheet form, the witness stated: "So what they're doing is they're going to the Professional Nurse Council Meeting. So they're trying to learn about our Professional Nursing Council Meeting that we have monthly. And we have subcommittees of that, many subcommittees. So I'm sure that's what they were doing. They were going to go there. And that's interactive, the students can absolutely ask lots of questions.").
[121] The Provider's witness testified that the data technician who was responsible for collecting, scanning, and storing the time studies in 2013 no longer works at Beaumont, and while they have been searching for the time studies, the time studies submitted in Exhibits P-11B and P-19 were the only ones they were able to locate. Tr. Day 2 at 168-169. It is unclear whether the Provider had any concern in FY 2013 when preparing the FY 2013 cost report with the inadequacy of the time studies or whether the concern only arose as a result of preparing the present appeal, however, testimony during the hearing for this case has been given that the searching for those time studies was very slow and certainly more recent than just in (or following the close of) FY 2013. Regardless, the Provider apparently considered the inadequate time studies reasonable enough upon which to base their calculations for the FY 2013 as-filed cost report, which is also true of the FY 2013 student rosters that the Board has similarly questioned based on the testimony given at the hearing.
[122] Tr. Day 2 at 159.
[123] *Id.*
[124] *Id.* at 160.

that it was difficult for everyone to understand the difference between the two concepts and, as a result, Beaumont included the following explanation of these concepts on the bottom of the timesheet[125]:

> - **Time Spent by RN <u>directly teaching</u>:** this is the time when the RN is actually explaining procedures to you, working with you during a procedure, answering questions, reviewing films, discussing medications or patient care. You are learning from the interaction with the RN.
>   - Ex. RN explains how to insert an IV line, instructs you on planned patient activities for the day.
> - **Time Spent by student <u>observing</u> the RN:** this is the time when you are in the same room with the RN observing a procedure or surgery, listening to report, watching the RN prepare patients for discharge.
>   - Ex. Watching RN remove meds from the PXYIS, listening to report at shift change.[126]

At the bottom of the timesheet is the name and phone number of the program director who the students are instructed to call with any questions.[127] However, the time sheets themselves present concerns based on how they were filled out, with some students submitting what appeared to be duplicate time,[128] and the submissions showing no consistency in terms of how they were filled out and which information was filled in and provided.[129]

Also concerning is the *description* of the two categories of time: observing and directly teaching quoted above. Beaumont failed to distinguish the time the students are in the presence of its nurses *from the **incremental** time* incurred by those nurses for actually providing cohort clinical training. As a result, Beaumont ***improperly*** included 100 percent of the time the students reported under both categories in its calculations of the *incremental* cohort clinical training costs. The Board notes that the January 12, 2001 Federal Register describes *incremental* costs as those that "in the absence of the students, would ***not*** be incurred by the provider."[130]

> [A]llowable clinical training costs should be limited to those incremental costs that the provider actually incurs in the course of training nursing or allied health students. If a provider must hire additional staff or increase the salaried hours of existing staff to accomplish the clinical training, the costs of the staff time for providing the training would be considered allowable costs. These staff could include clinical training instructors and administrative and clerical support. However, if the provider merely adds the

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[125] *Id.* at 162-166.
[126] *See* Exhibits 11B, 19 (time sheets submitted during appeal before the Board).
[127] *Id.*
[128] *See supra* note 117.
[129] *See* Exhibits 11B, 19.
[130] 66 Fed. Reg. at 3358, 3368 (Jan. 12, 2001) (emphasis added).

> supervision of students to a floor nurse's list of duties and this is accomplished without the provider incurring additional costs, there is no incremental cost to be claimed.[131]

The record is void of any "additional staff or increase[d] salaried hours of existing staff" by Beaumont to support cohort clinical training. Thus, it is possible that the "supervision of students" was accomplished without adding ***any*** of these particular additional costs (*i.e*., there appears to be no incremental cost). The record does not show how much time, if any, that the cohort clinical training adds to the nurse's day. There is nothing in the regulation, nor guidance, that suggests a student's mere presence with Beaumont's nurses qualifies for *incremental* cohort clinical training costs, yet that is precisely what Beaumont appears to have claimed.

Observing time, as defined on the form, does not reflect 100 percent *incremental* time because Beaumont's nurse still has to perform the regular tasks as he or she would without a student observing (*i.e.,* the act of someone observing itself does not create incremental time). In other words, Beaumont's nurse is performing patient care while conducting training. The regulation at 42 C.F.R. § 413.85(d)(2)(ii) explicitly states that "[t]hese costs do ***not*** include patient care costs."[132] Indeed, as the patient care time can be billed, there is the concern that allowing this time as teaching time would have the result of paying the provider twice for the same thing, once, billed as patient care, and again, as *incremental* teaching costs.

Further, the percentage of time for FY 2013 allocated to incremental cost due to cohort clinical training increased from approximately 25 percent in FY 2012 to 67 percent in FY 2013. Beaumont's witness testified that the only change in FY 2013 was that, in calculating the observation time, Beaumont did not discount 50 percent as had been done in prior years.[133] The witness further explained that, when a nurse has a nursing student observing what she is doing, the nurses slow down.[134] However, if true, *incremental* costs still "would not . . . include the costs of a charge or floor supervisor nurse who may spend a portion of his or her time supervising student nurses but who, in the absence of the students, would still have to be employed by the provider."[135] In summary, *100 percent* of the time that the student spent with the nurse would not and *could no*t all meet the definition of ***incremental*** costs. Further, this decision to count observation time *at 100 percent* (instead of 50 percent, as in prior years) is another material example of the inadequacy of Beaumont's argument that nothing changed between years and plainly lacks any support in the record.

With regard to Beaumont's argument that the Medicare Contractor is collaterally estopped from relitigating the Federal Court's determination that Beaumont has adequate cost data supporting its clinical training expenses, Beaumont cites to Federal Court cases on *collateral estoppel*, including one arguing that *collateral estoppel* can be applied to such cases where the same issue has been

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[131] *Id.* at 3369.
[132] (Emphasis added.)
[133] Tr. Day 1 at 210-11.
[134] Tr. Day 1 at 260-61.
[135] 66 Fed. Reg. 3358, 3368 (Jan. 12, 2001).

previously decided, even though the calendar year in dispute is different when the parties and issues are identical.[136]

Beaumont argues that "because the Board is to make conclusions of law under 42 C.F.R. § 405.1873(b), it also must follow the *collateral estoppel* doctrine and apply it here."[137] Beaumont cites to *Clark Regional Med. Ctr. v. U.S. Dep't of Health and Human Servs,* 314 F.3d 241 (6th Cir. 2002), related to the determination of the number of available bed days for purposes of calculating providers' indirect medical education or disproportionate share payments, as support for its argument that *res judicata* is applicable in this case:

> In a later appeal to the [Board], the providers disputed the intermediary's inclusion of observation bed days and swing bed days in the available bed count. The intermediary argued that collateral estoppel applied, and gave it no choice but to follow the *Clark* decision. The [Board] agreed, finding "that the Intermediary was bound by [the *Clark* decision] that concluded the Department's interpretation of the regulation to exclude swing and observation beds from the count of available beds is arbitrary and capricious and otherwise not in accordance with the law.[138]

This decision cited a prior Board decision issued on Jan. 29, 2015 (*OhioHealth2004 Clark Bed Days Groups v. CGS Adm'rs*, PRRB Dec. 2015-D01 (Jan. 29, 2015)). The Board acknowledged in that decision 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."[139]

In response, the Medicare Contractor asserts that the District Court decision on the prior fiscal years is not applicable to the Board for FY 2013. First, while the District Court decision dealt with incremental nursing costs, the decision was based on the Medicare Contractor's imposition of a retroactive requirement on the Provider to submit contemporaneous time studies. However, in the FY 2013 appeal, the Provider *did* provide contemporaneous time studies; *but*, the Medicare Contractor asserts those time studies are not compliant with the requirements of the PRM and are not otherwise adequate cost information as required under 42 C.F.R. § 413.24(c). Because the issue addressed in the District Court decision is not the same as the issue before the Board, the doctrine of *collateral estoppel* cannot be applied.

Second, the Medicare Contractor contends that "collateral estoppel is an equitable doctrine, and the Board is not a tribunal of equity. The Board has previously found that it cannot apply collateral estoppel.[140] The Medicare Contractor gives the example of the Board's August 31, 2020 decision in *District Hospital* (PRRB Dec. 2020-D20). In that Board decision, the Medicare Contractor noted that even though the issue considered in the Board's prior decision addressed the

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[136] Provider's Post-Hearing Brief at 12-14 (Oct. 21, 2021).
[137] *Id.* at 14.
[138] *Id.*
[139] *Id.* at 14-15.
[140] Medicare Contractor's Post-Hearing Brief at 21.

same legal issue involved in the instant appeals except for an earlier fiscal year, "the Board still found that it did not have authority to apply collateral estoppel."[141]

To be clear, the Board's prior decision that was cited by Beaumont addressed whether the *Clark* decision applied to the providers of that case, specifically, whether the *Clark* decision was controlling legal precedent *as to the meaning of the* ***regulation*** *at issue*, and the Board found that it was because it was a Circuit Court decision, the providers were located in that Circuit, and it made findings on what a regulation meant that would apply to any hospital located in the states for that Circuit. Significantly, the Board did ***not*** apply, or address, the doctrine of *collateral estoppel* in its discussion and decision in that case.

In the Board's prior 2020 decision cited by the Medicare Contractor,[142] the Board considered whether it had the authority under 42 U.S.C. § 1395oo and 42 C.F.R. Part 405, Subpart R to apply *res judicata* based on a D.C. District Court decision for the providers that addressed the same legal issue involved in the Board's case except that the District Court's decision involved an earlier fiscal year. Essentially, the providers invoked the doctrine of *collateral estoppel* (also known as issue preclusion) which "precludes a party from relitigating an issue actually decided in a prior case and necessary to the judgement."[143] The providers requested that the Board apply *collateral estoppel* to prohibit the Board from relitigating an issue that was resolved for an earlier fiscal year in the District Court decision. The Medicare Contractor asserts that this is the same request that Beaumont has made in the instant case and, as such, the same analysis applies.

First, the Board *agrees* with the Medicare Contractor that the issue in the instant case is ***not*** the same as the issue in the District Court decision for prior fiscal years. While the District Court's decision also addressed whether the cost data and information provided was adequate to determine incremental nurse training costs for FYs 2005 and 2006, in that decision, the Court agreed with the Board that it was unfair for the Medicare Contractor to impose a *retroactive* requirement on Beaumont to submit contemporaneous time studies. Beaumont had not been told by the Medicare Contractor until the 2010 audit of FYs 2005 and 2006 that time studies were required. The instant case is for FY 2013, a fiscal year that occurred *well after* the 2010 audit of FYs 2005 and 2006, and for which Beaumont has submitted time studies to support its incremental nurse training costs for FY 2013 (7 years after the fiscal years at issue in the prior litigation). Indeed, the District Court did not make findings on the Beaumont's incremental cohort nurse training costs for FYs 2005 and 2006 but rather remanded to the Secretary to give her the opportunity to consider Beaumont's proffered evidence and then determine the extent of compensation for those costs. Following remand, CMS and Beaumont entered into a settlement agreement to resolve that litigation and, under the terms of that agreement, the settlement "does not constitute an admission of fact or law by either party and has no precedential effect."[144] Accordingly, the Board declines to apply prior litigation relating to FYs 2005 and 2006 to FY 2013, the fiscal year at issue here. The Board further finds that the sufficiency of the time

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[141] *Id.* at 21-23.
[142] *Id.* at 21 (citing to *UHS 2006-2009 Medicare Bad Debts Still at Agency CIRP Group v. Novitas Solutions, Inc.*, PRRB Dec. No. 2020-D20 (Aug. 31, 2020)).
[143] *Id.* at 22.
[144] Exhibit P-3 ¶ 4.3 (copy of the Settlement Agreement).

studies for FY 2013 is relevant as well as the sufficiency of the other data used in the calculation for that fiscal year (*e.g.*, the sufficiency of the student roster for FY 2013).[145]

Even if the District Court's decision did address the same issue, the Medicare Contractor notes that "the Board is an administrative forum which has specific, and limited, authority defined by 42 U.S.C. § 1395oo and the implementing regulations at 42 C.F.R. Part 405, Subpart R."[146] The regulation at 42 C.F.R. § 405.1867 defines the scope of the Board's authority:

> In exercising its authority to conduct proceedings under this subpart, the Board must comply with all the provisions of Title XVIII of the Act and regulations issued thereunder, as well as CMS Rulings issued under the authority of the Administrator as described in § 401.108 of this subchapter. The Board shall afford great weight to interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS.

The Board is not granted general powers of equity. Congress dictated in the Board's governing statute that "[a] decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole."[147] Based on these authorities, the Board finds that Congress did not confer power to the Board to apply the doctrine of *collateral estoppel*.

Similarly, it is the Board's finding that the Secretary also did not confer on the Board the authority to apply the doctrine of *collateral estoppel*. The Secretary promulgated regulations at 42 C.F.R. Part 405, Subpart R to govern proceedings before the Board. The Board finds that these regulations do not confer on the Board the authority to prohibit re-litigation of an issue across fiscal years[148] and, in this regard, the Board notes that neither its decisions nor those of the Administrator have general controlling precedence.[149] Therefore, consistent with prior Board rulings,[150] the Board concludes it has no authority to apply the doctrine of *collateral estoppel* as requested.

In summary, the Board finds that the cost data, information and documentation submitted by Beaumont are not adequate to determine the incremental costs associated with the cohort clinical training at Beaumont in FY 2013. Further, the submitted evidence is not auditable, as required by 42 U.S.C. § 1395g(a) and 42 C.F.R. § 413.24(a), (c). Similarly, the accuracy of the student roster for the fiscal year at issue (including the hours) has not been established. As a result, multiple

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[145] Just because certain data was gathered and maintained in an auditable manner for one fiscal year, does not mean that a provider will maintain the same practice, procedure, and/or standards for gathering and maintaining that same type of data in subsequent fiscal years. Indeed, this just highlights why hospitals are subject to audit each year.
[146] *Id.*
[147] 42 U.S.C. § 1395oo(d).
[148] The Board notes that Rule 8(c)(1) of the Federal Rules of Civil Procedure ("FRCP") lists *res judicata* as an affirmative defense and the Secretary has not required the Board to apply the FRCP except in certain limited discovery circumstances specified in 42 C.F.R. Part 405, Subpart R.
[149] *See* PRM 15-1 § 2927(e) (entitled "Nonprecedential Nature of the Administrator's Review Decision").
[150] The Board includes thorough analysis in the following 2020 decision: *UHS 2006-2009 Medicare Bad Debts Still at Agency CIRP Group v. Novitas Solutions, Inc.*, PRRB Dec. No. 2020-D20 (Aug. 31, 2020).

variables used in the calculation of the pass-through reimbursement have not been established.[151] As in all proceedings before the Board, the Provider carries the burden of production of evidence and burden of proof to establish, by a preponderance of the evidence, that it is entitled to relief on the merits of the matter at issue.[152] Beaumont has not carried that burden in this appeal.[153]

B. Issue 2: Square Footage – Allied Health Programs

On its as-filed FY 2013 cost report, Beaumont allocated square footage to various Nursing and Allied Health Programs. Significantly, this was the *first* year that Beaumont had ever claimed square footage on a cost report.[154] Accordingly, this is a change in Beaumont's reporting/handling of costs for these programs from prior years and, due to this change, it was flagged for audit.[155]

Beaumont's witness provided testimony on this issue and referred to Exhibit P-12, which includes her measurements of the square footage. In her testimony, she asserted that Beaumont had certain classrooms and a conference room dedicated to the Allied Health Programs, as well as a Program Director who dedicated 100 percent of their time to operate these programs.[156] She acknowledged that the square footage (as measured by the facility person) did not identify the Allied Health Programs and that, as a result, when she filed the FY 2013 cost report, she did *not*

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[151] This means that, even if the Board were inclined to consider using the approach it used in FY 2005 and 2006 (as discussed *supra*), the Board cannot, given the fact there are multiple factors outside of the time studies that are not accurate and cannot be used. Further, the Board declines to consider using prior years' data (*e.g.*, data from FY 2012) due to the extent of Beaumont's recordkeeping issues with FY 2013 notwithstanding the fact that Beaumont knew it needed to maintain these records. The recordkeeping issues that came to light during the hearing for this case are new to the Board. In this regard, the Board notes that the ***only*** fiscal years in which it reviewed *and made findings* on this issue were for FYs 2005 and 2006 as reflected in PRRB Dec. No. 2016-D12 and the student roster process for the FY 2005/2006 was described very differently from FY 2013 and the reason why Beaumont had no time studies was very different. *See* Exhibit P-15 at 165-67, 192; *see supra* note 28 and accompanying text; *but also see* supra notes 144 and 145 and accompanying text. While the Board made no findings on the FY 2007 to 2009 appeals to the Board as those cases were withdrawn, the transcript from those proceedings show that ACEMAPP was not used until sometime during FY 2009. Exhibit P-17 38-42. Further, the testimony at the hearing for this case suggests that some of the student roster issues/concerns (as listed *supra*) may have impacted earlier years, *i.e.,* FYs 2010 to FY 2012. The fact that Beaumont had an acrimonious separation of the employee charged with maintaining specific records does not excuse Beaumont's failure to maintain those records and ensure that they are auditable. The burden of proof does not fall on a specific employee, but on the Provider as a whole. *See also infra* note 153.

[152] 42 C.F.R. § 405.1871(a)(3).

[153] *See Lancaster Hosp. Corp. v. Becerra*, 58 F.4th 124 (4th Cir. 2023) (stating "Lancaster asserts that—even if some reduction were warranted—the Board erred by denying its entire 1997 reimbursement request. There appears no doubt Lancaster provided services to Medicare beneficiaries in 1997 and denying all reimbursement for that year may seem harsh. But the principle that people "must turn square corners when they deal with the Government" "has its greatest force when a private party seeks to spend the Government's money." *Heckler v. Community Health Servs. of Crawford Cnty., Inc.*, 467 U.S. 51, 63, 104 S.Ct. 2218, 81 L.Ed.2d 42 (1984). "As a participant in the Medicare program," Lancaster "had a duty to familiarize itself with the legal requirements for cost reimbursement," *id.* at 64, 104 S.Ct. 2218, including the need to provide cost data in a form "capable of being audited," 42 C.F.R. § 413.24(c). 3 The Board's decision to deny reimbursement for fiscal year 1997 was neither arbitrary nor capricious and was supported by substantial evidence."); *Springs Mem'l Hosp. v. Palmetto GBA*, PRRB Dec. 2019-D24 (Apr. 30, 2019), *decl'd review* Adm'r Ltr. (Jun. 27, 2019).

[154] Tr. Day 1 at 111-12.

[155] Exhibit C-4; Tr. Day 3 at 55-56.

[156] Tr. Day1 at 113.

have the true square footage.[157] She stated that, subsequently, she attempted to fill this gap by personally measuring the square footage with a tape measure in response to the FY 2013 cost report audit, which concluded on July 18, 2017,[158] and then documented those measurements in Exhibit P-12, which is dated August 21, 2017.[159] Beaumont's witness asserted that she only counted space that was dedicated 100 percent to the Allied Health Programs. As an example, she explained that, for the clinical pathology lab, she arrived at 264 square by using the percentage of the Allied Health Program cost, divided by the total cost in the lab, to come up with the percentage to allocate the maximum square foot to clinical pathology lab's square footage; however, the Medicare Contractor disallowed the 264 square feet, notwithstanding her contention that the total square footage used by clinical pathology lab is actually much larger at 1,304 square feet.[160] She contended that the measurements at Exhibit P-12 do not include all of the square footage that got disallowed in FY 2013 because from FY 2013 through FY 2017 more than half of the program was closed when she tried to do the physical measurement.[161]

The Medicare Contractor's audit workpaper states that Beaumont's reclass of square feet was based on an allocation of cost based on Beaumont's position that ". . . since the individuals who teach the classes do not work for allied health program 100%, a portion of their workspace should be allocated to the program."[162] Beaumont gave the following explanation, in its preliminary position paper, to support the FY 2013 allocation of additional square footage ***for the first time*** in a cost report:

> The faculty training the students are not teaching full time, as they are also performing patient care themselves. Therefore, the provider allocated a portion of the departmental square footage using a ratio of the Allied Health program direct cost to the total direct cost of the department.[163]

Beaumont's witness testified that they had classrooms dedicated 100 percent to the program, and a conference room dedicated to the program and a Program Director who dedicated 100 percent of their time to operate the program.[164] In addition, she asserted that the square footage is dedicated to the specific program and *not* shared with other functions of the hospital.[165] However, this testimony is contrary to what Beaumont initially reported in its Preliminary Position Paper where it is explained that the departmental square footage is ***not*** fully dedicated to the respective NAH programs, *as patient care is also provided in this space*[166] and argued that a portion of its workspace should be allocated to the program. Therefore, Beaumont computed the net cost of the allied health program to the total cost of that cost center and allocated a percentage to the allied

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[157] Tr. Day 1 at 112-13.
[158] Exhibit C-2 (copy of the Medicare Contractor's Management Letter dated July 18, 2017). *See also* Exhibits C-1, C-4, C-5 (Medicare Contractor workpapers).
[159] Tr. Day 1 at 115-16.
[160] Tr. Day 1 at 118-20, 310-11.
[161] Tr. Day 1 at 112-20.
[162] *See* Exhibit C-4, at 1.
[163] Provider's Preliminary Position Paper at 7. *See also* Exhibit C-8 at 2.
[164] Tr. Day 1 at 114.
[165] Tr. Day 1 at 270-71.
[166] Provider's Preliminary Position Paper at 7.

health program based on the reclassified amount on Worksheet A-6.[167] In contrast, in its Final Position Paper, Beaumont's representation of the facts and position changed stating: "After the audit, Beaumont conducted a physical tour of the space used by these programs. The space was measured and the square footage information was provided by Allied Health program directors. The space used by Allied Health programs is dedicated to these programs, not shared with other functions of hospital."[168] These statements from the position papers are contradictory. A ratio of NAH cost to total cost of a cost center (as was done in the as-filed FY 2013 cost report) would ***not*** be necessary if the cost center was not shared with other hospital functions. Moreover, the Board notes that Beaumont's sole witness for this issue is the Director of Reimbursement and she was unable to resolve Beaumont's contradictory statements and shifting positions since she has no direct knowledge of or responsibility over the operations of the NAH programs.[169] Accordingly, the Board declines to give any weight to the witness's testimony about the square footage used by the NAH programs.

Relevant here, the regulation at 42 C.F.R. § 413.85(d)(2) explicitly states in clause (i) that allowable educational costs must be "directly related to approved educational activities" and in clause (ii) that "[t]hese costs do *not* include patient care costs."[170] The Board finds that Beaumont failed to support its claim relating to square footage because it is not clear from the evidence before the Board that the specific classrooms at issue were used ***only*** for the allied health programs, or that certain persons taught 100 percent and their office was used by only them. Indeed, the only evidence in the record to support that claim is testimony from Beaumont's witness who, as noted above, was ***not*** directly involved in the NAH programs. Moreover, the square footage is *not* incremental to a nurse's services such that, for example, 20 percent of the square footage would be equivalent to 20 percent of the nurse's time dedicated to teaching.[171] The Board agrees with the Medicare Contractor that, consistent with 42 C.F.R. § 413.85(d)(2), "[s]imply training students in the ancillary area does not, in and of itself, make a percentage of the area or any of the equipment used an allowable pass-through cost" as "[t]hese areas would exist regardless of whether the provider had NAH programs and nothing suggests the areas are larger because of additional equipment purchased specifically for the allied health programs."[172] Further, the Provider did not do its square footage measurements until 2017, after the audit of the FY 2013 cost report had been completed.[173] Consequently, the measurements and calculations that Beaumont took in 2017 were *not* submitted during the audit and, therefore, have not been subject to review and do not identify proposed square footage for all cost centers under appeal.

For these reasons, the Provider has not met its burden in showing, by a preponderance of the evidence, that the square footage was exclusively dedicated to the nursing allied health programs

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[167] *Id*.
[168] Provider's Final Position Paper at 13.
[169] Tr. Day 1 at 26-28, 112-14, 116, 267-71. The Board recognizes these transcript references document the witness' assertion that she spoke with various directors of the NAH programs in arriving at her measurements. However, none of those directors were present at the hearing for examination by the Medicare Contractor or the Board.
[170] (Emphasis added.)
[171] *See* 66 Fed. Reg. at 3368-3369 for the definition of incremental time, which is quoted in the Statements of Facts and Relevant Law section, *supra*, for Issue 1.
[172] Medicare Contractor's Final Position Paper at 14.
[173] *Id.* at 15-16; Tr. Day 1 at 282-83; Tr. Day 3 at 56.

at issue, as required by 42 C.F.R. § 405.1871(a)(3).[174] Accordingly, the Board finds that the auditor's removal of square footage from the cost centers for the NAH programs of Radiology, Nuclear Medicine, Radiation, Lab, and Pharmacy was proper.

C. Issue 3: Conference and Seminar Expenses - Kidney Acquisition Cost Center

The Board finds that Beaumont has not submitted sufficient documentation to support the costs associated with seminar and conference expenses that were billed through the Kidney Acquisition cost center.[175] Beaumont argues that the "seminar and conference expenses are direct costs of an employee's department, as opposed to general service costs,"[176] and that there is a specific account number that is used to record seminar and conference expenses for each department, as evidenced by the working trial balance in Exhibit P-14.[177] Beaumont provides the following explanation:

> First, the attending employee's manager must approve attendance at the conference or seminar. Then, the expenses are either paid directly by the hospital or by the employee who submits an expense report for reimbursement. Either way, the expenses are directly charged to the employee's cost center. Approval is required at both the departmental level and through Beaumont's accounting department to ensure that expenses are charged correctly.[178]

Nevertheless, Beaumont did not: (1) submit a list of employees who attended the conferences and seminars; (2) show how the attendees/employees' salaries were treated on the cost report (*i.e.*, reported in which cost center); or (3) provide an agenda for the conferences and seminars that shows the topics presented at the conferences and seminars to confirm that they were related to kidney acquisition consistent with 42 C.F.R. § 412.100(b). Beaumont argues that "this should not preclude reimbursement because Beaumont has supplied sufficient documentation to the [Medicare Contractor]."[179] However, as in all proceedings before the Board, the Provider carries the burden of production of evidence and the burden of proof to establish, "by a preponderance of the evidence, that [it] is entitled to relief on the merits of the matter at issue."[180] Beaumont has failed to do so and, therefore, the Board finds that, based on the record before it, the seminar and conference expenses were properly re-assigned from the Kidney Acquisition cost center to the A&G cost center.

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[174] The Provider not only failed to support its argument relating to square footage, but this cost is contrary to the redistribution of cost principle. The square footage was reviewed because none was claimed in prior periods. The reason given for it not being previously claimed is that no effort was made to document the square footage previously. The regulation prevents such redistribution of costs once those costs are reimbursed under capital pass through. 42 C.F.R. § 413.85(c).
[175] *See* 42 C.F.R. § 405.1871(a)(3).
[176] Provider's Post-Hearing Brief at 26 (Oct. 21, 2021).
[177] *Id.* at 27.
[178] *Id.*
[179] *Id.*
[180] 42 C.F.R. § 405.1871(a)(3).

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In summary, the Board finds that, for each of the 3 issues, the Provider failed to "carr[y] its burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue."[181] Accordingly, the Board finds that, for each of these issues, the Medicare Contractor's adjustments were proper.

DECISIONS

After considering the Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds the following:

1. The Medicare Contractor properly disallowed all of Beaumont's pass-through costs reported for the cohort clinical nurse training program for FY 2013.

2. The Medicare Contractor properly removed square footage from the cost centers for the nursing allied health programs of Radiology, Nuclear Medicine, Radiation, Lab, and Pharmacy.

3. The Medicare Contractor's reclassification of conference and seminar expenses from the Kidney Acquisition cost center to the Administrative & General cost center was proper.

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FOR THE BOARD:

2/26/2024

X Clayton J. Nix

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

[181] *Id.*