PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

On the Record
2026-D27

PROVIDER –
Montefiore New Rochelle Hospital

PROVIDER NUMBER- 33-0184

vs.

MEDICARE CONTRACTOR –
Wellpoint Federal Solutions, Inc.

RECORD HEARING DATE –
March 21, 2025

COST REPORTING PERIOD ENDED –
December 31, 2015

CASE NUMBER – 19-2612

INDEX

ISSUE STATEMENT

Whether the Medicare Contractor's denial of the Provider's nursing and allied health education ("NAHE") managed care payment for its fiscal year ending December 31, 2015 was proper.[1]

DECISION

After considering the Medicare law and regulations, the arguments presented, and the evidence admitted,[2] the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor's adjustment to disallow the Provider's NAHE managed care payment for its fiscal year ending December 31, 2015 was proper.

INTRODUCTION

Montefiore New Rochelle Hospital ("Provider" or "New Rochelle") is located in New Rochelle, New York.[3] The Provider's assigned Medicare contractor[4] is Wellpoint Federal Solutions, Inc.[5] ("Medicare Contractor").[6] On March 6, 2019, the Medicare Contractor issued a Notice of Program Reimbursement ("NPR") for the Provider's cost reporting period ending December 31, 2015.[7] In issuing the Provider's NPR, the Medicare Contractor "reimbursed the Provider on a pass-through reasonable cost basis for its nursing school but denied the entire additional NAHE managed care payment."[8] The disallowance of the NAHE managed care payment was "because the Provider did not claim NAHE reimbursement for the nursing school on its cost report for the period ending December 31, 2012."[9]

New Rochelle timely appealed the issue to the Board and has met the jurisdictional requirements for a hearing. The Board approved a record hearing on March 21, 2025. The Provider was represented by Stephanie Webster, Esq. of Ropes & Gray, LLP. The Medicare Contractor was represented by Edward Y. Lau, Esq. of Federal Specialized Services.

STATEMENT OF FACTS

As part of its desk review of New Rochelle's cost report for the fiscal year ended ("FYE") December 31, 2015, the Medicare Contractor determined that New Rochelle "did not meet the criteria needed to qualify."[10]

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[1] Medicare Contractor's Final Position Paper ("Medicare Contractor's FPP") at 3 (Feb. 13, 2025).
[2] Any arguments or evidence, whether or not specifically referenced or discussed herein, were considered by the Board in the deliberations of this appeal.
[3] Medicare Contractor's FPP at 2.
[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 relevant law may refer to FIs and MACs interchangeably, and the Board will use the term "Medicare contractor" to refer to both FIs and MACs, as appropriate and relevant.
[5] Previously known as National Government Services, Inc.
[6] Provider's Final Position Paper ("Provider's FPP") at 2 (Jan. 17, 2025).
[7] Stipulations ("Stip.") at ¶ 2 (Mar. 18, 2025).
[8] *Id*.
[9] *Id*. at ¶ 3.
[10] Medicare Contractor's FPP at 5.

In preparation for the hearing on the record, the parties collaborated to develop agreed-upon Stipulations. Set forth in the pertinent parts of these Stipulations are the following facts:

> 4. In November 2013, Montefiore Health System ("Montefiore") acquired two financially distressed hospitals, Sound Shore Medical Center and Mount Vernon Hospital, from Sound Shore Health System, which had filed for bankruptcy. Following the acquisition, Sound Shore Medical Center and Mount Vernon Hospital were renamed Montefiore New Rochelle Hospital and Montefiore Mount Vernon Hospital, respectively. Provider Exhibit 4 at P-30, P-32.[11]
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> 5. As part of the acquisition, Montefiore also acquired the Dorothea Hopfer School of Nursing previously operated by the former Mount Vernon Hospital. Effective January 1, 2014, Montefiore transferred the management and administration of the nursing school from Montefiore Mount Vernon Hospital, Provider No. 33-0086, to Montefiore New Rochelle Hospital, Provider No. 33-0184, and renamed the nursing school as the Montefiore School of Nursing. *Id.* The costs of the Montefiore School of Nursing were reported on Montefiore New Rochelle's cost report as of January 1, 2014. *See* Provider Exhibit 5 at P-51.[12]
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> ***
>
> 9. In 2014, following the transaction, the students formerly enrolled at Dorothea Hopfer School of Nursing were transferred to the Montefiore School of Nursing. The transfer of the management and administration of the nursing school did not result in the nursing school physically moving.[13]
>
> 10. Montefiore expressed in both internal and external announcements that it would "continue the school of nursing," Provider Exhibit 4 at P-45. Montefiore's application to the State Education Department of New York ("NYSED") in September 2013, required in situations in which programs change ownership, similarly stated that Montefiore planned "to continue the operation of Dorothea Hopfer School of Nursing at Mount Vernon Hospital through the end of this year," and that Montefiore had agreed "to maintain the School after acquisition in order to confer degrees to the prospective December 2013 graduates." *Id.* at P-32.[14]

[11] Stip. at ¶ 4.
[12] *Id*. at ¶ 5; *see also* Exhibit ("Ex.") 4 at P-30 and P-32.
[13] *Id*. at ¶ 9.
[14] *Id*. at ¶ 10; *see also* Ex. 4 at P-32 and P-45.

11. The application to NYSED also explained that the "experienced faculty, same curriculum and evaluation processes will continue in the Montefiore School of Nursing program," *id.* at P-37, consistent with a subsequent report regarding the change in ownership submitted to the accreditation body, the Accreditation Commission for Education in Nursing, *id.* at P-30. Subsequent communications with the New York State Education Department explained that all students enrolled in the Dorothea Hopfer School of Nursing would be transferred to MSON in 2014. *Id.* at P-42.[15]

12. Montefiore Mount Vernon Hospital and Montefiore New Rochelle Hospital did not merge, and thus, the two hospitals remain independent providers with separate and distinct Medicare provider numbers.[16]

13. The MAC's position is that the hospital must have received Medicare reasonable cost payment for an approved nursing or allied health education program under its cost reporting period for FYE 12/31/12, which is the two years prior to FY 2015.[17]

STATUTORY AND REGULATORY BACKGROUND

In 1999, Congress enacted the Balanced Budget Refinement Act ("BBRA") and in § 541(A), added 42 U.S.C. § 1395ww(l) to provide for additional payments to be made to qualifying hospitals to cover the costs of Medicare Managed Care patients associated with approved NAHE programs.[18] This statutory provision describes the methodology for determining the additional payments and sets forth the rules for determining an additional payment amount for any qualifying hospital that receives payments for its cost of operating an approved NAHE program under 42 C.F.R. § 413.85. The Secretary implemented BBRA § 541(a) at 42 C.F.R. § 413.87 to set forth the qualifying conditions that must be met in order to receive an additional payment amount associated with programs that have Part C Managed Care utilization.[19]

In 2000, Congress passed the Benefits Improvement and Protection Act ("BIPA") and, in § 512(A), amended 42 U.S.C. § 1395ww(l)(2)(C) to change the formula for determining NAHE Part C Managed Care payments by adding consideration of a provider's Part C managed care utilization.[20]

For the instant appeal, the pertinent part of the statute at 42 U.S.C. § 1395ww(l) (effective December 28, 2015 to December 12, 2016) read as follows:

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[15] *Id*. at ¶ 11; *see also* Ex. 4 at P-30, P-37, and P-42.
[16] *Id*. at ¶ 12.
[17] Id. at ¶ 13.
[18] Pub. L. 106-113, Appendix F at § 541(a), 113 Stat. 1501A-321, 1501A-391 (1999).
[19] 65 Fed. Reg. 47026, 47051-52 (Aug. 1, 2000) (initial codification of 42 C.F.R. § 413.87). At that time, Medicare Managed Care was referred to as "Medicare+Choice." In later years, this was also referred to as Medicare Part C Managed Care.
[20] Pub. L. 106-554, Appendix F § 512(a), 114 Stat. 2763A-463, 2763(A)-533 (2000).

(l) Payment for nursing and allied health education for managed care enrollees

(1) In general

For portions of cost reporting periods occurring in a year (beginning with 2000), the Secretary shall provide for an additional payment amount for any hospital that receives payments for the costs of approved educational activities for nurse and allied health professional training under section 1395x(v)(1) of this title.

(2) Payment amount

The additional payment amount under this subsection for each hospital for portions of cost reporting periods occurring in a year shall be an amount specified by the Secretary in a manner consistent with the following:

(A) Determination of managed care enrollee payment ratio for graduate medical education payments

The Secretary shall estimate the ratio of payments for all hospitals for portions of cost reporting periods occurring in the year under subsection (h)(3)(D) of this section to total direct graduate medical education payments estimated for such portions of periods under subsection (h)(3) of this section.

(B) Application to fee-for-service nursing and allied health education payments

Such ratio shall be applied to the Secretary's estimate of total payments for nursing and allied health education determined under section 1395x(v) of this title for portions of cost reporting periods occurring in the year to determine a total amount of additional payments for nursing and allied health education to be distributed to hospitals under this subsection for portions of cost reporting periods occurring in the year; except that in no case shall such total amount exceed $60,000,000 in any year.

(C) Application to hospital

The amount of payment under this subsection to a hospital for portions of cost reporting periods occurring in a year is equal to the total amount of payments determined under subparagraph (B) for the year multiplied by the ratio of—

> **(i)** the product of (I) the Secretary's estimate of the ratio of the amount of payments made under section 1395x(v) of this title ***to the hospital for nursing and allied health education activities for the hospital's cost reporting period ending in the second preceding fiscal year,*** to the hospital's total inpatient days for such period, and (II) the total number of inpatient days (as established by the Secretary) for such period which are attributable to services furnished to individuals who are enrolled under a risk sharing contract with an eligible organization under section 1395mm of this title and who are entitled to benefits under part A of this subchapter or who are enrolled with a Medicare+Choice organization under part C of this subchapter; to
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> **(ii)** the sum of the products determined under clause (i) for such cost reporting periods.[21]

These statutory provisions were implemented at 42 C.F.R. § 413.87, and if certain conditions are met, allow a hospital with a NAHE program to receive additional payments associated with its Part C Managed Care utilization. In pertinent part, the regulation, effective October 1, 2005, provides:

> (a) Statutory basis. This section implements section 1886(l) of the Act, which provides for additional payments to **hospitals that operate and receive Medicare reasonable cost reimbursement for approved nursing and allied health education programs** and the methodology for determining the additional payments.
>
> (b) Scope. This section sets forth the rules for determining an additional payment amount to hospitals that receive payments for the costs of operating approved nursing or allied health education programs under § 413.85.
>
> (c) Qualifying conditions for payment.
>
> (1) For portions of cost reporting periods occurring on or after January 1, 2000 and before January 1, 2001, a hospital that operates and receives payment for a nursing or allied health education program under § 413.85 may receive an additional payment amount associated with Medicare + Choice utilization. The hospital may receive the additional payment amount, which is calculated in accordance with the provisions of paragraph (d) of this section, if both of the conditions in paragraphs (c)(1)(i) and (c)(1)(ii) of this section are met.

[21] (Bold headings in original. Bold/Italics emphasis added).

> (i) **The hospital must have received Medicare reasonable cost payment for an approved nursing or allied health education program under § 413.85 in its cost reporting period(s) ending in the fiscal year that is 2 years prior to the current calendar year.** (For example, if the current year is calendar year 2000, the fiscal year that is 2 years prior to calendar year 2000 is FY 1998.) For a hospital that first establishes a nursing or allied health education program after FY 1998 and receives reasonable cost payment for the program as specified under § 413.85 after FY 1998, the hospital is eligible to receive an additional payment amount in a calendar year that is 2 years after the respective fiscal year ***so long as*** the hospital also meets the condition under paragraph (c)(1)(ii) of this section.
>
> (ii) The hospital must be receiving reasonable cost payment for an approved nursing or allied health education program under § 413.85 in the current calendar year.
>
> **(2) For portions of cost reporting periods occurring on or after January 1, 2001, in addition to meeting the conditions specified in paragraphs (c)(1)(i) and (c)(1)(ii) of this section, the hospital must have had a Medicare + Choice utilization greater than zero in its cost reporting period(s) ending in the fiscal year that is 2 years prior to the current calendar year.**[22]

For cost reporting periods occurring on or after January 1, 2001, 42 C.F.R. § 413.87(e) specifies that the additional payment amount is determined according to the following steps:

> (e) Calculating the additional payment amount for portions of cost reporting periods occurring on or after January 1, 2001. For portions of cost reporting periods occurring on or after January 1, 2001, subject to the provisions of §413.76(d) relating to calculating a proportional reduction in Medicare + Choice direct GME payments, the additional payment amount specified in paragraph (c) of this section is calculated according to the following steps:
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> (1) Step one. Each calendar year, determine for each eligible hospital the total –
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> (i) **Medicare payments received for approved nursing or allied health education programs based on data from the settled cost reports for the period(s) ending in the fiscal year that is 2 years prior to the current calendar year**; and
>
> (ii) Inpatient days for that same cost reporting period.

[22] (Emphasis added).

> (iii) Medicare + Choice inpatient days for that same cost reporting period.
>
> (2) Step two. Using the data from step one, determine the ratio of the individual hospital's total nursing or allied health payments, to its total inpatient days. Multiply this ratio by the hospital's total Medicare + Choice inpatient days.
>
> (3) Step three. CMS will determine, using the best available data, for all eligible hospitals the total of all –
>
> (i) Nursing and allied health education program payments made to all hospitals for all cost reporting periods ending in the fiscal year that is 2 years prior to the current calendar year;
>
> (ii) Inpatient days from those same cost reporting periods; and
>
> (iii) Medicare + Choice inpatient days for those same cost reporting periods.
>
> (4) Step four. Using the data from step three, CMS will determine the ratio of the total of all nursing and allied health education program payments made to all hospitals for all cost reporting periods ending in the fiscal year that is 2 years prior to the current calendar year, to the total of all inpatient days from those same cost reporting periods. CMS will multiply this ratio by the total of all Medicare + Choice inpatient days for those same cost reporting periods.
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> (5) Step 5. Calculate the ratio of the product determined in step two to the product determined in step four.
>
> (6) Step 6. Multiply the ratio calculated in step five by the amount determined in accordance with paragraph (f) of this section for the current calendar year. The resulting product is each respective hospital's additional payment amount.[23]

Finally, subsection (f) sets forth the process by which CMS will calculate the payment "pool":

> (1) Subject to paragraph (f)(3) of this section, each calendar year, CMS will calculate a Medicare + Choice nursing and allied health payment "pool" according to the following steps:
>
> (i) Determine the ratio of projected total Medicare + Choice direct GME payments made in accordance with the provisions of

[23] (Emphasis added).

> § 413.76(c) across all hospitals in the current calendar year to projected total direct GME payments made across all hospitals in the current calendar year.
>
> (ii) Multiply the ratio calculated in paragraph (f)(1)(i) of this section by projected total Medicare nursing and allied health education reasonable cost payments made to all hospitals in the current calendar year.
>
> (2) The resulting product of the steps under paragraphs (f)(1)(i) and (f)(1)(ii) of this section is the Medicare + Choice nursing and allied health payment "pool" for the current calendar year.
>
> (3) The payment pool may not exceed $60 million in any calendar year.

On May 23, 2003, CMS issued a Program Memorandum, Transmittal A-03-043 ("PM A-03-043") that instructed Medicare Contractors on the six (6) steps to follow in calculating Medicare + Choice NAHE Payments.[24] Per the PM A-03-043 instructions, ***Step 1 directs Medicare Contractors to determine the following three data points from the hospital's cost reporting period ending in the federal fiscal year that is two years prior to the payment year: (1) Total NAHE Part A payments,*** (2) Total inpatient days (excluding Medicare + Choice inpatient days) for that same period; and (3) Total Medicare + Choice inpatient days for that same period.[25]

For clarification of the regulations, in the instant appeal, the cost reporting period under appeal is the FYE December 31, 2015. Thus, the current calendar year is also 2015. The federal fiscal year ("FFY") that is 2 years prior to the current calendar year is FFY 2013, which covers October 1, 2012 through September 30, 2013. The applicable New Rochelle cost reporting period ending in FFY 2013 is the FYE December 31, 2012. The Medicare Contractor would use that cost report for New Rochelle to calculate the necessary data points as discussed above.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The sole issue in this appeal concerns how to interpret and apply 42 C.F.R. § 413.87(c). This regulation addresses certain "[q]ualifying conditions for payment." This case focuses on the "qualifying" condition in § 413.87(c)(1)(i), which requires "the hospital" to have "received Medicare reasonable cost payment for an approved [NAHE] program under § 413.85 in its cost reporting period(s) ending in the fiscal year that is two years prior to the current calendar year."[26]

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[24] Program Memorandum, Transmittal A-03-043 (May 23, 2003) (available at: https://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/a03043.pdf) (last accessed Aug. 25, 2026).
[25] *See id.* at 2
[26] 42 C.F.R. § 413.87(c)(1)(i).

The Provider's Position

New Rochelle argues that the "[p]lain [l]anguage of the Medicare [s]tatute and [a]ccompanying [r]egulation [d]ictate that the Provider [r]eceive a NAHE [m]anaged [c]are [p]ayment."[27] New Rochelle contends that, unlike the regulation at 42 C.F.R. § 413.87(c)(1)(i)), the statute (42 U.S.C. § 1395ww(l)) "does not condition payment on hospitals reporting NAHE reasonable cost payments on their cost report for the prior two years."[28] In addition, the Provider argues that 42 C.F.R. 413.87(c)(1)(i):

> as applied in the MAC's determination here, is contrary to the plain language of the Medicare statute, which requires that this payment be made to "*any hospital*," like the Provider, that '*receives* payments for the costs of approved education activities for nursing and allied health professional training under section 1395x(v)(1) of this title.'[29]

New Rochelle argues that since it received reasonable cost payment for its nursing school in 2015 under section 1395x(v)(1), it is then entitled to receive an additional managed care payment for that year as stated in the statute.[30] New Rochelle maintains that the Medicare Act specifies that the Secretary calculates the "payment amount" partly using an "estimate of the ratio of the amount of payments made under section 1395x(v) [of this title] to the hospital for nursing and allied health education activities for the hospital's *cost reporting period ending in the second preceding fiscal year*."[31] Thus, New Rochelle contends that the statute refers to this two-year period only as it relates to calculating payment amounts, not determining entitlement to payment.[32] As a result, the Provider maintains that the Medicare Contractor "should have relied on data from [Montefiore's] Mount Vernon Hospital's FY 2013 cost report to assess the two-year lookback window for [New Rochelle's] 2015 NAHE managed care payment under the governing regulation."[33]

New Rochelle argues that the Medicare Contractor's denial of its entire 2015 NAHE managed care payment, due to the fact that no NAHE reasonable cost payment was made on its 2013 cost report, should be reversed.[34] Specifically, New Rochelle asserts that:

> [t]he preamble to the final rule implementing the regulation at issue indicates that CMS did not intend to penalize hospitals, like those commonly owned here by Montefiore, that transfer the management and administration of an existing NAHE program to

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[27] Provider's FPP at 8.
[28] *Id.*
[29] *Id.* at 9-10 (quoting 42 U.S.C. § 1395ww(l)(1)).
[30] *Id*. at 7.
[31] *Id*. at 8-9 (citing 42 U.S.C. § 1395ww(l)(2)(C)(i) (emphasis added).
[32] *Id*. at 9.
[33] *Id*. at 12-13.
[34] *Id*. at 16.

> preserve the program, *see* 65 Fed. Reg. at 47,037,[35] and thus the MAC's disallowance here penalizing the Provider cannot stand.[36]

New Rochelle further argues that:

> [w]hile CMS's final rule interpreted the two-year look back in the statute as applying to both the payment calculation *and* entitlement to payment, the preamble indicates that CMS *only* intended to penalize a hospital that 'first establishes' an NAHE program that never existed before, not a hospital that transfers its *previously existing program* to a related hospital. *See* 65 Fed. Reg. at 47,037.[37]

Therefore, the Provider maintains that, since Montefiore acquired the pre-existing nursing school under its common ownership, and then transferred the nursing school from Mount Vernon Hospital to New Rochelle, the program was not new and therefore, should be excluded from the two-year lookback, instead using data from Mount Vernon Hospital's 2013 cost report for the necessary calculation.[38] Thus, the Provider contends that the Medicare Contractor has not fulfilled its contractual obligation to ensure proper payment due to New Rochelle under the Medicare program.[39]

Finally, New Rochelle offers several reasons why the "MAC's [d]enial of the Provider's NAHE [m]anaged [c]are [p]ayment is [a]rbitrary and [c]apricious" and must be reversed.[40] New Rochelle contends that the Medicare Contractor failed to justify its inconsistent handling of New Rochelle's NAHE program, which transferred a nursing school between hospitals, when compared to CMS' treatment of new medical residency programs.[41] New Rochelle argues that CMS clarified in the 2010 final rule,[42] that if an existing program simply relocates to a new site, that does not make it a "new" program, and that it should be treated as a continuation of the

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[35] The Board notes that the 2000 IPPS Final Rule at 65 Fed. Reg. 47037 states:

> Accordingly, we are providing that the hospital must have received reasonable cost Medicare payment for a nursing or allied health education program(s) in its cost reporting period(s) ending in the fiscal year that is 2 years prior to the current calendar year. For example, if the current calendar year is calendar year 2000, the fiscal year that is 2 years prior to calendar year 2000 is FY 1998. In this example, if a hospital did not receive reasonable cost payment for approved nursing or allied health education programs in FY 1998, but first establishes these programs and receives such payment as specified in § 413.85 after FY 1998, the hospital will only be eligible to receive an additional payment amount in the calendar year that is 2 years after the respective fiscal year. For example, if the hospital establishes a nursing or allied health program in FY 1999, it will first be eligible to receive an additional payment amount in calendar year 2001.

[36] Provider's FPP at 10.
[37] *Id.* at 10-11.
[38] *Id.* at 1-2, 7, 12-13.
[39] *Id at* 13.
[40] *Id*. at 14.
[41] *Id.* at 15.
[42] 74 Fed. Reg. 43754 (Aug. 27, 2009).

original program.[43] Thus, New Rochelle maintains that if CMS does not treat a relocated residency program as "new," then a nursing school program that merely changed "management and administration" with no site change should not be treated as new, either.[44] The Provider cites to various cases to support its inconsistency argument.[45] Additionally, the Provider asserts that CMS included the Provider's own current-year reasonable cost data in the pool from which the NAHE managed care payments are made, yet deny it any payment from that same pool.[46] Lastly, New Rochelle contends that the Medicare Contractor's strict application of 42 C.F.R. § 413.87(c) disregards the Provider's reasonable reliance on prior CMS communication, which offered no indication that the transfer of the nursing school between hospitals would impact its eligibility for NAHE managed care payment.[47] The Provider asserts its budgeting and financial decisions was based on its communication with CMS.[48] Referring to *Encino Motorcars, LLC v. Navarro*,[49] the Provider claims that when agencies change their position, they are required to consider the "serious reliance interests" formed by established policy, which the Medicare Contractor neglected to do in this situation.[50]

The Medicare Contractor's Position

The Medicare Contractor focuses on the facts that: (1) Montefiore School of Nursing ("MSON") "is a transfer of the Dorothea Hopfer School of Nursing from Montefiore Mount Vernon Medical Center to Montefiore New Rochelle Hospital," and (2) "the nursing school was required to file an application for a new program."[51] As such, the Medicare Contractor argues that MSON was treated as a "new" program for Medicare purposes after the New York State Education Department ("NYSED") approved the registration, effective January 1, 2014.[52]

While the Provider argues that the movement of MSON to Montefiore was only a hospital transfer, the Medicare Contractor contends that a new program had to be established in order to do so.[53] Regardless of whether the NAHE program is "new" or "transferred," the Medicare Contractor argues that neither New Rochelle nor Mount Vernon "met the necessary criteria to claim the managed care payment in the cost reporting period at hand [FYE 2015]."[54]

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[43] Provider's FPP at 15 (citing 74 Fed. Reg. at 43909; 43912).
[44] *Id.*
[45] *Id.* at 15-16 (citing to *Utility Air Regul. Grp. v. EPA*, 885 F.3d 714, 723 (D.C. Cir. 2018); *Kreis v. Sec'y of Air Force*, 406 F.3d 684, 687 (D.C. Cir. 2005); *Util. Solid Waste Activities Grp. v. EPA*, 901 F.3d 414, 430 (D.C. Cir. 2018)).
[46] *Id.*at 16.
[47] Provider's Response Brief at 8 (March 18, 2025) and Provider Exhibit 8 (Declaration of David Menashy) at ¶ 6.
[48] Provider Exhibit 8 at ¶ 6.
[49] 579 U.S. 211, 222 (2016).
[50] Provider's Response Brief at 8.
[51] Medicare Contractor's FPP at 9.
[52] *Id.* Additionally, the Medicare Contractor notes that "[t]he students were transferred from the Dorothea Hopfer School of Nursing to MSON. On September 30, 2013, an application for a new program under the name MSON was filed with the New York State Education Department ("NYSED"). This application laid out the details of Montefiore acquiring the Dorothea Hopfer School of Nursing and Montefiore's intention to operate the new school as MSON. Montefiore had to submit a Master Plan Amendment due to MSON being Montefiore New Rochelle Hospital's first degree level program. On December 23, 2023, a letter from the NYSED and the NYS Board of Regents approved the registration of a new program, MSON, with an effective date of January 1, 2014." *Id.*
[53] *Id.* at 14.
[54] *Id.*

In response to New Rochelle's argument that, under 42 U.S.C. § 1395x(v)(1), it is entitled to receive an additional managed care payment, because it received reasonable cost payment for its nursing school in FY 2015, the Medicare Contractor counters by asserting that it is only one (1) of the three (3) conditions necessary for payment and that it correctly applied the regulation.[55] In support, the Medicare Contractor cites to the following excerpt from the preamble of the final rule published in the Federal Register on January 12, 2001 that discusses the NAHE pass-through payments under § 1395x(v)(1), as follows:

> The pass-through payment can be made to any provider that trains students in a nursing and allied health program as long as the program is operated by the provider, whether the provider is the originator of the program or whether the provider is one to which the students are rotated. However, the original provider of the program (or any other provider) may not claim the costs of training the students in the program while the students are rotating to another provider—***only*** the provider ***actually*** *training* the students and incurring the clinical training costs may be paid on a reasonable cost basis. ***That is, a provider may not claim the costs of a third party provider.***[56]

The Medicare Contractor argues that while this statutory provision allows a hospital to receive reasonable cost pass-through payments for a NAHE program, it does not speak to the additional NAHE managed care payment.[57]

Summarized as follows, the Medicare Contractor maintains that to qualify for the Medicare + Choice payment, the hospital must satisfy the three (3) criteria identified in 42 C.F.R. § 413.87(c)(1).[58]

First, "[t]he hospital must have received Medicare reasonable cost payment for an approved nursing and allied health program under § 413.85 in ***its*** cost reporting period(s) ending in the fiscal year that is 2 years prior to the current calendar year."[59] The Medicare Contractor claims that New Rochelle did not receive such payment two years prior to its 2015 cost reporting period, since "it was not the operator of the [nursing] program before January 1, 2014."[60] Furthermore, the Medicare Contractor contends that the regulation's use of the word "its" in reference to the cost reporting period bars New Rochelle from using the prior operator's historical data.[61] For these reasons, the Medicare Contractor concludes that "the Provider does not meet the first criterion."[62]

Secondly, the Medicare Contractor points out that the Provider must currently be receiving

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[55] *Id*. at 16-17.
[56] *Id*. at 14-15 (citing to 66 Fed. Reg. 3358, 3370 (Jan. 12, 2001) (emphasis added); *see also* Ex. C-11.
[57] *Id*. at 15.
[58] *Id.*
[59] *Id.* (quoting 42 C.F.R. § 413.87(c)(1) (emphasis added)).
[60] *Id.*
[61] *Id.*
[62] *Id.*

reasonable cost payment for the NAHE program under § 413.85.[63] The MAC acknowledges that New Rochelle meets this requirement.[64]

Third, for cost reporting periods beginning on or after January 1, 2001, an extra requirement applies. According to 42 C.F.R. § 413.87(c)(2), "the hospital must have had a Medicare + Choice utilization greater than zero in its cost reporting period(s) ending in the fiscal year that is 2 years prior to the current calendar year."[65] The MAC acknowledges that the Provider also meets this requirement.[66]

The Medicare Contractor contends that irrespective of the Provider's assertion of entitlement, the absence of a required criterion precludes calculation of a nonzero amount.[67] Furthermore, the Medicare Contractor argues that the Provider cannot disregard the unmet criterion to receive the managed care payment.[68] The Medicare Contractor relies on 42 U.S.C. § 1395x(v)(1)(A) to emphasize that fulfillment of all criteria is necessary and maintains that the "statute shows that the regulations will determine what methods are used in order to calculate the amount of the payment."[69]

The Medicare Contractor asserts that it is important to emphasize that none of the criteria permit a provider to utilize another provider's cost reporting data when claiming the NAHE Medicare managed care payment.[70] Further, the Medicare Contractor argues that New Rochelle is asking to use Mount Vernon's costs to meet the requirements for a NAHE Medicare managed care payment, and then cites to 42 C.F.R. § 413.24(d)(7), stating that it prohibits one provider from claiming another provider's costs.[71] The MAC avers that using Mount Vernon's 2012 cost report to satisfy New Rochelle's shortfall would violate 42 C.F.R. § 413.87(c)(1)(i).[72] Also, the Medicare Contractor contends that the managed care payment cannot be given to Mount Vernon, as the Provider requested, since Mount Vernon failed to meet the current-year reasonable cost requirement.[73]

Finally, the Medicare Contractor refutes the Provider's argument regarding inconsistency with other payment calculations where CMS combines hospital data from merged hospitals.[74] The Medicare Contractor argues the FTE cap and DSH Factor 3 examples which the Provider cited both involve actual hospital mergers, whereas Montefiore New Rochelle and Montefiore Mount Vernon "remain two separate entities with separate cost reports."[75] Also, the Medicare Contractor cites to *Bon Secours Memorial Regional Medical Center*, PRRB 2023-D23

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[63] *Id.* (quoting 42 C.F.R. § 413.87(c)(1)(ii)).
[64] *Id.* at 15–16.
[65] *Id.* at 16. *See* also Ex. C-6 at 2.
[66] *Id.* The Medicare Contractor notes that the FY 12/31/2012 cost report includes 3,925 days on Worksheet S-3. *See* Table A, FYE 12/31/2012.
[67] *Id.*
[68] *Id.* at 17.
[69] *Id;* Ex. C-12 at 1.
[70] *Id.*
[71] *Id.*
[72] *Id.* at 17-18.
[73] *Id.* at 18.
[74] *Id.*
[75] *Id.*

(September 15, 2023), reinforcing that 42 U.S.C. § 1395ww(1) provides for additional payments to hospitals operating NAH programs, implemented at 42 C.F.R. § 413.85, which allows for additional payments tied to Part C managed care utilization if qualifying conditions under § 413.87(c) are satisfied.[76]

Board Analysis

As explained more fully below, the Board finds that New Rochelle did not receive Medicare reasonable cost payment for its nursing education program during the applicable two-year lookback period (*i.e.*, New Rochelle's FYE 12/31/2012), and therefore, did not qualify for the NAHE managed care add-on payment for its cost reporting period ending December 31, 2015. By its own admission, New Rochelle did not meet this criteria because the Montefiore School of Nursing costs were first reported by New Rochelle beginning on January 1, 2014, and claimed on its December 31, 2014 cost report.[77]

As previously noted in the Statutory and Regulatory Background section, 42 U.S.C. § 1395ww(l), authorizes additional payments to qualifying hospitals to cover the costs of Medicare Managed Care patients associated with approved NAHE programs. This statutory provision establishes the methodology for calculating these additional payments and sets forth the rules and conditions for hospitals receiving reasonable cost payment for an approved NAHE program under 42 C.F.R. § 413.85. For cost reporting periods beginning on or after January 1, 2001, 42 C.F.R. § 413.87(c) specifies that a hospital operating a NAHE program may receive the additional managed care payment ***only*** if it satisfies all three (3) of the following criteria:

> (1)(i) The hospital must have received Medicare reasonable cost payment for an approved nursing or allied health education program under § 413.85 in its cost reporting period(s) ending in the fiscal year that is 2 years prior to the current calendar year . . . .;
>
> (ii) The hospital must be receiving reasonable cost payment for an approved nursing or allied health education program under § 413.85 in the current calendar year.; [and]
>
> (2) For portions of cost reporting periods occurring on or after January 1, 2001, in addition to meeting the conditions specified in paragraphs (c)(1)(i) and (c)(1)(ii) of this section, the hospital must have had a Medicare+Choice utilization greater than zero in its cost reporting period(s) ending in the fiscal year that is 2 years prior to the current calendar year.

Similarly, the Board notes that 42 U.S.C. § 1395ww(l)(2)(C)(i) specifies that the reimbursement be based, in part, on "the Secretary's estimate of the ratio of the amount of payments made under section 1395x(v) of this title ***to the hospital*** *for nursing and allied health education activities* for

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[76] *Id.* at 19.
[77] Ex. C-3 at C-0007, C-0021, and C-0037. *See also* Provider's FPP at 5-6; Stip. at ¶ 5.

the hospital's cost reporting period ending ***in the second preceding fiscal year***."[78] Accordingly, the statute, implementing regulations, and the CMS guidance are aligned and clear on the qualification requirements for the NAHE managed care payment. By its own admission, New Rochelle was not the operator of the nursing program during the federal fiscal year two years prior to the current calendar year and therefore it did not receive any reasonable cost Medicare payment for the NAHE program during that period. Since New Rochelle did not satisfy all three required criteria, it did not qualify for the additional NAHE managed care payment for its cost reporting year ending December 31, 2015. The Medicare Contractor's disallowance is affirmed.

The Board also rejects New Rochelle's alternative argument that the Medicare Contractor should have relied on Mount Vernon Hospital's cost data to satisfy the two-year lookback requirement. New Rochelle argues this substitution is proper because: 1) the nursing school was already an established program; 2) it remained under common Montefiore ownership; 3) it stayed physically located on Mount Vernon Hospital's campus; and 4) New Rochelle merely assumed management and administration of the nursing program.[79] However, these facts do not overcome a straightforward regulatory obstacle, Mount Vernon hospital holds its own Provider Number and files its own, separate cost report and MSON, the NAHE program at issue, was considered a new program when it moved to New Rochelle. New Rochelle cannot borrow the historical cost report data of the previous operator of the nursing school (Mount Vernon Medical Center), to satisfy the two-year lookback requirement, when that prior operator had a different provider number.[80] Both the statute and regulation require "the hospital" to have had Medicare-reimbursable NAHE activities in the fiscal year that is two (2) years prior to the fiscal year for which the NAHE managed care payment is being sought. Thus, this requirement must be met by the Provider claiming the NAHE managed care payment. Common ownership and shared physical location do not convert two unique providers, each with independent Medicare reporting responsibilities, into a single reporting provider for purposes of this calculation.

The Board also rejects New Rochelle's arguments that the Medicare Contractor treated this NAHE reimbursement situation inconsistently with CMS' treatment of relocated skilled nursing facilities and GME residency training programs, and also inconsistently when compared with CMS' practice of combining hospital data from merged hospitals in other payment calculations such as FTE caps and DSH Factor 3.[81] The Board does not have discretion to ignore the plain language of the regulation,[82] and, as discussed above, the regulation clearly requires "the hospital" to have "received Medicare reasonable cost payment for an approved nursing or allied health education program under § 413.85 in its cost reporting period(s) ending in the fiscal year that is 2 years prior to the current calendar year."[83] Regardless, the Provider's argument is flawed. First, these other reimbursement situations do not involve NAHE and are inherently different, particularly as it relates to GME programs. Second, most of the situations referenced involve mergers and the case before us does not involve a hospital merger, which is inherently different from a relocation (particularly when the transferred program is considered "new" and subject to the State survey and

[78] (Emphasis added).
[79] *See* Provider's FPP at 11.
[80] 42 C.F.R. § 413.85(g) provides limited exceptions to meeting the "operator requirements" in 42 C.F.R. § 413.85(f) and none of them are applicable here.
[81] *See* Provider's FPP at 15-16.
[82] 42 C.F.R. § 405.1867.
[83] 42 C.F.R. § 413.87(c)(1)(i).

certification process). Third, these comparisons fail because New Rochelle was denied Medicare managed care payment because it did not operate (and thereby receive Medicare reimbursement for) the program during the relevant cost reporting period. This is an independent reason for denial, regardless of CMS' approach to relocated or merged programs. New Rochelle did not satisfy all three (3) statutory and regulatory criteria required to qualify for the additional NAHE managed care payment for its cost reporting year ending December 31, 2015, and no comparison to a different payment structure or context changes that outcome.

Finally, the Board rejects New Rochelle's argument that the Medicare Contractor failed to account for the Provider's reliance on prior communications with CMS, in which CMS gave no indication that the nursing school's transfer would adversely affect New Rochelle's Medicare reimbursement or its qualification for an additional NAHE managed care payment.[84] The Board reviewed the Provider's Exhibit 5, which contains the email communication between the Provider and CMS. The Board finds that the Provider never posed any specific question to CMS regarding its qualification for a NAHE managed care payment following MSON's transfer to New Rochelle. The term "managed care payment" does not appear in any of the emails, and the discussion focuses on the pass-through reimbursement only. Because the record contains no evidence that New Rochelle's sought or received any assurance from CMS on the additional NAHE managed care payment issue, its claimed "serious reliance interests"[85] are not supported by the record and are disingenuous.

DECISION AND ORDER

After considering the Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor's adjustment to disallow the Provider's NAHE managed care payment for its fiscal year ending December 31, 2015 was proper.

BOARD MEMBERS:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

FOR THE BOARD:

9/9/2026

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair
Signed by: KEVIN D. SMITH -A

[84] *See* Stip. at ¶¶ 6, 7.
[85] Provider's Response Brief at 8.