CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Brigham and Women's Hospital	Provider Cost Reimbursement Determination for Cost Reporting Period Ending: Various
Provider	
vs.	
National Government Services, Inc.	Review of PRRB Dec. Nos. 2020-D5
Medicare Administrative Contractor	Dated: February 24, 2020

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in § 1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). The CMS' Center for Medicare (CM) and the Medicare Administrative Contractor (MAC) submitted comments, requesting reversal of the Board's decision. The parties were notified of the Administrator's intention to review the Board majority decision. Comments were also received from the Provider requesting that the Administrator affirm the Board's decision. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

BACKGROUND

The Provider is an acute care hospital located in Boston, Massachusetts. For the fiscal periods in dispute, the MAC made adjustments to the Provider's FY 2010, FY 2011, and FY 2012 cost reports to disallow the pass-through costs for the Ultrasound and Nuclear Medicine Allied Health Clinical Training programs because it determined that the Provider failed to demonstrate that these costs were claimed and paid on the most recent cost reporting period that ended on or before October 1, 1989. The Provider appealed the disallowance of these costs to the Board.

ISSUE AND BOARD'S DECISION

Issue No. 1 was whether the MAC improperly disallowed the Provider's reasonable costs for the Ultrasound Allied Health Clinical Training Program (UAHCTP) that is not operated by the Provider.[1]

Issue No. 2 was whether the MAC improperly disallowed the Provider's reasonable costs for Nuclear Medicine Allied Health Clinical Training Program that is not operated by the Provider.[2]

The Board addressed the issues together. The Board held that the MAC improperly disallowed the Provider's reasonable costs for the Ultrasound Allied Health Clinical Training Program and the Nuclear Medicine Allied Health Program for the cost reporting periods in dispute. In reaching this determination the Board determined that the Ultrasound and Nuclear Medicine Allied Health Programs existed in fiscal year 1989 and that each of the programs were included in the Provider's paramedical costs for its submitted fiscal year 1989 cost report.[3] Accordingly, the Board concluded that the Provider met the criteria for reimbursement of clinical training costs of non-provider operated programs set out in the statute and in the regulations at 42 C.F.R. § 413.85(g).

In addition, the Board determined that the MAC's prior determination that the Provider's 1989 "as submitted" cost report claimed paramedical education for the Ultrasound and Nuclear Medicine programs met the definition of "predicate fact" in 42 C.F.R. § 405.1885(a)(1)(ii), as it was a finding of fact that was used to determine the Provider's reimbursement from FY 1989 through FY 2009. The Board noted that for 20 years, the MAC both accepted the fact that the Provider claimed on its as filed FY 1989 cost report, paramedical educations for Ultrasound and Nuclear Medicine programs, and reimbursed the Provider its reasonable cost for these programs under the grandfather clause of 42 C.F.R. § 413.85(g)(2)(ii). Moreover, the regulations at 42 C.F.R. § 405.1885(a)(1) bars a Medicare contractor from reopening a "predicate fact" unless it is within the three year window to reopen the original determination that established the predicate fact. Accordingly, the MAC is precluded from revisiting that "predicate fact" – whether through

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[1] *See*, Provider's Final Position Paper at 3. The amount at issue for the Ultrasound Allied Health Clinical Training Program totals $136,728, comprised of $45,472, $43,890 and $47,441 in FYs 2010, 2011, and 2012 respectively.

[2] *Id*. The amount at issue for the Nuclear Medicine Allied Health Clinical Training Program totals $156,355, comprised of $30,863, $55,218, and $70,274 in FYs 2010, 2011 and 2012, respectively.

[3] *See*, PRRB Dec. No. 2020-D5 at 7: "Although the Board does not have a breakdown..., the Provider's A-6 reclassification worksheet for FY 1989 indicates this amount includes Ultrasound and Nuclear Medicine as line 24.04 is described as "Paramed Ed Xray Diag & Ultrasound…. "

reopening, modification or a course correction – because the three year reopening has expired.

SUMMARY OF COMMENTS

The Centers for Medicare (CM) submitted comments requesting that the Administrator reverse the Board's decision. CM disagreed with the Board's determination that the MAC improperly disallowed the Provider's reasonable costs for the Ultrasound and the Nuclear Medicine Allied Health programs for the cost reporting periods in dispute.

CM disagreed that, the MAC's prior determination that the Provider's 1989 "as submitted" cost report claimed paramedical education cost for the Ultrasound and Nuclear Medicine programs met the definition of a "predicate fact" that was used to determine the Provider's reimbursement from FY 1989 through 2009. CM argued that the 42 C.F.R. § 405.1885(b)(2)(iv) provides an exception to the "predicate fact" rule for reasonable cost payment determinations. Specifically, since payments for nursing and allied health education programs fall under § 1861(v) of the Act, then finding relating to such payments either on the 1989 cost report or subsequent cost reports are not subject to the "predicate fact" rule. Therefore, since the "predicate facts" rule does not apply to reasonable cost determinations, the MAC acted correctly in reviewing and revising past reasonable cost determinations. CM explained that, whether the determinations were made by the same MAC, or a previous MAC, or whether those payments were made to the Provider historically, is not germane.

With regard to whether the Ultrasound program met the requirements at 42 C.F.R. § 413.85(g)(2), CM contends that the Provider did not meet this requirement because the Provider's 1989 Notice of Program Reimbursement (NPR) was not issued until September 16, 1991. The regulations require that if the NPR was not issued by November 5, 1990, the clinical training cost can still be claimed as pass-through cost if the MAC included the clinical training costs in the allowable cost used to determine the interim rate for the most recent cost reporting period ending on or before October 1, 1989 or 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. This is not the case. While the Provider may have intended to report the costs of the Ultrasound program as a pass-through on its initially submitted 1989 cost report, it failed to actually do so.

Regarding whether the Nuclear Medicine program was paid as a pass-through on the 1989 cost report, CM contends that the program did not exist in 1989. Moreover, the Provider has failed to provide documentation demonstrating that the Nuclear medicine program was approved by a state licensing organization or if not licensed accredited by a national recognized professional organization. Failure to document in a verifiable manner that a program is accredited/licensed is grounds for disallowance.

Finally, CM addressed the Provider's misunderstandings that 1) in order for a non-provider operated program to qualify for reasonable cost payment of its clinical costs, a provider only needs to prove that the percentage of allowable clinical training costs in the current year does not exceed the percentage of total clinical training cost in 1989, and that 2) the provider need not prove that the clinical costs being paid for in the current year pertain only to programs that were actually in existence and paid for in 1989, rather than new non-provider operated programs that were started after 1989. CM explained that the regulations at 42 CFR 413.85(g)(2)(iii) state: "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. 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."

After reviewing the preamble in the September 22, 1992 Federal Register (57 FR 43664-5), CM stated that, inter alia, the intent of the provision was to protect certain hospitals that had come to rely on the pass-through payment received through interim rates, even though they no longer actually qualified for pass-through payment because their programs were not provider-operated. Since the intent of the OBRA 1990 provision was to protect hospitals that relied on the payments received, while not increasing Medicare expenditures, it follows that the payment percentage calculated under 42 CFR 413.85(g)(2)(iii) must be determined using only the costs of programs that existed in 1989 for which the hospital received reasonable cost payment at that time.

The MAC submitted comments requesting that the Administrator review and reverse the Board's decision. The MAC contends that the Board erred in its determination that the Provider claimed Nuclear Medicine and Ultrasound clinical training costs as pass-through costs on its submitted FY 1989 cost report because to meet the requirements of 42 C.F.R. § 413.85(g)(2)(ii), the costs associated with the ultrasound program would have had to have been included in the interim rate for the Provider's 1989 cost reporting period or the Provider would have had to have claimed the costs for its ultrasound program as a pass-through cost on its initially submitted 1989 cost report, they were not.

Finally, the MAC contends that the Board erred in its determination of the "predicate fact" rule. The MAC noted that 42 C.F.R. §405.1885(b)(2)(iv) prohibits the application of the "predicate fact" rule in this case because Nursing and Allied Health Education programs falls under § 1861(v) of the Act. More specifically, the "predicate fact" rule will not apply to findings when made as part of a determination of reasonable cost under § 1861(v)(1)(A) of the Act.

The Provider submitted comments requesting that the Administrator affirm the Board's decision. The Provider contended that the MAC's prior determination that the Provider

claimed the costs of the Ultrasound and Nuclear Medicine training programs as pass-through cost on its as-submitted 1989 cost report is a "predicate fact." Moreover, it is not open to a different interpretation as the MAC and CM contend. The Provider argued that either the costs were claimed in accordance with the regulation or they were not. The MAC found that the costs were properly claimed on the 1989 as submitted cost report or the Notice of Program Reimbursement (NPR) dated September 16, 1991. Therefore, this determination is a "predicate fact" that cannot be changed because the 3-year reopening period has expired.

The Provider further contended that the MAC and CM's argument that the regulation at 42 C.F.R. § 405.1885(b)(2)(iv) prohibits the application of the "predicate fact" rule to findings "when made as part of a determination of reasonable cost under § 1861(v)(1)(A) of the Act, is misplaced. The Provider contended that 42 C.F.R. § 405.1885(b), draws a distinction between a MAC's "own motion" reopening and a provider's request to reopen. Section 405.1885(b)(1) controls "own motion" reopening by the MAC, the Secretary, or the Board, whereas § 405.1885(b)(2), upon which the MAC and CM relies, controls reopening "request" made by a provider. It is in paragraph (b)(2), the provisions regarding a provider's request for a reopening, that the reasonable cost exception appears (405.1885(b)(2)(iv)). The exception clearly applies to provider-initiated reopenings. To the contrary, the section regarding MAC reopenings, 42 C.F.R. § 405.1885(b)(1), contains no such exception language. In other words, a MAC may only reopen a base year "predicate fact" determination within three years. There is no exception to the 3-year limit in § 405.1885(b)(1) to allow a MAC to redetermine a "predicate fact" on a reasonable cost item decades later.

Accordingly, while the initial determination that the Provider satisfied the 1989 base year criteria is a "predicate fact" it does not prevent an audit to determine whether the current year costs satisfies the remaining factors for reimbursement of allied health costs. Specifically, an auditor may examine whether the Provider satisfied the regulatory criteria in 42 C.F.R. § 413.85(g) for the current year; whether the proportion of total allowable costs of the program in the current year do not exceed the proportion of the costs to total allowable cost in 1989((g)(2)((iii); whether the hospital receives a benefit through clinical services for the financial support it provides to allied health program ((g)(2)(iv); and whether the costs incurred by the hospital do not exceed those that would have been incurred if the hospital had operated the program ((g)(2)(vi)).

Finally, the Provider contended that CM's argument is arbitrary and capricious and unduly prejudiced because it severely disadvantages the Provider in requesting documents that are decades old. The Provider noted that it successfully provided the MAC with documentation for all prior year audits, however, the MAC began disallowing the at-issue costs in 2010, some twenty-one years after the 1989 base year, with the hearing in this appeal taking place nearly thirty years after the 1989 base year. The Provider stated that it does not have further documentation that the MAC has not already seen and, given the lengthy time lapse since the establishment of the base year, the Provider could not

reasonable be expected to have other documentations. Additionally, potential witnesses with knowledge are no longer available.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

Under § 1861(v) of the Social Security Act, Medicare has historically paid providers for the program's share of the costs that providers incur in connection with approved educational activity. In making such payments, §1815(a) provides that: "The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate, the amounts so determined, with necessary adjustments on account of previously made overpayments or underpayments; except 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 under this part for the period with respect to which the amounts are being paid or any prior period." [4]

Pursuant to 42 C.F.R. § 413.20(b) cost reports are required from providers on an annual basis with reporting periods based on the provider's accounting year. For payment to be made on the basis of reimbursable cost, 42 CFR § 413.24 requires adequate cost data and cost finding. This must be based on their financial and statistical records which must be capable of verification by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting,

While many payments are now made on a prospective payment basis, certain costs continue to be paid on a reasonable cost basis, often referred to as "pass through costs." These include certain approved nursing or allied health education program costs incurred by providers. Section 4404(b) of the Omnibus Reconciliation Act of 1990 (OBRA 1990) provides that effective with cost reporting periods beginning on or after October 1, 1990, if certain conditions are met, the cost incurred by a hospital for clinical training conducted on the premise of the hospital under an approved nursing or allied health education program that is not operated by the hospital are treated as pass-through costs and paid on a basis of reasonable costs. These provisions are codified in the regulations at 42 C.F.R. § 413.85(g).

[4] See also 42 C.F.R. § 413.5 "Cost reimbursement: General. (a) In formulating methods for making fair and equitable reimbursement for services rendered beneficiaries of the program, payment is to be made on the basis of current costs of the individual provider, rather than costs of a past period or a fixed negotiated rate.

Sections 413.85(g)(1) and (2) specify that pass-through payment for the clinical costs (not classroom costs) of certain non-provider-operated programs may be made to a hospital if, in part, the hospital claimed and was paid for clinical training costs on a reasonable cost basis during its most recent cost reporting period that ended on or before October 1, 1989. Specifically, 42 C.F.R. § 413.85(g)(2)(ii) and (iii) state:

> (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 intermediary 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 costs for clinical training in the provider's most recent cost reporting period ending on or before October 1, 1989.5

The regulations at 42 C.F.R. §413.85(g)(iv) through (vi) provide that:

> (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 or 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.6

Relevant to this case, in 2013, CMS issued a final regulation which procedurally addressed factual determinations in a base year that have an impact on subsequent cost reporting

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[5] *See*, 42 C.F.R. § 413.85(g)(2)(ii).
[6] See, 42 C.F.R. §413.85(g)(iv) through (vi).

years[7]. Set forth at 42 C.F.R. § 405.1885, applicable to cost report reopenings, the regulation provides:

> (a) General. (1) A Secretary determination, *a contractor determination*, or a decision by a reviewing entity (as described in § 405.1801(a)) *may be reopened, with respect to specific findings on matters at issue in a determination* or decision, by CMS (with respect to Secretary determinations), *by the contractor* (with respect to contractor determinations), or by the reviewing entity that made the decision (as described in paragraph (c) of this section).
> (i) A specific finding on a matter at issue may be legal or factual in nature or a mixed matter of both law and fact.
> (ii) A specific finding on a matter at issue may include a factual matter that arose in or was determined for the same cost reporting period as the period at issue in an appeal filed, or a reopening requested by a provider or initiated by a contractor, under this subpart.
> (iii) A specific finding on a matter at issue may include a predicate fact, which is a finding of fact based on a factual matter that first arose in or was first determined for a cost reporting period that predates the period at issue (in an appeal filed, or a reopening requested by a provider or initiated by a contractor, under this subpart), **and once determined**, was used to determine an aspect of the provider's reimbursement for one or more later cost reporting periods.
> (iv) Except as provided for by this section, § 405.1887, and § 405.1889, a specific finding on a matter at issue may not be reopened and, if reopened, revised. (Emphasis added.)

In addition, the time limits are set forth at 42 C.F.R. § 405.1885(b) provides time limits to such reopenings:

> (b) Time limits –
> (1) *Own motion reopening of a determination* not procured by fraud or similar fault. An own motion reopening is timely only if the notice of intent to reopen (as described in § 405.1887 of this subpart) is mailed no later than 3 years after the *date of the determination* or decision that is the subject of the reopening. The date the notice is mailed is presumed to be the date indicated on the notice unless it is shown by a preponderance of the evidence that the notice was mailed on a later date.
> (2) Request for reopening of a determination not based on fraud or similar fault.
> (i) A reopening made upon request is timely only if the request to reopen is received by CMS, the contractor, or reviewing entity, as appropriate, no later than 3 years after the date of the determination or decision that is the

[7] *See*, 78 Fed. Reg. 74826, 75162-69 (Dec 10, 2013) (2013 Rule).

> subject of the requested reopening. The date of receipt by CMS, the contractor, or the reviewing entity of the request to reopen is conclusively presumed to be the date of delivery by a nationally-recognized next-day courier, or the date stamped "Received" by CMS, the contractor or the reviewing entity (where a nationally-recognized next-day courier is not employed), unless it is shown by clear and convincing evidence that CMS, the contractor, or the reviewing entity received the request on an earlier date.
> (ii) A request to reopen does not toll the time in which to appeal an otherwise appealable determination or decision.
> (iii) A request to reopen that is received within the 3-year period described in this paragraph is timely, notwithstanding that the notice of reopening required under § 405.1887 of this subpart is issued after such 3-year period.
> (iv) The 3-year period described in paragraphs (b)(2)(i) through (b)(2)(iii) of this section applies to, and is calculated separately for, each specific finding on a matter at issue (as described in paragraphs (a)(1)(i) through (a)(1)(iv) of this section, *but not to such findings when made as part of a determination of reasonable cost under section 1861(v)(1)(A) of the Act.*

In promulgating the clarification of the Secretary's policy on reopening in the 2013 rule, the Secretary explained the general concept of "predicate facts" in the context of reasonable cost reimbursement:

> [T]he factual underpinnings of a specific determination of the amount of reimbursement due to a provider may first arise in, or be determined for, a different fiscal period than the cost reporting period under review. We refer to these factual determinations as "predicate facts." Some of the factual underpinnings of determinations of reasonable cost reimbursement under section 1861(v) of the Act are subject to review for each cost report in which the provider claims the cost under the general principle that "payment is to be made on the basis of current costs of the individual provider, rather than costs of a past period" (42 CFR 413.5(a)). For example, reimbursement for a provider's bad debts arising from unpaid Medicare deductibles and coinsurance may be denied under 42 CFR 413.89 in the first fiscal period it is claimed because the collection effort on the account has not ceased and the account cannot yet be deemed worthless. However, the same bad debt may be deemed allowable in the following fiscal period, when the collection effort has ceased and the account has been determined to be worthless. Similarly, interest expense is subject to review each fiscal period to determine whether it is allowable for each fiscal period during the life of the loan (42 CFR 413.153). 78 Fed. Reg. 74826, 75163 (Dec.10, 2013)

The Secretary contrasted that with those predicate facts that are once determined and subsequently used for several fiscal periods thereafter.

> Other "predicate facts" are determined once, either in the first fiscal period in which they arise or are first determined, or in the first fiscal period that they are used as part of a formula for reimbursement, and then applied as part of that reimbursement formula for several fiscal periods thereafter. These facts are not reevaluated annually to determine whether they support a determination that a particular cost is reasonable because the formula is a proxy for reasonable costs. Instead, the formula itself will provide for changes in costs through an updating factor or otherwise. 78 Fed. Reg. 74826, 75163 (Dec.10, 2013)

Consequently, the Secretary concluded that:

> As discussed above, we also recognize that not all facts occurring in prior fiscal periods *are "predicate facts" in the same sense*, because they are not determined once, but may be subject to review on an annual basis as part of the determination of a provider's reasonable cost reimbursement under section 1861(v) of the Act, such as the facts underpinning reimbursement for Medicare bad debts or allowable interest expense. *Because these facts are subject to review each fiscal period by the intermediary, the intermediary's findings should also continue to be subject to review, either through an appeal or reopening.* 78 Fed. Reg. 74826, 75164.

In response to commenters, the Secretary pointed out:

> However, in light of the comments we received, we are limiting the scope of this final rule to "predicate facts" *that are determined once* and then used to determine payments for one or more fiscal periods after the fiscal period in which the facts arose or were determined. *We are not applying these final provisions to facts that are subject to annual evaluation as part of the intermediary's final determination of reasonable cost reimbursement under section 1861(v) of the Act.* We believe that narrowing the definition of "predicate facts" in this fashion will help allay commenters' concerns that the proposed revisions will be subject to ad hoc exceptions that only serve to disadvantage providers. We note that the annual evaluation of certain predicate facts in the determination of reasonable cost reimbursement can increase the provider's reimbursement in later fiscal periods. For example, if a provider incurs a Medicare bad debt in 2002, but the debt is not deemed uncollectable until 2009, the bad debt would be reimbursable in 2009 if all the requirements of § 413.89 were satisfied. *Id.* at 75167.

In sum, the final rule provided that:

> After consideration of the public comments we received, we are adopting the proposed revisions to §§ 405.1885(a)(1) and (a)(2)(iv) to clarify that the specific "matters at issue in a determination" that are subject to the

> reopening rules include factual findings for one fiscal period that are predicate facts for later fiscal periods with the following modifications: We are adding language to paragraph (a)(1)(iii) that defines the "predicate facts" that are subject to the revisions as factual findings for one cost reporting period *that once determined* are used in one or more subsequent cost reporting periods to determine reimbursement. *We are adding language to paragraph (b)(2)(iv) to clarify that it does not apply to factual findings when made as part of a determination of reasonable cost under section 1861(v)(1)(A) of the Act.* Paragraph (a)(1)(iv) also was reworded for clarity. *Id*. at 75168

In summary, 42 CFR 405.1885(a)(1)(iii), consistent with longstanding practice, specifically excludes reasonable cost determinations from the definition of a predicate fact and the related three-year limitation on reopening as reasonable cost determinations are made annually.[8] In contrast, the three -year limitation is applicable to those predicate facts, defined as "once determined" and that are used in one or more subsequent cost reporting periods to determine payment. In addition, in response to commenters, the clarification promulgated pursuant to the 2013 regulation, at 42 C.F.R. §405.1885(b)(2)(iv), also affirmed that the three-year limitation for a "predicate fact" was not applicable to provider's request for reopening with respect to reasonable cost payment determinations assuring symmetry in the process.

In this case, the Board made the following findings on the cost report adjustments at issue: (1) the Provider claimed Nuclear Medicine and Ultrasound clinical training costs as pass-through costs on its submitted FY 1989 cost report and, therefore, met the requirements of 42 C.F.R. § 413.85(g)(2)(ii); and (2) the MAC's determination that the Provider's FY 1989 submitted cost report included paramedical education costs for the non-provider operated Ultrasound and Nuclear Medicine Allied Health Program, was a "predicate fact" that cannot be changed because the three-year reopening period has expired.

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[8] *See e.g. HealthEast Bethesda Lutheran Hospital & Rehabilitation Center v. Shalala,* 164 F.3d 415 (8th Cir. 1998). This was also recognized in the 2013 preamble. ("The other cases cited by commenters do not concern "predicate facts" as defined in the proposed revisions. *HealthEast Bethesda Lutheran Hospital & Rehabilitation Center v. Shalala,* 164 F.3d 415 (8th Cir. 1998), concerned interest expenses evaluated under § 413.153(b)(2). As we have discussed above, interest expense, when considered on a reasonable cost basis, is subject to reexamination in each fiscal period to determine whether the cost at issue qualifies as "necessary" interest expense for that fiscal period. We refer readers to §413.5(a) of the regulations. The facts associated with these expenses, like bad debt arising from non-payment of Medicare deductibles and coinsurance, are not determined once and applied thereafter to determine reimbursement in subsequent fiscal periods. They are not within the scope of the proposed revisions, as we have revised it in response to the comments.") *Id.* at 75167.

Relevant to this case, he regulation at 42 C.F.R. § 413.85(g)(2), states:

> 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:…
>
> (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 –
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> (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
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> (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….[9]

A review of the record shows that the Provider's NPR for FY 1989 was issued on September 16, 1991. As the NPR for the Provider's September 30, 1989 cost report was not issued on or before November 5, 1990, the regulation requires that the Provider had to have claimed the Ultrasound clinical training cost and the nuclear medicine costs on its initially submitted FY 1989 cost report. The amount of costs in question was $316,562. The factual issue has appeared to evolve from whether the provider reclassified program expenses from Ultrasound cost center to the X/Ray Therapy cost center in the initial cost report, to whether the $316,562 (which the parties appear to agree was claimed on the initially filed cost report) reflects inclusion of the costs of the two programs.

For example, the MAC stated at its final position paper at page 8 that:

> The MAC's review of the Filed FY 1989 cost report included at Exhibit P-7[10] shows that $316,562 was reclassified on Worksheet A-6 from the Radiology Ancillary Cost Center to the Radiology Paramedical Cost Center Line 24.04 via reclassification S. [Exhibit P-8, page 2.] The FY 1989 work papers prepared by the Provider indicate that salary costs in the amount of

[9] *See*, 42 C.F.R. § 413.85(g).

[10] Note the copy of the FY 1989 cost report in the record Exhibit P-6 is not at the required resolution for the size of the print, making it illegible.

> $35,547 for the Ultrasound Education Coordinator was included in the adjusted Worksheet A-6 reclassified amount of $351,086 to the Paramedical Radiology Diagnostic cost center on the settled cost report at Exhibit P-8, page 4. The variance between the Filed Worksheet A-6 reclassification of $316,562 and the Settled Worksheet A-6 reclassification of $351,086 is $34,524, which is comparable to the $35,547 salary of the Ultrasound Education coordinator at Exhibit P-8, page 3. *However, no documentation was included at Exhibit P-8, nor submitted during the audit review, detailing the composition of the $316,562 costs to allow the MAC to confirm that this reclassification to the Paramedical Radiology Diagnostic Cost Center, reported on Worksheet A-6 of the Filed FY 1989 cost report, included Ultrasound Allied Health Clinical Training costs."* (Emphasis added.)

In addition, with respect to the Nuclear Medicine, the MAC similarly argued:

> The MAC argues that per review of the FY 2008 MAC audit work papers and Provider work papers at Exhibit P-11, the auditor's reliance on the Provider's work papers to support that the Nuclear Medicine Training Program Costs were allowable Allied Health Costs for the FY 2008 year was improper, as the Provider's work papers only show the costs claimed on the filed and finalized cost reports that were reported in the Paramed Ed Xray Diagnostic Cost Center, Line 24.05, i.e., $316,562 and $351,086 respectively (Exhibit P-11) page 4 *but did not include any documentation detailing the composition of the $316,562 costs to allow the MAC to confirm that the $316,562 reclassification amount to the Paramedical Radiology Diagnostic cost center, reported on worksheet A-6 of the Filed FY 1989 cost report, included Nuclear Medicine Allied Health clinical Training costs.* (Emphasis added.)

CM in its comments stated that the amount of Ultrasound costs in question were $316,562 and to support its intentions, the Provider included papers showing a Worksheet A-6 reclassification from Radiology Diagnostic (cost center 41) to X/Ray Therapy (cost center 24.04). However, CM stated no amounts on those papers reconcile to the amount of $316,562. The Board members at the hearing pursued that line of questioning:

> Witness: Page 10 of 20?
> Provider Representative: No, the position paper.
> Board Member: No, the actual position paper.
> Witness: Okay, okay. Yeah.
> Board Member: Under the ultrasound -- well, ultrasound clinical training program, about three-quarters of the way down the page
> there's a sentence that states the MAC audited Provider's cost report in 1989 and increased the figure from 316,562 to 351,086. lf you look at the 351,086, is that the number identified on page 7 of 20 in P-l1 at line 24.04 under radiology diagnostic?
> Witness: Yes,

> Board Member: …And is it your understanding that the nuclear medicine costs were also included in the 351,086 expenses.
> Witness: Yes, I believe so. (Transcript of Oral Hearing, pp. 56-57.)

More specifically in the Transcript of Oral Hearing, a Board Member asked:

> Board Member: Yes, just one more question, And I'm just looking at the F on -- again, on P-12, and I'm just trying to follow the logic of the auditor. Then he says -- so he says, since we are relying on the filed 1989 cost report as our source document, our determination concludes there was no ultrasound training cost included in the paramedical ed cost center in 1989 on line 24,04, So in… the 2008 work papers it was concluded that the reclassification -- or -- or they believe that the reclassification of the 316 was on -- was made to the diagnostic radiology, and they said ultrasound, diagnostic radiology, is setting in the diagnostic cost center and it was included in that one re-class of 316,000. So I'm just wondering why we would look for a specific reclassification of -- of ultrasound and conclude somebody attested that it didn't exist, therefore I'm going to look for a reclassification in 1989, Uh, I didn't see it, therefore -- therefore, it didn't exist. Okay. *When it's clear when we look back at the 2008 work -- not clear, but the work – that -- that ultrasound and radiology is being included in the 316,000. So I guess what I'm saying is I -- I don't think we would expect to see it on the 1989 cost report because it was in the 316,000, ls -- ls it -- is the reasoning incorrect or ls that*? Do --do you see what I'm saying?
> MAC: I see exactly what you're saying, sir. As I sit here, I understand you question, I don't have -- and your point -- *I don't have an answer for you.*
> Board Member: Okay, All right. Well. thank you. (Transcript of Oral Hearing, pp. 85-88).(Emphasis added.)

Ultimately, the Board ultimately found that:

> Contractor maintains that the Ultrasound cost were not claimed in paramedical education in FY 1989 because it did not see a reclassification from the Ultrasound line to the Radiology diagnostic paramedical line 24.04 in FY 1989.[] However, Brigham and Women's witness testified that Ultrasound was included in Radiology diagnostic in FY 1989[]and, therefore, a separate reclassification would not have been necessary. The testimony is supported by the 1989 A-6 reclassification workpapers showing $316,562 from the "as filed" cost report being reclassified to Radiology diagnostic - paramedical line 24.04 with a footnote stating: "Xray-Diagnostic & Ultrasound costs were included together and reclassified from Xray Diagnostic."[]

The Board relied upon Provider Exhibits P-8 at 2, P-11, P-12, P-13 and the testimony of the Witness at Tr. 36-39, where the Witness testified that these costs were initially included

in the Radiology diagnostic cost center, and not in separate cost centers suggesting there would not be a separate reclassification to the Xray-Diagnostic shown.

A review indicates documentation that may address the component costs that comprised the $316, 562. In particular, Provider Exhibit P-8 set forth at page 3 shows the following "components" of the $316, 562:

> Stipends $78,128; Supervisors $197, 051; Educational consultants $70,907 (ultra sound 35,540 and radiology $35, 360) for a subtotal of $345,086 plus Fringe $72501, Supplies $5,000 for a total of $423,501 <fringe $72,501 (removed)> for a final total of $351,088.

The $351,088 includes the ultrasound educational consultant expenses, which when removed, approximates the $316,086 in the Paramed Ed Xray Diagnostic Cost Center. The subsequent pages of P-8 show the detailed expenses for the foregoing respective amounts by number of students/supervisors/hours/ per hour cost, etc. (For example, a break-down of the $197,051 for supervisors is shown.) A list of the 1st, 2nd and 3rd Year students is included (not identified by program). A contemporaneous Memorandum to the Reimbursement Analyst (dated May 29, 1990) from the Provider lists instructors for radiology and ultrasound and includes students (which are not identified by program) for FY 1989. Consequently, the further examination and clarification of P-8, in conjunction with other documents, may demonstrate specifically the expenses that comprise the $316,086 that are related to the Ultrasound or Nuclear Medicine program(s).

The MAC and CM cited problems with the Provider demonstrating licensing as to the Ultrasound clinical program and the Nuclear Medicine clinical training for FY 1989 in accordance with 42 C.F.R. § 413.85(g)(1). While the subsequent year MAC work papers for the Nuclear Medicine clinical training program shows a statement that the Provider conceded that the program was not in place until 1997, the Provider witness explained that conclusion was a misunderstanding and that the program was an approved program in 1989, but the costs were not separately recognized on the cost report until 1997. However, the witness also offered that, as it was not a provider-operated program, it would be the teaching institutions that would have the licenses relating to both programs' approvals. This documentation would not be maintained in the normal course of this Provider's business as these are non-provider operated educational programs. Thus, the Administrator finds remand would be appropriate to allow the Provider to obtain necessary documentation to demonstrate whether the programs were approved in 1989, without deciding, at this time, whether the MAC's prior determination, that the Provider's 1989 "as submitted" cost report claimed paramedical education cost for Ultrasound and Nuclear Medicine programs, is excluded from the definition of a "predicate fact" as outlined in the regulation at 42 C.F.R. § 405.1885(a)(1)(iii). .

Accordingly, the Administrator vacates the Board's decision and remands this case for further clarification and development of the record and findings as follows:

On whether the $316,562, was timely claimed in the initial cost report and, if timely claimed, included the expenses of the Ultrasound and Nuclear Medicine clinical training (*see e.g.* P-8); and

After allowing the Provider the opportunity to present further relevant evidence as to the question of the programs' licensing for FY 1989, determine whether the non-provider operated Ultrasound and Nuclear Medicine programs were approved in 1989; and

A Board decision will be subject to 42 CFR 405.1875.

Date: 4/24/2020

/s/

Demetrios L. Kouzoukas
Principal Deputy Administrator
Centers for Medicare & Medicaid Services