CENTERS FOR MEDICARE AND MEDICAID SERVICES

In the case of:	**Claim for:**
Brigham and Women's Hospital **Provider** **vs.** **National Government Services, Inc** **Medicare Contractor**	**Cost Reporting Period Ending:** **Various** **Review of:** **PRRB Dec. No. 2023-D29** **Dated: August 21, 2023**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board).[1] 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 Medicare Administrative Contractor (MAC) submitted comments requesting reversal of the Board's decision on the predicate fact issue. The Center for Medicare (CM) submitted comments, requesting that the Administrator reverse the Board's decision on the predicate fact issue. The Provider submitted comments requesting that the Administrator not disturb 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 adjusted 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.

On February 24, 2020, the Board issued PRRB Dec. No. 2020-D5, holding 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 the submitted fiscal year 1989 cost report. As such,

[1] The Administrator notes that the term PRRB and Board are used interchangeably to reference the same party, the Provider Reimbursement Review Board.

the Board concluded that the Provider met the criteria for reimbursement of clinical training costs of non-provider operated programs.
The Administrator vacated PRRB Dec. No. 2020-D5 and remanded the case for further clarification and development of the record. On October 19, 2020, the Board issued a Notice of reopening, pursuant to the Administrator's remand order. The Board held a live video hearing on May 25, 2021, and issued this decision (PRRB Dec, No. 2023-D29) on August 21, 2023, the subject matter of this appeal.

ISSUE AND BOARD DECISION

The issue is whether Provider timely claimed the $316,565 at issue in the initial fiscal year ("FY") 1989 cost report and, if timely claimed, whether those expenses included Ultrasound and Nuclear Medicine Clinical training costs.

On remand, 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 the submitted fiscal year 1989 cost report. 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 reopening, modification, or a course correction – because the 3-year reopening has expired.

SUMMARY OF COMMENTS

The MAC submitted comments requesting that the Administrator review and reverse the Board's decision on the predicate fact issue. The MAC contended that the Board erred in its determination of the "predicate fact" rule. The MAC noted that § 1885(b)(2)(iv) of the Act 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, § 1861(v)(1)(A) of the Act clearly provides that 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. Finally, *Saint Francis Med. Center v. Aza*, 894 F.3d 290 (D.C. Cir. 2018) on which the Board's decision, in part, relies, is

inapposite to the case because that case did not involve a determination of reasonable cost. Therefore, the Board's determination that the Provider's cost report was a "predicate fact," was erroneous. The MAC did not take a position as to any other aspect of the Board decision.

The CM submitted comments requesting that the Administrator not contest that the $316,562 was timely claimed in the initial cost report, nor contest that this included the expenses of the Ultrasound and Nuclear Medicine clinical training, as well as not contest that these programs were approved in 1989. The CM, however, did not agree with the Board regarding the applicability of the "predicate fact" regulation at 42 C.F.R. § 405.1885. CM reiterated that the regulations at 42 C.F.R. § 405.1885(b)(2)(iv), provide an exception to the "predicate fact" rule for reasonable cost payment determinations. Since payments for Nursing and Allied Health education programs fall under § 1861(v) of Act, then findings relating to such payments either on the 1989 cost report or subsequent cost reports are not subject to "predicate facts." This finding however, would not impact the allowance of these cost.

The Provider submitted comments requesting that the Administrator not reverse or remand the Board's decision. The Provider, however, disagreed with CM that, the reasonable cost exception found at 42 C.F.R. § 405.1885(b)(2)(iv), applied to "own motion" reopening by the MAC. The Provider contends that 42 C.F.R. § 405.1885(b)(2)(iv), only applies to provider-initiated reopening not "own motion" reopening by a MAC. The Provider's position is that 42 C.F.R. § 405.1885(b)(1) controls "own motion" reopening by a MAC and contains no reasonable cost exception language to the three-year limit to allow the MAC to redetermine a predicate fact on a reasonable cost item decades later. Therefore, the MAC may only reopen a base year predicate fact determination within three years, regardless of whether it involves a reasonable cost issue.

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DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits.

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. 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).

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 –
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> (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
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> (B) The provider claimed the clinical training costs as pass-through cost when the cost report for the most recent cost reporting period ending on or before October 1, 1989, was initially submitted.
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> (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.[2]

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.
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> (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.
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> (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.[3]

In 2013, CMS issued a final regulation which provided that factual determinations in a base year that have an impact on subsequent cost reporting years are final and binding once three years have passed and the issue has not been appealed, even if the facts later prove incorrect.[4] The 2013 Rule refers to base year facts as "predicate facts". A "predicate fact" is the factual underpinning of a specific determination of the amount of reimbursement due to a provider. As CMS indicated in the preamble to the 2013 Rule:

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[2] *See*, 42 C.F.R. § 413.85(g)(2)(ii).
[3] See, 42 C.F.R. §413.85(g)(iv) through (vi).
[4] *See*, 78 Fed. Reg. 74826, 75162-69 (Dec 10, 2013) (2013 Rule).

When the specific matter at issue is a predicate fact that first arose in, or was determined for, an earlier fiscal period and that factual data then is used differently or applied to determine reimbursement in one or more later fiscal periods, our longstanding interpretation and practice is that the pertinent provisions of the statute and regulations provide for review and potential redetermination of such predicate fact only by a timely appeal or reopening of: (1) The NPR for the cost reporting period in which the predicate fact first arose, or was first determined; or (2) the NPR for the period for which such predicate fact was first used or applied by the intermediary to determine reimbursement.

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Many reimbursement formulas require the use of predicate facts, where data or a factual fining is taken from an earlier fiscal period and used to determine the amount of provider reimbursement in the fiscal period under review. As discussed above, we believe that these predicate facts should be subject to change only through a timely appeal or reopening for the fiscal period in which the predicate fact first arose or was first determined by the intermediary or the fiscal period in which such fact was first used or applied to determine reimbursement. In some instances, a reimbursement statute may necessitate the use of data from a fiscal period that is not found in that period's cost report or NPR (such as "off the cost report" or underlying documentation). We believe that this kind of determination may be reviewed and re-determined through a timely appeal or reopening of the NPR for the cost reporting period in which the predicate fact was first used (or applied) by the intermediary to determine the provider's reimbursement pursuant to that reimbursement statute.

However, we recognize exceptions when a particular legal provision (of the Medicare statute, regulations, or CMS rulings) authorizes, as part of a specific reimbursement rule, the review and revision of a predicate fact after the expiration of the 3-year reopening period.

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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.

As we stated in the CY 2014 OPPS/ASC proposed rule (78 FR 43683), we believe that the above-described interpretation of our rules regarding the appeal and reopening of predicate facts furthers the interests of both providers and the agency

> in maintaining the finality of intermediary determinations. The alternative, of allowing appeal and reopening of a predicate fact after the expiration of the 3-year reopening period, may result in inconsistent intermediary determination on a reimbursement matter recurring in different fiscal periods for the same provider. An alternative approach of allowing appeal and reopening of a predicate fact beyond the 3-year reopening period could also result in intermediary determinations that are contrary to Medicare law and policy regarding a specific reimbursement matter. As with the target amount example discussed above, reimbursement for a various items is premised on a base period cost determination that could affect reimbursement for a given item for many cost reporting periods thereafter. If a provider disputes such a base period costs determination, it can appeal or request reopening of the NPR for the base period. However, unless such an appeal or reopening results in a different finding as the predicate fact in question, reimbursement for a given provider's cost should not be based on one finding about a predicate fact in the base period and a different finding about the same predicate fact for purposes of determining reimbursement in later fiscal periods.
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> Under our longstanding interpretation and practice, once the 3-year reopening period has expired, neither the provider nor the intermediary is allowed to revisit a predicate fact that was not changed through the appeal or reopening of the cost report for the fiscal period in which such predicated fact first arose or for the fiscal period for which such fact was first determined by the intermediary.[5]

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.

Applying the relevant law and program policy to the foregoing facts, the Administrator disagrees with the Board's finding that the MAC's prior determination that the Provider's 1989 "as submitted" cost report claimed paramedical education cost for Ultrasound and Nuclear Medicine programs met the definition of a "predicate fact" as outlined in the regulation at 42 C.F.R. § 405.1885(a)(1)(iii) and therefore cannot be disturbed. The regulations at 42 C.F.R. § 405.1885(b)(2)(iv) provide an exception to the "predicate fact" rule for reasonable cost payment determinations. Since payments for nursing and allied health education programs fall under § 1861(v) of the Act, then findings relating to such payments either on the 1989 cost report or subsequent cost reports are not subject to "predicate facts." The reasonable cost payment for the nursing education (based on whether the Provider claimed the costs for the programs in the 1989 cost year) is 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. The 1989 reasonable cost determination comprises the fact underpinning reimbursement for annual nursing education costs

[5] *Id.*

for those programs and these facts are subject to review each fiscal period by the MAC. Specifically, 42 C.F.R. § 405.1885(b)(2)(iv), states:

> (iv) The 3-year period described in paragraphs (b)(2)(i) through (b)(2)(iii) of the 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 sections, but not to such findings when made as part of a determination or reasonable costs under section 1861(v)(1)(A) of the Act.

Thus, the "predicate facts" rule that bars revisiting certain facts from prior cost years, does not apply to reasonable cost determinations. The Administrator concludes that the MAC acted properly in reviewing the past reasonable cost determinations as it impacted the cost years at issue reasonable cost determination. [6]Whether those determinations were made by the same MAC or a previous MAC or whether those payments were made to the Provider historically, is not germane.

In vacating the Board's prior decision (PRRB 2020-D05), the Administrator remanded the case for further clarification and development of the record and findings. After the review of the additional information provided and given the specific circumstances of this case, the Administrator agrees with the Board's determination that:

1. Brigham and Women timely claimed the $316,562 at issue in the initial FY 1989 cost report, and these expenses included Ultrasound and Nuclear Medicine clinical training costs.

2. The non-provider operated Ultrasound and Nuclear Medicine programs at issue were approved and licensed in and during FY 1989.

In sum, the Administrator holds that the Provider timely claimed the costs at issue in the initial FY 1989 cost reports and that these expenses included Ultrasound and Nuclear Medicine clinical training costs. The Administrator also finds that since payments for Nursing and Allied Health education programs fall under § 1861(v) of the Act, then findings relating to such payments either on the 1989 cost report or subsequent cost reports are not subject to "predicate facts," however, such a finding does not have an impact on the allowance of the costs in this case.

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[6] While the Board stated a reopening notice would have been required, this action does not require a reopening (or a notice to reopen) of the 1989 cost year as that year's reimbursement is not being disturbed, but rather is being examined in the context of the audit of the reasonable cost payments for the years at issue. Thus, similarly, the Provider's arguments that the predicate fact "bar" does not apply to reasonable cost determinations when reopened on own motion by the MAC but only when requested to be reopened by providers, is not procedurally applicable here. In addition, in a broader context, if a reopening is involved in a matter, whether by order of CMS, the MAC, or a request by the provider, it would be inconsistent to create an asymmetrical application of a rule, as argued by the Provider, nor would there be a rational basis for such asymmetrical application and it would be contrary to CMS' longstanding treatment of reasonable cost determinations as explained by CMS, *inter alia*, in the preamble text.

DECISION

The decision of the Board is modified in accordance with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: October 13, 2023

/s/
Jonathan Blum
Principal Deputy Administrator
Centers for Medicare & Medicaid Services