CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
UMDNJ-University Hospital	**Medicare Reimbursement** **Fiscal Year(s) Ending:** **06/30/2000; 06/30/2001;** **06/30/2002; 06/30/2003 and 06/30/2004**
Provider **vs.**	
Blue Cross Blue Shield Association/ **Cahaba Safeguard Administrators, LLC**	**Review of:** **PRRB Dec. No. 2013-D13** **Dated: April 25, 2013**
Intermediary	

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 Provider and CMS' Office of Financial Management (OFM) requested Administrator review. The parties were notified of the Administrator's intention to review the Board's decision. The Provider commented, requesting reversal of the Board's decision. Accordingly, the case is now before the Administrator for final administrative decision.

ISSUE AND BOARD'S DECISION

The issue is whether the Medicare administrative contractor[1] properly determined that the

[1] As a requirement of Section 911 of the Medicare Prescription Drug, Improvement & Moderization Act of 2003, the Secretary is to replace current contracting authority to administer, inter alia, Medicare Part A program under Section 1816 of the Act with new Medicare Contractor Authority. Although the Medicare Fiscal Intermediaries are replaced

Provider was not entitled to reimbursement for medical education pass-through costs related to the university's nursing education and allied health program because the Provider did not meet the requirement of operating the program.

The Provider appealed multiple issues for fiscal years (FYs) 2000 through 2003. The Board denied jurisdiction on May 2, 2006 because the costs at issue for FYs 2000 through 2003 were unclaimed or self-disallowed costs. The Provider appealed to the District Court of Columbia and the District Court issued a March 7, 2008 decision which found that "a provider may invoke the Board's jurisdiction under [42 U.S.C. §] 1395oo(a) by claiming dissatisfaction with the *total* amount of reimbursement determined in an NPR, and the Board has the power under 1395oo(d) to modify the total amount based on evidence not considered by the Intermediary."[2] As a result, the D.C. District Court found that the "Board has jurisdiction over the costs related to the clinical education programs for year 2000-2003" and that "the Board must now decide again whether it will hear these claims as a matter of discretion [under §1878 (d)], not statutory jurisdiction."[3] The Provider then filed an appeal to the D.C. Circuit Court and the Secretary filed a cross-appeal. The parties eventually reached a settlement agreement and voluntarily dismissed their respective appeals before the D.C. Circuit Court pursuant to the court ordered settlement agreement.

The settlement agreement between the Secretary and the Provider was set forth in a Stipulation of Settlement and Order of Dismissal, which the District Court filed on February 19, 2009 ("2009 Court Order"). The Order stated that "the PRRB shall have, and the PRRB shall exercise, jurisdiction over the matter at issue in those proceedings: whether UMDNJ is entitled to reimbursement for costs related to UMDNJ's clinical medical education programs for the 2000-2003 fiscal years." The Order further provides that "the PRRB shall issue a hearing decision on the matter at issue in accordance with 42 C.F.R. §405.1871." Also the Court ordered that "this case shall be remanded to the Secretary for implementation of the Stipulation," and "[t]he Secretary's delegate, the Administrator of CMS, then shall promptly remand the matter to the PRRB with instructions that the terms of this Stipulation be complied with fully."

In addition to the FYs 2000 through 2003 provided for in the 2009 Court Order, the Provider also appealed the clinical education cost issue for its FY 2004 on January 24, 2009. At the

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by Medicare Administrative Contractors (MACs), for purposes of this review, the terms are used interchangeably.

[2] *See* UMNDJ-University Hospital v. Leavitt, 539 F. Supp. 2d 70, 78, (D.D.C. 2008), appeal dismissed, 2009 WL 412888 (D.C. Cir. Feb. 5, 2009).

[3] *Id*. at 78-79.

Provider's request, the Board consolidated the Provider's FY 2004 appeal with the court-ordered remand proceedings on the Provider's appeals for its FY 2000 through 2003.

The Administrator issued a remand to the Board on March 11, 2009 and the Board reopened the cost years at issue in the remand through a letter dated April 3, 2009. The Board conducted a hearing on these consolidated appeals on April 27, 2011.

In its decision, the Board referred to the 2008 District Court Order which distinguished the Board's discretionary powers from statutory jurisdiction. Accordingly, the Board held that, according to the 2008 Court Order and 2009 Agreement, it had statutory jurisdiction over the cost years at appeal but refused to exercise its discretionary powers under Section 1878(d) of the Act to decide the case on the merits.

The Board conditionally stated that, although it declined to exercise its discretionary powers for FYs 2000-2004, and address the merits of the case, it would have upheld the Intermediary's finding that the medical education-pass-through costs at issue were a prohibited redistribution of costs.

SUMMARY OF COMMENTS

The CMS' Office of Financial Management (OFM) commented, requesting reversal of the Board's refusal to decide the merits of the reimbursement matter at issue in the case. The OFM stated that the Board incorrectly declined to exercise jurisdiction over the merits in this case because it was bound by the Stipulation Agreement and 2009 Court Order to have jurisdiction and to exercise jurisdiction. OFM noted that the Board correctly tracked the 2008 District Court order, but the 2009 Court Order was very different and specifically required the Board to exercise jurisdiction in accordance with 42 C.F.R. §405.1871(a)(1)(2012), which would require a hearing decision on the merits. OFM asserted that the 2009 Court Order is the final court action and that the Board's failure to issue a hearing decision on the merits of the reimbursement issue contravenes the 2009 Court Order and the hearing decision regulation at 42 C.F.R. §405.1871(a).

The OFM further requested that the Administrator adopt, as the final agency decision in these appeals, the Board's conditional analysis and rejection of the reimbursement matter at issue. The OFM asserted that the Board's conditional analysis and rejection of the reimbursement matter at issue is complete and consistent with law and policy.

The Provider commented requesting that the Administrator reverse the Board's decision refusing to decide the merits of the case and that the Administrator issue a decision concluding that the Provider is entitled to reimbursement for its nursing health related profession program costs. The Provider asserted that the Board's failure to issue a hearing decision on the merits of the case was a violation of the 2009 Court order and 42 C.F.R. §405.1871(a)(1) and requested that the Administrator issue a decision on the merits. The Provider alleged that the Board's conditional analysis is incorrect and the Provider should be entitled to reimbursement for its nursing and health related profession program costs. Referring to its Position Papers filed in this case, the Provider stated that UMDNJ is the "provider" and that costs were actually incurred by UMDNJ. Therefore, a prohibited redistribution of costs did not occur. The Provider also alleged that the facts in this case are distinguishable from *Thomas Jefferson University v. Shalala*, 512 U.S. 504 (1994), and that the Board's reliance on that case was misplaced.

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.

I. Provider Operated Nursing and Allied Health Education Programs

To be eligible for Medicare payments, an entity must be a "provider of services" with a provider agreement. The term "provider of services", under §1861(u) of the Act, (u) "means a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program, or, for purposes of section 1814(g) and section 1835(e), a fund." From its inception in 1966 until 1983, Medicare paid for covered "hospital" inpatient services on the basis of "reasonable cost." Section 1861(v)(1)(A) of the Act defines "reasonable cost" as the cost actually incurred," less any costs "unnecessary in the efficient delivery of needed health services." While §1861(v)(1)(A) does not prescribe specific procedures for calculating reasonable cost, it authorizes the Secretary to promulgate regulations setting forth the methods to determine reasonable cost and the items to be included in reimbursable services.

In addition, Medicare historically has paid a share of the net costs of "approved medical education activities" under the reasonable cost provisions." The regulation at 42 C.F.R. §413.85(b)(2000)[4] defined approved education activities as:

> Formally organized or planned programs of study, usually engaged in by providers in order to enhance the quality of patient care in an institution. These activities must be licensed where required by State law. Where licensing is not required, the institution must receive approval from the recognized nation professional organization for the particular activity.[5]

The activities include approved training programs for physicians, nurses and certain paramedical health professionals. Under the reasonable cost system, the allowable costs of the activities included: the direct costs of salaries and fringe benefits of interns and residents, the salaries attributable to teaching physicians' supervisory time, other teachers' salaries; and indirect or institutional overhead costs, including employee health and welfare benefits, that were appropriately allocated to the proper cost center on a provider's Medicare cost report as determined under Medicare cost finding principles.[6] In addition, the regulation, ever since its inception, expressed that the costs of educational activities should be borne by the community but until the community shall undertake to bear the costs, the Medicare program will share approximately. In the spirit of this principle, the Secretary adopted rules that required a provider to be the legal operator of the nursing program to in order to obtain reimbursement for its associated costs. Because of certain adverse court rulings, the Secretary modified this standard in conformity with *St. John's Hickey Memorial Hospital v. Califano*, 595 F. 2d 803 (7th Cir. 1979).

In 1982, Congress modified the Medicare program to provide hospitals with better incentives to render services more efficiently. Pursuant to the Tax Equity and Fiscal Responsibility Act of 1982[7] (TEFRA), Congress amended the Act by imposing a ceiling on the rate-of-increase of inpatient operating costs recoverable by a hospital. Payments were

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[4] Recodified at 42 C.F.R. § 413.85(f)(2001).

[5] Originally codified at 42 C.F.R. 405.421 and resdesignated to 42 C.F.R. 413.85(1986). Further, redesignated at 42 C.F.R. §413.85(c)(2001) where the language states "*Definitions*…approved educational activities mean formally organized or planned programs of study of the type that: (1) Are operated by providers as specified in paragraph (c) [now (f)] of this section; (2) Enhance the quality of inpatient care at the provider; and (3) Meet the requirements of paragraph (e) of the section for the State licensing accreditation."

[6] 54 Fed. Reg. 40286 (1989).

[7] Pub. Law 97-248.

made pursuant to the TEFRA ceiling on the rate-of-increase based upon the target amount which is derived from the hospital's allowable net Medicare operating costs[8] year. However, under § 1886(a)(4), approved medical education costs were excluded from the definition of inpatient operating costs for purposes of the TEFRA base year and, thus, were not included in the hospital's TEFRA base year for purposes of determining the hospital's target amount.

In 1983, §1886(d) of the Act was amended to establish the inpatient prospective payment system (IPPS) for reimbursement of inpatient hospital services furnished to Medicare beneficiaries.[9] Under IPPS, providers are reimbursed their inpatient operating costs based on prospectively determined national and regional rates for each patient discharge, rather than on the basis of reasonable operating cost.

Under §§1886(a)(4) and (d)(1)(A) of the Act, the costs of approved medical education activities were specifically excluded from the definition of "inpatient operating costs" and, thus, were not included in the IPPS hospital-specific, regional, or national payment rates or in the target amount for hospitals not subject to IPPS. Instead, payment for approved medical education activities costs were separately identified and "pass-through," i.e., paid on a reasonable cost basis.[10] All other costs that could be identified and categorized as costs of educational programs and activities were considered to be part of normal operating costs covered by the per case payments made under the IPPS for hospitals subject to that system.

The regulation implementing IPPS at 42 C.F.R. §412.113(b) provides that the costs of "approved education activities," including training programs for nurses and paramedical (allied health) professionals, will be paid on a reasonable cost basis, as defined in 42 C.F.R. §413.85. The regulations at 42 C.F.R. §413.85 set forth the applicable principles for reimbursing the reasonable cost of educational activities under the Medicare program, and explicitly define the types of approved educational activities which are within the scope of these reimbursement principles.

The September 1, 1983 *Federal Register* publication of the "interim final rule" for IPPS provided at 42 C.F.R. §413.85(d) that:

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[8] "Operating costs" are defined in § 1886(a)(4) of the Act as including "all routine operating costs, ancillary service operating costs, and special care unit operating costs with respect to inpatient hospital services."

[9] Pub. Law 98-21 (1983).

[10] Section 1814(b) of the Act.

> (d) Activities not within the scope of this principle but are recognized as normal operating costs and are reimbursed in accordance with the applicable principles---…
> (6) Other activities which do not involve the actual operation or support of …an approved education program….[11]

In an effort to clarify the circumstances under which the costs of approved educational activities would be paid on a reasonable cost basis, and thus, eligible for pass-through, CMS explained in the January 3, 1984 *Federal Register*, Final Rule, entitled "Medicare Program; Prospective Payment for Medicare Inpatient Hospital Services," that:

> We believe that only the costs of those approved medical education programs operated directly by a hospital be excluded from the prospective payment system. If a program is operated by another institution, such as a nearby college or university, [it] must be noted that by far the majority of the costs of that program are borne by that other institution, and not by the hospital. While it is true that the hospital may incur some costs associated with its provision of clinical training to students enrolled in a nearby institution, the hospital also gains in return… We do not believe that this type of relationship was what Congress intended when it provided for a pass-through of the costs of approved medical education programs. Rather we believe that Congress was concerned with those programs that a hospital operated itself, and for which it incurs substantial direct cost. We are revising 42 C.F.R. §405.421(d) (6) [42 C.F.R. §413.85(d)(6)(2000)] to clarify that the costs of clinical training for students enrolled in programs, other than the hospital, are normal operating costs."[12]

Thus, 42 C.F.R. §413.85(d) was further clarified to state that activities not within the scope of this reasonable cost pass–through principle were "(6) clinical training of students not enrolled in an approved education program operated by the provider."[13] Therefore, since October 1, 1983, only the costs of educational programs operated directly by a hospital are paid on a reasonable cost basis and excluded from IPPS. Other allowable costs are reimbursed as normal operating costs.

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[11] 48 Fed. Reg. 39746, 39752, 39810 (Sept. 1, 1983).
[12] 49 Fed. Reg. 234, 267 (January 3, 1984). *See also* 48 Fed. Reg. 39752 at 313 (Sept. 1, 1983).
[13] Redesignated at 42 CFR §413.85(h)(6).

In 1989, Congress enacted §6205 of the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989)[14] which created a new temporary category of "hospital-based nursing schools" in addition to those recognized under 42 C.F.R. §412.113(b) and 42 C.F.R. §413.85. Under this provision, a hospital may claim the costs incurred for nursing or paramedical education, as pass-through costs, if all of the following criteria are met: (i) the hospital incurs at least fifty percent (50 percent) of the costs of training nursing students, (ii) the hospital and nursing school share some common board members, and (iii) all instruction is provided at the hospital or a building on the immediate grounds of the hospital.[15] The provision is effective only for cost reporting periods beginning on or after December 19, 1989, and before the issuance of the final regulations required by §6205(b)(2).[16] Section 6205(b)(2) of OBRA 1989, directed the Secretary to publish regulations clarifying the rules when the costs of approved educational activities are allowable and when those costs are eligible for pass-through under PPS. Section 6205(b)(2)(B) of OBRA 1989 provided that the final rule not be effective before October 1, 1990, or 30 days after the publication of the final rule, whichever is later.[17] CMS implemented this provision in a final rule with comment period published in the *Federal Register* on April 20, 1990 at 55 Fed. Reg. 15159 and made further revisions in the final rule that implemented changes to the IPPS for Federal FY 1991, which was published on September 4, 1990 at 55 Fed. Reg. 24887.

The directive of Congress in §6205 of OBRA 1989 was reaffirmed in §4004(b) of OBRA 1990.[18] That section contained several provisions affecting Medicare payment of reasonable cost under Medicare Part A for nursing and paramedical education costs for approved nursing and paramedical educational programs that are not operated by the hospital. Paragraph (1) of §4004(b), affects the reimbursement of nursing and paramedical educational costs, if certain conditions are met, for cost reporting periods beginning on or

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[14] Pub. Law 101-239.

[15] §6205(a)(1)(A) of OBRA 1989.

[16] While the cost reporting periods in this case do include FYEs 2000, and 2001, the Provider does not contend this provision of §6205 of OBRA 1989 is applicable.

[17] In addition, §6205(b)(1) of OBRA 1989 imposed a moratorium, effective until October 1, 1990, on the Secretary for cost reporting periods beginning on, or after, December 19, 1989, until October 1, 1990, from recouping, reducing or adjusting payments to hospitals because of alleged overpayments due to a determination by a provider's intermediary that costs claimed by a provider for the operation of a school of nursing or paramedical education are not eligible for payment on a reasonable cost basis CMS announced this provision of the moratorium in a program memorandum issued to fiscal intermediaries (Transmittal No. A-90-9: June 1990).

[18] Pub. Law 101-508 (November 5, 1990).

after October 1, 1990. Paragraph (2) of §4004(b), sets forth certain conditions that a hospital must meet in order to receive payment on a reasonable cost basis.[19] Congress implicitly accepted CMS' longstanding provider-operated policy as reflected in its narrow exception to the provider–operated policy as set forth by §4004(b)(2) of OBRA 1990 of the nonprovider-operated nursing and allied health education programs.

In response to the §6205(b)(2) of OBRA 1989 mandate, directing the Secretary to publish regulations clarifying the rules when the costs of approved educational activities are allowable and when those costs are eligible for pass-through under IPPS, CMS proposed the following five criteria that a nursing education program would have to meet to be considered provider-operated:

- The provider must incur the costs associated with the training, for example, the cost for books, supplies, and faculty salaries.
- The provider must directly control the curriculum, that is, the provider must determine the requirements to be met for graduation. In meeting this requirement, a provider may enter into an agreement with a college or university to provide the basic academic course requirements leading to a degree, diploma, or other certificate, while the provider is directly responsible for providing the courses relating to the theory and practice of the nursing or allied health profession that are required for the degree, diploma, or certificate awarded at completion of the program.
- The provider must control the administrative duties relating to the program. These duties include the collection of tuition, maintaining payroll records for the teaching staff, and being responsible for the day-to-day operation of the entire training program.
- The provider must employ the faculty.

[19] By its express terms Paragraph (2) applies only to reimbursement under Paragraph (1). Paragraph (2) has no application to reimbursement in the prior cost reporting periods governed by Paragraph 3. For Medicare cost reporting periods beginning on, or after, October 1, 1983, and before October 1, 1990, paragraph (3) of §4004(b), indefinitely prohibits the recoupment of Medicare overpayments made to hospital for pass-through costs related to approved nursing and allied health educational programs. In May 1991, CMS issued Program Memorandum Transmittal No. A-91-3, which provided instruction to intermediaries on implementing the provisions of section 4004(b)(3) of OBRA 1990.

- The provider must provide and control both classroom and clinical instruction.[20]

This proposed rule was made final on January 12, 2001.[21] The January 2001 Final Rule clarified 42 C.F.R. §413.85 to add the following criteria for identifying programs operated by a provider at paragraph (f):

> (f) *Criteria for identifying programs operated by a provider.*
> (1) Except as provided in paragraph (f)(2) of this section, for cost reporting periods beginning on or after October 1, 1983, in order to be considered the operator of an approved nursing or allied health education program, a provider must meet all of the following requirements:
> (i) Directly incur the training costs.
> (ii) Have direct control of the program curriculum. (A provider may enter into an agreement with an educational institution to furnish basic academic courses required for completion of the program, but the provider must provide all of the courses relating to the theory and practice of the nursing or allied health profession involved that are required for the degree, diploma, or certificate awarded at the completion of the program.)
> (iii) Control the administration of the program, including collection of tuition (where applicable), control the maintenance of payroll records of teaching staff or students, or both (where applicable), and be responsible for day-to-day program operation. (A provider may contract with another entity to perform some administrative functions, but the provider must maintain control over all aspects of the contracted functions.)
> (iv) Employ the teaching staff.
> (v) Provide and control both classroom instruction and clinical training (where classroom instruction is a requirement for program completion), subject to the parenthetical sentence in paragraph (f)(1)(ii) of this section.
> (2) Absent evidence to the contrary, the provider that issues the degree, diploma, or other certificate upon successful completion of an approved education program is assumed to meet all of the criteria set

[20] 57 Fed. Reg. 43659 (Sept. 22, 1992).
[21] 66 Fed. Reg. 3361 (Jan. 12, 2001).

> forth in paragraph (f)(1) of this section and to be the operator of the program.

The final rule restated that in order for a hospital to receive pass-through payment for the nursing and allied health education costs it must meet all of the criteria outlined above. In addition, the final rule also addressed providers entering into arrangements with colleges and universities and stated that:

> In certain situations, providers are entering into arrangements with colleges and universities that, in many cases, have involved provider representation on a joint committee with certain oversight responsibilities. Under these provider/college educational arrangements, the provider might not have direct responsibility for the curriculum and control day-to-day operation of the training programs. We proposed that unless the provider can demonstrate that it meets the requirements enumerated above, the costs incurred by the provider in connection with such joint programs would not be paid as separate pass-through costs.[22]

II. Community Support and Anti-redistribution

The House and Senate Committee reports accompanying the Social Security Amendments Act of 1965[23] raised the issue of the community support and redistribution of costs within the content of nursing and allied health educational activities and stated that:

> Many hospitals engage in substantial educational activities, including the training of medical students, internship and residency programs, the training of nurses and the training of various paramedical personnel. Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees as

[22] 66 Fed. Reg. at 3361-3362. The Administrator notes that decisions such as *St. Mary Medical Center*, PRRB No. 97-D82, *Barberton Citizen Hospital*, PRRB Dec No. 94-D61 and *St. Anne Hospital*, PRRB Dec. No. 93-D61, erroneously failed to recognize that the issue under IPPS involves which costs will be treated as pass through under IPPS as opposed to the issue of payment under the reasonable cost methodology at issue in *St. John's Hickey Memorial Hospital, Inc. v. Califano*, 599 F.2d 803 (7th Cir. 1979).

[23] Social Security Amendments of 1965, Pub. Law 89-97, 79 Stat. 286 (1965).

> well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne by an appropriate extent by the hospital insurance program.[24]

The principle behind the congressional committee report language, that Medicare would share in the costs of educational activities until communities bore them in some other way, has guided Medicare policy on educational activities from the inception of the Medicare program.

The regulations that were promulgated pursuant to this principle was first published on November 22, 1966 (31 Fed Reg. 14814), as well as Chapter 4 of the Provider Reimbursement Manual in 1971, reflected the congressional committee report language from 1965, that Medicare would share in the costs of educational activities until communities bore them in some other way. On November 22, 1966, CMS published a final rule promulgating regulations at 20 C.F.R. §405.421 addressing when the costs of educational activities are allowable under the Medicare Program.[25] The regulation repeated the 1965 Congressional Committee Report language that Medicare would share in the costs in the education activities until communities bore them in some other way and could not permit the redistribution of costs from educational entities to provider. In particular, as part of this final rule, CMS established the following regulatory guidance at §405.421(c):

> (c) Educational Activities. Many providers engage in educational activities including training programs for nurses, medical students, interns and residents, and various paramedical specialties. These programs contribute to the quality of patient care within an institution and are necessary to meet the community's needs for medical and paramedical personnel. It is recognized that the costs of such educational activities should be borne by the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support will be provided by those purchasing health care. Until communities undertake to bear those costs, the program will participate appropriately in support of these activities. Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by provider in conjunction with their operations, it is not intended that this program should participate in increased

[24] S. Rep. No. 89-404, at 36 (1965); H.R. Rep. No 89-213, at 32 (1965).
[25] 31 Fed. Reg. 14808 (Nov. 22, 1966).

> costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.[26]

On September 22, 1992, CMS published a proposed rule to implement the OBRA 1989 and OBRA 1990 amendments affecting nursing and allied health education under Medicare.[27] In this proposed rule, CMS more specifically set forth the term regarding the "redistribution of costs.[28] On January 12, 2001, CMS issued the final rule (January 2001 Final Rule) which was substantially the same as the proposed rule, with the addition of the inadvertently omitted the existing "community support" principle.[29] Specifically, the January 2001 Final Rule added the following definitions at 42 C.F.R. §413.85(c):

> *Approved educational activities* means formally organized or planned programs of study of the type that:
> (1) Are operated by providers as specified in paragraph (f) of this section;
> (2) Enhance the quality of inpatient care at the provider; and
> (3) Meet the requirements of paragraph (e) of this section for State licensure or accreditation…
> *Community support* means funding that is provided by the community and generally includes all non-Medicare sources of funding (other than payments made for furnishing services to individual patients), including State and local government appropriations. Community support does not include grants, gifts, and endowments of the kind that are not to be offset in accordance with section 1134 of the Act.
> *Redistribution of costs* means an attempt by a provider to increase the amount, or to expand the types, of the costs of educational activities that are allowed

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[26] *Id.* at 14814. In 1977, CMS redesignated the regulation as 42 C.F.R. §405.421 without altering or amending the subsection. 42 Fed. Reg. 52826 (Sept. 30, 1977). On September 30, 1986, CMS redesignated 42 C.F.R. §405.421 as 42 C.F.R. 413.85 without altering or amending subsection (c) of that regulation. 51 Fed. Reg. 34790, 34790-34791, 34813-34814 (Sept. 30, 1986).

[27] 57 Fed. Reg. 43659 (Sept. 22, 1992).

[28] *See Id*. at 43672.

[29] 66 Fed. Reg. 3358, 3368 ("We note the proposed revision in the proposed rule inadvertently did not include community support as the basis for an offset from the allowed cost of a GME or nursing and allied health program. In this final rule, we restate our longstanding policy that Medicare will only share in the costs of educational activities of the providers where communities have not assumed responsibility for financing these programs.")

> for Medicare payment purposes by claiming costs that previously were not claimed by the provider and were considered costs of an educational institution. For example, costs for a school of nursing or allied health education or a medical school that were incurred by an educational institution and were not allowable to the provider in its prospective payment or rate-of increase limit base year cost report, or graduate medical education per resident amount calculated under §413.86, are not allowable costs in subsequent fiscal years.[30]

In response to commenters, the Secretary stated that:

> As discussed in detail above, we believe that Congress intended to support nursing and allied health education programs operated by hospitals only until the community undertakes the costs of the programs itself. Nursing and allied health education programs operated by colleges and universities are considered to be programs in which the costs are borne by the community, since much of the costs of operating the programs are incurred by the colleges and universities. Therefore, we believe it is contrary to Congressional intent for Medicare to provide pass-through payments to providers, in addition to inpatient PPS payments, for the costs of non-provider operated programs….

In addition, while the related party principle at 42 CFR 413.17 states that: "costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization" this provision does not negate the community support and anti-redistribution requirements and must be read in concert with its principles. As CMS has consistently explained: [F]or purposes of determining the operator of an approved nursing or allied health education program, the fact that a provider and a college or university are considered related organizations under §413.17 ("Cost to related organizations.") would not be sufficient to allow a university-operated program to be considered provider operated. As we explain …. our policy concerning related organizations was established to avoid program recognition of costs of a provider for goods or services furnished by a related organization in excess of the costs incurred by the related organization."[31] Further, the Secretary again stated that: "[A] program operated by an educational institution that is related to the provider through common ownership or control

[30] 66 Fed. Reg. at 3374.

[31] 66 Fed. Reg. at 3361.

would not be considered to meet the criteria for provider operated."[32] In addition, the Secretary pointed out that:

> We believe that the language included in the Committee Report that accompanied Public Law 101-508 [OBRA 1990] supports this distinction between total allowable costs for provider-operated and nonprovider-operated programs. In that report, the conferees noted that—
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> > "[I]n the case of hospital-operated nursing and allied health education programs, the Secretary does not recognize costs incurred by a related educational organization as allowable educational costs since such costs are a redistribution of costs from the educational institution to the hospital. Although [section 4004 of Public Law 101-508] provides for recognition of the costs incurred by a related educational organization for clinical training on the hospital's premises in the case of a hospital-supported program, the conferees intend that nothing in [section 4004 of Public Law 101-508] should be construed as requiring the Secretary to modify his current policy in regard to the determination of reasonable costs for a hospital-operated program' (H.R. Rept. No. 964, 101st Cong., 2d Sess. 719 (1990)).
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> We note that this clear statement of Congressional intent is also consistent with our policy on provider-operated programs stated above of not recognizing the costs of related organizations in determining a provider's total costs of approved educational programs.

Notably, the policy of not recognizing the costs of related organizations in determining a provider's total costs of approved educational programs has consistently been recognized in such final decisions as *Thomas Jefferson, supra,* and *Baptist Memorial Medical Center*, PRRB Dec. No. 2001-D13.

III. Findings and Conclusions

The issue in this case specifically relates to whether the costs at issue are allowable as provider-operated nursing and allied health program costs. In this case, UMDNJ is a corporate body of the State of New Jersey.[33] UMDNJ consists of eight schools, five health

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[32] 66 Fed. Reg. at 3362.

[33] *See, e.g.,* Provider Exhibit P-6.

care entities, and one managed care network. [34] The payment of certain educational costs of the UMDNJ-School of Nursing (SON) and UMDNJ-School of Health Related Professions (SHRP), as approved educational costs of the Provider "UMDNJ-University Hospital" is at issue in this case.

The Provider contended that UMDNJ is not a healthcare "system" but rather UMDNJ is a healthcare provider and a hospital unto itself. UMDNJ both legally and in practice, operates and controls the SON and SHRP. The Provider finds it significant that there is only one tax identification number between the three facilities and one Medicare number belonging to UMDNJ. The Provider asserted CMS issues its NPRs to UMDNJ. The Provider concluded that UMDNJ, therefore, easily meets the requirement of "operation and control" of the SON and SHRP under 42 C.F.R. §413.85(f) because it is the "provider in fact."[35] UMDNJ as the "provider" operates and controls the SON and SHRP and, thereby, meets the requirements of 42 C.F.R. §413.85(f) governing provider-operated nursing and allied health programs. In particular, the nursing and allied health programs qualify as provider-operated under §413.85(f)(1) as UMDNJ incurs all costs and controls all administration of the educational programs at issue and under §413.85(f)(2) as UMDNJ awards and issues the degrees for these programs. The Provider argued that reimbursement of the costs at issue does not result in a prohibited redistribution of costs because UMDNJ is a single legal entity. In particular, the Provider maintains that the U.S. Supreme Court's decision in *Thomas Jefferson University v. Shalala*, 512 U.S. 504 (1994) (*(Thomas Jefferson)* is not controlling in this case because the findings in *Thomas Jefferson* were based upon differences in both fact and law. The Hospital and University were separate legal entities and the regulation specifically prohibited the redistribution of costs between "entities or *units.*"[36] The Provider points out the "or units" language was subsequently removed from the regulation as part of the January 2001 Final Rule.

The Intermediary contended that the Provider, UMDNJ-University Hospital, does not operate "provider" approved educational activities. The SON and the SHRP are part of the University and not the Provider. The Intermediary asserted that students apply for enrollment and pay tuition to the University and that the Provider (hospital) does not incur any costs of the classroom education programs. The Intermediary emphasized that, while the Provider (hospital) and the University may operate as one corporate entity, under one Federal tax identification number, the Medicare regulations pay only those hospitals that directly incur costs of approved nursing and allied health education programs. The

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[34] *See, e.g.*, Intermediary Exhibit I-8.
[35] *See* Provider's Final Position Paper at 5-9.
[36] *Id.* at 508 (citing C.F.R. §413-85(c)).

Intermediary noted that UMDNJ-University Hospital (the Provider) did not claim the cost of the SON and SHRP education programs for the fiscal years 2000 through 2004 and had not claimed such costs in preceding years' cost reports. The Intermediary stated that the Medicare regulations specifically prohibit the redistribution of costs from educational institutions to patient care institutions, and states that the Medicare program will not assume the cost of educational activities previously borne by the community. The Intermediary asserted that it is clear that the Provider, UMDNJ-University Hospital, is claiming education and training costs that historically have been borne by the University and were never before claimed as medical education pass-through costs by the Provider.

The Board determined that it would not exercise discretion to review in this case, but that, in the alternative, if had exercised jurisdiction, it would have denied the nursing and allied health education pass-through costs at issue as a prohibited redistribution of costs. The Administrator finds that the Board incorrectly declined to exercise jurisdiction in this case. The plain language of the 2009 Court Order, *inter, alia*, incorporating the regulation at 42 C.F.R. §405.1871(a)(1) required that the Board issue a hearing a decision on the merits.[37] Accordingly, the decision on the merits is appropriate for review.[38]

The Administrator first determines that the Provider was not the operator of the programs at issue for which it now requests reimbursement.[39] The record shows that, for purposes of Section 1861(u) of the Act, UMDNJ-University Hospital is the "provider of services." Contrary to the Provider's contentions, "UMDNJ" is not a "provider of services" as that term is defined under the statute. Accordingly, the focus of the inquiry is whether UMDNJ University Hospital meets the criteria of 42 CFR 413.85(f). In this case, the record shows that the Provider, UMDNJ University Hospital, cannot demonstrate that the program(s) at

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[37] The Administrator notes that the 2009 Agreement and Order do not reflect present or past longstanding policy regarding Board jurisdiction where a provider has not claimed a cost. *See, e.g.*, for discussion of longstanding policy at 73 Fed. Reg. 30190, 30195-30198 (May 23, 2008) "Medicare Program: Provider Reimbursement Determinations and Appeals."

[38] The Provider's appeal for FY 2004 was not addressed by the 2009 Agreement and Order. However, because of the specific related identical and or similar facts of these cases, the FY 2004 cost year will be treated consistent with the Secretary's 2009 Agreement and Order for FYs 2000-2003.

[39] *See also, e.g. Community Care Foundation v Thompson*, 318 F. 3d 219 (2003); *Baptist Health v. Thompson*, 458 F 3d 768 (8th Cir. 2006) regarding discussion of the "provider of Services" under section 1861(u) of the Act.

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issue are provider operated. In fact, when discussing the separate criteria that are used to demonstrate a provider-operated program, the Provider repeatedly refers to UMDNJ's role and responsibilities and not the Provider's (UMDNJ University Hospital's) role and responsibilities in the operation of the program. The Provider pointed out that UMDNJ directly incurred all the costs and controls all administration of the educational programs at issue including collection of tuition, payroll and other related activities.[40] In addition UMDNJ employs the teaching staff and provides and controls classroom instruction and clinical training, has direct control over SON and SHRP curricula and therefore is responsible for day-to–day program operations.[41] UMDNJ grants the students their degrees.[42] Consequently, the Administrator finds that the Provider, UMDNJ University Hospital, has failed to demonstrate that it is the "operator" of the program(s) at issue.

In addition, the fact that the Provider and the educational institutions are under common ownership and or control of a single legal entity, does not circumvent the regulations that determine when the costs of the educational institution are attributable to the provider hospital for purposes of Medicare reimbursement.[43] The Medicare reimbursement system is based on the costs incurred by individual provider hospitals, without regard to underlying ownership structure. The longstanding policy, of not recognizing the costs of related organizations in determining a provider's total costs of approved educational programs, has consistently been recognized in final administrative and court decisions.

In addition, the circumstance addressed by the anti-redistribution clause is when a hospital submits "increased costs" arising from approved educational activities. The regulation provides, in unambiguous terms, that the "costs" of these educational activities will not be reimbursed when they are the result of a "redistribution," or shift, of costs from an "educational" facility to a "patient care" facility, even if the activities that generated the costs are the sort "customarily or traditionally carried on by providers in conjunction with their operations." The Secretary's reliance on a hospital's own historical cost allocations, and when evidence is available, those of an affiliated educational facility or institution is a simple and effective way of determining whether a prohibited "redistribution of costs" has occurred.

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[40] Referring to Provider Exhibits P-6, P-8 and P-9.

[41] Referring to Provider Exhibits P-6 at 7, P-8 and P-9.

[42] Referring to Provider Exhibit P-6 at 7.

[43] *See, e.g., Thomas Jefferson University v. Shalala*, 512 U.S. 504, 114 S. Ct. 2381, 129 L.Ed.2d 405 (1994) (affirming that a medical college could not redistribute some costs of an approved educational program to an associated provider hospital where both were owned and operated by the same legal entity)

The Board found that the UMDNJ consolidated financial statements,[44] the Provider's cost report filings, and the Provider's State licensure[45] demonstrate that UMDNJ is primarily an educational institution with various operating "units" and that the UMDNJ-University Hospital, SON and SHRP are each a separate operating "unit." The "Notes to Consolidated Financial Statements" for FY 2000 states that: "The University of Medicine and Dentistry of New Jersey (The University) was established in 1964 and operates under the "Medical and Dental Education Act of 1970. The Act provided for the combination of Rutgers Medical School and New Jersey College of Medicine and Dentistry into a single entity known as the College of Medicine and Dentistry, which was subsequently renamed the University of Medicine and Dentistry of New Jersey. The Act provides for the appointment of a Board of Trustees by the Governor of New Jersey. The Board of Trustees has general supervision over and is vested with the conduct of the University…..the University is a body corporate and politic of the State of New Jersey." The "Notes" lists eight Schools of the University, including the SON and SHRP and "University Health Care Units" which includes the Provider, UMDNJ-University Hospital.[46]

The Administrator agrees with the Board regarding the application of the redistribution principle for FYs 2000-2004, and that the costs of the SON and SHRP programs are not allowable under the anti-redistribution and community support principles found in 42 C.F.R. §413.85 as they existed both prior to, and after, the January 2001 Final Rule. The regulation provides that "it is not intended that this program should participate in increased costs resulting from redistribution of costs" from educational institutions or units to patient care institutions for units.[47] It is undisputed that UMDNJ is an entity of the State of New Jersey

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[44] As the Board noted, the UMDNJ "Notes to Consolidated Financial Statements" for FY 2000 lists the "units" governed by UMDNJ. The SON and SHRP are listed as "units" under the "Schools of the University" and UMDNJ-University is listed as a "unit" under the "University Health Care Units." *See* Provider Exhibit P-6 at 7-8.

[45] *See* Provider's Post-Hearing Submission, dated July 6, 2011, Exhibit D (various licensure issued to the Provider-UMDNJ University Hospital). The Board noted that Exhibits C and E pertaining to revalidation of Medicare enrollment information and Exhibit F pertaining to Federal taxes are not relevant as, *inter alia*, they are dated subsequent to the time period at issue.

[46] *See* Provider Exhibit P-6 at 7-8.

[47] In the January 2001 Final Rule, the definition of the term "redistribution of costs" located in 42 C.F.R. §413.85(c) removed the "institution or units" language from the regulatory provision and inserted an "example" into the definitions. These changes did not alter the

and that these educational costs were being supported by the community through non-Medicare sources of funding (other than payments made for furnishing services to individual patients), including State and local government appropriations. The increased costs at issue were the result of a "redistribution" of these costs from the educational institutions, SON and SHRP, to the Provider, UMDNJ University Hospital.

The "community support" principle states that the costs of educational activities "should be borne by the community," but that, "[u]ntil communities undertake to bear these costs, the [Medicare] program will participate appropriately in the support of these activities." The community support language in 413.85 is an independent ground for denying the requested reimbursement. This language prohibits Medicare reimbursement for educational activities that "have been historically borne by the community." As noted by the Secretary in the 2001 final rule: "If the university undertakes the classroom education of the students, including the collection of tuition, the employment of the faculty, the control of the curriculum, and the awarding of the degree, the community has undertaken the responsibility for training nurses and allied health personnel and relieved the hospital of the costs. …To the extent the hospital incurs costs for the non-provider–operated program, the hospital receives payment for these costs through the inpatient PPS payments."[48] The SON and SHRP educational costs at issue were costs of educational units for which the community was bearing the costs. In this case, that the Provider had failed to seek reimbursement for the disputed costs in previous years is evidence of the community support for these activities.[49] To allow the community to withdraw that support and pass these costs to the Medicare program would violate the community support principle, and would encourage the community to abdicate its commitment to education to an insurance program intended to provide care for the elderly.

Consequently, the Administrator finds that the medical education costs at issue in this case are not an allowable as educational pass-through costs under IPPS. The educational program(s) at issue were not operated by the Provider, UMDNJ University Hospital, as

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application of this principle to the facts in this case for any years subsequent to the 2001 date as the meaning and application of the principle did not change.

[48] 66 Fed. Reg. 3358, 3363.

[49] *See* Provider's cost reports As noted by the Board, reflected in the UMDNJ's income statements and the "reconciliation" to Provider's costs claimed on Worksheet A of the Medicare cost report, the SON and SHRP educational costs at issue were not claimed in the as-filed Medicare cost reports, nor on any Medicare cost reports from previous years, and, as a result, the SON and SHRP educational costs at issue remained a cost of the educational unit. *See* Provider's Post Hearing submission dated July 6, 2011, Exhibits A and B; Intermediary's Post Hearing Brief at 3.

required by 42 C.F.R. 413.85. In addition, the allowance of such increased costs would represent a prohibited redistribution of costs from the educational institutions/UMDNJ. The allowance of these costs would also be contrary to the community support principle as the costs of these programs were being supported by the community.

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: June 26, 2013

/s/
Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services

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