CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
William Beaumont Hospital – Royal Oak	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 2005-2006**
Provider	
vs.	
Wisconsin Physicians Services	**Review of PRRB Dec. Nos. 2016-D12**
Medicare Administrative Contractor	**Dated: June 03, 2016**

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)). Comments were received from the Medicare Administrative Contractor (MAC). Accordingly, the parties were notified of the Administrator's intention to review the Board's decision. Comments were also received from CMS' Center for Medicare (CM). All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue is whether the William Beaumont Hospital, Royal Oak (Provider) submitted sufficient documentation for its non-Provider-operated nurse clinical training program costs to support pass-through reimbursement for fiscal years (FYs) 2005 and 2006.

The Board held that the MAC improperly disallowed all of the pass-through reimbursement for the incremental clinical nursing training for FYEs 2005 and 2006. In addition, the Board held that the MAC improperly disallowed the pass-through payment for the incremental costs of two (2) administrative and clerical support

employees in connection with the non-provider operated nursing school. The Board directed the MAC to apportion the salaries of the 2 employees based upon the job responsibilities provided by the Provider in Exhibits A and B, and to allow the amount apportioned up to a cap of $50,000).[1]

SUMMARY OF COMMENTS

The MAC submitted comments contending that the Board's decision is contrary to Medicare regulations and should therefore be reversed. The MAC contended that the Provider did not have adequate documentation at the time it submitted its cost report, during the settlement of its cost report, and subsequently, until the year 2013. The MAC argued that the Provider's newly submitted data which was developed in 2013 is based on nothing more than estimates, and guesses. Neither of which is auditable or verifiable data. Accordingly, the Provider's newly created documentation is insufficient and its submission to the Board does not change the undeniable fact that the MAC properly denied the Provider's claims for the incremental costs incurred in offering clinical training to nursing students.

The CM submitted comments requesting that the Administrator reverse the Board's decision. The CM agreed with the MAC determination that the clinical costs are not eligible for pass-through payments and instead should be reclassified as operating costs.

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.

Section 1861(v) (1) (A) of the Act requires that providers of services to Medicare beneficiaries are to be reimbursed the reasonable cost of those services. Reasonable cost is defined as the "the cost actually incurred, excluding therefrom part of the incurred cost found to be unnecessary in the efficient delivery of needed health

[1] *See*, MAC's Post Hearing Brief at 9 fn. 1. At the March 19, 2014 hearing, two issues were heard by the Board. On March 31, 2014, the MAC withdrew it pursuit of the following issue — "[w]hether the [MAC] properly disallowed pass-through reimbursement for the Provider's FY 2005 and 2006 costs of training nursing students in a non-provider operated nurses training program, based upon the Provider's inability to produce the underlying documentation supporting its nurse clinical training costs from its 1988 cost report."

services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included …" *Id.* This section does not specifically address the determination of reasonable cost, but authorizes the Secretary to promulgate regulations and principles to be applied in determining reasonable costs. One of the underlying principles set forth in the Act is that Medicare shall not pay for costs incurred by non-Medicare beneficiaries, and vice-versa, i.e., Medicare prohibits cross-subsidization of costs. These principles are reflected and further explained in the regulations. The regulations at 42 C.F.R. §413.9(a) (2005) provides that the determination of reasonable cost must be based on costs related to the care of Medicare beneficiaries. Further, §1815(a) of the Act provides that: "no such payment shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amount due such provider under this part for the period with respect to which the amounts are being paid or any prior period." *Id*

Consistent with the requirements of §1815 of the Act, the regulations at 42 C.F.R. §413.20 and 42 C.F.R. §413.24 set forth the general documentation and accounting requirements. The regulations at 42 C.F.R. §413.20 and 42 C.F.R. §413.24 require that providers maintain adequate financial records and statistical data for the accurate determination of costs reimbursable under Medicare. The process of determining such reimbursable costs involves the review of data available from the provider's usually-maintained accounts to arrive at the proper payment amounts for services to beneficiaries.

Specifically, the regulation at 42 C.F.R. §413.24 set forth the requirement that cost data and cost finding be adequate. That regulation provides, in part:

> Providers receiving payment on the basis of reimbursable cost must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors. The costs data must be based on an approved method of cost finding and on the accrual basis of account.
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> …
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> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended. Adequate data capable of being audited is consistent with good business concepts and effective and efficient management of any organization, whether it is operated for profit or on

> a nonprofit basis. It is a reasonable expectation on the part of any agency paying for services on a cost-reimbursement basis. In order to provide the required costs data and not impair comparability, financial and statistical records should be maintained in a manner consistent from one period to another. However, a proper regard for consistency need not preclude a desirable change in accounting procedures if there is reason to effect such change.[2]

In addition, 42 C.F.R. §413.20, entitled "Financial data and reports" provides, in relevant part, that:

> (a) General. The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program….
>
> (d) Continuing provider recordkeeping requirements.
>
> (1) The provider must furnish such information to the intermediary as may be necessary to—
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> (i) Assure proper payment by the program, including the extent to which there is any common ownership or control (as described in §413.17(b)(2) and (3)) between providers or other organizations, and as may be needed to identify the parties responsible for submitting program cost reports;
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> (ii) Receive program payments; and
>
> (iii) Satisfy program overpayments determinations.
>
> (2) The provider must permit the intermediary to examine such records and documents as are necessary to ascertain information pertinent to the determination of the proper amount of program payments due.

Moreover, the above principles are set forth in the Provider Reimbursement Manual (PRM), which provides policies to implement Medicare regulations for determining the reasonable cost of provider services. The PRM at §2300 states that providers receiving payment on the basis of reimbursable cost must provide adequate cost data

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[2] 42 C.F.R. § 413.24(c).

based on financial and statistical records which can be verified by qualified auditors. Further, the PRM at §2304 states that cost information must be current, accurate, and in sufficient detail to support costs claimed by providers in rendering services to beneficiaries. Documentation to substantiate costs is to include, among other things, ledgers, books, records and original evidences of cost.

Finally, as the proponent of this action, the Provider bears the burden of proving by a preponderance of the evidence that it is entitled to receive the amount of claimed pass through reimbursement under the applicable rules and regulations.[3]

In this case, the record reflects that the Provider claimed pass-through reimbursement for clinical training costs it incurred in a non-provider operated nurse training program for FYs 2005 and 2006. The MAC disallowed the costs as pass-through costs and reclassified them as operating costs because the costs could not be adequately supported."[4] The Board held that the MAC improperly disallowed the pass-through payment for the incremental costs of 2 administrative and clerical support employees in connection with the non-provider operated nursing school. The Board directed the MAC to apportion the salaries of the 2 employees based upon the job responsibilities provided by the Provider and to allow the amount apportioned up to a cap of $50,000.

Applying the relevant law and program policy to the foregoing facts, the Administrator does not agree with the Board's determination. The Administrator finds that the Provider did not maintain contemporaneous records to support its claimed FY 2005 and 2006 incremental costs associated with providing clinical training to nursing students. To satisfy its burden of proof in this case, the Administrator finds that, the Provider must demonstrate by a preponderance of the evidence that its claimed reimbursement is supported by "adequate cost data" that is based on the Provider's "financial and statistical records" which must be capable of verification by qualified auditors. Furthermore, the Administrator finds that, under the regulations, "the [adequate cost] data [is to] be accurate and in sufficient detail to accomplish the purposes for which it is intended.

A review of the record shows that the Provider during the relevant fiscal years at issue, did not maintain actual records evidencing and supporting the incremental

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[3] The Administrative Procedure Act provides that the proponent of any action has the burden of proof. 5 U.S.C. §556(d) ("the proponent of a rule or order has the burden of proof"). *See also* HFCA Ruling 79-60(c) n.46. This principle has consistently been recognized by the courts. *See Fairfax Hospital Association, Inc. v. Califano*, 585 F.2d 601, 611 (4t h Cir. 1978) (adopted as HCFA Ruling 79-60(c)).

[4] Medicare Contractor Exhibit 1-7.

costs in providing clinical training to nursing students. In particular, the Provider's May 11, 2013 Final Position Paper states that during the relevant cost report audits, it was unable to located and provide all of the MAC's requested records to substantiate the claimed pass-through costs.[5] In fact, as part of its submissions to the Board, the Provider specifically relied on data from cost periods beyond the 2005 and 2006 years at issue in this case because, during the relevant audits and up through mid-2013, it was unable to locate all of the records from 2005 and some of the records from 2006.[6]

The Administrator finds that the Provider's late 2013 submissions to the Board and the accompanying documentation and affidavits supporting its claimed pass-through costs are insufficient to satisfy the Provider's burden of proof. The record shows that the Provider's claimed pass-through costs are based on nothing more than estimates as to nursing and administrative staff time and salaries; none of which were provided to MAC auditors during the 2005 and 2006 cost report audits at issue in this case.[7] The record shows that when discussing the nurse salaries relied upon by the Provider to develop its claimed pass-through costs, the Provider's witness, testified that the salary amounts relied upon were "an estimate of what the [Provider] thought was the best average and that the relied upon salaries are "not accurate," nor are they "verifiable by an auditor as to each and every nurse that did training."[8] The record further shows that the Provider did not keep contemporaneous records capable of being verified and audited. Mrs. Barbara Juliano further testified that the 1.5 hours per day that the nursing staff devoted to clinical training of nursing students was an estimate and that the Provider did not track the time nurses spent training nursing students.[9]

Finally, with respect to the two employees for which the Board order that their salaries be apportioned up to $50,000, the Administrator finds that the documentation relied on by the Board is not adequate cost data that is verifiable by a qualified auditor and thus, not appropriate documentation for Medicare reimbursement purposes. The record shows that in 2005 and 2006, the staff of the nursing education department was different than it is today and the documentary record does not include any job descriptions or other evidence setting forth the roles and responsibilities of those employed in the nursing education department during the time periods under appeal. The Board disagreed with the MAC's contention that the

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[5] *See* Provider's Final Position Paper at 5.
[6] *Id.*
[7] *See* Transcript (Tr.) at 106:9-17 (Mar. 19, 2014).
[8] *Id.* at 360-5-12.
[9] *Id.*

Provider did not provide time studies that were contemporaneous with the period under appeal. The Administrator does not agree.

The PRM 15-1 §2311.F specifies that, where salaries of individual(s) must be apportioned among multiple functions, "periodic time studies, in lieu of ongoing time reports, may be used to allocated the direct salaries and wages." *Id.* This section also details the criteria that the time studies must meet. As with time studies completed by teaching physicians that document time spent between Medicare Part A and Part B activities, time studies are an obvious tool for nurse preceptors to use in documenting the percentage of their salaries associated with clinical training versus other activities. Accordingly, because the Provider has failed to meet its burden of proof in this case, as set forth in §§413.20 and 413.24, the Administrator reverses the Board's decision.

DECISION

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

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

Date: 8/01/2016

/s/
Patrick H. Conway, M.D., MSc
Acting Principal Deputy Administrator
Centers for Medicare & Medicaid Services