CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Walter O. Boswell Memorial Hospital **Medical Center** **Provider** **vs.** **Blue Cross /Blue Shield Association** **AdminaStar Federal Illinois** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 12/31/95 through 12/31/2003** **Review of:** **PRRB Dec. No. 2010-D50** **Dated: September 28, 2010**

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 the Intermediary requesting review and reversal of Issue No. 2 of the above captioned case. Comments were also received from the Provider requesting review and reversal of Issue No. 1 of the above captioned case. The parties were notified of the Administrator's intention to review the Board's decision. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

Issue No.1 1 involves whether the Provider's nursing education program qualified as provider-operated.

The Board held that the Provider's nursing education program did not qualify as provider-operated because the Provider did not meet all of the regulatory requirements outlined at 42 C.F.R. § 413.85(f) in order to be considered provider-operated. The Board found that the Provider did not (1) control the administration of the program (2) employ the teaching staff and (3) the Provider did not have control over the program's curriculum.

With respect to control of the program's administration, the Board found that the regulation at 42 C.F.R § 413.85(f)(1)(iii) required that the Provider must collect the tuition. In this case, the Board found that Mesa Community College (MCC) set and collected the tuition. Therefore, since the tuition was not collected by the Provider nor used for the Provider's benefit, (i.e., it was not netted against expenses incurred by the Provider), the Board found that the Provider did not meet the regulation's explicit requirement for control of the program's administration.

With respect to the regulatory requirement for employing the teaching staff, the Board found that MCC employed the teaching staff and maintained the payroll records. With respect to control over the program's curriculum, the Board found that the program's curriculum was controlled by MCC. The fact that the Provider's Director on Nursing was a member of the curriculum committed did not give the Provider direct responsibility for the curriculum as required by the regulation.

Finally, the Provider's contended that the 2001 revision to 42 C.F.R. § 413.85(f) cannot be applied to fiscal years ending (FYE) 1995 through 2000 because the regulation change was not finalized until 2001, the Board noted that the regulation plainly stated that the 2001 regulation changes applied to cost reporting periods beginning on or after October 1, 1983 and the that the Board had no authority to invalidate the expressed effective date of the 2001 change.

Issue No. 2 involves whether, assuming the Provider's nursing education program did not qualify as provider-operated, the Provider is entitled to receive an additional payment to account for services provided to Medicare manage care patients (fiscal years 2000-2003 only).

The Board held that the Provider was entitled to an additional payment for its Medicare managed care patients since the provider received Medicare payment for the costs of its clinical training associated with the Boswell/Mesa nursing education program.

SUMMARY OF COMMENTS

The Provider submitted comments requesting that the Administrator reserve the Board's decision with respect to Issue No. 1. The Provider argued that its nursing education program qualifies as provider-operated. The Provider noted that no question was raised as to the provider-operated status of the nursing education program until the 2001 issuance of the criteria in 42 C.F.R. § 413.85(f). Furthermore, prior to 2001, none of the five criteria identified in the 2001 regulation appeared in the prior version of the regulation. Therefore, they cannot be applied retroactively.

The Provider contended that the five criteria in 42 C.F.R. § 413.85(f) must be interpreted consistently with prior standards (i.e., pre 2001) for provider-operated status, and, as so interpreted, the provider's nursing education program meets these criteria.

First, the Provider contends that it controlled the day-to-day administration of the program both hands-on control and through it funding of the program. To support this contention the Provider stated that the Director of the Boswell nursing education program (an employee employed by the Provider) was responsible for overseeing all clinical and administrative aspect of the program and controlled the program's day-to-day operation. In addition, the Provider employed an administrative assistant, whose responsibility was to aid in the administration of the nursing education program, and a Faculty Lab Coordinator, who helped guide students through the clinical curriculum. The fact that the Provider delegated some of the administrative responsibilities to MCC, did not alter the conclusion that the Provider maintained overall administrative control of the nursing education program, thereby satisfying this criterion for provider-operated status. Furthermore, this cost-effective arrangement is consistent with the 2001 provider-operated regulations which permit a provider to "contract with another entity to perform some administrative functions."

Second, the Provider argued that it employed the teaching staff. The Provider maintained that since the regulation does not defined the word "employ", one must look to the common law definition of "employ" and the traditional principles of agency law. *See New York Life Ins. Co. vs. United States*, 190, F.3d 1372, 1382 (D.C. Cir 1999) (applying common law definitions of employee in the Medicare context). The Provider noted that the Intermediary conceded this fact that the Provider met the common law standard for employing the teaching faculty. To support this contention the Provider noted that except for some part-time faculty that were paid directly by the Provider, the nursing school faculty salaries were paid from restricted fund that was maintained by MCC, but was funded by the Provider, consistent with its contractual obligation. It addition, the Provider was financially responsible for the cost of the faculty's salary and fringe benefits, including payroll taxes. All salary increases for the nursing school faculty were subject to the Provider's approval. The fact that both the Provider and MCC employ faculty should not undercut the conclusion, as the regulation does not require that a provider be the sole employer of the teaching staff and does not preclude a joint employment relationship. In this case both the Provider and MCC retained some degree of control over the faculty and the services rendered by the faculty benefit both institutions. Accordingly, both the Provider and MCC may be viewed as employing the faculty.

Third, the Provider relied on Board precedent establishing that a nursing program is provider-operated if the hospital incurred such costs as salary and benefits of

personnel who are involved in the training, capital costs related to classrooms, offices, and equipment used for the training, and overhead costs in support of the training. The Provider argued that it met these standards by incurring substantial costs relating to the program, including salaries of the faculty Director, administrative assistant, and the Faculty Lab Coordinator. In addition, the Provider also incurred the non-salary costs of the training program including supplying the building in which the non-clinical instruction occurred as well as the computer, laboratory and other equipment used for instruction.

Fourth, the Provider contended that it controlled the curriculum because the Provider's nursing program Director is a member of the MCC Nursing Program (NP) Nursing Instructional Council, and members of the Provider's faculty serve on the MCCNP's Community & Curriculum Integration team, which helps develop and implement the nursing school curriculum. Finally, the Provider asserted that it controls the classroom instruction as well as the clinical training. The Provider noted that all nursing students enrolled in the Provider's nursing program take all required classes in nursing theory and practice on the Provider' campus. In addition, classroom instruction takes place in a Provider's building that is dedicated to the nursing program. The only classes that the Provider's nursing students do not take at the Provider's facility are a few required classes not specifically related to nursing, which is permitted by the regulations. Finally, the Provider controls the clinical training. The Program's Director, who is an employee of the Provider, determines the types and locations of clinical experiences and another employee of the Provider, the Faculty Lab coordinator, helps guide students through the clinical curriculum.

With respect to Issue No. 2 the Provider submitted comments requesting that the Administrator affirm the Board's determination that the Provider was entitled to an additional payment for services to Medicare managed care patients. The Provider argued that the plain language of the status entitles the Provider to the Medicare manage care payment regardless of whether the Provider's nursing education program is determined to be provider-operated as long as it meets the statutory requirements. The Provider noted that the criteria for payment in 2000 was that a provider receive reasonable cost reimbursement two years prior to the cost reporting period for an approved nursing or allied health training program as well as receiving reasonable cost reimbursement in the current year for the approved nursing or allied health training program. For cost reporting periods beginning with 2001, the statute also required that the provider have some Medicare managed care utilization in order to receive payment.

The Intermediary submitted comments stating that the Administrator should affirm the Board's determination with respect to Issue No. 1.

With respect to Issue No. 2 the Intermediary argued that since the Board found that the Provider was not the operator of the nursing program, then no additional payment should be made for Medicare managed care under 42 C.F.R. § 413.87. The regulation limits the additional payment to hospitals that operate an approved nursing program. Therefore, since the Board determined that the nursing education program was not provider-operated, the Provider is not entitled to the additional payment for Medicare managed care patients.

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.

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 regulations at 42 C.F.R. § 413.85(b)[1] defines 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.[2]

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

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

[2] 42 C.F.R. §413.85(b).

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.[3] 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 (7 th 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[4] (TEFRA), Congress amended the Act by imposing a ceiling on the rate-of-increase of inpatient operating costs recoverable by a hospital. Payments were 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[5] 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 prospective payment system (PPS) for reimbursement of inpatient hospital services furnished to Medicare beneficiaries.[6] Under PPS, 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 PPS hospital-specific, regional, or national payment rates or in the target amount for hospitals not subject to PPS. Instead, payment for approved medical education activities costs were separately identified and "pass-through," i.e., paid on a reasonable cost basis.[7] All other costs

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[3] 54 Fed. Reg. 40286 (1989).

[4] Pub. L. 97-248.

[5] "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."

[6] Pub. L. 98-21 (1983).

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

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 PPS for hospitals subject to that system.

The regulation implementing PPS 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.

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 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, **if [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) [now 42 C.F.R. § 413.85(d) (6)] to clarify that the costs of clinical training for students enrolled in programs, other than the hospital, are normal operating costs."[8]

Therefore, since October 1, 1983, only the costs of programs operated directly by a hospital are paid on a reasonable cost basis and excluded from PPS. Other allowable costs are reimbursed as normal operating costs.

[8] 49 Fed. Reg. 267, 313 (January 3, 1984). *See also* 42 C.F.R. § 413.85(f).

In 1989, Congress enacted § 6205 of the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989)[9] 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 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.[10] 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). 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.[11]

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.[12]

The directive of Congress in § 6205 of OBRA 1989 was reaffirmed in § 4004(b) of OBRA 1990.[13] 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 after October 1, 1990. Paragraph (2) of § 4004(b),

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[9] Pub. L. 101-239.

[10] *Id*. § 6205(a)(1)(A).

[11] CMS implemented this provision in a final rule with comment period published in the Federal Register on April 20, 1990 (55 FR 15159) and made further revisions in the final rule that implemented changes to the inpatient hospital prospective payment system for FY 1991, which was published on September 4, 1990, (55 FR 24887).

[12] CMS announced this provision of the moratorium in a program memorandum issued to fiscal intermediaries (Transmittal No. A-90-9: June 1990).

[13] Pub. L. 101-508 (November 5, 1990).

sets forth certain conditions that a hospital must meet in order to receive payment on a reasonable cost basis.[14] Finally, 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.[15]

In response to § 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 PPS, 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 t6he teaching staff, and being responsible for the day-to-day operation of the entire training program.
- The provider must employ the faculty.
- The provider must provide and control both classroom and clinical instruction.[16]

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[14] 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).

[15] 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.

[16] 57 Federal Register 43659 (Sept.22, 1992).

This proposed rule was made final on January 12, 2001.[17] 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. It stated in 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.[18]

For the cost reporting periods under appeal the Provider included the costs associated with this nursing program as pass through cost on their Medicare cost reports. The Intermediary proposed adjustments to deny pass through treatment of these costs because the Provider was not deemed to be the operator of the nursing program as defined by 42 C.F.R. § 413.85(f). The Intermediary removed these costs through a revised Notice of Program Reimbursement (NPR) for the cost years 1995-2000. The Intermediary removed these costs on the original NPR for cost reporting periods 2001 through 2003. The Board held that the Provider's nursing education program did not qualify as provider-operated because the Provider did not meet all of the regulatory requirements outlined at 42 C.F.R. § 413.85(f) in order to be considered provider-operated.

Applying the above provisions to the facts of this case, The Administrator concurs with the Board's determination that the Provider's nursing education program did not qualify as provider-operated. Section 42 C.F.R. § 413.85(f)(1) specifies that in the absence of a hospital-issued diploma, a program may still be considered provider operated if the hospital meets *all* of the following requirements.

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[17] 66 FR 3361 (Jan 12, 2001).

[18] *Id* at 3361-3362. The Administrator 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*.

(i) Directly incur the training costs.
(ii) Have direct control of the program curriculum.
(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.
(iv) Employ the teaching staff.
(v) Provide and control both classroom instruction and clinical training.

With respect to requirement number (iii), the Administrator finds that MCC carried out several significant administrative functions that are specifically cited in the regulation. 42 C.F.R. § 413.85(f)(1(iii) clearly states that, in order for the program to be considered provider operated, the hospital must collect tuition and maintain payroll for teaching staff, where applicable. In this case, both the collection of tuition and the maintenance of payroll records are functions carried out primarily by MCC. MCC collects all tuition from students and maintains payroll records for all but one of the full-time faculty and several of the adjunct faculty. In addition, MCC provides infrastructure used for enrolling students, issues report cards, maintains e-mail accounts for students, and issues a diploma to graduates of the program.\

With respect to requirement number (iv), the Administrator finds that MCC is the employer of record for all but one of the full-time faculty and several of the adjunct faculty. While the Provider employees some of the teaching staff, including the program director, it does not employ all of the teaching staff. CMS policy is that the hospital must employ all of the teaching staff in order for the nursing program to be considered hospital-based. In this instance, it cannot be considered a hospital-based program, since the hospital has not met this requirement of the regulation.

Finally, the Administrator finds that the Provider does not have direct control of the program curriculum as required by §413.85(f)(1)(ii). While the record shows that the Provider provides and controls both classroom instruction and clinical training, the program's curriculum is controlled by a committee of the MMC district. The record reflects that the program director of the Provider's nursing program is a member of this committee. However, the Administrator finds that the existence of one of the Provider's staff on the committee does not give the Provider direct responsibility for the curriculum. Therefore, it appears that the Provider does not meet this requirement of the regulation in addition to the tow requirements sited above.

The Administrator notes that the Provider takes issue with application of 42 C.F.R. §413.85(f) arguing that the regulation cannot be lawfully applied retroactively because the regulation was adopted on January 12, 2001. The Administrator finds

that 42 C.F.R. § 413.85(f) is simply a restatement of the criteria used by CMS to identify programs operated by a provider since this requirement was established in January 1984.

In September 22, 1992, Federal Register (beginning on page 43659), CMS explained that these criteria have been used to identify provider-based programs since 1984 and proposed a new section of the regulation (§ 413.85(e)) that would codify these requirements. The January 12, 2001, adoption of § 413.85(f) is simply a clarification and restatement of existing CMS policy. Therefore, application of these requirements to time periods predating January 12, 2001, is not retroactive, it is merely consistent application of a longstanding CMS policy.

Therefore, the Administrator finds that Board's determination finding that the Provider's nursing program is not provider-operated is affirmed in accordance with this opinion.[19] The Provider is not eligible to receive pass-through payments for the clinical and classroom educational cost of the program.

Relevant to the matter involved at Issue No. 2, in addition to the reasonable cost pass through payments under section 1861(v)(l)(A) of the Act, Congress required that certain costs for non-provider-operated nursing education would be reimbursable on a reasonable cost basis under the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990).[20] The regulations at 42 C.F.R. §413.85(g)(l)(2001) implemented OBRA 1990

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[19]As *St. John's Hickey* is not the appropriate standard to be applied, the Administrator finds that the Board's discussion under that standard is dicta and not controlling in this case.

[20] OBRA 1990 §4004(a), Pub. Law 101-508 (1990). Section 4004(b)(1) states: The reasonable costs incurred by a hospital (or by an educational institution related to the hospital by common ownership or control) during a cost reporting period for clinical training (as defined by the Secretary) conducted on the premises of the hospital under approved nursing and allied health education programs that are not operated by the hospital shall be allowable as reasonable costs under part A of title XVIII of the Social Security Act and reimbursed under such part on a pass-through basis." The law at (b)(2) set the requirements for reimbursement of costs for non-provider operated programs stating that: The hospital claimed and was reimbursed for such costs during the most recent cost reporting period that ended on or before October 1, 1989; The proportion of the hospital's total allowable costs that is attributable to the clinical training costs of the approved program, and allowable under (b)(1) during the cost reporting period does not exceed the proportion of total allowable costs that were attributable to the clinical training costs during the cost reporting period described in subparagraph; The hospital receives a benefit for the support it furnishes to such program through the provision of clinical services by nursing… students participating

and allowed payment on a reasonable cost basis for costs "incurred by a provider" for the "clinical training of students enrolled in an approved nursing or allied health education program that is not operated by the provider" if certain conditions are met.

With respect to the additional payment to hospitals that treat Medicare manage care patients § 1886(l) of the Act states in relevant part that:

> (1) In general.—For portions of cost reporting periods occurring in a year (beginning with 2000), the Secretary shall provide for an additional payment amount for any hospital that receives payments for the costs of approved educational activities for nurse and allied health professional training *under section 1861(v)(1)*. (Emphasis added.)

The implementing regulation at 42 C.F.R. § 413.87 (2001) states in part that:

> (a) Statutory basis. This section implements section 1886(l) of the Act which provides for additional payments to hospitals *that operate and receive Medicare reasonable cost reimbursement for approved nursing and allied health education programs and the methodology for determining the additional payments.*
> (b) Scope. This section sets forth the rules for determining an additional payment amount to hospitals that receive payments for the costs of operating approved nursing or allied health education programs under § 413.85.
> (c) Qualifying conditions for payment.
> (1) For portions of cost reporting periods occurring on or after January 1, 2000 and before January 1, 2001, a hospital that operates and receives payment for a nursing or allied health education program under § 413.85 may receive an additional payment amount associated with Medicare+Choice utilization. The hospital may receive the additional payment amount, which is calculated in accordance with the provisions of paragraph (d) of this section, if both of the conditions specified in paragraphs (c)(l)(i) and (c)(l)(ii) of this section are met.
> (i) The hospital must have receive Medicare reasonable cost payment for an approved nursing or allied health education program under § 413.85 in its cost reporting period(s) ending in the fiscal year that is 2 years prior to the current calendar year. (For example, if the

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in such program; and the costs incurred by the hospital for such program do not exceed the costs that would be incurred by the hospital if it operated the program itself.

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

In this case, with respect to Issue No.2, the Board found that the Provider was entitled to the additional payment for its Medicare+Choice patients because the Provider received Medicare payment for the costs of clinical training under the Boswell/Mesa nursing education program. Applying the above provisions to the facts of this case, the Administrator finds that the Provider is not entitled to the additional payment for its Medicare+Choice patients because the Provider is not the operator of the nursing education program. Section 1886(l) of the Act and the regulation at 42 CFR 413.87, provides for this additional payment if the hospital receives payment under 1861(v)(1) of the Act. Under this provision, the nursing educational hospital must be provider-operated. Pursuant to Issue No. 1, the Provider's nursing education program was found not to qualify as provider-operated. Because the Provider did not meet all of the regulatory requirements outlined at 42 C.F.R. § 413.85(f), the Provider cannot qualify for the additional Medicare managed care payment. Accordingly, the Administrator reverses the Board's decision on Issue No. 2, and finds that the Provider is not entitled to the additional payment for it Medicare+Choice patients.

DECISION

The decision of the Board with respect to Issue No. 1 is affirmed in accordance with the foregoing opinion. The decision of the Board with respect to Issue No. 2 is reversed in accordance with the foregoing opinion.

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

Date: 11/22/10

/s/

Marilyn Tavenner
Principal Deputy Administrator and Chief Operating Office
Centers for Medicare & Medicaid Services