PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

On the Record
2024-D17

PROVIDER –
Avera Sacred Heart Hospital

Provider No. –
43-0012

vs.

MEDICARE CONTRACTOR –
Noridian Healthcare Solutions, LLC

HEARING DATE –
November 8, 2022

Fiscal Year End –
06/30/2010

Case No. –
14-2534

INDEX

Page No.

Issue Statement 2

Decision 2

Introduction 2

Background and Applicable Authorities 3

Discussion, Findings of Fact, and Conclusions of Law 6

Decision 13

ISSUE STATEMENT

Whether the Medicare Contractor appropriately made adjustments which eliminated pass-through reimbursement of Avera Sacred Heart Hospital's ("Avera" or the "Provider") Nursing Education costs for fiscal year ("FY") 2010, pursuant to 42 C.F.R. § 413.85(g).[1]

DECISION

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board" or "PRRB") finds that the Medicare Contractor properly disallowed Avera's Nursing Education Program costs for FY 2010, because Avera did not meet the criteria for pass-through reimbursement of clinical training costs of nonprovider-operated programs.

INTRODUCTION

Avera is located in Yankton, South Dakota.[2] Mount Marty College operates a nursing school that conducts the related clinical training on the hospital campus of Avera.[3] The Medicare contractor[4] assigned to Avera is Noridian Healthcare Solutions ("Medicare Contractor").[5]

The Medicare Contractor made adjustments to Avera's FY 2010 cost report "[t]o report the Nursing School allied health program as A&G [*sic*] since the hospital is not the legal operator of the program," citing 42 C.F.R. § 413.85(d) and (f).[6] The Medicare Contractor's workpapers for its audit of Avera's FY 2010 cost report state that an accreditation could not be provided showing Avera as the legal operator of the nursing school program since that accreditation is assigned to Mount Marty College.[7] Further, the FY 2010 audit workpapers state that "documentation could not be obtained supporting pass through payments were paid for the Nursing School on the FYE 1989 cost report,"[8] which is a requirement under 42 C.F.R. § 413.85(g). Accordingly, the Medicare Contractor determined that "the costs are not allowable

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[1] Joint Stipulation and Motion (hereinafter "Stipulations") at Exhibit P-1 at ¶ 2 (Aug. 15, 2022).
[2] Provider's Final Position Paper (hereinafter "Provider's FPP") at 3 (June 16, 2021).
[3] *Id.* at 9.
[4] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs"), but these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate and relevant.
[5] Medicare Contractor's Final Position Paper ("hereinafter Medicare Contractor's FPP") at 2 (Jul. 14, 2021).
[6] *See* Initial Appeal Request (Feb. 20, 2014). While the Medicare Contractor's Audit Adj. No. 13 (Ref. 57) indicated the Nursing School allied health program cost was reported as "A&G," the costs were in fact reclassified to Adults and Pediatrics ("A&P"), as discussed later in the decision. The Board notes that while the Medicare Contractor cites to 42 C.F.R. § 423.85 on its adjustments to the cost report, it is clear that the Medicare Contractor meant to cite to 42 C.F.R. § 413.85, as is applicable here. Moreover, the cited regulatory subsection, § 423.85, does not exist as of the issuance date of this decision.
[7] Exhibits P-13 and C-4. The Exhibit List submitted with Provider's Final Position Paper lists only Exhibits P-1 through P-10, whereas the Provider submitted a total of 15 exhibits, up to Exhibit P-15. However, all 15 exhibits are listed and described within the Provider's Final Position Paper.
[8] Exhibit C-4 at 1.

as a pass through on the [FY 2010] cost report and will be reclassified to A&P [Adults and Pediatrics]."[9]

Avera timely appealed the Medicare Contractor's final determination and met the jurisdictional requirements for a hearing. Following the parties' submissions of Final Position Papers, the Board approved the parties' joint request for a record hearing on November 8, 2022. Avera was represented by Elizabeth Elias, Esq. of Hall, Render, Killian, Heath & Lyman, P.C. The Medicare Contractor was represented by Joseph Bauers, Esq. of Federal Specialized Services.

BACKGROUND AND APPLICABLE AUTHORITIES

Avera provides the following background on its history:

> Avera Sacred Heart Hospital was established by the Benedictine Sisters of Sacred Heart Convent in 1897. Provider started nursing education in 1905. Although the nursing educational programs have varied, it existed during the 1950s as a three-year diploma program. Because the costs of the program were steadily increasing, it was determined in 1961 by the Motherhouse (Benedictines) to utilize the facilities of its Mount Marty College, which had been in existence since 1936 on land adjacent to the Provider and had not previously offered a nursing education program. In August, 1961 it was decided that a four-year degree granting program in nursing would be offered by Mount Marty College. At the same time, the Motherhouse determined to phase out over a three year period Provider's diploma nursing program. Today, the Yankton [South Dakota] Benedictines still continue to sponsor both Mount Marty College and Sacred Heart Hospital. Avera Health was formed in the year 2000 by the Yankton Benedictine Sisters and the Presentation Sisters of Aberdeen, South Dakota.[10]

Since the inception of the Medicare program, Congress has supported the notion of the Medicare program bearing certain costs incurred by hospitals toward educating nurses and other health professionals in paramedical fields:

> 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 cost in some other

[9] *Id.* The Medicare Contractor's audit workpapers explain that "[i]n order to claim Nursing School and/or Allied Health education costs on [Worksheet] A, each program must be approved, and the hospital must be the legal operator of the program, per 42 C.F.R. § 413.85(d) and (f). If not, the hospital is not entitled to pass-through payments unless it meets the requirements of 42 C.F.R. § 413.85(g)."

[10] Provider's FPP at 7 (citation omitted). *See also* Exhibit P-4.

> way, that a part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program.[11]

When Congress enacted the inpatient prospective payment system ("IPPS") in 1983, it was careful to retain cost-based reimbursement (which it called "pass through") for "approved educational activities" undertaken by hospitals to educate nurses and other allied health professionals.[12] The basic concept remained the same after the implementation of IPPS as it had been before:

> Payment for a provider's net cost of nursing and allied health education activities is determined on a reasonable cost basis, subject to the following conditions and limitations:
> (i) An approved educational activity— (A) Is recognized by a national approving body or State licensing authority as specified in paragraph (e) of this section; (B) Meets the criteria specified in paragraph (f) of this section for identification as an operator of an approved education program. (C) Enhance the quality of health care at the provider.[13]

For educational programs not operated by the hospital, effective with cost reporting periods beginning on or after October 1, 1990, § 4004(b) of the Omnibus Budget Reconciliation Act of 1990 ("OBRA-90")[14] provided for pass-through costs in limited circumstances. Specifically, the costs incurred by a hospital for clinical training conducted on the premises of the hospital under an approved nursing or allied health education program that is not operated by the hospital are treated as pass-through costs and paid on the basis of reasonable cost, only if certain conditions are met.[15] Specifically, OBRA-90 § 4004(b) states:

> (b)UNIVERSITY HOSPITAL NURSING EDUCATION. —
> (1) IN GENERAL.—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.

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[11] S. Rep. No. 89-404, at 36 (1965); H.R. Rep. No. 89-213, at 32 (1965).
[12] *See* 42 U.S.C. § 1395ww(a)(4).
[13] 42 C.F.R. § 413.85(d).
[14] Pub. L. 101-508, § 4994(b), 104 Stat. 1388, 1388-89 (1990).
[15] 66 Fed. Reg. 3358, 3360 (Jan. 12, 2001).

> (2) CONDITIONS FOR REIMBURSEMENT – The reasonable costs incurred by a hospital during a cost reporting period shall be reimbursable pursuant to paragraph (1) ***only if*** –
>
> (A) *the hospital claimed and was reimbursed for such costs during the most recent cost reporting period that ended on or before October 1, 1989* [known as the "1989 base year"];
>
> (B) 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 (A);
>
> (C) the hospital receives a benefit for the support it furnishes to such program through the provision of clinical services by nursing or allied health students participating in such programs; and
>
> (D) 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.[16]

In 2001, CMS finalized a regulation, at 42 C.F.R. § 413.85(g), implementing OBRA-90 that governs payment for nursing and allied health education programs not operated by the provider requiring the provider to meet six criteria before the costs of such programs can be allowed as pass-through costs and paid on a reasonable cost basis. Specifically, 42 C.F.R. § 413.85(g) states, in pertinent part:

> (g) *Payment for certain non-provider operated programs*—
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> (1) *Payment rule*. Costs incurred by a provider, or by an educational institution that is related to the provider by common ownership or control (that is, a related organization as defined in § 413.17(b)), for the clinical training of students enrolled in an approved nursing or allied health education program that is not operated by the provider, are paid on a reasonable cost basis if the conditions specified in paragraph (g)(2) of this section are met.
>
> (2) *Criteria for identification of nonprovider-operated education programs*. Payment for the incurred costs of educational activities identified in paragraph (g)(1) of this section will be made **if the following conditions are met**:
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> ****

[16] (Emphasis added.)

(ii) The provider **must have claimed and been paid for clinical training costs on a reasonable cost basis during the most recent cost reporting period that ended on or before October 1, 1989**. This condition is met if a notice of program reimbursement (NPR) was issued for that cost reporting period by November 5, 1990, and the clinical training costs were included as pass-through costs. **If an NPR was not issued by that date, or an NPR was issued but did not treat the clinical training costs as pass-through costs, the condition is met if-**

(A) The intermediary included the clinical training costs in the allowable costs used to determine the interim rate for the most recent cost reporting period ending on or before October 1, 1989; or

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

(iii) In any cost reporting period, the percentage of total allowable provider cost attributable to allowable clinical training cost does not exceed the percentage of total cost for clinical training in the provider's most recent cost reporting period ending on or before October 1, 1989.[17]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

Avera's nursing education program is non-provider operated and, therefore, the requirements of 42 C.F.R. § 413.85(g) must be met in order for Avera to be eligible to receive pass-through reimbursement for the nursing education program costs.[18] The sole issue in this appeal is whether Avera both "claimed" and was "paid," as pass-through costs, the clinical training costs of the Nursing School Allied Health Program *for the cost reporting period that ended* ***on or before October 1, 1989***, such that the requirements of 42 C.F.R. § 413.85(g)(2)(ii) are met.[19]

The parties jointly stipulated that Avera's nursing education program costs "were claimed on its FYE 6/30/89 cost report under Worksheet A and were reallocated on Worksheet A-6 to other allowable cost centers."[20] However, the parties further stipulated that the FYE 6/30/89 costs "were *neither* claimed *nor* allowed as pass-through costs pursuant to 42 C.F.R. § 413.85(g)."[21]

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[17] (Bold emphasis added.)
[18] *See, generally,* 42 C.F.R. § 413.85(g). *See also* Initial Appeal Request; Provider's FPP.
[19] The parties have clarified that the allowability of the Provider's nursing education costs is not at issue in this appeal, as the Medicare Contractor allowed the Provider's nursing education costs on the 1989 and 2010 cost reports, but not as pass-through costs paid on a reasonable cost basis, which the Provider is now seeking for 2010. Stipulations at ¶¶ 3, 5.
[20] *Id.* at ¶ 4.
[21] *Id.* at ¶¶ 4, 5 (emphasis added).

Avera asserts that the Medicare Contractor's audit of its FY 2010 cost report was arbitrary and capricious because the Medicare Contractor allowed its "sister" hospital, St. Luke's Hospital (Prov. No. 43-0014),[22] to receive pass-through reimbursement for its nursing school costs for its FYE 06/30/10 after an "appropriate" audit review.[23] Avera contends that the Medicare Contractor's audit of its FY 2010 cost report was incomplete because the Medicare Contractor only examined its nursing school program under the lens of 42 C.F.R. § 413.85(d) and (f). Avera further argues that the Medicare Contractor's FY 2010 audit workpaper "plainly demonstrates no reference to Provider's PRRB appeal victories and history of costs being allowed under § 413.85(g), nor does it make any evaluation of the program under § 413.85(g). Rather, the MAC stopped its analysis with § 413.85(f)."[24]

However, contrary to Avera's assertions, the Medicare Contractor *does* reference § 413.85(g) in its FY 2010 audit workpaper.[25] Further, the parties jointly stipulated that the Medicare Contractor's workpapers for Provider's FY 2010 cost report audit plainly stated that "documentation could ***not*** be obtained supporting pass through payments were *paid* for the Nursing School on the FYE 1989 cost report, the costs are not allowable as a pass through on the cost report and will be reclassified to ~~A&G~~A&P [Adults and Pediatrics]."[26] That requirement to have documentation supporting such pass-through *payments* in 1989 is set forth in § 413.85(g)(2)(ii).

With regard to St. Luke's Hospital's FY 2010 audit, the Medicare Contractor's workpapers state that, "[p]er the cost report ending September 30, 1989, the hospital claimed the Nursing School . . . as educational activities on the cost report and ***received*** *pass-through payments* associated with [the] program[]"; and that, on this basis, the Medicare Contractor found that the criterion at § 413.85(g)(2)(ii)(B) was met.[27] To be clear, the Medicare Contractor did not discuss any prior Board decisions on the St. Luke's Hospital's FY 2010 audit workpapers *under its analysis of the § 413.85(g)*(2)**(ii)(B)** *criterion*. These workpapers for St. Luke's Hospital demonstrate that the cost report for its FY 1989, by itself, showed the costs were both claimed *and* reimbursed as pass-through costs that year.[28] In contrast, Avera's 1989 cost report *did* ***not*** show, in a satisfactory manner, that this same § 413.85(g)(2)(ii) criterion was met.

On closer review of the FY 2010 cost report audit for St. Luke's Hospital, the Medicare Contractor did *not* consider St. Luke's Hospital's reimbursement history for the nursing education costs prior to 1989. There was a prior Board decision discussed on St. Luke's Hospitals' FY 2010 audit workpapers but it was only in relation to determining whether criterion § 413.85(g)(2)**(v)**

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[22] The Provider explains that Avera Health was formed in the year 2000 by the Yankton Benedictine Sisters, who sponsor Sacred Heart Hospital, and the Presentation Sisters of Aberdeen, South Dakota, who historically operated St. Luke's Hospital. The Provider refers to St. Luke's Hospital as its sister facility, which provides clinical training of nursing students from Presentation College. Provider's FPP at 7, 9.
[23] *Id.* at 9, 13.
[24] *Id.* at 13. *See also* Provider's Reply Brief ("Reply Brief") at 3 (Aug. 16, 2021).
[25] *See* Exhibits C-4, P-13. The audit workpapers explain that, "[i]n order to claim Nursing School and/or Allied Health education costs on [Worksheet] A, each program must be approved and the hospital must be the legal operator of the program per 42 C.F.R. § 413.85(d) and (f). If not, the hospital is not entitled to pass-through payments unless it meets the requirements of 42 C.F.R. § 413.85(g)."
[26] Stipulations at ¶ 6 (strike through in original and bold and italics emphasis added) (citing to Exhibit C-4).
[27] Exhibit P-14 (emphasis added).
[28] *Id.*

was met.[29] That criterion requires that clinical training costs must be incurred by the provider or by an educational institution related to the provider by common control or ownership. In this regard, a Board decision rendered in 1980, PRRB Dec. 80-D6, determined that in 1952, "the College and the Hospital were operated by the Presentation Sisters of the Blessed Virgin Mary," and the organizations were found to be related by common ownership and control under the Order of the Presentation Sisters ("Sisters").[30] The Medicare Contractor found that the relationship between the Sisters, the College, and the Hospital is still in existence as members of the Sisters "hold board positions at both organizations and have the final approval rights on all (major and significant) decisions that are made at both organizations."[31] Thus, the Medicare Contractor's consideration of the Board "appeal victories" for St. Luke's Hospital was not relevant to the criterion at issue in the instant appeal. Moreover, the Medicare Contractor did not address the criterion at § 413.85(g)(2)(v) in its FY 2010 audit of Avera, presumably because it determined that the criterion at § 413.85(g)(2)(ii) was not met, which required a finding that the requirements set forth at § 413.85(g) were not met.

The prior Board decisions favorable to Avera, which Avera argues should be considered, are Board decisions regarding nursing education costs for cost reporting years 1973 through 1978.[32] Since the issuance of those decisions, the Medicare Program has implemented many changes (*e.g*., implementation of IPPS on October 1, 1983,[33] passage of OBRA-90 § 4004(b), and promulgation of 42 C.F.R. § 413.85), which make those prior Board decisions irrelevant to the determination at issue for Avera's FY 2010 cost report. Moreover, the Secretary explained in the preamble to the final rule, implementing the regulation at 42 C.F.R. § 413.85, that:

> Except as provided in OBRA 1990, we do not make pass-through payments to a hospital for the costs of a nursing and allied health education program not operated by a hospital because the costs are considered normal operating costs and the hospital receives payment for those costs through the inpatient prospective payment system payments. We believe that, in the case of programs that are not operated by a hospital, the majority of the training costs of the program are incurred by an entity (the college or university) other than the hospital; to the extent that a hospital incurs costs for a nonprovider-operated program, the inpatient PPS payment encompasses payment for those costs.

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[29] *Id.*
[30] *Id.*
[31] *Id.*
[32] Exhibits P-5, P-8, P-9.
[33] *See* 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412. Under inpatient PPS, Medicare pays hospitals for the operating costs of inpatient hospital services in predetermined, standardized amounts per discharge, subject to certain payment adjustments. *Id.* The final hospital inpatient prospective payment system rule published January 3, 1984, attempted to clarify the Medicare policy on the classification of training costs incurred by providers as costs of approved educational activities paid on a reasonable cost basis. *See* 66 Fed. Reg. 3358, 3370 (Jan. 12, 2001). That rule stated that only the costs of provider-operated approved medical education programs are excluded from the PPS and paid on a reasonable cost basis. *Id.* at 3371.

> In addition, as indicated in the proposed rule, the hospital benefits in a number of ways from its participating in a nonprovider-operated educational program: the hospital obtains services of the trainee during the training; the hospital might receive payments from the college or university for the costs incurred by the hospital; and the hospital might save staffing costs, as well as recruiting costs (many of the trainees ultimately become employees of the hospital). Furthermore, the distinction between provider-operated programs and nonprovider-operated programs is consistent with the provisions of OBRA 1989 and OBRA 1990.
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> In the case where a hospital enters into a joint program with an educational institution, the distinction between provider-operated and nonprovider-operated programs also reflects the community support principle, because the program has moved away from the provider-operated mode and into the community assumption of costs. The House and Senate Committee reports accompanying Public Law 89–97 reflect that Congress contemplated that Medicare would share the costs of educational activities *until* the community assumed the costs. If the university undertakes the classroom education of the students, including the collection of the 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 this cost. Again, to the extent that the hospital incurs costs for the nonprovider-operated program, the hospital receives payment for these costs through the inpatient PPS payments.
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> 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 (that do not meet the criteria under OBRA 1990).[34]

The Board notes that OBRA-90 § 4004(b) set 1989 as the base year for determining whether a provider qualified for pass-through payments for nonprovider operated nursing and allied health programs. Specifically, the Secretary describes the effect of OBRA-90 § 4004(b) as follows:

> The October 1, 1989 cost reporting period date set forth in the proposed rule was mandated by section 4004(b)(2)(A) of Public Law 101-508. The practical effect of this provision is that providers may receive payment on a reasonable cost basis under this provision for the clinical training of students enrolled in a nonprovider-operated program only if they had claimed and

[34] 66 Fed. Reg. 3358, 3362-63 (Jan. 12, 2001) (italics in original).

> received payment for periods prior to the enactment of the statute. This protects those providers that were relying on the payments.[35]

Significantly, the prior Board decisions ruling favorably for Avera were for cost reporting years 1973 through 1978, which, again, were prior to the implementation of the IPPS, and do not include the applicable 1989 base year. Moreover, the periods to which those decisions apply are *more than a decade prior to the 1989 base year* such that one cannot determine from those decisions whether the provider claimed and received a pass-through payment during the period immediately prior to the enactment of the statute (*i.e*., 1989). No evidence was admitted to demonstrate that Avera received pass-through costs on its FY 1989 cost report. Accordingly, Avera has failed to overcome the presumption that it did not receive pass-through costs during the period immediately preceding the enactment of the statute.

Avera contends that its FY 1989 cost report includes the nursing education costs, but then acknowledges that the costs are present in another section of the cost report, *i.e.*, "the incorrect place."[36] In this regard, Avera argues that the Board should be persuaded by, and should rule in the same way that it did for the provider in *Brigham and Women's Hosp. v. NGS* ("*Brigham*").[37] Avera contends that the Ultrasound program costs of the provider in *Brigham* were included in its FY 1989 cost report, albeit in the incorrect place within the cost report (similar to what appears on Avera's FY 1989 cost report for the nursing education costs at issue where costs were reported on Worksheet A and reallocated on Worksheet A-6).[38] Avera asserts that the Board's decision in *Brigham* is factually similar to the instant case where pass-through costs for the provider's Ultrasound Technician allied health program, which is a non-provider operated program, had been allowed for many years under 42 C.F.R. § 413.85(g)(2) with no scrutiny by the Medicare Contractor.[39]

While in *Brigham*, as in the instant case, the education programs at issue are non-provider operated, and therefore are subject to the criteria of 42 C.F.R. § 413.85(g), the Board found in *Brigham* that evidence in the record demonstrated that the provider claimed the expenses of the Ultrasound and Nuclear Medicine clinical training at issue on the initial FY 1989 cost report.[40] Further, the Board found that "[o]ver the next 20 years, the Medicare Contractor *consistently* found the costs associated with the programs at issue as allowable."[41] Thus, "for 20 fiscal years, the Medicare Contractor accepted the fact that [the provider's] claimed paramedical education costs for Ultrasound and Nuclear Medicine programs on its as-filed FY 1989 cost report, *and* **reimbursed**

[35] *Id.* at 3369.
[36] Provider FPP at 10 (citing Exhibit P-10).
[37] PRRB Dec. 2020-D5 (Feb. 24, 2020) (a copy of which is included in Provider Exhibit P-11). The Board notes that since the parties submitted their filings in this case, and the administrative record closed, the Board has issued a new decision in *Brigham* after the CMS Administrator vacated and remanded the Board's initial decision that was cited by the Provider. PRRB Dec. 2023-D29 (Aug. 21, 2023). In the new decision, the Board affirmed its prior decision, and therefore the Provider's contentions with regard to *Brigham* are still relevant as stated.
[38] Provider FPP at 10-11.
[39] *Id.* at 10.
[40] PRRB Dec. 2023-D29 at 2.
[41] *Id.* at 7.

[the provider's] its reasonable cost for these programs under the grandfather clause of 42 C.F.R. § 413.85(g)(2)(ii)."[42]

Consequently, in *Brigham*, the Board concluded that pursuant to § 405.1885(a)(1),[43] the Medicare Contractor is precluded from revisiting the predicate fact that the provider claimed paramedical education costs as pass-through costs on its as-filed FY 1989 cost report – whether through reopening, modification or a course correction – because the 3 year reopening timeframe has expired relative to both FYs 1989 and 2008.[44] The Board noted that its application of § 405.1885(a)(1) is consistent with the 2018 decision of the U.S. Court of Appeals for the District of Columbia in *Saint Francis Med. Ctr. v. Azar*[45] and that the very facts of the *Brigham* case highlight why the predicate fact regulation exists, particularly when it has been over 30 years since FY 1989 closed/ended.[46, 47]

Avera argues that, in the instant case, the Medicare Contractor is similarly barred from correcting predicate facts, and alleges that the Medicare Contractor corrected predicate facts with the 2010 cost reporting period under appeal.[48] The Board disagrees. The facts in *Brigham* are distinguishable from those of the instant case such that 42 C.F.R. § 405.1885(a)(1) is not applicable to the instant case. In *Brigham*, ***for 20 fiscal years***, the Medicare Contractor accepted the fact that the provider claimed paramedical education costs for Ultrasound and Nuclear

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[42] *Id.* at 11 (italics emphasis in original and bold, underline emphasis added).
[43] *Id.* (stating that the predicate fact regulation at 42 C.F.R. § 405.1885(a)(1) "bars a Medicare Contractor from reopening a predicate fact unless it is within the three-year window to reopen the original determination that established the predicate fact.")
[44] *Id.* at 11.
[45] 894 F.3d 290, 296-97 (D.C. Cir. 2018) (reviewing the predicate fact regulation and confirming its application is limited to reopenings made by Medicare contractors and does not apply to provider appeals).
[46] PRRB Dec. 2023-D29, at 12.
[47] The Board notes that the NPR at issue for FY 2010 was issued on August 30, 2013, which is before the December 2013 regulatory change at 42 C.F.R. § 405.1885(a)(1) was published in the Federal Register, and before the regulatory change effective date of January 1, 2014, which codified the Secretary's "longstanding" policy not to revisit predicate facts more than 3 years after the predicate fact arose or was determined in a final intermediary determination. *See* Exhibit C-1; *see also* 78 Fed. Reg. 74826, 75167 (Dec. 10, 2013). However, the Board previously explained in the first *Brigham* decision (PRRB Dec. 2020-D5, at 9), that while the regulation at 42 C.F.R. § 405.1885(a)(1) (2014) was not finalized until the December 10, 2013 Final Rule was issued, the Board finds this regulation relevant to prior fiscal years because the Secretary explained in the preamble to the Final Rule that this was longstanding policy and practice. *See* PRRB Dec. 2020-D5 at 9 (quoting 78 Fed. Reg. at 75163-64), as follows:

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

In the second *Brigham* decision, the Board noted that the NPRs at issue for FYs 2010, 2011 and 2012 were issued on October 7, 2014, December 1, 2014, and April 27, 2016, respectively, which are dates after the effective date of § 405.1885(a)(1). PRRB Dec. 2023-D29 at 11 n.62. While the NPR at issue in the instant case was issued on August 30, 2013, continuing to apply the logic that this was longstanding policy and practice, the Board concludes that this regulation is also relevant to the instant case. However, for reasons discussed herein, the Board finds it inapplicable to the facts and circumstances of this particular case.
[48] Reply Brief at 4-5.

Medicine programs on its as-filed FY 1989 cost report, *and **reimbursed*** the provider its reasonable costs (*i.e.*, pass-through costs paid on a reasonable cost basis) for these programs under the grandfather clause of 42 C.F.R. § 413.85(g)(2)(ii). In contrast, in this case, Avera stipulated that its final NPR and as-submitted cost report for FYE 6/30/89 did ***not** claim* the nursing education costs at issue *as pass-through costs*.[49] Further, there is no evidence, in FY 1989 or thereafter, that the Medicare Contractor either accepted or construed the nursing education costs *as pass-through costs* to be ***paid*** on a reasonable cost basis. Moreover, there is no evidence that Avera was ever reimbursed for pass-through costs in FY 1989. In fact, the parties' Stipulations clearly state these costs were ***not*** allowed as pass through costs in FYs 1989 or 2010.[50]

Thus, the regulation on predicate facts is not relevant here because Avera has not submitted any evidence to show that it had in fact claimed, or been reimbursed, reasonable costs (*i.e.*, pass-through costs) for its nursing education program under the grandfather clause of 42 C.F.R. § 413.85(g)(2)(ii), in the base year 1989, ***or** in any of the intervening years*. The Board acknowledges Avera's contention that both it and the provider in *Brigham* each reported the education costs in the same way on their respective FY 1989 cost reports. However, Avera's cost report for FYE 6/30/1989, the costs are originally reported on Worksheet A in the Nursing School line (line 20), but are then reclassed, via Worksheet A-6, to a variety of patient care areas, including A&P (Adults & Pediatrics).[51] It is this reclass that ***excludes*** the expense from pass-through treatment. This is not the same situation for the provider in *Brigham*, in which "Ultrasound Training Program costs were reclassified erroneously on the cost report from radiology-diagnostic to the radiology-diagnostic paramedical cost center, when the [p]rovider should have re-classified the costs to the ultrasound paramedical cost center."[52] In that case, the costs were in a paramedical cost center, but not the correct one. However, they were still in a cost center *which was treated and paid as pass-through cost*. That is not the case in the instant case.

Regardless, there are additional distinguishing facts from *Brigham* compared to the instant case. For example, in the instant case, the Medicare Contractor did not accept or allow the nursing education costs as pass-through costs paid on a reasonable cost basis, nor did the Medicare Contractor reimburse Avera any reasonable costs for its nursing education program, in 1989, or any subsequent years, whereas it did both in the *Brigham* case ***for 20 years***.

Lastly, Avera analogizes the instant case with another prior Board case for which there was a federal district court decision issued as *William Beaumont Hospital – Royal Oak v. Price* ("*Beaumont*").[53] *Beaumont* involved pass-through reimbursement for allied health education program costs. In *Beaumont*, after 16 successive years of obtaining pass-through reimbursement for its allied health education program costs, the provider's claim for pass-through reimbursement was denied based on the Medicare Contractor's new requirement that contemporaneous time studies must be submitted as documentation to support its claimed

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[49] *See* Stipulations at ¶¶ 4 & 5.
[50] *Id.*
[51] Exhibit P-10 at 2, 5, & 6.
[52] PRRB Dec. 2023-29 at 6.
[53] 455 F.Supp.3d 432 (E.D. Mich. 2020).

nursing education costs.[54] The facts in *Beaumont* are distinguishable from the instant case. Specifically, in *Beaumont*, the provider received pass-through reimbursement for the FYs 1988-2004, and the FYs 2005 and 2006 at issue were the first years that the provider was not reimbursed for those costs even though the provider submitted the same type of documentation it had submitted in prior years to support its claim for those costs. In the instant case, the Medicare Contractor never reimbursed Avera the reasonable costs of its nursing education program during the period of 1989 through the fiscal year at issue, FY 2010, such that it would be reasonable for Avera to expect such reimbursement in FY 2010 based on a prior pattern of being paid. Indeed, Avera had not been reimbursed for almost 20 years, and would not have expected such reimbursement in FY 2010. Consequently, the Board rejects Avera's argument that the decision in *Beaumont* case is relevant or provides any valuable guidance.

For the reasons discussed herein, the Board concludes that the Medicare Contractor properly reclassified the nursing education costs to Adults and Pediatrics on the FY 2010 cost report, as the requirements of 42 C.F.R. § 413.85(g)(2)(ii) have not been met.

DECISION

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor properly disallowed Avera's Nursing Education Program costs for FY 2010, because the Provider did not meet the criteria for reimbursement of clinical training costs of a non-provider operated program.

BOARD MEMBERS:

Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA

FOR THE BOARD:

6/5/2024

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

[54] Provider's FPP at 11-12 (citing *William Beaumont Hosp. – Royal Oak v. Price,* 455 F.Supp.3d 432 (E.D. Mich. 2020)). A copy of the *Beaumont* decision is included in Exhibit P-11. The Board notes that the Provider's List of Exhibits in its Final Position Paper indicates the *Beaumont* decision is in Exhibit P-12; however, it is instead included in Exhibit P-11.