PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2024-D32

PROVIDER –
Carolinas Medical Center – Behavioral Health

Provider No.: 34-0113

vs.

MEDICARE CONTRACTOR –
Palmetto GBA c/o National Government Services, Inc.

HEARING DATE –
May 3-4, 2023

Cost Reporting Periods Ended –
December 31, 2012, December 31, 2013

CASE NOS. –
19-2175, 19-2176

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ISSUE STATEMENTS:

1. Whether the Provider is entitled to pass-through reimbursement for the net costs of its Nursing, Medical Laboratory Science, Radiologic Technology, and Surgical Technology Programs for fiscal years ("FYs") 2012 and 2013.[1]

2. Whether the Medicare Contractor miscalculated the Part C component of the Provider's nursing and allied health ("NAH") payment for FYs 2012 and 2013.[2]

3. Whether the Medicare Contractor failed to account for all of the Provider's Medicaid eligible days in calculating the DSH payment for FY 2013.[3]

DECISION:

After considering the Medicare law, regulations, program guidance, the evidence presented, and the parties' contentions, the Provider Reimbursement Review Board ("Board") finds:

1. The Medicare Contractor properly disallowed the FY 2012 and 2013 pass-through reimbursement claimed by Carolinas Medical Center – Behavioral Health ("CMC" or "Provider") for the net cost of its Nursing, Medical Laboratory Science, Radiologic Technology, and Surgical Technology Programs.

2. The Medicare Contractor properly calculated the Part C component of the CMC's NAH payment for FYs 2012 and 2013 as it included the cost report lines/columns as directed by the CMS Program Memorandum, issued on May 23, 2003 under Transmittal A-03-043 ("the May 2003 Program Memorandum"),[4] in its total inpatient days portion of the calculation.

3. It is undisputed that the FY 2013 DSH calculation for CMC should be revised to include an additional net 127 Medicaid-eligible days in the numerator of the Medicaid fraction.

Accordingly, the Board remands Case No. 19-2176 to the Medicare Contractor to revise CMC's FY 2013 cost report as follows:

a. Revise Worksheet S-2, Part I as follows:

- Add an additional 221 in-state Medicaid eligible unpaid days to Line 24, Column 2;
- Add an additional 11 out-of-state Medicaid eligible unpaid days to Line 24, Column 4; and
- Subtract 105 duplicate in-state Medicaid paid days from Line 24, Column 1.

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[1] Transcript ("Tr.") (May 3, 2023) at 5. This issue pertains to Case Nos. 19-2175 and 19-2176. As the hearing occurred over two days, May 3-4, 2023, the Board will hereinafter refer to the hearing by day as follows, "Day-1 Tr." for the first day and "Day-2 Tr." for the second day.
[2] *Id* at 6. This issue pertains to Case Nos. 19-2175 and 19-2176.
[3] *Id*. This issue pertains to Case No. 19-2176 only.
[4] Copy available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/a03043.pdf (last accessed Sept. 2, 2024).

b. Revise Worksheet S-3, Part I as follows:

- Subtract 105 duplicate Medicaid-eligible days from Line 1, Column 7; and
- Add an additional 232 Medicaid-eligible days to Line 2, Column 7.

c. Recalculate CMC's DSH adjustment payment for FY 2013.

INTRODUCTION

CMC is an acute care hospital located in Charlotte, North Carolina. Its assigned Medicare contractor[5] is Palmetto GBA c/o National Government Services, Inc. ("Medicare Contractor").

The Medicare Contractor made adjustments to CMC's FY 2012 and FY 2013 cost reports, reclassifying the Nursing, Medical Laboratory Science, Radiologic Technology, and Surgical Technology program costs ("the Disallowed NAH Programs") as normal operating costs.[6] The Medicare Contractor determined that the Disallowed NAH Programs: (1) do not qualify for pass-through reimbursement based on its findings that CMC did not meet the criteria for legal operator of the programs, in accordance with 42 C.F.R. § 413.85(f); and (2) did not qualify for non-provider operated programs, under the requirements at 42 C.F.R. § 413.85(g)(3).[7] CMC disputes these findings.

In addition, the Medicare Contractor made adjustments to CMC's FY 2012 and FY 2013 cost reports to revise CMC's reported NAH Managed Care add-on payment on Worksheet E, Part A, Line 53.[8] In calculating the payment, the Medicare Contractor included Medicare Part C inpatient days in the total inpatient days portion of the calculation.[9] CMC alleges that Medicare Part C inpatient days should be excluded from total inpatient days.

Finally, the Medicare Contractor allowed a total of 92,240 Medicaid-eligible days on CMC's FY 2013 cost report.[10] CMC alleges its FY 2013 DSH payment should be revised to include additional Medicaid-eligible patient days that were not included in the numerator of the Medicaid fraction.

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[5] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and 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.
[6] Ex. C-2 at C0010-60 (Case No. 19-2175) (copy of the FY 2012 Audit Adjustment Report). Note – ***all*** citations to exhibits from the Medicare Contractor will be to the Final Position Paper in Case No. 19-2175 unless otherwise noted.
[7] *Id*. at C0010.
[8] *Id.* at C0069.
[9] Ex. C-23 at C0424. In its workpaper to adjust the Nursing and Allied Health payment, the Medicare Contractor accumulated Total Inpatient Days from Worksheet S-3, Column 6, using the data on Lines 1, 6 through 10, 14 and 14.01. The applicable Worksheet S-3 is included in Ex. C-23 at C0418. These lines reflect Total Adults & Peds Days, Specialty Unit Days (in this case, ICU, NICU, CCU, CVRU, Neuro ICU, Trauma ICU, PICU, and Peds ICU), and Excluded Unit Days (in this case, Subprovider and Peds Rehab). The Board notes that, per the Provider Reimbursement Manual, CMS Pub. 15-2 ("PRM-2"), § 3605.1, the instructions for Form 2552-96 which was used for this cost report, for Worksheet S-3, Columns 3 through 5, state: "Enter the number of inpatient days or visits, where applicable, for each component by program. Do not include HMO except where required (line 2, columns 4 and 5), organ acquisition, or observation bed days in these columns." For Worksheet S-3, Column 6, these instructions state, "Enter the number of inpatient days for all classes of patients for each component. Include organ acquisition and HMO days in this column."
[10] Parties' Joint Stipulations, Case No. 19-2176, at § 3.1 (filed May 2, 2023).

CMC timely appealed the FY 2012 and 2013 Notices of Program Reimbursement ("NPR")[11] to the Board and met the jurisdictional requirements for a hearing. The Board conducted a live hearing on November May 3-4, 2023. CMC was represented by Daniel Hettich, Esq. and Alek Pivec, Esq. of King & Spalding, LLP. The Medicare Contractor was represented by Jospeh Bauers, Esq. of Federal Specialized Services.

STATEMENT OF FACTS:

A. The Disallowed Nursing and Allied Health ("NAH") Programs

The Charlotte Memorial Hospital Authority of Charlotte, North Carolina was established in 1943 "as a public body to provide hospital care and engage in charitable, educational, and research programs."[12] In 1961, it changed its name to the Charlotte-Mecklenburg Hospital Authority ("Hospital Authority" or "CMHA").[13] At the time of founding in 1943, the Hospital Authority's primary function was "the establishment and then operation of Charlotte Memorial Hospital (later renamed CMC)."[14]

CMC participates in the Medicare program as a short-term acute care hospital under Provider No. 34-0113.[15] CMC is an "unincorporated doing-business-as component of the Hospital Authority and does not have a separate legal identity from the Hospital Authority."[16] Consistent with Medicare program guidance, CMC annually files a cost report and the Hospital Authority files a home office cost report.[17] The North Carolina Department of Health and Human Services issued the hospital license to operate CMC to the Hospital Authority and the license included a total bed capacity of 874 beds.[18]

Since its founding in 1943, the Hospital Authority has greatly expanded its operations and adopted its doing-business-as trade name of "Carolinas HealthCare System" which will hereinafter be referred to as "the CHC-System."[19] As a result, CMC was just one of thirty-eight

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[11] Both NPRs were issued January 8, 2019.

[12] Provider's Consolidated Final Position Paper ("Provider's CFPP") at 13 (Sept. 9, 2022). *See also* Exhibits ("Exs.") P-1 at 1, P-10. Note – all citations to CMC's exhibits are to those listed in CMC's Exhibit List filed on May 2, 2023, unless the Board specifically notes otherwise. The May 2, 2023 CMC Exhibit List shows exhibits marked P-1 through P-125.

[13] Ex. P-1 at 9; Ex. P-2 at 1.

[14] Provider's CFPP at 13; Day-1 Tr. at 124, 170.

[15] *See* Exs. P-38, P-39.

[16] Provider's CFPP at 13; Ex. 3.

[17] *See* Day-1 Tr. at 116, 129-30; Day-2 Tr. at 164.

[18] Ex. P-6.

[19] Ex. P-13 at 1, 4 (copy of the Hospital Authority's financial statements for CYs 2012 and 2013 describing the Hospital Authority as "d/b/a Carolinas HealthCare System" and KPMG cover letter stating "We have audited the accompanying financial statements of [the Hospital Authority] (d/b/a Carolinas HealthCare System) (the System) and its discretely presented component unit . . . ."). The Board takes administrative notice that the Hospital Authority apparently changed its d/b/a from CHC-System to Atrium Health and then merged with Advocate Health based on the common issue related party CIRP Groups for those d/b/as which are in OH CDMS all under the parent organization named Advocate Health. *See also* Ex P-41 at 2, 3, 5, (2019 email conversations between the Hospital Authority and CMS including the line "Carolinas HealthCare System is Atrium Health"). *See generally* organization websites at www.atriumhealth.org; www.advocateheatlh.org.

(38) hospitals operated by the Hospital Authority.[20] To give additional perspective on the size of the Hospital Authority (d/b/a the CHC-System), the Board notes that, in its 2012 Annual Report, the CHC-System summarized its operations as follows:

> The [CHC-]System operates *more than* ***three dozen hospitals*** and serves patients at more than 900 care locations including physician practices, freestanding emergency departments, outpatient surgery centers, pharmacies, laboratories, imaging centers and other facilities. . . .
>
> Altogether, [CHC-]System operations comprise *more than* ***7,400 licensed beds***, employ approximately 60,000 people, and account for more than 10 million patient encounters annually.[21]

Indeed, the Hospital Authority's Financial Statements for FYs 2013 and 2012 describe the CHC-System as "the *largest* healthcare system in North and South Carolina and the ***second largest*** *public*, multihospital system ***in the nation***."[22] In addition, the Hospital Authority "owns, operates and subsidizes" three different schools offering NAH education programs and, during 2012, had nearly 1400 students collectively:

1. CCHS (*i.e.*, Carolinas College of Health Sciences);
2. Mercy School of Nursing; and
3. Cabarrus College of Health Sciences.[23]

Specifically, in its 2012 Annual Report, the CHC-System described these 3 schools as follows:

> Through three of its hospitals, *the [CHC-]System owns, operates and subsidizes* ***three schools*** *that offer nursing and allied health programs* culminating in certificates, diplomas and degrees at the associate and baccalaureate levels as well as noncredit continuing

[20] Ex. P-101 at 5 (2012 Annual Report listing 38 different hospitals across North and South Carolina). Some of these 38 hospitals are specialty hospitals, such as inpatient rehabilitation facilities ("IRFs") or inpatient psychiatric facilities ("IPFs"). However, at least 15 of these hospitals are short-term acute care hospitals subject to IPPS. In this respect, the Board takes administrative notice that for 2012, the Hospital Authority pursued certain issues common to its short-term acute care hospitals in common issue related party ("CIRP") groups and these groups contain as many as 15 participants. For example, the fully-formed CIRP group under Case No. 15-3319GC entitled "QRS Carolinas HealthCare 2012 DSH SSI Percentage CIRP Group" has the following fifteen (15) participants: (1) Carolinas Medical Center/Behav Health (34-0113); (2) AnMed Health (42-0027); (3) Mount Pleasant Hospital (42-0104); (4) Roper Hospital (42-0087); (5) Atrium Health Union (34-0130); (6) Atrium Health Lincoln (34-0145); (7) Atrium Health Cleveland (34-0021); (8) Wilkes Regional Medical Center (34-0064); (9) Columbus Regional Healthcare System (34-0068); (10) Atrium Health University City (34-0166); (11) Carolinas Healthcare System Kings Mountain (34-0037); (12) Atrium Health Pineville (34-0098); (13) Murphy Medical Center (34-0160); (14) Stanly Regional Medical Center (34-0119); (15) Valdese General Hospital Inc. (34-0055).

[21] *Id.* at 4 (emphasis added).

[22] Ex. P-13 at 20. The Financial Statements further describe the Carolinas HealthCare System as follows: "The System's diverse network of care locations includes academic medical centers, hospitals, freestanding emergency departments, physician practices, surgical and rehabilitation centers, home health agencies, long-term care facilities and behavioral health centers, as well as hospice and palliative care services." *Id.*

[23] Exs. P-13 at 14, P-102 at 13.

> education programs and workshops. Carolinas College of Health Sciences and Mercy School of Nursing are located in Mecklenburg County, while Cabarrus College of Health Sciences is located in Cabarrus County. *Collectively,* ***nearly 1,400 students*** *are enrolled in programs* such as Nursing, Surgical Technology, Medical Lab Science, Radiation Therapy, Radiological Technology, Medical Assistant and Occupational Therapy. Carolinas College of Health Sciences was recognized in 2013 by StateUniversity.com as the number one two-year school in the nation based upon various criteria, including graduation rates. With 407 graduates in 2013, the [CHC-]System is one of the top producing nursing and allied health entities in the state of North Carolina. More importantly, the majority of graduates remain in the region, providing invaluable resources to alleviate local clinical personnel shortages.
>
> Additionally, the Charlotte Area Health Education Center, operated by the [CHC-]System, is the only organization providing continuing education to all area healthcare professionals from all settings, including hospitals, long-term care and physician practices.[24]

The cases before the Board focus on one of these 3 schools, CCHS.

1. History of CCHS

Website materials entered into the record suggest that, in May 1990, the Hospital Authority received initial approval from the North Carolina Board of Nursing to establish a new nursing program and began operating the Charlotte Memorial Hospital School of Nursing ("CMHA School of Nursing") as an unincorporated division of the Hospital Authority on CMC's campus.[25] The first students appear to have been admitted to the CMHA School of Nursing in fall 1990 with the first class graduating in 1992 after "[f]ull approval status was granted."[26] The earliest Worksheet A in the record is from CMC's FY 1993 cost report showing that nursing school costs were claimed on the FY 1993 cost report.[27]

On December 23, 1993, the CMHA Board of Commissioners passed a resolution to incorporate the CMHA School of Nursing as an education institution wholly owned by the Hospital Authority and to appoint a separate board of directors for the CMHA School of Nursing,[28] for purposes of complying with accreditation requirements.[29] This incorporation was effective

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[24] Exs. P-13 at 11, P-102 at 13 (emphasis added).
[25] Exs. P-7 at 2, P-8 at 1 (resolution approving the School's incorporation and stating "[the Hospital Authority has previously owned and operated the CMHA School of Nursing as an unincorporated division of [the Hospital Authority].")
[26] Ex. P-7 at 2.
[27] Ex. P-38 at 2.
[28] Ex. P-9 (copy of Articles of Incorporation of CMHA School of Nursing). *See also* Ex. P-8.
[29] Ex. P-8 at 1 (resolution approving the School's incorporation and, in support, stating: "WHEREAS, in order to receive SACS accreditation, the School of Nursing must meet certain SACS conditions of eligibility which conditions,

January 1, 1994[30] and the Hospital Authority delegated its authority to grant/award educational degrees to the college by the CMHA Board of Commissioners.[31]

In 1995, the CMHA School of Nursing received its initial accreditation from the Southern Association of Colleges and Schools.[32]

Effective January 1, 1997, the CMHA School of Nursing changed its name to Carolinas College of Health Sciences ("CCHS")[33] and "approved plans to incorporate other healthcare programs."[34] In August 1996, the hospital-based programs in radiologic technology and surgical technology appear to have been moved from CMC to CCHS and, similarly, the hospital-based medical technology program appears to have made a similar move.[35]

In March 1997, CCHS received its initial accreditation from the National League for Nursing Accrediting Commission, Inc.[36] On November 17, 2006, the Commission on Accreditation of Allied Health Education Programs accredited the Surgical Technology Program sponsored by CCHS.[37] On October 31, 2007, the Joint Review Committee on Education in Radiologic Technology ("JRCERT") gave continuing accreditation for the associate degree radiography program sponsored by CCHS.[38] In 2011, the medical technology program became the medical laboratory sciences program.[39] On August 30, 2013, JRCERT issued initial accreditation for the radiation therapy program sponsored by CCHS.[40]

Significantly, CCHS also includes a continuing education center as described in the following excerpt from CCHS' website:

> The Continuing Education Division of [CCHS] offers programs and workshops that will allow you to gain valuable hands-on

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among other things, required that an institution seeking accreditation have a separate, autonomous governing board that controls the business and financial affairs of the institution . . . ."). *See also* Ex. P-10 (copy of NC General Statute 131E-23(a)(31) stating that the Hospital Authority has the power "[t]o provide teaching and instruction programs and schools for medical students, interns, physicians, nurses, technicians and other health care professionals); Ex. P-8 at 1 (stating "Pursuant to N.C. Gen. Stat. 131E-23(b) the CMHA School of Nursing, Inc. is hereby authorized to operate the CMHA School of Nursing and to award associate degrees."); Ex. P-9 at 1.

[30] Ex. P-9 at ¶ 1. *See also* P-15 (noting the first CCHS By-Laws were effective as of Jan. 1, 1994).

[31] Ex. P-9 at ¶ 4; Ex. P-7.

[32] Ex. P-4.

[33] Exs. P-11 at 2, P-12 at 1.

[34] Ex. P-7 at 2.

[35] *See* Ex. P-7 at 2-3; Ex. P-38 at 2, 6, 10, 14 (CMC's Worksheet A for FYs 1993 through 1996, showing: paramed lab and paramed x-ray programs being claimed for FY 1993; and paramed lab, paramed x-ray, and paramed surgical tech programs being claimed for FYs 1994, 1995, and 1996); Ex. P-43 at 3 (CMC's Worksheet A for FY 1991 showing paramed lab and paramed x-ray programs being claimed); Ex. P-45 at 1 (CMC's Worksheet A for FY 1992 showing paramed lab and paramed x-ray programs being claimed). It is not fully clear whether the programs moved *per se* and received continuing accreditation; or in the alternative had to start again with initial accreditation. Similarly, it is unclear how "[I]n January of 1997, the School of Medical Technology became a part of CCHS" (Ex. P-98 at 5) as there are no business records documenting how this move occurred or including similar issues with any prior accreditation.

[36] Ex. P-20 at 1-2.

[37] Ex. P-26.

[38] Ex. P-25.

[39] Ex. P-7 at 3; Ex. P-98 at 5.

[40] Ex. P-24.

> experience. The continuing education hours can help you maintain your certification and licensure or just get you started on your new career path in healthcare.[41]

For 2012, the CCHS Board of Directors had nine (9) members breaking out as follows:[42]

Members	Source of Members	Organization & Title
1	CCHS	CCHS President
3	Hospital Authority, dba CHC-System	System Chief Academic Officer VP/System Chief Nursing Officer/Admin. System Assist. Sec. to Bd/Sr. Assoc. Gen. Counsel
1	CMC (operating division of the Hospital Authority)	VP/Chief Medical Officer
4	Community	Of Counsel, Poyner & Spruill (served as Chairman) Counsel, Moore & Van Allen Sr. VP, Operational Risk Exec, Bank of America A graduate from CCHS

Diplomas from CCHS are issued by CCHS and signed by executives from CCHS.[43]

The Hospital Authority and CCHS operate the nursing and allied health programs under three separate agreements:

1. The Bylaws for CCHS;[44]
2. The Clinical Education Affiliation Agreement between the Hospital Authority and CCHS ("Affiliation Agreement");[45] and
3. The Memorandum of Understanding between the Hospital Authority and CCHS ("MOU").[46]

According to CMC, the Affiliation Agreement is "meant to ensure that [CCHS] has access to the necessary clinical space to meet requirements for accreditation," while the MOU addresses "all non-clinical arrangements between the parties."[47]

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[41] Ex. C-8 at C0130. Note that the CCHS continuing education is separate from the continuing education program at the Charolotte Area Health Education Center that the Hospital Authority operates. *See* Exs. P-7 at 4, P-13 at 11.
[42] Table based on C-8 at C0140-41.
[43] Ex. C-8 at C0142 (sample diploma from the CCHS School of Nursing signed by the Chair of the CCHS Board of Directors, the CCHS President, the CCHS Provost, and the Dean for the CCHS School of Nursing); Ex. C-10 at C0219 (sample diploma from CCHS School of Clinical Laboratory Sciences signed by the Chair the CCHS Board of Directors, the CCHS President, the CCHS Provost, the Director of the CCHS School of Clinical Laboratory Sciences, and the Medical Advisor for the CCHS School of Clinical Laboratory Sciences); Ex. C-11 at C0264 (sample diploma from the CCHS Radiologic Technology Program signed by the Chair of the CCHS Board of Directors, the CCHS President, the CCHS Provost, and the Director of the CCHS Radiologic Technology Program); Ex. C-12 at C0311 (sample diploma from the CCHS School of Surgical Technology signed by the Chair of the CCHS Board of Directors, the CCHS President, the CCHS Provost, and the Director of the CCHS School of Surgical Technology).
[44] Ex. P-15.
[45] Ex. P-27.
[46] Ex. P-28.
[47] Provider's CFPP at 21; Exs. P-27, P-28.

2. September 2013 Bylaws Governing CCHS

The Bylaws governing CCHS were initially effective January 1, 1994 and the version in the record before the Board was "Amended September, 2013" and, as such, became effective for the last 3 months of the period at issue before the Board since the period at issue in these cases runs, in the aggregate, from January 1, 2012 to December 31, 2013.[48] It is unclear what changes were made to the bylaws in September 2013 (to the last version that was "Amended and Restated February 7, 2002[49]) and CMC did not provide any witness testimony on this fact.[50]

The September 2013 CCHS Bylaws state that the Hospital Authority is the sole member of the corporation that is CCHS and that the "business and affairs of the Corporation shall be managed by its Board of Directors" which consists of at least 5 directors with the actual number determined by the Hospital Authority.[51] The Bylaws further specifies the following:

1. The Board "shall establish broad institutional policies for [CCHS], including admission policies, employment policies, and policies ensuring academic freedom."[52]
2. The Board "shall approve of the [CCHS'] annual budget."[53]
3. The Hospital Authority "shall appoint from the nominees proposed by [CCHS] Board of Directors the directors of [CCHS]."[54]
4. CCHS "shall at all times permit and facilitate inspection of its books, records, properties and operations by the [Hospital Authority], and duly designated representatives thereof, or any other person granted permission to conduct such inspection by the [Hospital Authority]."[55]

Significantly, any action of the Hospital Authority concerning CCHS is to be taken by the Chief Executive Officer ("CEO") of the Hospital Authority unless the CEO authorizes another person to do so:

> All Member actions [*i.e.*, actions of the Hospital Authority] concerning the Corporation, including the exercise of any voting rights, ***shall*** *be taken by* ***the chief executive officer*** *of the [Hospital Authority*] or by such other persons as may from time to time be duly authorized by such officer to take such actions [and] actions [of the Hospital Authority] affecting the Corporation may be taken at any time.[56]

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[48] Ex. P-15 at 1.
[49] Cover page of the Bylaws identifies six versions which started with the original January 1, 1994 version and ended with "Amended September, 2013" version. The version that the immediately precedes the "Amended September, 2013" version is the "Amended and Restated February 7, 2002" version. *Id.* The Bylaws are not redlined (nor do they include a summary of any amendments that were made).
[50] *See, e.g.*, Day-1 Tr. at 179-82; Day-2 Tr. at 57-60.
[51] Ex. P-15 at 4.
[52] *Id.*
[53] *Id.*
[54] *Id.* at 5. *See also* Ex. P-16 (example of nominations to CCHS Board sent by CCHS to the Hospital Authority for approval and approved by Joseph Piemont, President/CCO of the Hospital Authority who is also shown on the Hospital Authority organization chart at P-54).
[55] Ex. P-15 at 9.
[56] *Id.* at 9 (emphasis added).

There is no indication in the record that anyone at the CMC operating division was authorized to direct CCHS.

3. Affiliation Agreement between CCHS and the Hospital Authority with Second and Third Amendments

On **January 1, 2005**, the Hospital Authority and CCHS executed the Affiliation Agreement.[57] Significantly, in 2012, the Senior Vice President & Chief Academic Office of Education and Research at the Hospital Authority signed the Second and Third Amendments to the Affiliation Agreement on behalf of the Hospital Authority[58] and he is identified with the corporate operations of the CHC-System.[59] Under its terms, CCHS's responsibilities included the following:

> a. [CCHS] *shall retain responsibility* for Student's education and for arranging appropriate clinical learning experiences for Students.
>
> b. *Prior to [CCHS] Personnel's placement* ***at any Facility***, [CCHS] shall provide *to [the Hospital Authority]* information concerning such [CCHS] Personnel's education and experience including proposed dates of assignment to such Facility; number of [CCHS] Personnel to be placed; names and pertinent identification information about such [CCHS] Personnel; [CCHS'] objectives for the clinical education experience; suggested curriculum outlines; and Students' prior clinical experiences.[60]

The Affiliation Agreement also specifies that the Hospital Authority's responsibilities included:

> a. [The Hospital Authority] shall provide [CCHS] Personnel access to first aid and emergency care for illnesses or accidents occurring to these persons while ***at any Facility***. [The Hospital Authority] shall be entitled to charge [CCHS] Personnel for such first aid and emergency care services.
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> b. Upon [CCHS'] request, [the Hospital Authority] will periodically provide [CCHS] an evaluation of [CCHS] Personnel's performance and progress.
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> ****
>
> d. [The Hospital Authority] shall maintain responsibility for patient care.[61]

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[57] Ex. P-27 at 1.
[58] *Id.* at 8, 13, 17.
[59] One of the directors on the 2011 CCHS Board of Directors Roster (Ex. P-55) is the same individual who signed Second and Third Amendments to the Affiliation Agreement. The director is identified as the "Chief Academic Officer" for "[CHC-]System" which is in contrast to another director listed as coming from CMC. *See also* Day-1 Tr. at 200 (describing the Chief Academic Office as "[a] high level individual within the Hospital Authority").
[60] Ex. P-27 at 2 (emphasis added).
[61] *Id.* at 5-6 (emphasis added).

Significantly, the Affiliation Agreement defined the term "Facility" as referring individually to any of the ten (10) healthcare facilities listed in Exhibit A which the Hospital Authority owns and/or operates.[62] The ten (10) "Facilities" listed in the original 2005 Exhibit A to that Agreement are:

> Carolinas Medical Center
> Carolinas Medical Center – Mercy
> Carolinas Medical Center – Pineville
> Carolinas Medical Center – Randolph
> Carolinas Medical Center – University
> Carolinas Physicians Network, Inc.
> Carolinas Institute of Rehabilitation
> Huntersville Oaks [Nursing Home]
> Sardis Oaks [Nursing Home]
> Mecklenburg County Health Department[63]

Similarly, the Affiliation Agreement defines the terms (a) "Faculty" as "faculty affiliated with [CCHS'] health-related professional programs"; (b) "Students" as "students . . . affiliated with [CCHS'] health-related professional programs"; and (c) "[CCHS] Personnel" as collectively Students and Faculty.[64]

The Affiliation Agreement gives the Hospital Authority the ability to delegate any of its obligations under the Agreement: "[The Hospital Authority] may assign any or all of its rights or interests, or delegate any or all of its obligations, in this Agreement to (a) any successor to [the Hospital Authority] or any acquirer of a material portion of the business or assets of [the Hospital Authority] or (b) one or more entities directly or indirectly controlling, controlled by, or under common control with, [the Hospital Authority]."[65] The record before the Board does not contain any documentation or evidence to suggest that there were any such delegations from the CHC-System-level of the Hospital Authority to the operating division, CMC (*e.g.*, delegation to the CMC President[66]).

On **January 17, 2012**, the Hospital Authority and CCHS executed the "Second Amendment" to the Affiliation Agreement to replace Exhibit A with an updated list of "Participating . . . Facilities" covered by the Affiliation Agreement and to add additional provisions applicable to CCHS' radiation therapy program.[67] In particular, the Second Amendment specified that "Radiation Therapy program students will be offered clinical experiences at the following CHS locations, ***in addition to*** *the primary sites set forth on Exhibit A*:

> -CMC Radiation Oncology
> -CMC - Northeast – George A. Batte, Jr. Cancer Center
> -Pineville Radiation Therapy Center

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[62] *Id.* at 1 (stating in the Background Statement that "CMHA owns and/or operate healthcare facilities, including but not limited to the facilities in Exhibit A (hereinafter referred to individually as 'Facility' or, collectively as 'Facilities')."
[63] *Id.* at 9.
[64] *Id.* at 1.
[65] *Id.* at 7.
[66] *See* Day-1 Tr. at 100 ("MR: BAUERS: Okay. Does CMC – the hospital – does it have its own President? THE WITNESS: It does have its own President, yes.").
[67] Ex. P-27 at 11.

-Rock Hill Radiation Therapy Center[68]

The Updated Exhibit A listed eleven (11) "Participating . . . Facilities" and reflected the addition of two (2) Facilities (Carolinas Medical Center – Lincoln and Carolinas Medical Center – Northeast) and removal of one (1) Facility (Mecklenburg County Health Department).[69]

On **October 31, 2012**, the Hospital Authority and CCHS executed the "Third Amendment" to the Affiliation Agreement to replace Exhibit A with an updated list of "Participating . . . Facilities" covered by the Affiliation Agreement.[70] The updated Exhibit A listed the twelve (12) "Participating . . . Facilities" and reflected the addition of one (1) Facility (Carolinas Medical Center – Union).[71]

4. The MOU (Unamended) Between CCHS and the Hospital Authority

On January 1, 1997, the Hospital Authority and CCHS executed the MOU.[72] The MOU specifies that the Hospital Authority "shall provide" certain services to CCHS and that CCHS shall compensate the Hospital Authority for these services:

> 2. [The Hospital Authority] Services. The Hospital Authority shall provide the following corporate services to [*sic* CCHS]: architectural, audio visual, business planning, communications, construction, environmental services, general accounting/financial services (accounts payable, cash management and payroll, human resources, legal services, mail, maintenance, management information systems, marketing, materials management, nurse recruitment, parking, safety, and insurance, security, and travel.
>
> 3. Compensation. As compensation for the corporate services provided by [the Hospital Authority], [CCHS] shall pay [the Hospital Authority] a monthly sum of two thousand dollars ($2000) payable on the first day of each month for the prior month. In addition, the cost of any items purchased through the various [Hospital Authority] departments shall be the responsibility of [CCHS]. Examples include the costs of supplies purchased through Materials, computer equipment purchased with the assistance of MIS and outside legal fees coordinated by the Legal Department.[73]

Under the MOU, the Hospital Authority pays "the employees/faculty of [CCHS] . . . under the common paymaster doctrine"; CCHS employees are "entitled to the benefits that are provided by [the Hospital Authority] to its employees and its subsidiaries' employees"; and the Hospital

[68] *Id.*
[69] *Id.* at 14.
[70] *Id.* at 15.
[71] *Id.* at 18.
[72] Ex. P-28.
[73] *Id.* at 1-2.

Authority charges CCHS for the costs of these wages and benefits.[74] The MOU further states that, "[s]ubject to approval by [CCHS's] Board of Directors, employees of [CCHS] shall be subject to [the Hospital Authority's] employee policies. Employees of [CCHS] shall also be subject to such policies as are approved by the [CCHS] Board. This Board may also choose to approve alterations or modifications to [Hospital Authority] policies as they are applied to the employees of [CCHS] where appropriate for an academic setting."[75]

Significantly, the MOU specifies that CCHS is "solely responsible for the development of its annual budget":

> Both parties recognize that *[CCHS] is **solely** responsible for the development of its annual budget*. [The Hospital Authority] shall appropriate funds to [CCHS] annually upon submission by [CCHS] of its budget as approved by [CCHS'] Board. Once funds are appropriated by [the Hospital Authority], *budget making, the establishment of priorities and the control of expenditures **become the responsibility of [CCHS]** and its Board of Directors*.[76]

B. CMC's NAH Part C Payment

The Parties differ on the definition of one of the data points that is used to determine a hospital's NAH Part C Payment which is the hospital's total number of inpatient days in the cost reporting period ending in the federal fiscal year that is two years preceding the payment year. For the purpose of CMC's CY 2012 payment determination, the Medicare Contractor accumulated the days from CMC's FY 2009 cost report, in accordance with the May 2003 Program Memorandum,[77] from Worksheet S-3, Part I, Column 6 (Total All [Patients]) as shown below:

Adults & Pediatrics (line 1)	171,427
Intensive Care Unit (line 6)	9,408
Neonatal Intensive Care Unit (line 6.01)	16,476
Coronary Care Unit (line 7)	5,829
CVRU (line 7.01)	2,155
Neuro Intensive Care Unit (line 9.01)	8,187
Trauma Intensive Care Unit (line 9.02)	8,860
Progressive Intensive Care Unit (line 9.03)	6,420
Pediatric Intensive Care Unit (line 9.04)	4,299
Subprovider (line 14)	23,508
Pediatric Rehab (line 14.01)	2,790
TOTAL Inpatient Days	259,359[78]

[74] *Id*. at 2.
[75] *Id.*
[76] *Id*. (emphasis added).
[77] *I.e.*, the CMS Program Memorandum issued on May 23, 2003 under Transmittal A-03-043.
[78] Ex. C-23 (Case No. 19-2175) at C0418, C0424. Ex. C-23 at C0418 has the individual line and days data and C0424 has the total used in the Medicare Contractor's workpaper.

Similarly, for the purpose of CMC's CY 2013 payment determination, the Medicare Contractor accumulated the days from CMC's FY 2010 cost report, consistent with the May 2003 Program Memorandum, from Worksheet S-3, Part I, Column 6 (Total All [Patients]) as shown below:

Adults & Pediatrics (line 1)	176,816
Intensive Care Unit (line 6)	10,010
Neonatal Intensive Care Unit (line 6.01)	14,940
Coronary Care Unit (line 7)	5,967
CVRU (line 7.01)	2,617
Neuro Intensive Care Unit (line 9.01)	8,672
Trauma Intensive Care Unit (line 9.02)	9,232
Progressive Intensive Care Unit (line 9.03)	6,792
Pediatric Intensive Care Unit (line 9.04)	4,318
Subprovider (line 14)	24,395
Pediatric Rehab (line 14.01)	2,708
TOTAL Inpatient Days	266,467[79]

Based on the phrase "excluding M + C inpatient days" in the May 2003 Program Memorandum, CMC contends that the Medicare Contractor should have excluded Medicare Part C days of 5,630 in FY 2009 and 7,688 in FY 2010, resulting in total inpatient days (net Part C days) for those periods of 253,729 and 258,779, respectively.[80]

C. CMC's FY 2013 DSH Payment Calculation

In connection with the FY 2013 Medicaid-eligible days issue, the Parties agreed to Stipulations setting forth, in pertinent part, the following undisputed facts:

> **3. The Sequence of Relevant Events**
>
> 3.1. In the cost reporting period under appeal, the Provider claimed 92,240 Medicaid days in the cost report for purposes of calculating the Medicare DSH payment. These days were claimed on Worksheet S-2, Part I, Line 24, Column 6. . . . Below is a summary of the days claimed in the cost report.

Type of Medicaid Day	**Number of Days**
In-state Medicaid paid days	75,203
In-state Medicaid eligible unpaid days	7,928
Out-of-state Medicaid paid days	3,884
Out-of-state Medicaid eligible days	4,969
Medicaid HMO days	256
Other Medicaid days	0
Total Medicaid days claimed in settled cost report	**92,240**

[79] Ex. C-23 (Case No. 19-2176) at C0428, C0432. Ex. 23 at C-0428 has the individual line and days data and C0432 has the total used in the Medicare Contractor's.

[80] Provider's CFPP at 52. This calculation excluded Medicare HMO days as reported on line 2, column 4 of Worksheet S-3, part I in each year. Ex. C-23 (Case No. 19-2175) at C0418; Ex. C-23 (Case No. 19-2176) at C0428.

3.2. . . . [T]he Provider alleged that the MAC "failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and not processed after the cutoff date and all out of state eligible days in the Medicaid percentage of the Medicare DSH calculation."

3.3. The MAC and Provider engaged in discussions to resolve [the Medicaid eligible days issue]. At the MAC's request, the Provider produced (1) a listing of the Medicaid eligible days already in the cost report, and (2) a listing of the Medicaid eligible days that the Provider sought to include in its cost report.

* * * *

3.5. Upon review of the sampled days, the MAC concluded that some of the days the Provider was seeking to include in the Medicaid fraction were days attributable to patients who were entitled to benefits under part A. The MAC applied a statistical disallowance with respect to these days. The MAC also disallowed certain days that it identified as duplicative. . . .

3.6. The Provider agrees with the MAC's adjustments. The Provider has joined a separate group appeal for this cost reporting period seeking the inclusion of the days that the MAC has concluded were entitled to benefits under Part A.

4. Summary of the Agreed Resolution

4.1. After deducting days of patients who the MAC concluded were entitled to benefits under part A, the MAC determined that the Provider was entitled to claim an additional 221 in-state Medicaid eligible unpaid days and 11 out-of-state Medicaid eligible unpaid days.

4.2. The MAC also determined that the Provider needed to deduct 105 duplicate days from the count of in-state Medicaid eligible paid days.

4.3. Thus, the MAC proposed a net increase of 127 Medicaid days. This proposal is reflected below and in Audit Adjustment No. 1 of the proposed audit adjustment report. Attachment C.

Type of Medicaid Day	**Before**	**Adjustment**	**After**
In-state Medicaid paid days	75,203	(105)	75,098
In-state Medicaid eligible unpaid days	7,928	221	8,149
Out-of-state Medicaid paid days	3,884	0	3,884
Out-of-state Medicaid eligible days	4,969	11	4,980
Medicaid HMO days	256	0	256
Other Medicaid days	0	0	0
Total Medicaid days claimed in settled cost report	**92,240**	**127**	**92,367**

> 4.4. . . . for purposes of resolving [the Medicaid eligible days issue], *the Provider agrees with the MAC's conclusions that it may claim 127 additional Medicaid days*.
>
> 4.5 The MAC is unable to resolve [this issue] via reopening because the cost report was settled more than three years ago. 42 C.F.R. § 405.1885(b)(1).
>
> 4.6 Furthermore, the MAC cannot resolve [this issue] through an administrative resolution because CMS has placed a stay on MACs revisiting DSH payment determinations for cost reporting periods within this timeframe.
>
> 4.7 Accordingly, the parties request that the Board issue an order directing the MAC to apply proposed Audit Adjustment No. 1 after CMS has lifted the stay on MACs revisiting DSH payment determinations.[81]

STATUTORY AND REGULATORY BACKGROUND:

A. Statutory and Regulatory Background on Medicare Pass-Through Payment for NAH Programs at Hospitals

Since the inception of the Medicare program in 1965, 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 costs in some other 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.[82]

The Secretary has similarly recognized "an obligation to share in the costs of educational activities sponsored by participating providers until the community at large chose to bear them in some other manner."[83] To this end, on November 22, 1966, the Secretary promulgated regulations at 20

[81] Parties' Joint Stipulations, Case No. 19-2176, at ¶¶ 3-4.7 (bold emphasis in original and underline and italic emphasis added).
[82] S. Rep. No. 89-404, at 36 (1965); H.R. Rep. No. 89-213, at 32 (1965) (emphasis added).
[83] 66 Fed. Reg. 3358, 3358 (Jan. 12, 2001).

C.F.R. § 405.421 to implement this policy and specifically recognized professional and paramedical educational and training programs including medical technology, nurse anesthetists, professional nursing, practical nursing, pharmacy residencies, and x-ray technology.[84]

The Secretary also provided addition guidance on its policies governing Medicare payment of its share of approved educational activities in the Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1").[85] In 1975, in response to concerns that "Medicare's liability for costs of nursing and allied health education activities was expanding to programs that were actually college or university programs to which the providers furnished some degree of support," PRM 15-1 was revised to do the following:

1. "[S]pecify that an approved nursing or allied health education program had to be operated by a provider for its costs to be allowable as the costs of approved educational activities"; and

2. [F]or the first time, . . . give guidance to intermediaries in determining when the community had undertaken the financing of an educational program [as then specified in 20 C.F.R. § 405.421(c)]."[86]

In 1977, the Secretary redesignated regulations at 20 C.F.R. § 405.421 to 42 C.F.R. § 405.421.[87]

Following provider litigation on the 1975 PRM 15-1 provisions, CMS (then known as HCFA) revised PRM 15-1 in January 1983 to specify that "provider costs incurred for clinical training

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[84] 31 Fed. Reg. 14767, 14814 (Nov. 22, 1966) (where § 405.421(a) set forth the general principle that "[a]n appropriate part of the net cost of approved educational activities is an allowable cost" and § 405.421(c) set forth the concept, "It is recognized that the costs of such educational activities should be borne by the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these costs, the program will participate appropriately in the support of these activities. Although the intent of the program is to share in the support of educational activities customarily or traditionally carried on by providers in conjunction with their operations, it is not intended that this program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units.")

[85] *See* 57 Fed. Reg. 43659, 43660 (Sept. 22, 1992).

[86] *Id.* at 43661-62 (quoting PRM 15-2, § 404.2 (Nov. 1975) which stated in part: "However, it is not intended that Medicare should be responsible for expenditures by a provider in subsidizing such programs that are operated by other organizations. Under Medicare principles of reimbursement an approved nursing or paramedical education program must be operated by a provider (or jointly by a group of providers) for Medicare to recognize the costs of the program as allowable costs of the provider(s)."). *See supra* note 84 quoting 42 C.F.R. § 405.421(c), as initially promulgated on Nov. 22, 1966. *See also St. John's Hickey Memorial Hospital, Inc. v. Califano*, 599 F.2d 803, 809 n.10 (7th Cir. 1979) (stating: "The pertinent part of this policy statement appeared in a revision to the defendant's Provider Reimbursement Manual which is a policy guide not published in the Federal Register and not part of defendant's Regulations. In pertinent part, the statement provided: 'Where a provider furnishes financial or other support (e. g., donated classroom or clinical space) to an approved nursing or paramedical education program of which it is not the legal operator, expenses attributable to the provider's support of the program are considered to be a contribution to a community effort, and may not be included in the hospital's allowable costs for Medicare reimbursement purposes'" (emphasis removed)).

[87] 42 Fed. Reg. 52826, 52826 (Sept. 30, 1977).

associated with an approved program operated by an entity other than a provider could be allowable."[88]

In April 1983, Congress enacted legislation to establish the inpatient prospective payment system for Medicare-participating short-term acute care hospitals.[89] In enacting IPPS, it was careful to retain payment of "approved educational activities" on a reasonable cost basis, *i.e.*, such costs were excluded from IPPS and instead "passed through" to be paid on a reasonable cost basis.[90] The Secretary implemented IPPS in the interim final rule published on September 1, 1983 and, as part of this rulemaking, revised 42 C.F.R. § 405.421(d)(6) to specify that allowable pass-through educational costs did not include "[o]ther activities which do not involve the actual operation or support (except through tuition or similar payments) of an approved education program, including the costs of interns and residents in anesthesiology who are employed to replace anesthetists."[91]

In the January 3, 1984 final rule,[92] the Secretary responded to comments on the September 1, 1983 interim final rule. In particular, in response to comments, the Secretary confirmed that pass-through educational costs were limited to provider-operated programs:

> *Comment*—A number of comments were received concerning whether the pass through of direct education costs is limited to only the costs of those approved medical education programs that a hospital directly operates itself. If this is the case, commenters were concerned that certain costs, such as the costs of clinical training for students enrolled in programs other than at the hospital, may not be excluded from the prospective payment system, but rather are considered to be normal operating costs.
>
> *Response*—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 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. For example, it obtains the services of the trainee (often at no direct cost to itself). We do not believe that this type of relationship was what Congress intended when it provided for a pass through of the costs

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[88] 57 Fed. Reg. at 43662. *See also* 599 F.2d at 814 (stating: "The policy or interpretation at issue here has never been properly published. The plaintiff had no notice of it until it was denied reimbursement in 1976, and the policy was not disseminated even to intermediaries such as Blue Cross until November 1975, about two and a half years after plaintiff had made its commitment to the College.").

[89] Social Security Amendments of 1983, Pub. L. 98-21, § 601, 97 Stat. 65, 149 (1983). *See also* 57 Fed. Reg. at 43663.

[90] *See* 42 U.S.C. § 1395ww(a)(4).

[91] 48 Fed. Reg. 39752, 39811 (Sept. 1, 1983). *See also* 57 Fed. Reg. at 43663.

[92] 49 Fed. Reg. 234 (Jan. 3, 1984).

> of approved medical education programs. Rather, **we believe that Congress was concerned with those programs that a hospital operates itself, and for which it incurs substantial direct costs**.
>
> We are revising § 405.421(d)(6) to clarify that the costs of clinical training for students enrolled in programs, other than at the hospital, are normal operating costs.[93]

On September 30, 1986, the Secretary redesignated 42 C.F.R. § 405.421 as 42 C.F.R. § 413.85.[94]

In 1989 and 1990, Congress enacted legislation addressing the payment of pass-through educational costs and grandfathered certain educational programs that were not hospital-operated education programs. In the Omnibus Budget Reconciliation Act of 1989 ("OBRA-89"), Congress enacted legislation for "recognition of costs of *certain* hospital-based ***nursing*** *schools*" in existence prior to June 15, 1989 where payment was to be made "as if they were allowable direct costs of a hospital-operated educational program."[95] Further, OBRA-89 also directed the Secretary to issue regulations regarding payment of these costs before July 1, 1990 and required these regulations to address the following:

> (i) *the relationship* ***required*** *between an approved* nursing or allied health education *program and a hospital* for the program's costs to be attributed to the hospital;
>
> (ii) the types of costs related to nursing or allied health education programs that are allowable by medicare;
>
> (iii) the distinction between costs of approved educational activities as recognized under [42 U.S.C. 1395ww(a)(3)] and educational costs treated as operating costs of inpatient hospital services; and
>
> (iv) the treatment of other funding sources for the program.[96]

The Conference Report accompanying OBRA-89 provided the following context and insight on this provision:

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[93] *Id.* at 267 (italics in original and bold and underline emphasis added).
[94] 51 Fed. Reg. 34790, 34790, 34813 (Sept. 30, 1986).
[95] Pub. L. 101-239, § 6205, 103 Stat. 2106, (1989) (emphasis added) (where subsection (a) is entitled "RECOGNITION OF COSTS OF CERTAIN HOSPITAL-BASED NURSING SCHOOLS" and subsection (a)(1)(A) stated in part: "The reasonable costs incurred by a hospital in training students *of a hospital-based nursing school*, shall be allowable as reasonable costs . . . and reimbursed . . . on the same basis ***as if they were allowable direct costs of a hospital-operated educational program*** (other than an approved graduate medical education program) if, before June 15, 1989, and thereafter, the hospital demonstrates that for each year, it incurs at least 50 percent of the costs of training nursing students at such school, the nursing school and the hospital share some common board members, and all instruction is provided at the hospital or, if in another building, a building on the immediate grounds of the hospital." (emphasis added)).
[96] OBRA-89 § 6205(b)(2)(C) (emphasis added).

Present law

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(g) Recognition of costs of certain hospital-based nursing schools.—The direct costs of approved medical education programs operated by a hospital are excluded from PPS and paid on a reasonable cost basis. HCFA has ruled that the costs of education programs operated at a hospital but controlled by another institution, such as a college or university, are not payable on a reasonable cost basis, but are included in PPS payment rates.

The Technical and Miscellaneous Revenue Act (TAMRA) of 1988[97] provided an exception to this rule **for a hospital paid under a demonstration waiver that expired on September 30, 1985**. If during its cost reporting period beginning FY 1985 and for subsequent cost reporting periods, such a hospital has incurred substantial costs due to educational activities of a nursing college with which it shares common directors, the activities shall be considered to be directly operated by the hospital for Medicare purposes, and shall be allowable as reasonable costs. Reimbursement is to be made on the same basis as if the costs were allowable direct costs of a hospital-operated approved educational program for cost reporting periods in FY 1989, 1990, and 1991.

Conference agreement

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(g) *Recognition of costs of certain hospital-based nursing schools*.—. . . . The Secretary is prohibited from recouping, or otherwise reducing or adjusting, Medicare payments to hospitals **before October 1, 1990**, for alleged overpayments to hospitals as a result of a determination that costs reported for nursing and allied health education programs were allowable only as routine operating costs and therefore excluded from the medical education pass-

[97] Pub. L. 100-647, § 8411, 102 Stat. 3342, 3800 (1988) (entitled "Treatment of Certain Nursing Education Programs"). Subsection (a) created a 5-year demonstration program for 5 hospitals who enter into a written agreement with educational institution for certain approved educational programs from July 1, 1989 to July 1, 1994 "for which the reasonable costs of conducting such activities are allowable under title XVIII of the Social Security Act *if conducted under a* ***hospital-operated*** *approved educational program* (other than an approved graduate medical education program), but only to the extent such activities are directly related to the operation of the educational program conducted pursuant to the written agreement between the hospital and the educational institution." *Id*. (emphasis added). Subsection (b) pertained only to hospitals who had been paid under a specific waiver that expired on September 30, 1985 and specified that, for 1985 and subsequent years, such hospital "has been and is associated with, and has incurred and incurs substantial costs with respect to, a nursing college with which it has shared and shares common directors, [then] educational activities of the nursing college shall be considered to be educational activities operated directly by such hospital for purposes of title XVIII of the Social Security Act, and shall be allowable as reasonable costs . . . on the same basis *as if they were allowable direct costs of a* ***hospital-operated*** *approved educational program* (other than an approved graduate medical education program), for hospital cost reporting periods beginning in fiscal years 1989, 1990, and 1991. *Id.* at 3801 (emphasis added).

through. The Secretary is required to issue regulations addressing payment of such costs by July 1, 1990, provided that the Secretary allows a comment period of not less than 60 days, consults with ProPAC, and any final rule is not effective before the later of October 1, 1990 or 30 days after publication in the Federal Register.

The regulations are to specify (1) the relationship required between a hospital and an approved nursing or allied health education program for the program's costs to be attributed to the hospital; (2) the types of costs for programs that are allowable; (3) the distinction between costs of educational activities eligible for pass-through and those treated as hospital operating costs; and (4) the treatment of other funding sources for the program.

The conferees expect the Secretary, in developing the regulations with respect to the relationship between a hospital and an educational program, to consider: (1) the degree of common ownership, broad membership, or control between the hospital, an educational institution, an academic medical center, a corporation or a related organization; (2) the degree to which instruction is provided in the immediate vicinity of the hospital; (3) the existence of a written agreement with an educational institution providing for joint activities in which the hospital incurs costs directly related to operation of the program; (4) reporting relationships or other affiliations between the education institution, the hospital, and, if applicable, an academic medical center; and (5) the responsibility and control of the hospital for administering the education program.

The conferees further expect that rules relating to types of allowable costs shall consider such costs as clinical costs, operating costs, classroom costs, appropriately allocated overhead, and faculty supervision, and that the treatment of other funding sources shall take into account State or local funding and costs redistributed from non-provider sources.

The conferees wish to emphasize that, in providing reimbursement criteria for the costs of certain types of hospital-based nursing schools, it is not their intention to prejudice the Secretary's determination as to the appropriateness of cost reimbursement for other hospital-based nursing and allied health education programs. The conferees further note that a program will comply with the requirement that instruction be conducted in a building on the immediate grounds of the hospital only if this instruction occurs on the hospital campus, not on the campus of an institution with which the hospital is affiliated.[98]

[98] OBRA-89 Conference Report, H.R. Rep. 101-386, 101st Cong. at 860-61, 868-69 (1989).

Before the Secretary issued this regulatory guidance, Congress enacted the Omnibus Budget Reconciliation Act of 1990 and similarly provided recognitions of costs of certain nursing and allied health programs conducted on the premises of the hospital but not operated by the hospital that were existing in the most recent cost reporting period that ended on or before October 1, 1989.[99] In passing this grandfather provision, Congress made clear in the Conference Report accompanying OBRA-90 that "the conferees intend that nothing in the provision should be construed as requiring the Secretary to modify his current policy with regard to the determination of reasonable costs for a hospital-operated program."[100]

On September 22, 1992, the Secretary published a proposed rule to implement the OBRA-89 and OBRA-90 provisions. In particular, "[i]n accordance with the mandate in OBRA-89 § 6205(b)(2), [101] . . . the . . . proposed rule addressed the Medicare rules governing which costs of nursing and allied health education programs are allowable and when these costs are eligible for the pass-through payment to a hospital paid under [IPPS]."[102] However, the Secretary did not complete that rulemaking process until January 12, 2001 when it issued a final rule, which included the above explanation of the proposed rule from 1992.[103] The final rule revised 42 C.F.R. § 413.85 "to explicitly set forth criteria that define approved nursing and allied health educational programs considered provider-operated, and rules for determining the net costs of provider-operated nursing and allied health educational programs."[104]

On August 1, 2003, the Secretary made further revisions to 42 C.F.R. § 413.85 to address, in pertinent part, subsequent questions concerning wholly-owned subsidiary educational institutions.[105] Following this final rule to the period at issue, there have been only minor changes the regulations.[106]

As a result of these rulemakings, the regulation at 42 C.F.R. § 413.85 (2011) sets forth the applicable standards for reimbursing the reasonable cost of "*approved* nursing and allied health education activities" under the Medicare program.[107] At the outset, § 413.85(a) makes clear that this section "implements section [42 U.S.C. § 1395x(v)(1)(A)] and section 4004(b) of [OBRA-90] by establishing the payment methodology for Medicare payment of the costs of approved nursing and allied health education activities."

Pursuant to § 413.85(c), the term "approved educational activities' is limited, in pertinent part, to programs "operated by providers" as defined in § 413.85(f):

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[99] Pub. L. 101-508, § 4004(b), 104 Stat. 1388, 1388-89 (1990).
[100] The OBRA-90 Conference Report, H.R. Rep. 101-964, 101st Cong., 719 (1990). The Conference Report further noted that the OBRA-90 provision "is a further modification of section 6205 of OBRA 89." *Id.*
[101] 57 Fed. Reg. 43659.
[102] 66 Fed. Reg. 3358, 3360-61 (Jan. 12, 2001).
[103] *Id.*
[104] *Id.* at 3361. The Secretary delayed implementing the final rule by 60 days. 66 Fed. Reg. 14342 (Mar. 12. 2001).
[105] 68 Fed. Reg. 45346, 45471 (Aug. 1, 2003).
[106] Minor changes to update cross-refences as part of final rule published on Aug. 11, 2004. 69 Fed. Reg. 48915, 49254 (Aug. 11, 2004). Minor changes in the final rules published on August 18, 2006 and August 16, 2010. 71 Fed. Reg. 47870, 48142 (Aug. 18, 2006); 75 Fed. Reg. 50041, 50418 (Aug. 16, 2010).
[107] (Emphasis added).

> *Approved education activities* means formally organized or planned programs of study of the type that:
>
> (1) Are **operated** by providers as specified in paragraph (f) of this section;
>
> (2) Enhance the quality of health care at the provider; and
>
> (3) Meet the requirements of paragraph (e) of this section for Sate licensure or accreditation.[108]

Section 413.85(d) (2011) sets forth the general payment rules for "approved nursing and allied health education activities" and, in pertinent part, conditions payment to a provider on that provider being the "operator" of the program for such activities and how the net costs are determined:

> (d) *General payment rules.* (1) 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) Enhances the quality of health care at the provider.
>
> (ii) The cost for certain nonprovider operated programs are reimbursable on a reasonable cost basis if the programs meet the criteria specified in paragraph (g)(2) of this section.
>
> (iii) The costs of certain non-provider operated programs **at wholly owned subsidiary educational institutions** are reimbursable on a reasonable cost basis **if the provisions of paragraph (g)(3) of this section are met**.
>
> (2) *Determination of net cost*. (i) Subject to the provisions of paragraph (d)(2)(iii) of this section, the net cost of approved educational activities is determined by deducting the revenues that a provider receives from tuition and student fees from the

[108] 42 C.F.R. § 413.85(c) (bold emphasis added).

> provider's total allowable educational costs that are directly related to approved educational activities.
>
> (ii) A provider's total allowable educational costs are those costs incurred by the provider for trainee stipends, compensation of teachers, and other costs of the activities as determined under the Medicare cost-finding principles in §413.24. **These costs do <u>not</u> include** patient care costs, **<u>costs incurred by a related organization</u>**, or costs that constitute a redistribution of costs from an educational institution to a provider or costs that have been or are currently being provided through community support.
>
> ****
>
> (iv) Net costs are subject to apportionment for Medicare utilization as described in §413.50.[109]

Section 413.85(f) sets forth the criteria for a provider to qualify as "the operator" of an allied health education program, stating:

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

[109] (Bold emphasis added). Note 42 C.F.R. § 413.85(d)(2)(iii) was not included as it relates to only CRNA programs which is not at issue in this case.

> (iv) **Employ** the teaching staff.
>
> (v) **Provide and control** both classroom instruction and clinical training (where classroom instruction is a requirement for program completion), subject to the parenthetical sentence in paragraph (f)(1)(ii) of this section.
>
> (2) Absent evidence to the contrary, the provider that issues the degree, diploma, or other certificate upon successful completion of an approved education program is assumed to meet all of the criteria set forth in paragraph (f)(1) and to be the ***operator*** of the program.[110]

Further, 42 C.F.R. § 413.85(g) (2011) addresses payment for certain ***nonprovider***-operated programs:

> (g) *Payment for certain nonprovider-operated programs*—(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:
>
> (i) The clinical training must occur on the premises of the provider, that is, in the hospital itself or in the physical area immediately adjacent to the provider's main buildings, or in other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings.
>
> (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—

[110] (Bold and italics emphasis added).

(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.

(iv) The students in the educational program must provide a benefit to the provider through the provision of clinical services to patients of the provider.

(v) The clinical training costs must be incurred by the provider or by an educational institution related to the provider by common control or ownership as defined in §413.17(b) (''Cost to related organizations.'') Costs incurred by a third-party, regardless of its relationship to either the provider or the educational institution, are not allowed.

(vi) The costs incurred by a provider does not exceed the costs the provider would have incurred if it was the sole operator of the program.

(3) *Special rule: Payment for certain nonprovider-operated programs at wholly owned subsidiary educational institutions*. (i) Effective for portions of cost reporting periods occurring on or after October 1, 2003, a provider that incurs costs for a nursing or allied health education program(s) where those program(s) had originally been provider-operated according to the criteria at paragraph (f) of this section, and then operation of the program(s) was transferred to a wholly owned subsidiary educational institution in order to meet accreditation standards prior to October 1, 2003, **and where the provider has <u>continuously incurred</u> the costs of <u>both</u> the classroom <u>and</u> clinical training portions of the program(s) at the educational institution, may receive reasonable cost payment for such a program(s) according to the specifications under paragraphs (g)(3)(ii) and (g)(3)(iii) of this section**.

> (ii) Payment for the incurred costs of educational activities identified in paragraph (g)(3)(i) of this section will be made on a reasonable cost basis **if a provider**, as described in paragraph (g)(3)(i) of this section, **received Medicare reasonable cost payment for those nursing and allied health education program(s) both prior and subsequent to the date the provider transferred operation of the program(s) to its wholly owned subsidiary educational institution** (and ceased to be a provider-operated program(s) according to the criteria under paragraph (f) of this section).
>
> (iii) The provider that meets the requirements in paragraphs (g)(3)(i) and (g)(3)(ii) of this section will be **eligible to receive payment under this paragraph for: (A) the clinical training costs incurred for the program(s) as described in paragraph (g)(3)(i) of this section; and (B) classroom costs, but only those costs incurred by the provider for the courses that were included in the programs**.[111]

In the preamble to the August 1, 2003 final rule, the Secretary clarified that wholly-owned or controlled educational programs can still qualify for pass-through payment if the program continue to meet the provider-operated criteria in § 413.85(f):

> [A]s we have stated in the January 12, 2001 final rule (66 FR 3363), and reiterated in the preamble to the proposed rule, if the hospital that wholly owns the educational institution meets the provider-operated criteria, the hospital would qualify to receive reasonable cost pass-through payment. Specifically, we stated in the proposed rule (68 FR 27210) that ''Concerning those hospitals that have established their own educational institution to meet accrediting standards, we believe that, in some cases, these providers can be eligible to receive payment for the classroom and clinical training of students in approved programs. * * * An example of a program that could be considered provider-operated would be one in which the hospital is the sole corporate member of the college, elects the board of trustees, has board members in common, employs the faculty and pays the salaries, controls the administration of the program and the curriculum, and provides the site for the premises of the hospital (emphasis added). Thus, while we still believe that transferring operation of previously provider-operated programs to educational institutions, even if the institutions are wholly owned by the hospital, does not necessarily mean that the programs continue to meet our provider-operated criteria under § 413.85(f) (68 FR 27211), *we reiterate that **only** in instances where the hospital **continues** to meet the provider-*

[111] (Bold and underline emphasis added.)

> ***operated criteria under § 413.85(f)*** *would the hospital continue to* ***qualify*** *for reasonable cost pass-through payments, as it did prior to transferring operation of a provider-operated program(s) to a wholly owned educational institution*.
>
> The commenter also mentioned the generally applicable "related-entity" rules, and suggested that a wholly owned school would be a related entity that should be treated as if it is the provider. Thus, a wholly owned educational institution would remain provider-operated. However, we note that, for purposes of nursing or allied health education payment under § 413.85, it is not sufficient for a program to be operated by a related entity. Rather, ***the "related entity" principles do not apply*** *under the agency's nursing and allied health education payment policy* ***because***, as indicated in previous rulemakings, *that policy requires that a program be directly operated by the provider itself*. Requiring direct operation of a program by the provider ensures that, under § 413.85(c), costs borne by related organizations (that is, the community) are not redistributed to the hospital and claimed as a pass-through under the Medicare program.[112]

Finally, 42 C.F.R. § 413.85(h) defines what costs from educational activities are treated as normal operating costs for which there is ***no*** pass-through payment:

> (h) *Cost of educational activities treated as normal operating costs*. The costs of the following educational activities incurred by a provider but not operated by that provider are recognized only as normal operating costs and paid in accordance with the reimbursement principles specified in Part 412 of this subchapter. They include:
>
> (1) Orientation and on-the-job training.
>
> (2) Part-time education for bona fide full-time employees at properly accredited academic or technical institutions (including other providers) devoted to undergraduate or graduate work.
>
> (3) Educational seminars, workshops, and continuing education programs in which the employees or trainees participate that enhance the quality of medical care or operating efficiency of the provider and, effective October 1, 2003, do not lead to the ability to practice and begin employment in a nursing or allied health specialty.
>
> (4) Maintenance of a medical library.

[112] 68 Fed. Reg. 45346, 45433 (emphasis added).

> (5) Training of a patient or patient's family in the use of medical appliances or other treatments.
>
> (6) **Except as provided in paragraph (g) of this section**, **clinical training and classroom instruction of students enrolled in an educational program that is not operated by the provider**. The following are clinical training and classroom instruction costs that are allowable as normal operating costs:
>
> (i) Costs incurred in the clinical training of students, including the clinical training or clerkship of undergraduate medical school students that takes place in a provider.
>
> (ii) Classroom instruction costs incurred by a provider that meet the following criteria:
>
> > (A) The provider's support does not constitute a redistribution of nonprovider costs to the provider. The support must be in addition to the costs already being incurred by the nonprovider-operated program. If the nonprovider entity reduces its costs due to receiving provider support, this reduction constitutes a redistribution of costs from an educational institution to a patient care institution and is a nonallowable provider cost.
> >
> > (B) The provider receives a benefit for the support it furnishes.
> >
> > (C) The cost of the provider's support is less than the cost the provider would incur were it to operate the program.
>
> (7) Other activities that do not involve the actual operation of an approved educational program.[113]

B. Statutory and Regulatory Background on NAH Part C Payments

Section 541 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 ("BBRA")[114] added 42 U.S.C. § 1395ww(1) to provide for additional payments to hospitals that operate NAH programs. Section 512 of the Benefits Improvement Act of 2000 ("BIPA")[115] further revised 42 U.S.C. § 1395ww(l).

The statutory provision was implemented at 42 C.F.R § 413.85 which allows for additional payments associated with Part C Managed Care utilization *if qualifying conditions are met under § 413.87(c)*. CMC contends that, contrary to CMS's instructions in Transmittal A-03-043, the Medicare Contractor did not use the Hospital's total inpatient days (net of Part C days) to calculate

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[113] (Bold and underline emphasis added.)
[114] Pub. L. 106-113, Appendix F at § 541, 113 Stat. 1501, 1501A-321, 1501A-392 (1999).
[115] Pub. L. 106-554, Appendix F at § 512, 114 Stat. 2763, 2763A-463, 2763A-534 (2000).

the Hospital's NAH Part C payment for CY's 2012 and 2013. 42 C.F.R. § 413.87(e) (as of January 8, 2019[116]) specifies that the additional payment amount is determined according to the following steps:

> (e) *Calculating the additional payment amount for portions of cost reporting periods occurring on or after January 1, 2001*. For portions of cost reporting periods occurring on or after January 1, 2001, subject to the provisions of §413.76(d) relating to calculating a proportional reduction in [Part C Managed Care] direct GME payments, the additional payment amount specified in paragraph (c) of this section **is calculated according to the following steps**:
>
> (1) *Step one*. Each calendar year, determine for each eligible hospital the total –
>
> (i) Medicare payments received for approved nursing or allied health education programs based on data from the settled cost reports for the period(s) ending in the fiscal year that is 2 years prior to the current calendar year; and
>
> (ii) Inpatient days for that same cost reporting period.
>
> (iii) [Part C] inpatient days for that same cost reporting period.
>
> (2) *Step two*. Using the data from step one, determine the ratio of the individual hospital's total nursing or allied health payments, to its total inpatient days. Multiply this ratio by the hospital's total [Part C] inpatient days.
>
> (3) *Step three*. CMS will determine, using the best available data, for all eligible hospitals the total of all –
>
> (i) Nursing and allied health education program payments made to all hospitals for all cost reporting periods ending in the fiscal year that is 2 years prior to the current calendar year;
>
> (ii) Inpatient days from those same cost reporting periods; and
>
> (iii) [Part C] inpatient days for those same cost reporting periods.
>
> (4) *Step four*. Using the data from step three, CMS will determine the ratio of the total of all nursing and allied health education

[116] This is the date of the NPR issued for FY 2013 and, as of this date, the regulation had been modified twice since May 2003, namely 69 Fed. Reg. 49265 and 70 Fed. Reg. 47489 (Aug. 12, 2005) which made minor revisions to update regulatory cross-references. Only the 2004 rulemaking resulted in a change to subsection (e) where the cross-reference to "§ 413.86(d)(4)" was removed and was replaced with "§ 413.76(d)."

> program payments made to all hospitals for all cost reporting periods ending in the fiscal year that is 2 years prior to the current calendar year, to the total of all inpatient days from those same cost reporting periods. CMS will multiply this ratio by the total of all [Part C] inpatient days for those same cost reporting periods.
>
> (5) *Step five*. Calculate the ratio of the product determined in step two to the product determined in step four.
>
> (6) *Step six*. Multiply the ratio calculated in step five by the amount determined in accordance with paragraph (f) of this section for the current calendar year. The resulting product is each respective hospital's additional payment amount.

CMS published the May 2003 Program Memorandum[117] to implement BBRA § 541 and BIPA § 512. The 2003 Program Memorandum instructed Medicare Contractors on the six (6) steps to follow in calculating Medicare+Choice NAH Education Payments. Per the instructions, Step 1 directs Medicare contractors to determine the following three data points from the hospital's cost reporting period ending in the federal fiscal year that is two years prior to the payment year: (1) NAH Part A payments, (2) Total inpatient days (excluding Part C inpatient days); and (3) Total Part C inpatient days. Specifically, the May 2003 Program Memorandum describes these points as follows:

> - Total Medicare payments received for approved nursing or allied health education programs based on data from the settled cost reports for the period(s) ending in the fiscal year that is 2 years prior to the current calendar year. (In general, use the sum of the payment amounts from the Medicare cost report, CMS-2552-96, on Worksheet D, Part III, line 101, column 8 – Total Medicare Part A inpatient routine other pass through cost including subproviders, and Worksheet D, Part IV, line 101, column 7 – Total Medicare Part A ancillary other pass through costs, including subproviders. However, if a provider has an amount greater than zero in column 1 of Worksheet D, Part III and/or Worksheet D, Part IV (for non-physician anesthetist cost), then, for purposes of this step 1, remove all non-physician anesthetist cost from column 1, and re-run the cost report to determine total Medicare nursing and allied health payments excluding any pass-through costs associated with non-physician anesthetists.)
>
> - Total inpatient days (***excluding*** *M+C inpatient days*) for that same cost reporting period. (Use the sum of line 1, lines 6 through 10, and lines 14 and 14.01 of column 6 from Worksheet S-3, Part I); and

[117] *I.e.*, the CMS Program Memorandum issued on May 23, 2003 under Transmittal A-03-043.

> - Total Medicare+Choice inpatient days for that same cost reporting period. (If applicable, obtain the number of Medicare+Choice inpatient days from the Provider Statistics and Reimbursement Report (PS&R), report type 118. Medicare+Choice encounter days associated with providers and units excluded from the IPPS issued by CMS may be added to the inpatient days from report type 118. However, subject to the rules concerning time limitation for submitting provider claims at §3600.2 of the Intermediary Manual, additional documentation to revise the [Medicare contractor's] determination may be submitted by the provider, but will be subject to audit by the [Medicare contractor]).[118]

C. Statutory and Regulatory Background on the DSH Adjustment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the Inpatient Prospective Payment System ("IPPS").[119] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[120]

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[121] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[122]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[123] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment that should be paid to a qualifying hospital.[124] The DPP is defined as the sum of two fractions expressed as percentages.[125] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. Both fractions consider whether a patient was "entitled to benefits under part A."[126]

The fraction at issue in this case is the Medicaid fraction, which the statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) defines as:

> [T]he fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the

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[118] (Emphasis added.)
[119] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[120] *Id.*
[121] *See e.g.* 42 U.S.C. § 1395ww(d)(5).
[122] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[123] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[124] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv), (vii)-(xiii); 42 C.F.R. § 412.l06(d).
[125] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(vi).
[126] *See e.g.* 42 C.F.R. § 412.106(b)(3) & (4).

> Medicaid program], but who were *not entitled to benefits under part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period.[127]

The DSH regulation at 42 C.F.R. § 412.106(b)(4) (2009) requires the Medicare Contractor to calculate the Medicaid fraction for a hospital's cost reporting period by "determin[ing] . . . the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A and divides that number by the total number of patient days in the same period."

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW:

A. The Disallowed NAH Programs

1. Whether CMC met the "Provider-Operated Program" Criteria at 42 C.F.R. § 413.85(f) to qualify for pass-through reimbursement.

a) The Positions of the Parties

CMC contends that the Disallowed NAH Programs meet the criteria in 42 C.F.R. § 413.85(f) to be considered as provider-operated. First, CMC asserts that it (*i.e.*, the hospital) and the Hospital Authority "are one and the same legally and operationally, such that the actions of the Hospital Authority are the actions of [CMC]."[128] In support of its position, CMC asserts the following facts:

1. CMC is "an unincorporated doing-business-as component of the Hospital Authority" as "CMC is simply a trade name of [the Hospital Authority]";[129]
2. CMC "does not have its own Board, directors or corporate officers";[130]
3. CMC "is governed by the Hospital Authority's Board of Commissioners";[131]
4. "[T]he license to operate [CMC] is in the name of the Hospital Authority";[132]
5. "[CMC's] Provider Agreement with Medicare is in the name of [CMC] as a trade name of the Hospital Authority,"[133] thereby showing that "both [CMC] and the Hospital Authority meet the definition of a 'provider of services.' [. . . at] 42 U.S.C. § 1395x(u)."[134]

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[127] (Italics emphasis added.)
[128] Provider's CFPP at 25-26.
[129] *Id.* at 25 (citing to Ex. P-3, which is described as "Certificate of Assumed Name").
[130] *Id.* (with footnote stating that the Hospital Authority has "several employees who are specifically assigned to the [CMC] business line" such as the CMC President and CMC Controller; but neither of these employes are corporate officers of CMS or the Hospital Authority).
[131] *Id.*
[132] *Id.* at 26 (citing to Ex. P-6).
[133] *Id.* (citing to Ex. P-37).
[134] *Id.* n.21.

Second, CMC asserts that "[CMC, *through the Hospital Authority*, operates the Disallowed Programs and should be compensated on a pass-through basis."[135] In support of this assertion, CMC first asserts that the all the Disallowed NAH Programs meet the requirements of 42 C.F.R. § 413.85(d) because these programs:

(1) Provide approved educational activities recognized by the relevant national accrediting organizations[136]; and

(2) Enhance the quality of care for CMC patients given the patient services these programs provide on the CMC campus.[137]

CMC expounds on its contention that it operates the Disallowed NAH Programs by asserting that it meets (and has met since the inception of these programs) the "provider operator" requirements specified in 42 C.F.R. § 413.85(f).[138] CMC recognizes that, in order for a provider's NAH program to qualify as provider operated, the provider must satisfy the following elements described in § 413.85(f):

(i) Directly incur the training costs of the program
(ii) Directly control program curriculum of the program;
(iii) Control the administration of the program;
(iv) Employ the teaching staff for the program; and
(v) Provide and control classroom instruction and clinical training for the program.[139]

In the alternative, CMC argues that, in situations such as this where a hospital establishes a separate educational corporation for its allied health educational programs in order to meet accreditation standards, the Secretary has recognized in the October 3, 2001 final rule that the hospital may still qualify as an operator of the program for purposes of 42 C.F.R. § 413.85(f) "as long as the hospital 'elects the board of trustees, has board members in common, employs the faculty and pays the salaries, controls the administration of the program and curriculum and provides the site for the clinical and classroom training on the premises of the hospital.' 66 Fed. Reg. at 3363."[140]

With respect to directly incurring training costs, CMC argues that "[CMC], *through the Hospital Authority*, employed and paid the salaries and benefits of the [d]isallowed [p]rograms' staff."[141] Specifically, CMC notes that: (1) the Hospital Authority employs all of the CCHS faculty and pays their salaries and benefits from one of the Hospital Authority's bank accounts; and (2) CMC personnel provide the "hands-on" clinical training.[142] CMC similarly contends that it must fund the majority of the CCHS's overall operating costs since CCHS' tuition fees only offset a "fraction" of CCHS' costs.[143] CMC asserts that, *through the Hospital Authority*, it incurs the

[135] *Id.* at 26 (removed title caps and underline emphasis, but added italics emphasis).
[136] *Id.* (citing to Exs. P-20 – P-26).
[137] *Id.*
[138] *Id.* at 27.
[139] *Id.* (citing to 42 C.F.R. § 413.85(f)).
[140] *Id.*
[141] *Id.* at 27-28 (citing to Exhibit P-17 at ¶ 5(e)).
[142] *Id.* at 28 (citing to Ex. P-17 at ¶¶ 5(i), 5(e), 6(b), 6(h)).
[143] *Id.*

costs for CCHS since: (1) "[a]ll of [CCHS'] expenses appear on the Hospital Authority's audited financial statements" and (2) "[CMC] is not claiming on its Medicare cost report *any* costs incurred by [CCHS] because all of [CCHS'] costs are incurred by the Hospital Authority."[144]

With respect to directly controlling the program curriculum, CMC contends that "[CMC], *through the Hospital Authority*, sets the curriculum and determines the graduation requirements."[145] In support of this contention, CMC asserts: (1) the Interdisciplinary Advisory Committee for CCHS substantially controls the program curriculum since this Committee "advises [CCHS] on instruction, identifies competencies, helps develop courses, and maintains accreditation standards";[146] (2) CMC has significant control over this Committee since a majority of the committee members are CMC personnel;[147] (3) the Hospital Authority employs all CCHS faculty and, thereby, has "ultimate oversight over all personnel implementing the program curriculum";[148] and (4) "***all*** *critical decisions* . . . is [*sic* are] approved by Hospital Authority personnel before being voted on by [CCHS]";[149] and (5) the CCHS President who is responsible for executing CCHS' curriculum also serves as Hospital Authority's VP of Medical Education and reported to the Hospital Authority's VP & Deputy Chief Academic Officer of Medical Education.[150]

With respect to directly controlling program administration, CMC contends that "CMC, *through the Hospital Authority*, controls the administration of the Disallowed Programs."[151] In support, CMC points to: (1) the MOU between the Hospital Authority and CCHS which specifies that "*the Hospital Authority* is responsible for CCHS's administrative functions;"[152] and (2) the fact that "the person responsible for the administration and the day-to-day operations of [CCHS] programs is *the Hospital Authority's* Vice President of Medical Education, who also serves as the CCHS President. . . . [and] reports to the [CCHS] Board" over which the Hospital Authority exerts "considerable influence" as discussed above.[153] In addition to the Hospital Authority's control over the curriculum and Advisory Committee discussed above, CMS maintains that it and the Hospital authority exercised administrative control over clinical and classroom training because (1) "[a]ll classroom training occurs at the Hospital, as does the *vast majority* of clinical training"; and (2) "[t]he Hospital Authority controls the number of [CCHS] students that are assigned to [CMC] in specific clinical areas"; and "[t]he Hospital Authority is responsible for patient care and can exclude any [CCHS] student or faculty member from [CMC's] facilities."[154]

Similarly, CMC contends that "[CMC], *through the Hospital Authority*, also exercises control over [CCHS's] finances."[155] In support of this contention, CMC asserts: (1) *both* "the Hospital

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[144] *Id*. (citing to Ex. P-17, ¶ 5(h)).
[145] *Id.* (emphasis added).
[146] *Id.* (citing to Ex. P-29).
[147] *Id.* (citing to Ex. P-30).
[148] *Id.* (citing to Ex. P17, ¶ 5(e)).
[149] *Id.* at 28-29 (citing to Ex. P-18).
[150] *Id.* at 29 (citing to Exs. P-17, ¶ 5(m), P-35, P-54).
[151] *Id.* (emphasis added).
[152] *Id.* (citing to Ex. P-28 at § 2).
[153] *Id*. at 29 (citing to Ex. P-17 at ¶ 5(n)).
[154] *Id.* at 31 (citing to Exs. P-31 at ¶ 6(a)-(b), P-27 at ¶ 2(a), P-31 at ¶ 6(f), P-27 at ¶¶ 4(d) & 2(b)) (emphasis added).
[155] *Id*. at 30.

Authority's VP of Finance *and* [CMC's] Controller are responsible for [CCHS's] budget;[156] (2) Any CCHs expenditures (whether operating or and capital) require the approval of the one or more of the following *Hospital Authority* executive leadership: the Vice President of Medical Education, the Deputy Chief Academic Officer, and the Senior VP of Medical Education.[157]

CMC alleges that it collects CCHS tuition and fees "*through the Hospital Authority*" which "received *directly*" all of these tuition/fees.[158] Specifically, CMC describes the Hospital Authority's collection process as "channel[ing receipt] through a single account that is maintained for both [CMC] and [CCHS]" and then "track[ing any tuition/fees owed] in a Tuition Receivables account in the Hospital Authority's books."[159]

With respect to employing the teaching staff CMC contends that "[CMC], *through the Hospital Authority*, employs the teaching staff for the disallowed programs."[160] In support of this contention, CMC asserts that: (1) all CCHS faculty, officers and staff are employees of the Hospital Authority; (2) the Hospital Authority provides human resources services to CCHS which encompasses paying all CCHS salaries and benefits, managing CCHS's payroll "from a bank account exclusively under the Hospital Authority's control,"[161] and providing the same benefits to CCHS employees that are provided to the Hospital Authorities employees; (3) the Hospital Authority "exercises control over the conduct and activities of [CCHS] faculty and staff" since "[CCHS] faculty and staff are subject to Hospital Authority employee policies. . . [and] the Hospital Authority can exclude any faculty member from [CMC's] facilities;"[162] and (4) the Hospital authority monitors performance and progress of CCHS faculty and staff by conducting evaluations of them.[163]

With respect to controlling both classroom instruction and clinical training, CMC contends that it both provides and controls them. In support of this contention, CMC asserts that: (1) the CCHS President also served as the Hospital Authority's Vice President of Medical Education and controlled the day-to-day operations of the allied health programs at issue; (2) all classroom instruction occurs at CMC since CCHS is located on the CMC campus; and "[n]early all of [CCHS'] clinical instruction occurs at [CMC] or at [CMC's hospital-based locations"; and CMC staff "provide the hands-on clinical training."[164]

In its opening statement, the Medicare Contractor explained that for Medicare purposes,

> [CMC] has a Medicare Provider Agreement and must submit an annual cost report using this Medicare Number. In contrast, the [Hospital Authority] is a home office. It does not have a Medicare Provider Agreement, nor does it submit an annual cost report. Instead, it files a home office cost statement using its specific

[156] *Id.* (citing to Ex. P-17 at ¶ 5(j)-(k)).
[157] *Id.* (citing to Exs. P-34, P-17 at ¶ 5(h)).
[158] *Id.* (emphasis added).
[159] *Id.* at 30-31 (citing to Ex. P-17 at ¶ 5(i), (g)).
[160] *Id.* at 31.
[161] *Id.*
[162] *Id.* at 31-32 (citing to Exs. P-28 at § 6 and P-17 at ¶ 6(c), P-27 at § 2(b)).
[163] *Id.* at 32 (citing to Ex. P-32).
[164] *Id*. at 32 (citing to Exs. P-17 at ¶ 5(m), P-31 at ¶ 6(a)-(b), P-17 at ¶ 6(h)).

> Home Office Number, which is 34-9014, unique and distinct from [CMC]. Using the home office cost statement, certain costs are allocated to the Medicare Providers, including [CMC]. By definition, a home office cannot be a Medicare Provider.[165]

The Medicare Contractor emphasizes that CMC "repeatedly uses the phrase, "'the hospital, through the Hospital Authority'"[166] in its arguments. The Medicare Contractor goes on, to explain:

> Per Medicare, the hospital is not the Hospital Authority and the Hospital Authority is not the hospital. So, the record is clear, the Provider -- [CMC] -- is not the operator of the disallowed NAH programs; and again, only the cost of those programs operated directly by a Provider are paid on a reasonable cost basis. Again, neither the [Hospital Authority] nor [CCHS] is a Provider. [CMC] seems to argue that all the entities within the [Hospital Authority] constitute a single Provider entity. Of course, there is more than one hospital -- more than one Provider -- under the control of the [Hospital Authority] and those hospitals are treated as separate Medicare Providers, so, that argument necessarily fails.[167]

b) Board Analysis and Findings

At the outset, the Board observes that the Secretary seemingly addressed the situation existing in this case in the following example discussed in the preamble to the January 12, 2001 Final Rule:

> Concerning those hospitals that have established their own educational institution to meet accrediting standards, we believe that, in some cases, these providers *can be eligible to receive payment for* ***the classroom and clinical training*** *of students in approved programs*. If the provider demonstrates that the educational institution it has established is wholly within the provider's control and ownership and that the provider continues to incur the costs of both the classroom and clinical training portions of the program, the costs would continue to be paid on a reasonable cost basis. An independent college would not meet these criteria.
>
> An example of a program that could be considered provider-operated would be one *in which* ***the hospital*** is the sole corporate member of the college, elects the board of trustees, has board members in common, employs the faculty and pays the salaries, controls the administration of the program and the curriculum, and provides the site for the clinical and classroom training on the

[165] Day-1 Tr. at 21-22.
[166] Day-1 Tr. at 23.
[167] Day-1 Tr. at 23-24.

> premises of the hospital. We believe that, *in these situations, the community has not undertaken to finance the training of health professionals*; ***the provider has merely restructured its provider-operated program to meet certain State or accrediting requirements***. In most cases, providers have aligned themselves with already established educational institutions. We note that a program operated by an educational institution that is related to the provider through common ownership or control would not be considered to meet the criteria for provider operated.[168]

In response to a question from a hospital regarding the meaning of the above discussion, the Secretary clarified in the preamble to the August 1, 2003 Final Rule that, if a provider moves its direct operation of an NAH education program to a corporation/educational institution, then the programs would no longer meet the provider-operated criteria at § 413.85(f) unless the hospital "'demonstrates that the educational institution . . . is *wholly within the provider's control* and ownership and that the provider continues to incur the costs of both the classroom and clinical training portions of the program.'"[169] The Secretary clarified that "wholly within the provider's

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[168] 66 Fed. Reg. at 3363 (emphasis added).

[169] 68 Fed. Reg. at 45432 (emphasis added) (quoting 66 Fed. Reg. at 3363). The full context for this statement is:

> We have received a question from a hospital that pertains to the cited preamble language in the narrow circumstance where the hospital previously received Medicare reasonable cost payment for direct operation of nursing or allied health education programs and then established its own wholly owned subsidiary college to operate the programs, in order to meet accreditation standards. The hospital has continued to receive Medicare payments after the hospital moved operation of the programs to the wholly owned subsidiary college. The hospital believes that, based on the cited preamble language regarding wholly owned subsidiary colleges and the lack of prior specific guidance on this particular organizational structure (as well as its continued receipt of pass-through payments) and because the hospital continues to pay all of the costs of the nursing and allied health education programs, the hospital is still the direct operator of the programs and should continue to receive pass-through treatment. However, we believe that once the hospital moved the direct operation of its nursing and allied health education programs to the college, the programs no longer met our provider-operated criteria at § 413.85(f). At the very least, it appears that the hospital did not hire the faculty for the program(s) and did not have direct control of the curriculum of the program(s) after operation was transferred to the wholly owned subsidiary college. As we stated in the preamble language quoted above: "a program operated by an educational institution that is related to the provider through common ownership or control would not be considered to meet the criteria for provider operated" (66 FR 3363).
>
> However, we understand that some hospitals, including this hospital, may have interpreted the preamble language that stated, ''if the provider demonstrates that the educational institution it has established is wholly within the provider's control and ownership and that the provider continues to incur the costs of both the classroom and clinical training portions of the program, the costs would continue to be paid on a reasonable cost basis'' (Ibid.), to mean that hospitals that establish wholly owned subsidiary colleges or educational institutions would continue to receive Medicare reasonable cost payment if the hospitals incur the costs of the classroom instruction and clinical training. In the May 19, 2003 proposed rule, we proposed to clarify that transferring operation of previously provider-operated programs to educational institutions, even if the institutions are wholly owned by the hospital, does not necessarily mean that the programs continue to meet our provider-operated criteria under § 413.85(f). In order to remain provider operated, the hospital must have *direct control* of the program; the hospital itself must employ the teaching staff, have direct control of the program curriculum, and meet other requirements, as stated at § 413.85(f).

Id. at 45430 (emphasis added)).

control" means "the hospital must have *direct control* of the program; the hospital itself must employ the teaching staff, have direct control of the program curriculum, and meet other requirements as stated at § 413.85(f)."[170] The fact that the hospital "transfer[s] operation of ***previously*** provider-operated programs to educational institutions" in order to meet accreditation requirement does not alter this policy; rather, in such situations, a hospital *may* continue to qualify for reasonable cost pass-through payments if "the hospital continues to meet the provider-operated criteria under § 413.85(f)."[171] Thus, the fact that CCHS was set up in order to meet accreditation requirements does not alter CMC's obligation to demonstrate that it meets each of the provider-operated criteria in 42 C.F.R. § 413.85(f). As described below, the Board finds that CMC did not demonstrate that the educational institution . . . is *wholly within [its] control*."[172]

CMC contends that it does meet the provider-based criteria at § 413.85(f) and its position essentially revolves around its contention that, *through the Hospital Authority*, it met all, or virtually all, of the provider-operated criteria in 42 C.F.R. § 413.85(f) during FYs 2012 and 2013, the time period at issue. As made clear above in the *Statement of the Facts*, the Hospital Authority is a very large organization with many unincorporated[173] and incorporated[174]

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[170] *Id.* (emphasis added).

[171] *Id*. at 45433. The full comment in preamble to the August 1, 2003 Final Rule is:

> The commenter is incorrect in stating that, in the proposed rule, we indicated that wholly owned (or wholly controlled) programs by definition cannot meet the provider-operated criteria and, therefore, would not qualify for reasonable cost pass-through payments. In fact, as we have stated in the January 12, 2001 final rule (66 FR 3363), and reiterated in the preamble to the proposed rule, if the hospital that wholly owns the educational institution meets the provider-operated criteria, the hospital would qualify to receive reasonable cost pass-through payment. Specifically, we stated in the proposed rule (68 FR 27210) that "Concerning those hospitals that have established their own educational institution to meet accrediting standards, we believe that, in some cases, these providers can be eligible to receive payment for the classroom and clinical training of students in approved programs. * * * An example of a program that could be considered provider-operated would be one in which the hospital is the sole corporate member of the college, elects the board of trustees, has board members in common, employs the faculty and pays the salaries, controls the administration of the program and the curriculum, and provides the site for the premises of the hospital (emphasis added). *Thus, while we still believe that transferring operation of previously provider-operated programs to educational institutions, even if the institutions are wholly owned by the hospital, does not necessarily mean that the programs continue to meet our provider-operated criteria under § 413.85(f) (68 FR 27211), we reiterate that only in instances where the hospital continues to meet the provider-operated criteria under § 413.85(f) would the hospital continue to qualify for reasonable cost pass-through payments, as it did prior to transferring operation of a provider-operated program(s) to a wholly owned educational institution*.

Id. (emphasis added).

[172] *Id*. (emphasis added).

[173] The February 2013 organizational chart for the Hospital Authority at Ex. C-17 includes 9 "operating divisions, not separately incorporated" of which: 4 are short-term acute care hospitals (CMC, Carolinas Medical Center – University, Carolinas Medical Center – Lincoln, and Carolinas Medical Center – NorthEast); 2 are specialty providers (Behavioral Health Center CMC Randolph, and Carolinas Rehabilitation); 2 are nursing homes (Huntersville Oaks and Sadis Oaks); and one is a research center.

[174] The February 2013 organizational chart for the Hospital Authority at Ex. C-17 includes at least:

1. 10 wholly-owned corporations;
2. 8 wholly-owned limited liability corporations; and
3. 9 health systems that the Hospital Authority manages through management agreements.

divisions/units as well as a central corporate home office that are organized under the CHC-System dba.[175] Indeed, under the CHC-System dba, the Hospital Authority operates over 38 different hospitals, has more than 7400 licensed beds across many different provider types,[176] and operates 3 different NAH schools, of which only one is at issue in this case. To this end, the February 2013 organizational chart for the Hospital Authority shows many operating divisions/units of the Hospital Authority. In making this contention, CMC is essentially arguing that CMC (as an "operating division, not separately incorporated,"[177] of the Hospital Authority) *is* the Hospital Authority and, *for Medicare purposes*, can attribute all relevant actions of the Hospital Authority to CMC, regardless of whether those actions are done by the CMC "operating division" or by another division/unit or by the corporate home office or corporate operations of the Hospital Authority (*i.e.*, the CHC-System level of the Hospital Authority).[178] The Board disagrees with CMC's position as, metaphorically, it would be the tail wagging the dog.

In particular, the 10 corporations include CCHS, Mercy Health Services, Inc., Carolinas Health Network, Inc., Hospice of Cabarras County, Inc., AV Insurance Company, and what appear to be 5 separately incorporated physician practices. Both Mercy Health Services, Inc. and Carolinas Health Network, Inc. have multiple sub-corporations which include hospitals and other providers. Mercy Health Services, Inc. also has the Mercy School of Nursing which is another school operated by the Hospital Authority that is not at issue in these cases. *See supra* note 24 and accompanying text.

[175] For example, with respect to CCHS, CMC's witness confirmed: "That's my understanding, is the School of Nursing [*i.e.*, CCHS] was converted to an incorporated unit and the reasoning for that was for accreditation purposes." Day-1 Tr. at 145. *See also* Day-1 Tr. at 38-39 ("The expenses can be incurred through all the different operating units across the Hospital Authority as a whole, but then when expenses are paid, they're paid through that main depository – main operating – account."); Day-1 Tr. at 43-44 (stating: "MR. PIVEC: And is the college financially independent – or does it possess funds in its own name – to pay for its operating expenses? THE WITNESS: It is exactly as other operating units would be as well – similar – it's part of our centralized cash environment and all expenses that are related with the college are appropriately coded to that line of business, so to speak."); Day-1 Tr. at 112 (stating: "MR. BAUERS: Okay. If the hospital and the Hospital Authority or the healthcare system are one in the same, why are there 37 other hospitals listed on this page [*i.e.*, Ex. C-9 at C0149]? THE WITNESS: They're all – well not all because I'll point to one in a second that I see – but they're all operating units underneath [the Hospital Authority]."); Day-1 Tr. at 118-19 (stating: "THE WITNESS: --Many on that page [*i.e.*, Ex. C-9 at C0149] would be separating [*sic* separate] operating units under the Hospital Authority.").

[176] Ex. P-101 at 4-5.

[177] Ex. C-17 (Hospital Authority organization chart dated February 2013).

[178] Documents from the Hospital Authority makes distinctions between CHC-System executives and those at the CMC operating division. *See, e.g.*, Ex. P-55 (CCHS Board of Directors roster differentiating between directors from the CHC-System and CMC, namely, compare director identified as "VP/Chief Medical Officer" at CMC with the 2 directors identified as "Chief Academic Officer" and "Vice President Chief Nursing Officer/Administration" from the CHC-System as well as the director from the CHC-System Office of General Counsel); Ex. P-41 at 2, 3, 5 (email from Vice President of Finance/Revenue Cycle, at "Corporate Operations" for the Hospital Authority/CHC-System); Ex. P-103 at 2 (stating "E. Sheppard shared her recent interactions with [CHC-System] executives related to the BSN Proposal. Our proposal received positive support from [CHC-System] nurse executives."); Day-1 Tr. at 29 (CMC witness describing himself as the Group Vice President for the Hospital Authority with the "responsibility for the financial consolidation for . . . the Hospital Authority – as well as the overall general ledger for the healthcare system as a whole"); Day-1 Tr. at 30 (CMC witness agreeing with the accuracy of the describing the Hospital Authority "as a healthcare system" owning "multiple hospitals"); Day-1 Tr. at 78 (CMC witness stating "The home office – Carolinas Healthcare System – maintains the books of all entities"); Day-1 Tr. at 196 (CMC witness reading excerpt from Ex. P-103 referencing "[CHC-System] executives" and acknowledged that it was for Carolinas HealthCare System which is the Hospital Authority); Ex. P-35 (while it is a little more than 2 years after the fiscal year at issue, this job description for the President of CCHS, who also serves as the Assistant Vice President of Medical Education for the Hospital Authority, does not have any reference to CMC, but rather only to the Hospital Authority which at that time was doing business as Atrium Health as opposed to CHC-System).

Consistent with OBRA-89 § 6205(b)(2)(C), 42 C.F.R. § 413.85(d) specifies the conditions that a "provider" must meet in order to receive payment of NAH education costs as a pass-through payment. One of those conditions is to meet the criteria listed in § 413.85(f) for the "provider" to qualify as an operator of the approved NAH education program.[179] The Board recognizes that the Hospital Authority operates a healthcare chain or system (*i.e*, the CHC-System) consisting of 38 hospitals and multiple other providers as well as 3 nursing schools; however, the Hospital Authority itself does not qualify as a "provider," notwithstanding the fact that at least 4 of the hospitals, including CMC, are "operating divisions, not separately incorporated."[180] 42 U.S.C. § 1395x(u) defines the term "provider of services" as "a hospital, critical access hospital, rural emergency hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, [or] hospice program . . . ."[181] To this end, *each* year:

1. Each Medicare-participating provider[182] in the CHC-System, including, but not limited to CMC, files a separate Medicare cost report which sets forth the provider's expenses and revenue;[183] and

2. The Hospital Authority, as the corporate home office for the various providers that comprise the CHC-System, is *not* a "provider" and, as a result, is not entitled to Medicare reimbursement. Nevertheless, in its corporate operations function at the CHC-System level, the Hospital Authority provides certain centralized services on behalf of the CHC-System and is required to file a home office cost report each year so that those costs may be allocated to CHC-System providers and other non-provider components, as relevant and appropriate, for potential reimbursement on the providers' cost reports of the home office support functions.[184]

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[179] While they serve different purposes, these criteria are analogous to the provider-based criteria at 42 C.F.R. § 413.65.

[180] *Supra* note 173 describes 9 "operating divisions, not incorporated" that are shown on the February 2013 Hospital Authority organization chart at Ex. P-17. *Supra* note 174 described the many other incorporated divisions/units of the Hospital Authority.

[181] *See also* 42 C.F.R. § 400.202 (defining the term "provider" as "a hospital, a CAH, a skilled nursing facility, a comprehensive rehabilitation facility, a home health agency, or a hospice that has in effect an agreement to participate in Medicare, or a clinic, a rehabilitation agency, or a public health agency that has in effect a similar agreement . . ., or a community mental health center that has in effect a similar agreement . . . ."

[182] Each provider must meet certain conditions of Medicare participation requirements. *See, e.g.*, 42 C.F.R. Part 482 (conditions of participation for hospitals); 42 C.F.R. § 413.65 (criteria for provider-based status).

[183] 42 C.F.R. § 413.24(f) (stating in part: "For cost reporting purposes, the Medicare program requires ***each*** *provider of services* to submit periodic reports of its operations that generally cover a consecutive 12-month period of the provider's operations." (emphasis)).

[184] Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1"), § 2150 addresses "Home Office Costs – Chain Operations" and states in part:

> ***A chain organization*** *consists of a group of two or more health care facilities which are owned, leased, or through any other device,* ***controlled by one organization***. Chain organizations include, but are not limited to, chains operated by proprietary organizations and chains operated by various religious, charitable, and governmental organizations. A chain organization may also include business organizations which are engaged in other activities not directly related to health care. (See §§l002.2 and l002.3 for definitions of common ownership and control.)
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> Home offices of chain organizations vary greatly in size, number of locations, staff, mode of operations, and services furnished to the facilities in the chain. ***The home office of a chain is not a provider in itself***; therefore, its costs may not be directly reimbursed by the program. *The relationship of the home office to the Medicare program is that of a related organization to*

Thus, *for Medicare program purposes,* CMC and the Hospital Authority identify themselves as two separate entities through CMC's filing of its cost report and the Hospital Authority's filing of its home office cost statement.[185] Indeed, the Hospital Authority appears as a related party or home office, identified as Carolinas Health System, on Worksheet A-8-1 of CMC's FY 2012 and FY 2013 Medicare Cost reports.[186] Further, the Board notes that previous discussion addressed the four unincorporated acute care hospital entities on the Hospital Authority's February 2013 Organizational Chart. It is ***not*** possible that all 4 of these entities, which file separate Medicare cost reports, could also be the "same" entity (the Hospital Authority, which files a separate home office cost statement) as CMC would have it be.[187]

Accordingly, under 42 C.F.R. § 413.85(f), the acts and responsibilities of the Hospital Authority (as the corporate home office of the CHC-System) cannot be imputed down to the operating division CMC (as the provider) *for purposes of meeting or satisfying the Medicare program's* ***provider****-operated requirements* except where provided in § 413.85(f)(1).[188] Indeed, the Secretary confirms this in the excerpts from the preambles to the January 12, 2001 and August 1, 2003 Final Rules that the Board has included in APPENDIX A to this decision. Consistent with CMC having a

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> *participating providers*. Home offices usually furnish central management and administrative services such as centralized accounting, purchasing, personnel services, management direction and control, and other services. To the extent the home office furnishes services related to patient care to a provider, the reasonable costs of such services are includable in the provider's cost report and are reimbursable as part of the provider's costs. Where the home office of the chain provides no services related to patient care, neither the costs nor the equity capital of the home office may be recognized in determining the allowable costs of the providers in the chain.

(Emphasis added.)

[185] *See also* Day-2 Tr. at 8-9.

[186] Exs. P-122, P-123.

[187] *See supra* notes 173-74; *see also* Ex. C-17. *See also Baptist Health v. Thompson*, 458 F.3d 768, 778-79 (8th Cir. 2006) ("*Baptist Health*"):

> The Secretary correctly noted that, while Baptist Health is a corporation that operates several provider hospitals and nursing schools, it does not itself qualify as a provider under the statute. *See* 42 U.S.C. § 1395x(u) ("The term 'provider of services' means a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, [or] hospice program ...."). Moreover, the fact that a provider hospital and an educational institution are under common ownership does not circumvent the regulations that determine when the costs of the educational institution are attributable to the provider hospital for Medicare purposes. *See Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504 . . . (1994) (affirming that a medical college could not redistribute some costs of an approved educational program to an associated provider hospital where both were owned and operated by the same legal entity). In short, the Medicare reimbursement system is based on the costs incurred by individual provider hospitals, without regard to underlying ownership structure. Indeed, if Baptist Memorial's common-ownership reimbursement theory were accurate, there would be no need for each of the four hospitals owned and operated by Baptist Health to have separate Medicare provider numbers. We conclude that substantial evidence supports the Secretary's finding that Baptist Memorial was not the operator of the educational activity.

[188] The criterion where "some" functions appear to be able to be provided by the home office is the criterion at § 413.85(f)(1)(iii) addressing control over administration: "(iii) Control the administration of the program, including collection of tuition (where applicable), control the maintenance of payroll records of teaching staff or students, or both (where applicable), and be responsible for day-to-day program operation. (*A provider may contract with another entity to perform some administrative functions, but the provider must maintain control over all aspects of the contracted functions*.)" Thus, § 413.85(f)(1)(iii) makes clear that "the provider must maintain control over all aspects of the contracted functions."

separate identity from the home office *for purposes of the Medicare Program* is the fact that CMC has a separate tax identification number ("TIN") from the Hospital Authority which CMC represents is used "primarily for Medicare, Medicaid, and commercial payor billing."[189]

Similarly, the Board notes that CCHS was not itself directly controlled by the CMC operating division but rather was controlled by the CHC-System-level corporate home office of the Hospital Authority as evidenced by the following:

1. The February 2013 organizational chart for the Hospital Authority was created as "a legal structure document"[190] and shows the relationships of the various operating divisions/units of the Hospital Authority.[191] Significantly, CMC presented this chart to the Medicare Contractor during the audit in support of its claimed costs[192] and it is specifically referenced in the Medicare Contractor's workpapers. Testimony at the hearing, by one of the Provider's witnesses, confirmed the veracity of the organization chart.[193] Significantly, CCHS is not shown as a subdivision or subunit of CMC but is shown as a direct report to the Hospital Authority. Similarly, CMC is not shown even next to CCHS but rather is on a wholly *separate* reporting line to the Hospital Authority and has only one sub-operating unit underneath it – the "Behavioral Health Center CMC Randolph."[194]

2. As discussed in **Subsection A(2)** of the STATEMENT OF FACTS, CCHS is wholly owned by the Hospital authority and only the CEO of the Hospital Authority has the authority to direct CCHS to take actions unless the CEO authorizes another person to do so.[195] Here, the CEO apparently delegated this authority to the Senior Vice President & Chief Academic Officer of Education and Research at the Hospital Authority who signed the Affiliation Agreements on behalf of the Hospital Authority.[196] Further, "[t]he Members of the [CCHS] Board [of Directors] are selected from their own internal Board, but then approved by the [Hospital Authority] Board of Directors."[197]

3. As discussed above in **Subsection A(3)** of the STATEMENT OF FACTS, the Affiliation Agreement between the Hospital Authority and CCHS, as amended, lists twelve (12) different sites (Participating [CHC-System] Facilities) for FY 2013 where [CCHS'] faculty and students can perform their clinical experiences.[198] CMC is named as one of

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[189] Provider's Consolidated Preliminary Position Paper ("Provider's CPPP") at 12. *See also* Ex. P-5. CMC acknowledges that the Medicare program required the separate TIN. Provider's CPPP at 22.
[190] Day-1 Tr. at 133-138.
[191] The February 2013 Hospital Authority organizational chart is marked as Ex. C-17 and includes at least 11 operating divisions/units that have one or more subunits below it. Indeed, some have multiple subunits with additional subunits.
[192] Ex. C-3 at C0075 (audit workpaper stating: "*Based on the organizational chart* for all operations of the Home Office ([the] Hospital Authority DBA Carolinas HealthCare Systems) which owns both CCHS and CMC, the College does not fall under any of CMC's operations."); C-3 at C0071 (audit workpaper listing "Organizational Chart for the Charlotte-Mecklenburg Hospital Authority [*i.e.*, the Hospital Authority]" as one of the sources received from CMC).
[193] Day-1 Tr. at 32, 43.
[194] Ex. C-17 (showing CMC on a reporting line to the far left leading up to the Hospital Authority on the right side, while CCHS is shown on a *separate* line directly underneath the Hospital Authority).
[195] Ex. P-15 at 9 (Art. VI, § 2).
[196] *See* **Subsection A(3)** of the STATEMENT OF THE FACTS.
[197] Day-1 Tr. at 179. *See also* **Subsection A(2)** of the STATEMENT OF THE FACTS.
[198] Ex. P-27 at 18.

those twelve (12) sites *without **any** distinction*.[199] Indeed, prior to FY 2013, the Affiliation Agreement included a site outside of the CHC-System – the Mecklenburg County Health Department.[200]

4. The President of CCHS also served as the Assistant Vice President of Medical Education at the corporate home office of the Hospital Authority (as opposed to the CMC operating division).[201] This individual in turn reported to the Vice President of Medical Education or the Vice Chief Academic Officer within the Hospital Authority.[202]

The Board reviewed each of the 5 criteria in § 413.85(f)(1)(i) to (v) for provider-operated educational programs to confirm whether the operating division CMC, as the provider, met that criterion or whether it is improperly relying on acts and responsibilities the CHC-System-level corporate home office of the Hospital Authority to meet the criterion. Board review of each of these criteria reinforces the Board's findings that the corporate operations of the CHC-System at the Hospital Authority are separate and distinct from those at the CMC operating division and that CCHS is a separate legal entity controlled by the corporate operation of the CHC-System at the Hospital Authority.

First, the criterion at 42 C.F.R. § 413.85(f)(1)(i) addresses whether the provider "directly incur[s] the training costs." The Board finds that CMC does not meet this criterion because the training costs were directly incurred *not* by CMC, but rather by CCHS, which (as discussed above) is a separate entity from CMC and not controlled by CMC. In reviewing the working trial balance used to prepare CMC's cost reports, the Board notes that the Hospital Authority recorded[203] CCHS costs in Business Unit 1000 for Carolinas College of Health Sciences, not in Business Unit 01- Carolinas Medical Center.[204] In the preparation of its FY 2012 and 2013 cost reports, CMC accumulated multiple Business Units from the CHC-System general ledger; however, this *post-hoc* accumulation does not establish that these Business Units were under the control of

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[199] One of the 12 sites is CMC – Randolph which appears to be an inpatient psychiatric facility ("IPF") unit that is excluded from IPPS and, as such, would be a separate Medicare participating entity with its own subprovider number. *See* P-38 at 77, 82, 87 (showing IPF subprovider on CMC's Worksheet A for FYs 2011, 2012, and 2013).

[200] Ex. P-27 at 9. *See also* Day-1 Tr. at 241-42 (discussing how there was at least one other clinical training sites outside the CHC-System and that, in such situations, there would be a separate MOU between that outside organization and the Hospital Authority).

[201] Ex. P-35 (CCHS job description for "President (Asst. Vice President-Medical Education, Atrium Health)"); Day-1 Tr. at 199 (CMC witness testimony that the 2016 job description at Ex. P-35 was the same during FYs 2012 and 2013); Day-1 Tr. at 236-37; Day-1 Tr. at 246 (stating she primarily interfaced with CMC *or **other** CHC-facilities* serving as clinical sites through the clinical units, *e.g.*, through the CMC Chief Nursing Executive if it is a nursing program); Day-1 Tr. at 204 (CMC witness who serves as CCHS President stating "The Hospital Authority has the right to allow any student or any teammate from the college *into its clinical facilities* . . . ." (emphasis added)).

[202] Ex. P-35 at 4; Day-1 Tr. at 199-200. *See also* discussion in **Subsection A(3)** of the STATEMENT OF THE FACTS (discussing how the Senior Vice President & Chief Academic Officer of Education and Research at the Hospital Authority signed the Affiliation Agreements on behalf of the Hospital Authority).

[203] Day-2 Tr. at 14 (CMC witness confirming that the home office/Hospital Authority maintains the books of all CHC-System entities).

[204] Exs. P-120, P-121. *See also* Day-2 Tr. at 15-17 (Medicare Contractor witness stating "[t]his appears to be two separate entities, one being the Carolinas Medical Center, which is coded 01, and the college, which is [coded] 1,000"); Day-2 Tr. at 22-23 (discussing CCHS faculty salaries recorded in Business Unit 1000).

CMC during the preceding fiscal year.[205] The Board also notes that the Audited Financial Statements for the Hospital Authority present the balance sheet, income statement, and statement of cash flows for only two identified units, Primary Enterprise and Component Unit.[206] The Notes to the Financial statements explain these units further, stating:

> For financial reporting purposes, the [CHC-System] is divided into the "Primary Enterprise" and a "Component Unit." The Primary Enterprise consists of The Charlotte-Mecklenburg Hospital Authority (d/b/a Carolinas HealthCare System) and all affiliates whose assets and income the System controls without limitation. The Carolinas HealthCare Foundation, Inc. (the Foundation), the System's sole Component Unit, raises and holds economic resources for the direct benefit of the System.[207]

Thus, the numerous individual hospitals, which file separate Medicare cost reports, as well as other entities, such as CCHS, are all included in the Primary Enterprise. However, there are numerous cost reports filed, as discussed previously. As each business unit is separate on the general ledger, and expenses/revenue are allocated or "pushed down" to each business unit separately, the simple *post-hoc* inclusion of certain business units on the CMC working trial balance does not mean they are under the same control or that decisions are made at the same level, in the same manner, for those business units. As the Medicare Contractor's witness testified in the hearing,

> WITNESS: So, let's keep in mind that there are seven [CMC Nursing and Allied Health programs at issue, and only four under appeal.
>
> MR. PIVEC: Uh-huh.
>
> WITNESS: Other programs that we're not here discussing today were recorded to the [business unit] 01.
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> MR. PIVEC: And so those programs, would you determine that those programs that were recorded to 01, the cost of those programs were directly incurred by CMC?
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> WITNESS: Yes.[208]

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[205] Exs. P-120 at 1, P-121 at 1. (The Board notes that the Business Units included in the CMC cost report trial balance in 2012 included 29 Business Units, including 01 (CMC) and 1000 (CCHS), additionally, it included 15 faculty business units, and 06 (CMC-Randolph). Further, it contained the Cannon Research Center (12), and new units for Pediatric Surgery/CSO (1042) and CCS Support & Virtual Care (1043). In the following year, 2013, many of the units were the same, but CCS Support and Virtual Care (1043) was excluded and new units for CHS Mobile Medicine (1059), Behavioral Health Davidson (16), and Corporate Behavioral Health (18) were added, as was unit 05 (CMC-Mercy), for only the 4th quarter. It appears that CMC is inconsistent in the Business Units it reports from year to year, but more importantly, that this accumulation is a grouping mechanism which can be changed, at the decision of the CHC-System annually.)

[206] Ex. P-102 at 14-16.

[207] *Id.* at 17.

[208] Day 2 Tr. at 39.

The Hospital Authority, the CHC-System, included these costs in the business unit 1000 (representing CCHS), not business unit 01 (representing CMC). As such, the CCHS expenses were not costs incurred on CMC's books, which is a requirement the Secretary made clear in the following excerpt from the January 12, 2001 Final Rule:

> The existing regulation concerning related organizations set forth in § 413.17 was established to avoid program recognition of artificially inflated costs that might be generated from less than an arm's length transaction. This policy was not intended to expand the range of items and services for which a provider could claim payment. With respect to educational costs (with the limited exception for certain graduate medical education costs incurred by a related medical school as provided in Intermediary Letter 78-7) our policy has been that the provider, rather than the related organization, *must directly incur the costs on its books and records* before the costs will be recognized for Medicare payment purposes. Otherwise, the principle that Medicare payment for medical education costs should not result in a redistribution of costs from the educational institution to the provider would be violated.[209]

The Board takes note of the 2021 decision of the U.S. District Court for South Carolina (the District Court") in *Medical University Hospital Authority v. Becerra* ("*MUHA*") but finds that the facts of *MUHA* are distinguishable from those in the CMC cases before the Board.[210] In *MUHA*, the District Court reversed the Board's decision that the medical center (MUHA) did not directly incurr training costs and did not maintain control over its Pharmacy Program. In the *MUHA* case, when the medical center separated, legally, from a university (MUSC), the medical center was formally recognized as a separate entity, "but still a component of [the university], rather than a divisional unit."[211] Specifically, the medical center and university "entered into an affiliation agreement specifying the financial and operational obligations of each entity."[212] In the present CMC cases, the situation is much more complex since CMC is just one of many operating divisions under the Hospital Authority. In this respect, while there are agreements regarding the nursing and allied health programs between the Hospital Authority and CCHS (the college), the record contains no evidence of such CCHS-related agreements between CMC (the hospital) and CCHS or CMC and the Hospital Authority (*e.g.*, delegations of authority from the Hospital Authority to the CMC operating component such as to the CMC President).[213] Further, in the *MUHA* case, "[t]he agreement required [the medical center] to provide sufficient funding to pay

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[209] 66 Fed. Reg. at 3367.

[210] No. 19-1755, 2021 WL 1177860 (D. S.C. 2021). Instead, the Board finds that this case is more analogous to the facts in the *Baptist Health* case, as illustrated by the excerpt from the Eighth Circuit's decision in *supra* note 180.

[211] *Id.* at *3. *See also id* at *11 (noting that "both [the university] and [medical center] are governed by the same president and board of trustees).

[212] *Id.*

[213] *See supra* note 66. For example, the Affiliation Agreement between the Hospital Authority and CCHS ***only*** refers to CMC in the context of one the 11 "Participating [CHC-System] Facilities" in Exhibit A to the Agreement. Ex. P-27 at 18. The Agreement then refers to CCHS faculty having access to train at the facilities listed in Exhibit A but "[t]he number of students accepted at Facility [*i.e.*, one of the facilities listed in Exhibit A] for assignment to a clinical area *shall be* ***determined solely*** *by [the Hospital Authority]*." *Id.* at 1 (quoting ¶ 2(a)) (emphasis added).

the university for salaries and other expenses associated with the operation of the residency program. Some costs were paid initially by [the university and the medical center] transferred funds to [the university] on a monthly basis to cover those costs."[214] In the present CMC cases, no expenses are transferred to CMC, but instead, CCHS's business unit is combined on a *post-hoc* basis with CMC's business unit for cost report preparation only. Secondly, there is no discussion of funding from CMC to reimburse (in whole or in part) the Hospital Authority or CCHS for their expenses, as there is no agreement between either of those parties and CMC. Indeed, the only discussion regarding reimbursement is a $2,000 monthly payment from CCHS to the Hospital Authority stated "as compensation for the corporate services provided by [the Hospital Authority]."[215] This flat monthly payment (as set in January 1, 1997) appears to be nominal considering the scope and nature of "corporate services" listed in the Memorandum of Understanding between CCHS and the Hospital Authority.[216] In the end, the Board finds that, as CMC did not directly incur the training costs of the disallowed programs, CMC does not meet the requirement set forth at 42 C.F.R. § 413.85(f)(1)(i).

Second, the criterion at 42 C.F.R. § 413.85(f)(1)(ii) addresses whether the provider has "direct control of the program curriculum." The Board finds CMC does not meet this criterion because CCHS, not CMC, that controls the curriculum of the disallowed programs. Rather, it is the Board of Directors of CCHS that controls the curriculum. Article 3 – Board of Directors, Section 1 - General Powers and Responsibilities of the Bylaws of CCHS specifies the following: "The Board of Directors shall determine the size and character of the student body and shall approve of the number and types of degrees, the number and nature of departments, divisions, schools or colleges through which the curriculum is offered and the extent to which the institution should offer graduate work and off-campus programs."[217] The program curriculums are substantially controlled by the Interdisciplinary Advisory Committee, which is maintained by CCHS. Additionally, the Board notes that the program accreditations for the disallowed programs are all in the name of CCHS.[218] Likewise, the program diplomas are issued in the name of CCHS. The diplomas imply that the program curriculums are controlled by CCHS.[219] As the program curriculums of the disallowed programs are controlled by CCHS, not CMC, CMC does not meet the requirement set forth at 42 C.F.R. § 413.85(f)(1)(ii).

Third, the criterion at 42 C.F.R. § 413.85(f)(1)(iii) addresses whether the provider "[c]ontrol[s] 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." The Board finds that CCHS, not CMC, controls

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[214] 2021 WL 1177860 at *3.
[215] Ex. P-28 at 1.
[216] There is no documentation in the record to suggest that this amount has changed since 1997. Per the MOU, "corporate services" is defined as follows: "CMHA shall provide the following corporate services to CMHA: architectural, audio visual, business planning, communications, construction, environmental services, general accounting/financial services (accounts payable, cash management and payroll: human resources, legal services, mail, maintenance, management information systems, marketing. materials management, nurse recruitment, parking, safety and insurance, security, and travel." Ex. P-28 at 1.
[217] Ex. P-15 at 4.
[218] Exs. P-20 (Nursing), P-22 (Medical Laboratory Science), P-24 (Radiologic Technology), P-26 (Surgical Technology).
[219] Exs. C-8 at 41 (Nursing), C-10 at 42 (Medical Laboratory Science), C-11 at 43 (Radiologic Technology), C-12 at 45 (Surgical Technology).

the administration of the program. The MOU between the Hospital Authority and CCHS stipulates that the Hospital Authority shall provide certain "corporate services" to CCHS and is responsible for CCHS's administrative functions. The person responsible for the administration of the day-to-day operations of CCHS programs is the Hospital Authority's Vice President of Medical Education, who also serves as the CCHS President.[220] In this respect, the Board notes that the Hospital Authority provided centralized collection and billing of tuition not just for CCHS but also for other schools owned and operated by the Hospital Authority such as the one operated at Cabarrus.[221]

Additionally, the Hospital Authority exercises control over CCHS's finances. The Board recognizes that the MOU expressly states that "[o]nce funds are appropriated by [the Hospital Authority to CCHS], budget making, the establishment of priorities and the control of expenditures become the responsibility of [CCHS] and its Board of Directors."[222] However, the Hospital Authority's VP of Finance is ultimately responsible for overseeing and approving CCHS's budget based on input from the employee who served as Controller of both CCHS and CMC[223] (note CMC does not have a chief financial officer[224]). All operating and capital expenditures of CCHS require the approval of the Hospital Authority's Vice President of Medical Education, the Hospital Authority's Deputy Chief Academic Officer and/or the Hospital Authority's Senior VP of Medical Education.[225] This is not a situation where certain limited discreet services (*e.g.*, payroll function) is being provided by the home office on behalf of a hospital, but rather where all or virtually all control of CCHS' finances are occurring at the corporate home office, at the CHC-System level.[226]

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[220] *See also* Day-1 Tr. at 173-4 (current President of CCHS and AVP of Medical Education discusses the responsibilities of his position).

[221] Day-1 Tr. at 160 ("[BOARD CHAIR: . . . . And so, I know that there was a question -- there was some discussion -- about the tuition billing and I take it -- that's provided by the Authority -- and I take it that that tuition billing is provided not just for the Carolinas -- by the college that we're referring to and that we're here today discussing, but also other educational programs. I believe there's also -- like -- one at Mercy, as well as Cabarrus? THE WITNESS: Cabarrus, yes. [THE BOARD CHAIR]: Cabarrus? THE WITNESS: Yep. So, they would have billing function as well -- or – tuition billing function as well.").

[222] Ex. P-28 at ¶ 9. *See also* Day-1 Tr. at 216 (CMC witness: "So the way it works is, [CCHS] then assumes responsibility for spending the dollars that are allocated to it or within our budget that is approved by the Hospital Authority; and primarily I would say as the Chief Executive Officer and President of [CCHS], I have final say in how those dollars are spent up to within those dollar limits that Mr. Thomas mentioned, beyond some dollar limit that I had in 2011 and 12' – I'm sorry 12' and 13' – I don't remember exactly what those dollar limits were, but there was a dollar limit that we would have to go to that next level or even higher approval but the college does internally then manage those funds.").

[223] Day-1 Tr. at 85; Day-1 Tr. at 160-61 (CMC witness confirming that the corporate home office of the Hospital Authority oversees the budget of all components, including CCHS and other colleges: "our budget process would encompass every aspect of the hospital Authority as a whole."); Day-1 Tr. at 169 (CMC witness stating that "[CCHS] can't expend the funds without going through the [budget] process we talked about"). *See also* Day-1 Tr. at 195 (MR. HETTICH: Even when it comes to new [educational] programs, can the college Board establish new programs without approval of the Hospital Authority; I think you said – THE WITNESS: No, we would not, no they could not, it would not be approved ultimately through the budgeting process. MR. HETTICH: In your experience, has [CCHS] ever declined to establish a new [educational] program because it did not have approval from the Hospital Authority? THE WITNESS: Yes.").

[224] Day-1 Tr. at 100.

[225] Provider's CFPP at 25.

[226] 42 C.F.R. § 413.85(f)(iii) refers to the ability of a provider to "contract with another entity to perform some administrative functions, but the provider must maintain control over all aspects of the contracted functions." This provision

Lastly, the Hospital Authority collects tuition and fees for the disallowed programs. All tuition "is received directly by the Hospital Authority and channeled through a single account that is maintained for both [CMC] and [CCHS]. . . . Any tuition or fees owed by students is tracked in a Tuition Receivables account in the Hospital Authority's books."[227] Similarly, Exhibit P-58 contains a policy and procedure for the CHC-System Loan Forgiveness Program that is entitled for CCHS but applies to both the college at Mercy as well as CCHS and is administered by the Dean of Administrative and Financial Services at the CHC-System level of the Hospital Authority.[228] As the Hospital Authority, not CMC, is responsible for CCHS's administrative functions, CMC does not meet the requirement set forth at 42 C.F.R. § 413.85(f)(1)(iii).

Fourth, the criterion at 42 C.F.R. § 413.85(f)(1)(iv) addresses whether the provider "employ[s] the teaching staff." The Board finds that CMC does not meet this criterion because the teaching staff is employed by the corporate home office of the Hospital Authority, not the CMC operating division. As stipulated in the MOU, the Hospital Authority provides certain "corporate services" to CCHS (based on a monthly fee of $2,000 per month) and these "corporate services" include human resources and insurance (as well as payroll as discussed above).[229] As a result, all CCHS faculty, officers and staff are employees of the Hospital Authority and the Hospital Authority is responsible for paying all salaries and benefits ("under the common paymaster doctrine") and manages the payroll from a bank account under the Hospital Authority's exclusive control.[230] Further, CCHS staff are subject to Hospital Authority employee policies, with modifications as appropriate for an academic setting,[231] And, as noted in the Consolidated Final Position Paper, "[t]he Hospital Authority also conducts evaluations of [CCHS] faculty and staff to monitor performance and progress."[232]

As the Hospital Authority, not CMC, employs the teaching staff for the disallowed programs, CMC does not meet the requirement set forth at 42 C.F.R. § 413.85(f)(1)(iv).

With respect to the requirement at 42 C.F.R. § 413.85(f)(1)(v), the Board finds that the Hospital Authority and CCHS exercise control over clinical and classroom training for the disallowed programs. CMC states that the Hospital Authority and CCHS "operate their [nursing and allied health] programs under two agreements. The first is a Clinical Affiliation Agreement, which is meant to ensure that [CCHS] has access to the necessary clinical space to meet requirements for accreditation."[233] Under the Clinical Affiliation Agreement, CCHS "retain[s] responsibility for the [s]tudent's education and for arranging appropriate clinical learning experiences for [s]tudents."[234]

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is not met since essentially all control over the CCHS administrative functions was occurring at either the corporate home office of the Hospital Authority or at CCHS. Control did not occur at the CMC operating component.

[227] Provider's CFPP at 30-31.

[228] Ex. P-58 (entitled "[CCHS Policy and Procedure" where the subject is entitled "[CHC-System] Educational Loan Forgiveness Program" and the CCHS Policy is entitled "Mercy-CCHS Concurrent [CHC-System] Loan Forgiveness and lists the reviewer as Dean of Administrative and Financial Services). Under the CHC-System Loan Forgiveness Program, the CHC-System "makes available a student loan program to CCHS students and {the [CHC-]System sets all terms of the loan program." *Id.*

[229] Ex. P-28 at ¶¶ 2, 3.

[230] *Id.* at ¶ 5.

[231] *Id.* at ¶ 6.

[232] Provider's CFPP at 32.

[233] *Id.* at 21.

[234] Ex. P-27 at 2.

The Clinical Affiliation Agreement also specifies that, prior to CCHS personnel's placement at any facility, CCHS is responsible for providing to the Hospital Authority:

> [I]nformation concerning such [CCHS] personnel's education and experience including proposed dates of assignment to such [f]acility; number of [CCHS] personnel to be placed; names and pertinent identification information about such [CCHS] personnel; [CCHS's] objectives for the clinical education experience; suggested curriculum outlines; and [s]tudents' prior clinical experiences.[235]

In considering the question of control over clinical training, the Board looks to the testimony of one of the Provider witnesses at the hearing. When asked where students receive clinical training the witness testified: "Primarily at Carolinas Medical Center; they do receive clinical training at some of the other hospitals or care locations within the Hospital Authority, but primarily Carolinas Medical Center."[236] Later, the witness continued: "This [the Clinical Education Affiliation Agreement] gives us the ability to go to any of those facilities for clinical training. Again, we primarily use Carolinas Medical Center, but we did have to go to some of these other facilities for certain programs or certain experiences."[237] As examples, the Board notes that with respect to the Medical Laboratory Sciences program, the "[c]linical practicum occurs in the laboratories of [CMC], [Carolinas Medical Center – Mercy], the Health Department, and other CHS owned facilities."[238] As to the Radiologic Technology Program, "[t]he core courses combine didactic classroom lectures, radiologic laboratory practicum, and comprehensive clinical education at the numerous radiology departments in the [CHC-System] in and around Charlotte, North Carolina."[239] This clinical education is conducted at multiple facilities, including 4 hospitals and one clinic[240]:

- CMC
- Carolinas Medical Center – Mercy
- Carolinas Medical Center – University
- Carolinas Medical Center – Pineville and
- Carolinas Medical Center – Myers Park[241]

As CCHS, not CMC, has control over classroom instruction and clinical training for the disallowed programs, CMC does not meet the requirement set forth at 42 C.F.R. § 413.85(f)(1)(v).

Again, the Board takes note of the *MUHA* decision, in which the District Court found that the medical center "exercised sufficient control over the Pharmacy Program to be identified as an 'operator.'"[242] However, again, the cases are not similar. In the *MUHA* case, the medical center

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[235] *Id.*
[236] Day-1 Tr. at 208-209.
[237] Day-1 Tr. at 217-218.
[238] Provider Exhibit P-98 at 21.
[239] Ex. P-99 at 4.
[240] CMC, Carolinas Medical Center – Mercy, Carolinas Medical Center – University, and Carolinas Medical Center – Pineville are listed as hospitals in Ex. P-101 at 5. Similarly, Carolinas Medical Center – Myers Park is listed as a clinic associated with CMC in Exs. C-2 at C0052 (Audit Adj. No. 49), C-8 at C0143 (Line 90.04).
[241] Ex. P-99 at 36. JRCERT also lists each of these sites as recognized clinical settings. Ex. C-11 at C0229.
[242] *MUHA*, 2021 WL 1177860 at *12.

was found to have sufficient control because the medical center was part of the affiliation agreement. However, in the CMC cases, it may be reasonable to find CCHS as the operator of the program. However, it is not possible for that to extend to CMC, in the Board's opinion, as there was no delegation from the corporate home office of the CHC-System to CMC's operating division (*e.g.*, to the CMC President[243]). Virtually all of the control over CCHS was at the corporate home office (as illustrated in the February 2013 organization chart showing CCHS under the Hospital Authority rather than a sub-component under the CMC operating component[244]). As such, the Board does not find *MUHA* persuasive or precedential in this case.

The Board recognizes that there is a presumptive criteria at 42 C.F.R. § 413.85(f)(2) that specifies, "absent evidence to the contrary," a provider may be "assumed to meet" the provider-operated criteria in 413.85(f)(1) if the provider itself issues the diploma. However, it is not applicable because we have contrary evidence and the sample diplomas in the record demonstrate CCHS (not CMC) issues the diplomas.[245]

Finally, the Board rejects CMC's alternative argument that it fits within the following example given in the preamble to the January 12, 2001 Final Rule:

> An example of a program that could be considered provider-operated would be one in which ***the hospital*** *is the sole corporate member of the college*, elects the board of trustees, has board members in common, employs the faculty and pays the salaries, controls the administration of the program and the curriculum, and provides the site for the clinical and classroom training on the premises of the hospital. We believe that, in these situations, the community has not undertaken to finance the training of health professionals; the provider has merely restructured its provider-operated program to meet certain State or accrediting requirements.[246]

We do not have this situation here. As discussed above, CMC is not the sole corporate member of CCHS and CCHS is not a sub-organization of CMC. Nor does CMC appoint the CCHS Board of Directors, employ the CCHS faculty, or pay the salaries for that faculty.

In summary, the Board finds that CMC is not entitled to pass-through reimbursement for the net cost of its Nursing, Medical Laboratory Science, Radiologic Technology, and Surgical Technology Programs. With respect to these programs, as discussed, CMC did not meet the requirements specified in 42 C.F.R. § 413.85(f), and therefore did not qualify for paramedical pass-through reimbursement.

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[243] *See supra* note 66 confirming CMC has its own president.
[244] Again, this chart was submitted by CMC to the Medicare Contractor during the audit of the programs. *See supra* notes 193 and 194 and accompanying text.
[245] *See supra* note 43 and accompanying text.
[246] 66 Fed. Reg. at 3363 (emphasis added).

3. ***In the alternative****, whether CMC is entitled to certain pass-through reimbursement based on the exception at 42 C.F.R. § 413.85(g)(3).*

a) The Positions of the Parties

In the alternative, CMC argues that, "even if [CMC] does not meet the provider-operated requirements of 42 C.F.R. § 413.85(f), it is nonetheless entitled to pass-through reimbursement for the [d]isallowed [p]rograms *under the exception to the operator requirement contained in 42 C.F.R. § 413.85(g)(3)*."[247] CMC asserts that "[u]nder that exception, a provider that, in order to meet accreditation requirements, transferred a provider-operated program to a wholly-owned educational institution prior to October 1, 2003, and has continued to incur and claim the cost of the program after the transfer, will continue to qualify for pass-through reimbursement *even if it ceases to meet the provider-operated requirements at 42 C.F.R. § 413.85(f)*."[248]

CMC asserts that it, t*hrough the Hospital Authority*, operated the disallowed programs ***prior to*** *transferring them to CCHS*, and that "[n]otably, prior to the time the Disallowed Programs were transferred to [CCHS], there was no regulation in effect that specified the criteria for provider-operated status."[249] In support, CMC notes that "[t]he current regulation at 42 C.F.R. § 413.85(f) was not enacted until January 12, 2001 -- well after [CMC] transferred the [d]isallowed [p]rograms to [CCHS]."[250] Accordingly, CMC maintains that "CMS cannot apply [§] 413.85(f) retroactively back to the time that [CMC] transferred the [d]isallowed [p]rograms to [CCHS]."[251]

CMC goes on to explain that "[i]n 1993, the Hospital Authority's Board of Commissioners passed a resolution to separately incorporate the CMHA School of Nursing as a wholly owned subsidiary. . . . The resolution stated that it was in the best interests of the CMHA School of Nursing to receive accreditation from the Southern Association of Colleges and Schools Commission on Colleges."[252] CCHS "was therefore formed as a wholly owned nonprofit subsidiary in 1994 as CMHA School of Nursing, Inc. . . . The Hospital Authority was made the sole member of the CCHS. . . . [CMC] could not be the sole member, as it not itself a legal entity."[253]

In refuting CMC's arguments, the Medicare Contractor argues that the main issue presented is whether CMC is the operator of the disallowed programs. The Medicare Contractor asserts that the disallowed programs "were operated by [CCHS], which is a related party through the Hospital Authority"[254] or the CHC-System. To be eligible for Medicare payments, an entity must be a Medicare-participating provider with a Medicare provider participation agreement. However, CCHS is not a provider *per se*, nor does it have a Medicare provider participation agreement, so "it is not eligible to receive Medicare payments."[255] Similarly, the Medicare Contractor maintains that the same is true for the corporate home office operations of Hospital Authority. The regulation

[247] Provider's CFPP at 33 (emphasis added).
[248] *Id.* (italics emphasis added).
[249] *Id.*
[250] *Id.*
[251] *Id.*
[252] *Id.* at 35.
[253] *Id.* at 36.
[254] Day-1 Tr. at 19.
[255] *Id.*

at 42 C.F.R. § 413.85(d)(2)(ii) makes clear that "allowable educational costs" for an NAH educational program does ***not*** include the "cost incurred by a related organization."[256]

The Medicare Contractor also refutes CMC's argument that it is nonetheless entitled to pass-through reimbursement for the disallowed programs under 42 C.F.R. § 413.85(g). The requirements to qualify under section 413.85(g)(2) include "the [p]rovider 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 01, 1989,"[257] CMC's October 1, 1988 through September 30, 1989 cost report period. The Medicare Contractor asserts that two of the disallowed programs, nursing and surgical technology were not claimed on that FY 1989 cost report. The other two disallowed programs, medical laboratory science and radiologic technology were deemed to be provide-operated on that cost report. Thus section 413.85(g)(2) does not apply.[258]

Next, the Medicare Contractor looked at section 413.85(g)(3) to determine its applicability. The Medicare Contractor determined that "[CCHS] is not a wholly owned subsidiary of [CMC], it is a related entity under the [Hospital Authority] home office."[259] Therefore, the Medicare Contractor asserts that section 413.85(g)(3) does not apply.[260]

b) Board Analysis and Findings

The Board first reviewed whether the exception at 42 C.F.R. § 413.85(g)(2) applied. Significantly, the (g)(2) exception is a grandfather exception that is only applicable to ***nonprovider***-operated programs existing since FY 1989. Here, while CMC did have multiple NAH educational programs claimed on its FY 1989 cost report, the only ones relevant to this hearing were for "Paramed (Lab)" and "Paramed (X-Ray)".[261] These would relate only to the Medical Laboratory Science and Radiologic Technology programs at issue (and not to either the Nursing or Surgical Technology programs). Based on the historical information provided in the record (as discussed above in **Subsection A(1)** of the STATEMENT OF THE FACTS), the Board finds that these programs existed but are not subject to the § 413.85(g)(2) grandfather clause since it appears that they were provider-operated (as opposed to *nonprovider*-operated) during 1989 as evidenced by the fact that the costs for these 2 paramedical programs were claimed on the 1989 cost report as pass-through costs and the accreditation certificates for those 2 programs were issued in the name of CMC; and (2) section 413.85(g)(2) implemented OBRA-90 § 4004(b)(1). Further, this grandfather provision appears to be focused on then-existing nonprovider-operated programs as it was protecting providers that were then relying on payments.[262] Regardless, the evidence in the record suggests

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[256] *Id.* at 19-20.
[257] *Id.* at 25.
[258] *Id.*
[259] *Id.* at 26.
[260] *Id.*
[261] Ex. C-14 at C0330 (Worksheet A from the FY 1989 cost report for CMC). Worksheet A for FY 1989 also shows a claim for a "Paramed (CRNA)" NAH program, but this CRNA program is not at issue in these cases. There are no other NAH educational programs claimed on the FY 1989 cost report.
[262] *See* 66 Fed. Reg. at 3369 (stating: (1) "This protects those providers that were relying on the payments."; and (2) "Again, we believe that the Congressional intent was to protect providers who had come to rely on Medicare payments for nonprovider-operated education programs without increasing Medicare expenditures."); OBRA-90 Conference

that these two "Paramed" programs were provider-operated until they were moved to CCHS. After those programs joined CCHS, CMC no longer supported those programs as discussed above and below. Accordingly, the Board finds that § 413.85(g)(2) is not applicable to any surviving "Paramed (Lab)" and "Paramed (X-Ray)."

The Board next reviewed whether the exception at 42 C.F.R. § 413.85(g)(3) applied. Significantly, the (g)(3) exception only applies to wholly-owned subsidiaries under the control of the provider and, if the exception applies, limits payment to classroom and clinical training costs. The Board rejects CMC's argument that it is entitled to pass-through reimbursement for the disallowed programs under the exception to the operator requirement contained in 42 C.F.R. §-413.85(g)(3). The Board notes that a provider must meet the requirements in 42 C.F.R. § 413.85(g)(3)(i) and (g)(3)(ii) in order to fall under paragraph (g)(3)(iii) and be eligible to receive payment under that paragraph. 42 C.F.R. § 413.85(g)(3)(2) is key in this case, as it states:

> Payment for the incurred costs of educational activities identified in paragraph (g)(3)(i) of this section will be made on a reasonable cost basis if a provider, as described in paragraph (g)(3)(i) of this section, received Medicare reasonable cost payment for those nursing and allied health education program(s) both prior and subsequent to the date the provider *transferred operation of the program(s) to its wholly owned subsidiary educational institution* (and ceased to be a provider-operated program(s) according to the criteria under paragraph (f) of this section).[263]

As evidenced in the record, the Board finds that CCHS is not a wholly-owned subsidiary of CMC, and is not controlled by CMC, as highlighted by the fact that the organizational chart for the Hospital Authority does not show CCHS as a sub-unit or sub-organization of CMC. Indeed, this depiction on the organizational chart is borne out in the documents and testimony of CMC's witnesses at the hearing as discussed above – the corporate home office of the Hospital Authority controlled CCHS rather than the CMC operating division. It is an independent college, as well as a related entity under the Hospital Authority. Therefore, the Board concludes that section 413.85(g)(3) does not apply to the disallowed programs.[264]

Report, H.R. Rep. 101-964, 101st Cong., 719 (1990) (stating: "Payments for hospital-supported programs would be limited to those programs for which a hospital claimed costs and was paid, at least on an interim basis, (as allowable nursing and allied health education costs payable on a reasonable cost basis under section 1861(v)(1)) on its most recent cost reporting period ending on or before October 1, 1989. The conferees note that in the case of hospital-operated nursing and allied health education programs, the Secretary does not recognize costs incurred by a related educational organization as allowable educational costs since such costs are a redistribution of costs from the educational institution to the hospital. Although the provision provides for recognition of the costs incurred by a related educational organization for clinical training on the hospital's premises in the case of a hospital-supported program, the conferees intend that nothing in the provision should be construed as requiring the Secretary to modify his current policy in regard to the determination of reasonable costs for a hospital-operated program.").

[263] 42 C.F.R. § 413.85(g)(3)(ii) (italics emphasis added).

[264] Regardless, if the Board were to find that 413.85(g)(3) were applicable, the Board would need to determine whether each of the programs at issue were transferred to CCHS "in order to meet accreditation standards prior to October 1, 2003." While the nursing program appears to meet that criteria, it is not clear that the medical laboratory science, radiologic technology, and surgical technology programs would meet that criteria, based on the record before the Board.

B. CMC's Nursing and Allied Health Part C Payment

The Board recognizes that the May 2003 Program Memorandum includes additional verbiage not included in 42 C.F.R. § 413.87. Specifically, the May 2003 Program Memorandum states that *M+C inpatient days* (*i.e.*, Part C days) should be ***excluded*** from the Total inpatient days portion of the calculation, while the regulation does not contain that specific language. The Board further notes that, while the May 2003 Program Memorandum mentions "excluding M+C inpatient days,"[265] it also specifically identifies the cost report lines to be used to accumulate this data as follows:

> Total inpatient days (excluding M+C inpatient days) for that same cost reporting period. (Use the sum of line 1, lines 6 through 10, and lines 14 and 14.01 of column 6 from Worksheet S-3, Part I [of Medicare cost report CMS-2552-96])[266]

The regulation at 42 C.F.R. § 413.87(e)(1)(ii) identifies the second data point for Step One as "Inpatient days for that same cost reporting period." There is no mention of excluding anything.

Further, CMC gives the following formula, citing it as coming from CMS:

NAH Part A Payments			Part C				
Total Inpatient Days		x	Days				
(net Part C days)				=	Payment Ratio		
	$6,134,256						[267]

However, the Board notes that, in the May 2003 Program Memorandum, an example is given as follows:

___			___					
$100,000			2,800 M+C					
28,000 inpatient days		x	inpatient days					
				x	$26,000,000 = $10,400			
$250,000,000			14,200,000 M+C					
142,000,000 inpatient days		x	inpatient days					
___			___					[268]

It is clear using the example, that the May 2003 Program Memorandum does not include the phrase "net Part C days," as the Provider contends. Furthermore, an explanation is given of the calculation in the Program Memorandum which explains:

The Board understands these programs were transferred to CCHS (*see supra* note 35 and accompanying text), but the record does not appear to demonstrate that those programs were transferred in order to meet accreditation standards.

[265] May 2003 Program Memorandum Transmittal A-03-043 at 2.

[266] *Id.* When the 2003 Program Memorandum was issued, the cost report form in effect was CMS-2552-96.

[267] Provider's CFPP at 51-52.

[268] May 2003 Program Memorandum Transmittal A-03-043 at 3.

> In its cost reporting period ending in FY 1999, Hospital A received $100,000 in total Medicare payments for approved nursing and allied health education programs. Hospital A's total inpatient days were 28,000. Total Medicare + Choice inpatient days were 2,800. Its total additional payment amount for portions of its cost reporting period that occur in CY 2001 would be determined as follows:

$100,000			2,800 M+C inpatient				
28,000 hospital inpatient		x	days				
days				x	$43,663,043 "pool" = $71,179		
	$6,134,256						

[269]

The Board notes that the denominator in the example is the same as the denominator in the calculation presented by CMC in their Consolidated Final Position Paper. Yet, it also, does not state any exclusion for Part C (or M+C) days.

Finally, the 2003 Program Memorandum makes clear that the add-on Part C payments are made from a defined pool that is divided between all qualifying NAH providers and, as a result, it is critical that there be consistent treatment of these costs across all providers. However, there is no evidence in the record to suggest that the Medicare Contractor's treatment is any different from other providers operating NAH programs across the nation. To skew the calculation on one hospital without certain proof that it was consistent with other hospitals would be improper.

In reviewing the Medicare Contractor's calculation of CMC's Medicare+Choice NAH Payment, the Board finds that the Medicare Contractor used the lines indicated by the Program Memorandum in its accumulation of the total inpatient days portion of the calculation.[270]

C. CMC's FY 2013 DSH Payment Calculation

The last issue in this appeal concerns whether CMC's DSH payment for the FY 2013 should be revised to include additional patient days that were excluded from the numerator of the Medicaid fraction. As discussed above in **Subsection C** of the STATEMENT OF THE FACTS, the parties have agreed to the stipulations to resolve this issue. Specifically, in the Parties' Joint Stipulations filed in Case No. 19-2176, the parties have agreed that an additional *net* 127 Medicaid eligible days[271] should be added to the numerator of the FY 2013 Medicaid fraction for purposes of the FY 2013 DSH adjustment calculation, but the Medicare Contractor maintained it is unable to either reopen the NPR at issue or enter into an administrative resolution. The parties' agreement

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[269] *Id.* at 4.

[270] Medicare Contractor's Exhibit C-23 in Case No. 19-2175 and Exhibit C-23 in Case No. 19-2176.

[271] Specifically, the parties agree that: (1) in-state Medicaid eligible days and out-of-state Medicaid eligible unpaid days should be increased by 221 days and 11 days, respectively; and (2) in-state Medicaid eligible days should be decreased by 105 days. This agreement would increase Medicaid eligible days by a net 127 days (*i.e.*, 221 days + 11 days - 105 days = 127 days). Parties Joint Stipulations, Case No. 19-2176 at ¶ 4.3, Attachment C.

to add an additional 127 Medicaid eligible days is captured in the proposed audit adjustment report attached to the Parties Joint Stipulations as Attachment C.

Consistent with 42 C.F.R. § 412.106(b)(4) *and* based on the its finding of jurisdiction and its review of the parties' stipulations, the parties' agreement to conduct a hearing on the record, and the record before the Board, the Board accepts the data in ¶ 4.3 of the Stipulations (as quoted *supra*) and the proposed Audit Adjustment Report at Attachment C to the Parties' Joint Stipulations and finds that the cost reporting period's DSH calculation for CMC should be revised to include an additional *net* 127 Medicaid-eligible days in the numerator of the Medicaid fraction. Accordingly, the Board remands this appeal to the Medicare Contractor with direction to apply the proposed audit adjustments reflected in and attached to the Parties' Joint Stipulations as Attachment C, and to make the additional DSH payment calculated for the cost reporting period as a result of those adjustments. Specifically, the Board directs the Medicare Contractor to add an additional *net* 127 Medicaid-eligible days (as reflected in that Attachment C) to the number of Medicaid-eligible days on the Provider's settled cost report as agreed in the Stipulations of the Parties.

DECISION:

After considering the Medicare law, regulations, program guidance, the evidence presented, and the parties' contentions, the Provider Reimbursement Review Board ("Board") finds:

1. The Medicare Contractor properly disallowed the FY 2012 and 2013 pass-through reimbursement claimed by CMC for the net cost of its Nursing, Medical Laboratory Science, Radiologic Technology, and Surgical Technology Programs.

2. The Medicare Contractor properly calculated the Part C component of CMC's NAH Payment as it included the cost report lines/columns as directed by the May 2003 Program Memorandum, in its total inpatient days portion of the calculation.

3. The FY 2013 DSH calculation for CMC should be revised to include an additional net 127 Medicaid-eligible days in the numerator of the Medicaid fraction.

Accordingly, the Board remands Case No. 19-2176 to the Medicare Contractor to revise CMC's FY 2013 cost report as follows:

a. Revise Worksheet S-2, Part I as follows:

   - Add an additional 221 in-state Medicaid eligible unpaid days to Line 24, Column 2;
   - Add an additional 11 out-of-state Medicaid eligible unpaid days to Line 24, Column 4; and
   - Subtract 105 duplicate in-state Medicaid paid days from Line 24, Column 1.

b. Revise Worksheet S-3, Part I as follows:

   - Subtract 105 duplicate Medicaid-eligible days from Line 1, Column 7; and
   - Add an additional 232 Medicaid-eligible days to Line 2, Column 7.

c. Recalculate CMC's DSH adjustment payment for FY 2013.

BOARD MEMBERS PARTICIPATING:

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

FOR THE BOARD:

9/30/2024

X Clayton J. Nix

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

APPENDIX A

EXCERPTS FROM THE JANUARY 12, 2001 AND AUGUST 1, 2003 FINAL RULE ADDRESSING RELATED ORGANIZATIONS

I. Excerpt from the August 1, 2003 Final Rule.—

"The commenter also mentioned the generally applicable 'related-entity' rules, and suggested that a wholly owned school would be a related entity that should be treated as if it is the provider. Thus, a wholly owned educational institution would remain provider-operated. *However, we note that, for purposes of nursing or allied health education payment under § 413.85, it is not sufficient for a program to be operated by a related entity*. Rather, *the 'related entity' principles do **not** apply* under the agency's nursing and allied health education payment policy because, as indicated in previous rulemakings, that policy requires that a program be directly operated by the provider itself. *Requiring direct operation of a program by the provider ensures that, under § 413.85(c), costs borne by related organizations (that is, the community) are not redistributed to the hospital and claimed as a pass-through under the Medicare program*."[272]

II. Excerpts from January 12, 2001 Final Rule.—

A. Excerpts in the context of determining provider-operated NAH educational programs

"We proposed that, for purposes of determining the operator of an approved nursing or allied health education program, the fact that a provider and a college or university are considered related organizations under § 413.17 (''Cost to related organizations.'') *would **not** be **sufficient** to allow a university-operated program to be considered provider operated*. As we explain in section II.C. of this preamble, our policy concerning related organizations was established to avoid program recognition of costs of a provider for goods or services furnished by a related organization in excess of the costs incurred by the related organization."[273]

B. Excerpts in the context of determining net costs of approved NAH education programs

"We clarified in the proposed regulations that the term 'tuition' includes these additional charges and fees and specified a proposed formula for determining the net costs to indicate that 'total costs' includes only direct and indirect costs incurred by a provider that are directly attributable to the operation of an approved educational activity. These costs do not include usual patient care costs that would be incurred in the absence of the educational activity, such as the salary costs for nursing supervisors who oversee the floor nurses and student nurses. *Moreover, these costs do **not** include costs incurred by a related organization*.

The existing regulation concerning related organizations set forth at § 413.17 was established to avoid program recognition of artificially inflated costs that might be generated from less than arm's length transaction. This policy was not intended to expand the range of items and services for which a provider could claim payment. With respect to educational costs (with the limited exception for certain graduate medical education costs incurred by a related medical school as provided in Intermediary Letter 78–7) *our policy has been that the provider, rather*

[272] 68 Fed. Reg. at 45433 (emphasis added).
[273] 66 Fed. Reg. at 3361 (emphasis added).

than the related organization, ***must directly incur the costs on its books and records*** *before the costs will be recognized for Medicare payment purposes*. Otherwise, the principle that Medicare payment for medical education costs should not result in a redistribution of costs from the educational institution to the provider would be violated.

Whereas providers that operate their own programs may receive reasonable cost reimbursement for both the classroom instruction and the clinical training costs, but no reimbursement for costs incurred by a related educational institution, providers that would qualify under section 4004(b) of Public Law 101–508 may receive reasonable cost reimbursement for the clinical training costs only, and for the clinical training costs incurred by a related educational institution. We believe that the language included in the Committee Report that accompanied Public Law 101–508 supports this distinction between total allowable costs for provider-operated and nonprovider-operated programs. In that report, the conferees noted that—

> 'in the case of hospital-operated nursing and allied health education programs, the Secretary does not recognize costs incurred by a related educational organization as allowable educational costs since such costs are a redistribution of costs from the educational institution to the hospital. Although [section 4004 of Public Law 101– 508] provides for recognition of the costs incurred by a related educational organization for clinical training on the hospital's premises in the case of a hospital-supported program, the conferees intend that nothing in [section 4004 of Public Law 101– 508] should be construed as requiring the Secretary to modify his current policy in regard to the determination of reasonable costs for a hospital-operated program' (H.R. Rept. No. 964, 101st Cong., 2d Sess. 719 (1990)).

We note that this clear statement of Congressional intent is also *consistent with our policy* on provider-operated programs stated above *of not recognizing the costs of related organizations in determining a provider's total costs of approved educational programs*."[274]

C. Exception for certain nonprovider-operated programs

"Section 4004(b)(1) of Public Law 101– 508 also required that we define allowable clinical training costs under this provision for payment for certain nonprovider-operated programs. At 57 FR 43667 in the September 22, 1992 proposed rule, we proposed to define these costs as the incremental costs that, in the absence of the students, would not be incurred by the provider. These incremental costs would include the costs of clinical instructors and administrative and clerical support staff whose function is to coordinate rotations with a nursing school and to schedule clinical rotation for each student nurse. They would not, however, include the costs of a charge or floor supervisor nurse who may spend a portion of his or her time supervising student nurses but who, in the absence of the students, would still have to be employed by the provider. In general, these costs are payroll and related salary costs. Although some provider-incurred overhead costs directly related to the cost of the students would be allowable, overhead costs incurred by the related organization generally would not be considered allowable."[275]

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[274] *Id.* at 3367 (emphasis added).
[275] *Id.* at 3368-69.

APPENDIX B

EXAMPLES OF EVIDENCE CONFIRMING THAT THE NAH EDUCATIONAL PROGRAMS AT CCHS OCCUR AT MULTIPLE HOSPITAL CAMPUSES OUTSIDE OF CMC

I. Exhibit P-98 – Description of the 2011 Clinical Laboratory Sciences Program

The Exhibit (page 5) states, as part of the Program's mission statement, that "*In partnership with CMC*, the college focuses on preparing individuals for employment in general and specialized healthcare fields for the Charlotte metropolitan area."

- The 2011 10-member Advisory Committee for the Program included only included 3 CMC employees. The other 7 members were from the corporate office of the Hospital Authority (3 members), CCHS (2 members), the Carolinas Medical Center – Pineville (1 member), and the University of North Carolina (1 member).[276]

- Clinical instruction occurred at multiple locations outside of CMC: "Clinical practicum occurs in laboratory of [CMC] main campus, *CMC-Mercy, the Health Department, and other CHS owned facilities*."[277]

II. Exhibit P-99 – Description of the Radiologic Technology Program

- "The core courses combine didactic classroom lectures, radiologic laboratory practicum, and comprehensive clinical education ***at the numerous*** *radiology departments* ***in the CHS hospital system*** *in and around Charlotte North Carolina*."[278]

- "The interdisciplinary College Advisory Committee serves in an advisory capacity to enhance the relationship of Carolinas College *and its* ***Internal (CHS [i.e., Carolinas Healthcare System])*** *and external community*."[279]

- "Clinical education is conducted at CMC facilities. These facilities are as follows: **CMC-Main; CMC Mercy; CMC-University; CMC-Pineville; CMC-Meyers Park**."[280]

- "The annual budget is approved or amended by College administration, and the director subsequently reviews monthly expenditures and reports any variances from the monthly budgetary allocations to the Dean of Business and the College Provost."[281]

- "We reviewed the downward trend of graduate placement into radiography positions in the system."[282]

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[276] Ex. P-98 at 7.
[277] *Id.* at 21.
[278] Ex. 99 at 4 (emphasis added).
[279] *Id.* at 6 (emphasis added).
[280] *Id.* at 36.
[281] *Id.* at 37.
[282] *Id.* at 38.