PROVIDER REIMBURSEMENT REVIEW BOARD HEARING DECISION

2000-D35

PROVIDER -
Rapid City Regional Hospital
Rapid City, South Dakota

Provider No. 43-0077

vs.

INTERMEDIARY -Wellmark/
Blue Cross and Blue Shield of Iowa
Blue Cross and Blue Shield Association

DATE OF HEARING-
October 12, 1999

Cost Reporting Period Ended -
June 30, 1993

CASE NO. 97-2148

INDEX

ISSUES:

1. Was the Intermediary's classification of School of Nursing Joint Education Program cost proper?

2. Was the Intermediary's adjustment eliminating Part A hours for Medical Directors proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Rapid City Regional Hospital ("Provider") is a 417-bed tertiary care facility located in the western part of South Dakota. It services a 300-mile radius of a five-state area, including the western part of South Dakota.[1] . Beginning in 1972, the Provider and its predecessors operated a hospital-based nursing education program.[2] After graduation, the students were eligible to take the examination for a registered nursing license. The Provider's program was approved by the State Board of Nursing and accredited by the National League for Nursing.[3] The program was located on the Provider's campus. The program offered classroom education in the School of Nursing, a Provider owned building, and clinical training at the Provider's facility and other area hospitals and clinics.[4]

In 1989, the Provider entered into an agreement with the State Board of Regents ("Agreement") to establish a Joint Education Program. The Agreement provided for both a two and a four year nursing degree program to be offered by the University of South Dakota ("USD"), and South Dakota State University ("SDSU") and the Provider (the Joint Education Program), and the phase out of the Provider's three year diploma program. All of these events were to occur during a three year transition period starting in the fall of 1988.[5]

In its cost report for FYE June 30, 1993, the Provider reported only the costs associated with building and maintenance of the building that the Provider provides for the Joint Education Program in a pass-through cost center. Wellmark/Blue Cross and Blue Shield of Iowa ("Intermediary") reclassified the costs and statistics for the Nursing School from a pass-through cost center to a non-pass-through cost center because they concluded that the Provider was not the legal operator of the Joint Education Program.[6]

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[1] Transcript ("Tr.") at 35.

[2] Tr. at 34, 88.

[3] Tr. at 34, 55.

[4] Id. at 33.

[5] See Tr. at 44-47.

[6] See Tr. at 90-98, Intermediary Position Paper at 16.

Regarding the Medical Directors' Part A hours, the Intermediary adjusted the Provider's cost report to remove Part A hours for various medical directors from Worksheet A-8-2. The adjustment was based on the Intermediary's position that the Provider did not maintain adequate time records throughout the year to document the Part A hours allocated. The Intermediary questioned the accuracy of the medical director time studies (Provider Exhibit 34) because the Hospital's Director of Budget/Reimbursement did not request that the physicians complete time records until May 24, 1994, which was well into the fiscal year at issue.[7] The Intermediary contends that the Provider does not meet the Medicare regulations regarding record-keeping requirements.

The Provider appealed the Intermediary's adjustments to the Provider Reimbursement Review Board ("Board") and has met the jurisdictional requirements of 42 C.F.R.§ 405.1835-.1841. The amount of Medicare reimbursement in controversy is approximately $138,523.[8] The Provider is represented by Daniel F. Miller, Esquire, of von Briesen, Purtell & Roper, s.c. The Intermediary is represented by Bernard M. Talbert, Esquire, of the Blue Cross and Blue Shield Association.

ISSUE 1: JOINT EDUCATION PROGRAM

STATEMENT OF FACTS AND BACKGROUND:

The Agreement to establish the Joint Education Program required that the Provider:

A. Accept no new enrollees in its three year program at the School of Nursing after September, 1988 and close this program upon graduation of the class of May, 1991.[9]

B. Provide ongoing clinical experience for the nursing students.[10]

C. Pay an initial fee of $250,000 to start up the programs.[11]

D. Contribute ongoing use of office, classroom and conference room space in the School of Nursing - a building that is owned by the Provider and located approximately three miles from the Provider's campus.[12]

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7 Intermediary Position Paper at 7.

8 Intermediary Position Paper at 5.

9 Tr. at 47.

10 Tr. at 48-50.

11 Tr. at 99-100.

12 Tr. at 47-48.

E. Provide office and classroom equipment and furniture that was utilized by the Provider's School of Nursing in its three year program.[13]

F. Annually provide in-kind services including audiovisual and print libraries, education equipment and models, a learning resource laboratory and computers.[14]

The Provider, pursuant to the Agreement, also participates in the Management Advisory Committee ("MAC") and the Nursing Education Advisory Committee ("NEAC").[15] The MAC addresses the Board of Regents on matters including:

A. Resolution of issues uniquely related to the Joint Education Program;

B. Recommendations to the participating institutions and the Provider when problems occur;

C. Review of the Joint Education Program's budget as it relates to the Program's needs and goals, and make recommendations;

D. Review of enrollment plans for consistency with market need for nursing graduates in Western South Dakota and the broader service area and review the availability of direct and in kind resources;

E. Receipt and review of the reports of the NEAC and oversight of any other ad hoc committees as may be necessary to support or assist in the Joint Education Program; and

F. Appropriate arrangements for the receipt and administration of any funds donated to support students or otherwise in support of the Joint Education Program.

See Tr. at 51-54.

The NEAC advises the administrators of the Board of Regents on matters including:

A. Healthcare delivery trends relevant to curriculum design and content;

B. Definition of roles and utilization of the baccalaureate and associate nurse;

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[13] Id.

[14] Id.

[15] Id. at 51-52.

C. Recruitment of students;

D. Representation of the Joint Education Program to the public;

E. Enhancement of the image of the Joint Education Program through public relations efforts; and

F. Securing resources for the Joint Education Program (i.e., fund raising for scholarships).

See Tr. at 52-54.

The Provider, as required by the Agreement, has had consistent representation on these committees since the inception of the Joint Education Program.[16]

In addition to its representation on these committees, the Provider, through its department managers, meets with the School of Nursing instructors approximately every six weeks to discuss issues regarding the clinical rotations. Further, the Provider and USD/SDSU meet on an annual basis to discuss various policies and procedures including any necessary curriculum changes.[17]

The Provider asserts that its role in the operations of the Joint Education Program, is evidenced by the following:

A. The Provider provides clinical experiences, with both Medicare and non-Medicare patients, for students of the Joint Education Program and participates in the development of the clinical aspects of the Joint Education Program.[18]

B. The Provider assists in the coordination of the scheduling and assignment of clinical experiences.[19]

C. The Provider provides approximately 25,000 square feet of classroom and office space and equipment for instruction and clinical experiences.[20]

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[16] Tr. at 54.

[17] Tr. at 52, 54-55.

[18] Tr. at. 48-50,53, 56-58.

[19] Tr. at 53, 56-58.

[20] Tr. at 59-61.

D. The Provider provides parking spaces to the Joint Education Program's instructors and the students.[21]

E. The Provider allows students and instructors the same access to its cafeteria as provided to its employees.[22]

F. The Provider participates with the School of Nursing in periodic evaluations of the Joint Education Program and any changes to the Program are recommended to the Board of Regents jointly.[23]

G. The Provider is entitled to request the withdrawal of any student or instructor whose performance or conduct is detrimental to the Provider's patients or personnel. [24]

H. The Provider allows students access to its medical library and education departments. [25]

I. The Provider's employees actively engage in working with students to coordinate the clinical experiences offered as part of the Joint Education Program. [26]

J. All clinical instructors and students of the Joint Education Program are governed by the Provider's employee policies and procedures while at the Provider's facilities, and the Provider is legally responsible for the students' actions.[27]

K. The Provider recruits a substantial number of its nurses from the Joint Education Program. [28]

L. The Provider has the ability to opt out of the operation of the Joint Education Program pursuant to the Joint Education Program Agreement.[29]

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[21] Tr. at 61-62.

[22] Tr. at 62

[23] Tr. at 54-55, 72.

[24] Tr. at 58.

[25] Tr. at 62-63.

[26] Tr. at 75-76.

[27] Tr. at 57-58.

[28] Tr. at 63-66.

[29] Tr. at 117-119.

PROVIDER'S CONTENTIONS -JOINT EDUCATION PROGRAM:

The Provider contends that based upon the evidence included in the record, it is clear that it operates the Joint Education Program as defined in the Medicare regulations, Federal court cases and previous Administrative decisions. The Provider asserts that it has ongoing responsibilities not only for providing the building in which the Joint Education Program is housed on a rent-free basis, but also for maintaining that building. It is the Provider's position that it exercises the requisite amount of direction and control, as required by Federal case law and previous Administrative decisions, over the Joint Education Program. Thus, the Provider believes that it is a joint operator of the Joint Education Program and should receive pass-through treatment on its costs associated with the Joint Education Program.

The Provider rejects the Intermediary's position that it does not operate the Program. It is the Providers primary position that it operates the program as defined in the regulations, Federal court cases and Administrative decisions. The Provider refers to the regulations at 42 C.F.R. §412.113(b) which require Medicare payment for approved medical education costs as described in 42 C.F.R. §413.85. The Provider points out that under 42 C.F.R. §413.85(a), payment for approved educational activities is an allowable pass-through cost except for those activities described in 42 C.F.R. §413.85(d). The term "approved educational activities" is defined in 42 C.F.R. §413.85(b) as:

> formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of patient care in an institution. These activities must be licensed if required by State law. If licensing is not required, the institution must receive approval from the recognized national professional organization for the particular activity.

Pursuant to 42 C.F.R. §413.85(c),

> 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 [Medicare] 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 [the Medicare] program should participate in increased costs resulting from redistribution of costs from educational institutions or units to patient care institutions or units. (Emphasis added).

The Provider Reimbursement Manual, Part 1 ("HCFA Pub. 15-1")§404.2 states in relevant part:

> The responsibility for operating and supporting approved educational programs which are necessary to meet the community's needs for nursing and paramedical personnel should be borne by the community.

> Where the community has not yet recognized and accepted this responsibility, the Medicare program does participate appropriately in the support of such approved programs as are operated by providers in conjunction with their patient care activities. 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 where the provider receives no, or disproportionately little, benefit for the amount it expends.

In addition, HCFA Pub. 15-2, §2807 states that for cost reporting periods beginning on or after October 1, 1990, both classroom and clinical costs are allowable as pass-through costs, as defined in 42 C.F.R. §413.85, if the Provider operates an approved nursing or allied health education program that meets the criteria of 42 C.F.R. §§412.113(b) and 413.85.

In this case, the Provider believes that the Intermediary reclassified the nursing education program costs solely because it concluded that the Provider was not the legal operator of the program.[30] However, the Provider contends that the Intermediary's interpretation of the regulations is inconsistent with Federal case law and previous administrative decisions addressing the issue.

The Provider references several court decisions and Board decisions that address joint education costs when the issue relates to whether the Provider operated the program. The Provider asserts that these decisions have allowed pass-through cost reimbursement in circumstances similar to this case, even when the provider was not the "legal operator" of the program.

The Provider contends that the leading court decision addressing this issue is St. John's Hickey Memorial Hospital, Inc. v. Califano, 599 F.2d 803 (7th Cir. 1979) ("St. John's Hickey"). The Provider points out that in this case, the court rejected the argument that the hospital must be the "legal operator" of the nursing school program to satisfy the "engaged in" requirement of 42 C.F.R. §413.85 (then 42 C.F.R. §405.421). Further, the court found that the "engaged in" requirement may be satisfied and pass-through costs paid as a result of the following: (1) the hospital's contract to participate in the program clinically and financially; (2) the use of the hospital's premises for clinical classroom instruction and training; (3) participation of the hospital's staff in the clinical portion of the program; (4) compliance by the instructors with the hospital's rules and practices; and (5) resolution of any differences with respect to conduct by the administrators of both institutions. St. John's Hickey at 809. In St. John's Hickey, the court set forth the criteria, as required by the regulations, for allowing the educational costs to be reimbursable:

A. the provider is engaged in (operated) the approved educational activity;
B. the education program is approved;
C. the program contributes to the quality of patient care within an institution;

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[30] See Tr. at 94.

D. the community has not undertaken to finance the program;
E. the program does not result in the redistribution of costs from the educational institution to the provider.

St. John's Hickey, 599 F.2d at 808-810.

The Provider notes that the Seventh Circuit's reasoning in St. John's Hickey was also adopted by the District Court for the District of Columbia in Los Alamitos General Hospital, Inc. v. Donnelly, 558 F.Supp. 1141 (D.D.C. 1983) ("Los Alamitos").

The Provider further notes that in a number of other administrative decisions, the Board found that the Provider operated the Joint Education Program under similar facts. See Barberton Citizens Hospital v. Blue Cross and Blue Shield Association /Community Mutual Insurance Company, PRRB Dec. No.94-D61, July 28, 1994, Medicare & Medicaid Guide (CCH) ¶ 42,587, (1994); St. Ann's Hospital v. Blue Cross and Blue Shield Association/Community Mutual Insurance Company, PRRB Dec. No. 93-D61, July 21, 1993, Medicare & Medicaid Guide (CCH) ¶41,616, (1993) and St. Mary's Medical Center Duluth, Minnesota v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Minnesota, PRRB Dec. No. 97-D82, July 15, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,503, (1997). In these decisions, the Provider asserts that the Board has consistently rejected the Intermediary's position that the Provider did not operate a joint education program. The Provider contends that in each of the above decisions, the Board found that its opinion was consistent with the logic presented in the 7th Circuit's decision in the St. John's Hickey case, wherein the court found that the joint operation of a nursing program by a provider satisfied the regulatory requirement.[31]

The Provider refers to the Intermediary's Position Paper which references a HCFA Administrator decision dated April 7, 1978, which reversed PRRB Case No. 78-D7, Butler Memorial Hospital v. Blue Cross Association, et al ("Butler Memorial").[32] The Provider notes that in this decision, the HCFA Administrator held that the Intermediary's disallowances were proper and the provider was not entitled to reimbursement for any payments it made to Butler County Community College in support of the nursing education program. The Intermediary contended when comparing Butler Memorial and the case at hand, that "the facts in these cases are similar, if not exactly the same and the Board should follow the HCFA Administrator's ruling in the current appeal".[33] However, the Provider points out that the HCFA Administrator's decision was reversed by the United States District Court for the Western District of Pennsylvania. Butler County Memorial Hospital v. Califano, U.S. District Court, Western District of Pennsylvania, No. 78-652-C, October 17,1979, Medicare & Medicaid Guide (CCH) ¶

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[31] In the Provider's Post Hearing Brief at 15-24, the Provider provides an in depth analysis of each of the above three cases and how they relate and support the current case.

[32] See Intermediary Position Paper at 18.

[33] Id.

30,048, (1979). The district court based its decision on the fact that the Provider's nursing program met the requirements of the regulation and that the Administrator's interpretation of "engage in" to require that the hospital be the legal operator of the program was overly restrictive and not in accordance with the legislative history of the Social Security Act. Id. This decision was based, in part, on the 7th Circuit's decision in St. John's Hickey. The Provider contends that the 7th Circuit's decision in St. John's Hickey also formed the basis for several other district court decisions that reversed HCFA Administrator decisions similar to Butler Memorial. See Community Hospital of Indianapolis Inc. v. Califano (1979-2 Transfer Binder ¶ 29,999), Cleveland Memorial Hospital, Inc. v. Califano (1980 ¶30,487), The Archbishop Bergan Mercy Hospital v. Califano (1980 ¶30,512), Washington Adventist Hospital, Inc. v. Califano (1981-2 ¶31,470), and Los Alamitos .

Therefore, it is the Provider's position in the instant case that its Joint Education Program clearly meets the conditions set forth in 42 C.F.R. §413.85, St. John's Hickey and previous board decisions.

The Provider contends that it operates the Joint Education Program consistent with 42 C.F.R. §§412.113(b) and 413.85 and previous federal court and administrative decisions that have addressed this issue. More, specifically, the Provider supports this contention with the following:

A. The Provider has been engaged in a nursing education program on a continuing basis since 1972, the costs of which the Intermediary has allowed as pass-through. See Tr. at 34, 88.

B. During the cost reporting period in contention, the Provider was engaged in a Joint Education Program involving nursing education activities in conjunction with the USD and SDSU. See Tr. at 44-47.

C. The Joint Education Program is certified by the State Board of Nursing and accredited by the National League for Nursing. See Tr. at 34,55.

D. The terms and conditions that the Provider was subject to in its Agreement, include:

1. Providing ongoing clinical experience for the students enrolled in the Joint Education Program.

2. Paying an initial fee of $250,000 to start up the Joint Education Program.

3. Contributing ongoing use of office, classroom and conference room space in the School of Nursing, a building that is owned by the Provider and located on the Provider's campus.

4. Providing office and classroom equipment and furniture.

5. Annually providing in-kind services including audiovisual and print libraries, education equipment and models, a learning resource laboratory and computers.

See Tr. at. 47-50, 99-100.

E. The Provider provides clinical experiences for the students of the Joint Education Program and participates in the development of the clinical aspects of the Program. See Tr. at 48-50, 53, 56-58.

F. The Provider assists in the coordination of the scheduling and assignment of the clinical experiences. See Tr. at 53, 56-58.

G. The Provider provides approximately 25,000 square feet of classroom and office space and equipment for instruction and clinical experiences. See Tr. at 59-61.

H. The Provider provides parking spaces to the Joint Education Program's instructors and students. See Tr. at 61-62.

I. The Provider allows students and instructors the same access to its cafeteria as provided to its employees. See Tr. at 62.

J. The Provider allows students access to its medical library and educational departments. See Tr. at 62-63.

K. The Provider's employees actively engage in working with students to coordinate the clinical experiences offered as part of the Joint Education Program. See Tr. at 75-76.

L. All clinical instructors and students of the Joint Education Program are governed by the Provider's employee policies and procedures while at the Provider's facilities, and the Provider is legally responsible for the students' actions. See Tr. at 57-58.

M. The Provider is entitled to request the withdrawal of any student or instructor whose performance or conduct is detrimental to the Provider's patients or personnel. See Tr. at 58.

N. The Joint Education Program is the type of formally organized and planned program of study usually engaged in by a Provider to enhance the quality of patient care. See Tr. at 66.

0. The Joint Education Program is necessary to meet the community's and the Provider's need for nursing personnel. See Tr. at 66-67.

P. The Joint Education Program gives the Provider access to a pool of qualified nursing personnel. See Tr. at 63-66.

Q. The Provider recruits a substantial number of its nurses from the Joint Education Program. See Tr. at 63-66.

R. The Provider maintains consistent representation on the MAC and the NEAC, which oversee the Joint Education Program. See Tr. at 54.

S. The Provider maintains routine and consistent communication with the School of Nursing instructors regarding various issues related to clinical rotations. See Tr. at 52, 54-55.

T. The Provider meets annually with USD and SDSU to discuss policies and procedures. See Tr. at 52, 54-55.

U. The Joint Education Program has not resulted in any redistribution of costs from the educational institution to the Provider. See Tr. at 101.

V. The Provider has the ability to opt out of the operation of the Joint Education Program pursuant to the Joint Education Program Agreement. See Tr. at 117-119.

Additionally, the Provider asserts that it incurs substantially less costs by operating the Joint Education Program in conjunction with USD and SDSU than it would if it was forced to operate a freestanding nursing education program. Thus, the Provider contends that it follows that, as in the above referenced Federal court cases and administrative decisions, its costs associated with its Joint Education Program should methodically flow through the Medicare program's reimbursement process as allowable pass-through costs.

The Provider argues further that by disallowing pass-through treatment of its joint education costs, it would overturn 20 years of Medicare reimbursement history and constitute an arbitrary and capricious action, an abuse of discretion, and a violation of law. The Provider refers to the Intermediary's argument[34] that a recent HCFA Administrator decision, reversing the Board, Northwest Medical Center v. Blue Cross and Blue Shield Association of Arkansas, PRRB Dec. No. 99-D55, June 30, 1999, Medicare & Medicaid Guide (CCH), ¶80,326, rev'd HCFA Administrator, August 31, 1999, Medicare & Medicaid Guide (CCH), ¶80,336, ("Northwest") supports the Intermediary's position on the joint education issue. The Provider points out that in Northwest, the provider claimed the costs associated with the nursing school expenses, reimbursed to a party in its joint education agreement, as nursing education activity pass-through costs in its filed cost report. The intermediary reclassified the costs to a non pass-through cost center, allowing the claimed amount as operating cost for the provider. This Provider claims that the reclassification was based on the intermediary's belief that the provider did

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[34] Tr. at 21-22.

not operate the nursing school and, therefore, the costs claimed on its cost report were not reimbursable as passthrough education expenses pursuant to 42 C.F.R. § 412.113 and § 413.85. The provider appealed the intermediary's reclassification based on its belief that the reclassification was inconsistent with the Medicare regulations governing reimbursement of costs of nursing educational activities. The provider in Northwest specifically referenced 42 C.F.R. § 412.113(b) and 42 C.F.R. § 413.85.

The Board found that the provider appropriately included the net direct costs associated with the nursing education program as pass-through medical education cost under PPS consistent with existing Medicare regulations. Northwest at 201,035. The Provider asserts that the Board interpreted the prerequisite established under 42 C.F.R. § 412.113(b)(1) to mean that, if a provider can substantiate that its medical education activities meet the conditions set forth in 42 C.F.R. § 413.85, then costs associated with such activities will systematically flow through to the Medicare program's reimbursement process as an allowed PPS pass-through cost. Id.

The Board further found that the provider was significantly engaged in the joint operation of the nursing education program in accordance with the governing regulations. Id. Among the numerous factors which demonstrate the provider's participation in the nursing program, the Board found the provider's involvement in the following elements to be significantly noteworthy:

A. The provider's nursing staff provided extensive training and supervision to the students, including acting as preceptors, instructing in patient care functions and charting, lab interpretation and equipment use;

B. The teaching function was enhanced by allowing the students to interact with the provider's medical staff,

C. The provider's Director of Education also acted as a liaison between the provider and another party to the joint agreement; and

D. All instructors and students at BMSSN-Northwest were subject to the provider's policies and procedures while on campus, which specifically included those related to clinical practices, patient care and safety.

Id. at 201,035-201,036.

The Board again reasoned that its decision was consistent with the logic presented in the 7th Circuit's decision in the St. John's Hickey case.

The Provider points out that the Board's decision in Northwest was subsequently reversed by the HCFA Administrator (see HCFA Administrator's review of PRRB Decision No. 99-D55, dated

August 31, 1999).[35] The Administrator found that in applying the provisions of 42 C.F.R. § 413.85(d)(6) to the facts of this case, the provider was not entitled to be reimbursed on a reasonable cost basis for the costs of the nursing education because the provider was not the operator of the program, nor the joint operator of the nursing program as required by the PPS revised 42 C.F.R. § 413.85. HCFA Administrator's Review Northwest at 10. According to the Administrator, the provider incurred no direct costs of operating the program. It was the Administrator's opinion that the four factors that the Board lists as representative of the provider's engagement in the program, do not constitute "operation" of the nursing program.

As noted above in Northwest, the Administrator found that the four factors that the Board listed as representative of the provider's engagement in the program do not constitute "operation" of the nursing program. However, the Provider in the current case argues that those four factors are virtually indistinguishable as to the type of factors that the Board listed as representative of the Northwest providers' engagement in the nursing education programs in cases such as St. John's Hickey, Barberton, St. Mary's Medical Center, and St. Ann's Hospital. In all of these cases, the Board found that the providers' engagement in the nursing education programs was sufficient to constitute a "joint operation" of the nursing education programs. The Provider points out that in St. Mary's Medical Center, among others, the Administrator declined to review the Board's decision. Thus, the Provider asserts that the Administrator has accepted the Board's reasoning in these earlier cases.

The Provider argues that the only reasons for reversing 20 years of Medicare reimbursement history that the Administrator provided in Northwest are contained in footnote 21. According to the Administrator, the final decisions of the Secretary in such PPS cases as St. Mary's Medical Center, and St. Ann's Hospital, fail to recognize that there is a distinction in the use of the term "provider operated" in determining when costs are allowable operating costs or allowable passthrough costs, under PPS. Additionally, the Administrator opined that those cases failed to recognize that the criteria for treating nursing education costs as pass-through costs was not at issue in the pre-PPS St. John's Hickey case.

The Provider believes that the Administrator's rationale for reversing the Board's decision in Northwest as well as 20 years of Medicare reimbursement history cannot withstand analysis. The Provider contends that the Administrator acted arbitrarily and capriciously in reversing 20 years of Medicare history which many providers, including the Provider in this case, have reasonably relied upon for guidance related to Medicare reimbursement for nursing education costs.

In addition, the Administrator's action in reversing the Board's decision in Northwest ignores HCFA's historical treatment of nursing education costs since the inception of PPS. In determining the initial PPS reimbursement rates, HCFA excluded nursing education costs from base year costs used to calculate PPS rates, ostensibly because these expenses would continue to be treated as pass-through costs. The

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[35] The provider appealed the HCFA Administrator's decision on November 5, 1999 and the case is currently pending in the United States District Court for the District of Columbia.

Provider believes that the Administrator is now clearly attempting to include providers' costs associated with joint education programs as part of the providers' operating costs, which is not how HCFA has historically treated nursing education costs since the inception of PPS. Thus, the Administrator's reversal of the Board's decision in Northwest is arbitrary, capricious, not in accordance with law, unsupported by substantial evidence and clearly an abuse of the Administrator's discretion. Therefore, the Board should reject the Intermediary's suggestion that Northwest supports the Intermediary's adjustment in this case.

Finally, the Provider points out that the Social Security Act ("the Act") at 42 U.S.C. §1395(x)(v)(1)(A) prohibits shifting to non-Medicare patients the necessary direct or indirect costs of efficiently providing services to Medicare beneficiaries. In this case, both Medicare and non-Medicare patients are served by the Joint Education Program.[36] Thus, the Provider contends that the disallowance of its claim for pass-through treatment of the costs associated with the Joint Education Program would violate the Act by imposing the full cost of the Joint Education Program on individuals who are not Medicare patients.

INTERMEDIARY'S CONTENTIONS -JOINT EDUCATION PROGRAM:

In its as-filed cost report, the Provider classified the Nursing School program costs in a pass-through cost center. It is the Intermediary's position that the Provider is not the legal operator of the program; therefore, the costs cannot be considered as pass-through.[37] Accordingly, the Intermediary made an adjustment to reclassify the cost and statistics for the Nursing School cost center from a pass-through line to a non-pass-through line.[38]

The Intermediary contends that the adjustment to reclassify the School of Nursing costs and statistics was made in accordance with Medicare regulation 42 C.F.R. § 413.85 - Cost of Educational Activities, HCFA Pub. 15-1 § 404 - Approved Programs, Provider Reimbursement Manual (HCFA Pub. 15-2) § 2807 - Worksheet A - Reclassification and Adjustment of Trial Balance of Expenses, and Blue Cross Association (BCA) Administrative bulletin No. 834.

The Provider refers to 42 C.F.R. § 413.85(b) which states (Exhibit 1-14):

> Approved educational activities means formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of patient care in an institution.

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[36] See Tr. at 53.

[37] Intermediary Position Paper at 16.

[38] See Intermediary Exhibit I-13 for details of the adjustment.

In addition, 42 C.F.R. § 413.85 (c) states, in pertinent part:

> 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.

HCFA Pub. 15-2 § 404.2 states (Exhibit I-15):

> The responsibility for operating and supporting approved educational programs which are necessary to meet the community's needs for nursing and paramedical personnel should be borne by the community. Where the community has not yet recognized and accepted this responsibility, the Medicare program does participate appropriately in the support of such approved programs as are operated by providers in conjunction with their patient care activities. 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 where the provider receives no, or disproportionately little, benefit for the amount it expends.

Also the Intermediary refers to HCFA Pub. 15-2 § 2807 (Exhibit I-16) which states in pertinent part:

> For cost reporting periods beginning on or after October 1, 1990, if you do not operate the program, the classroom portion of the costs are not allowable as pass-through costs and therefore not reported on lines 21 and 24 of the Form HCFA-2552-92. They may, however, be allowable as routine service operating costs...

Id.

The Intermediary further contends that BCA Administrative bulletin No. 834 (Exhibit 1-17) mandates that Medicare will not reimburse nursing education programs that are not under the control and on the premises of a provider. The Intermediary asserts that since the nursing program is now conducted at the colleges, it cannot allow the payments made by the Provider in support of this program to be reimbursed by Medicare as pass-through costs.

The Intermediary references two HCFA Administrator decisions reversing the Board in support of its case. Intermediary Exhibit I-18 contains the HCFA Administrator's Decision for Butler County Memorial Hospital v. Blue Cross Association, et al, PRRB Case Number 78-D7, April 7, 1978, which reversed the Board's decision. The HCFA Administrator held that the intermediary's

disallowance was proper as the provider was not entitled to reimbursement by Medicare for any payments it made to Butler County Community College in support of the nursing education program. The Intermediary contends that the facts in these cases are similar, if not exactly the same and the PRRB should follow the HCFA Administrator's ruling in the current appeal.

At the hearing, the Intermediary referred to the HCFA Administrator's decision in Northwest.[39] It is the Intermediary's position that the Administrator's decision in Northwest presents "a good history of the evolution on the issue [in this case] and the proper interpretation of what is now the controlling regulation, 413.85 (d) (6), that to be eligible for pass-through costs, the program must be the Provider's program."[40] The Intermediary contends that the Provider cannot stretch its relationship with the nursing school to make itself the operator of the program. The Intermediary also points out that in Northwest, one of the arguments was that the school itself was a provider. In the instant case however, the Intermediary asserts that the sponsor of the program is two universities. Id. The Intermediary believes that there is an insufficient nexus between the Provider's participation in the program to make it the operator of the program. Consequently, it is the Intermediary's position that including the Provider's costs identified as nursing education in normal operating costs (instead of pass-through costs) was the correct decision. Id. Therefore the Intermediary requests that the Board affirm its adjustment.

ISSUE 2: MEDICAL DIRECTOR PART A HOURS:

STATEMENT OF FACTS AND BACKGROUND:

The Provider contracts with various physicians to provide medical director services for various hospital departments.[41] Per their contracts with the Provider, the physicians are required to complete time studies in support of the time devoted to their respective medical director duties.[42] Time studies are requested by the Provider annually to support the Provider Part A Hours worked by each medical director.[43]

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39 Tr. at 11, 21-22.

40 Tr. at 21-22.

41 See Tr. Insert at 123-126. The original transcript of the October 12, 1999 hearing was not complete. The transcriber omitted text from the transcript beginning on Page 120, Line 13. Accordingly, an insert to the transcript was obtained by the Provider and forwarded to the Board and to counsel for the Intermediary on November 19, 1999. This portion of the transcript will be referred to as "Tr. Insert".

42 Id. at. 131.

43 Id. at 133.

The Provider sent a letter (Provider Exhibit 36) on May 23, 1994, to physicians serving as medical directors, requesting their completed time studies for fiscal year 1994. According to the Provider, it sends these letters to physicians, who are new to the time study process or are having difficulty completing the time studies, in an attempt to educate them regarding the time study process and what the physicians are required to do with respect to the time studies per their contracts with the Provider.[44] The language of the medical director agreements (Provider Exhibit 35) requires the physician contractors to prepare and maintain time records in accordance with the Provider's procedures for physician time records for submittal to the Provider in preparation of its Medicare cost report and any audit.[45] The medical director agreements also provide that the physician contractors are responsible for preparing time records in order to accurately identify the amount of time spent performing Part A services and to maintain such records sufficient to allow the Provider to verify the same in accordance with the Medicare rules and regulations.[46]

The Intermediary questioned the accuracy of the medical director time studies (Provider Exhibit 34) because they were not requested throughout the year but were requested on May 23, 1994.[47] Based upon the Provider's letter to physicians requesting the time studies near the end of its fiscal year, the Intermediary adjusted the Provider's cost report to remove Part A Hours for various medical directors from Worksheet A-8-2.[48] The Intermediary's position is that since the Provider did request time studies until the end of its fiscal year, adequate time records to document the Part A Hours allocated were not maintained throughout the year. Accordingly, the Intermediary contends that the Provider does not meet the Medicare regulations record-keeping requirements. The Intermediary indicated, however, that it would accept the time studies if comprehensive backup for each time study completed and submitted was provided.[49]

According to the Provider, it attempted to comply with the Intermediary's request. However, prior to the Intermediary's request for backup documentation, some of the physicians had relocated to other states and left the Provider's staff, making it extremely difficult to get further documentation from them. Consequently, only limited information was provided.[50]

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[44] Id. at 133-135.

[45] Id. at 135.

[46] Id.

[47] See Tr. Insert at 135, 140-144.

[48] Intermediary Position Paper at 7.

[49] Id. at 142-146.

[50] Id. at 144-146.

The Provider contests the Intermediary's adjustment because it believes that the time studies it submitted provided adequate support for the Part A hours allocated on its 1994 cost report. The Provider believes that the time studies submitted to the Intermediary are accurate and reliable. Additionally, the Provider believes that the time studies are auditable and verifiable and have been accepted for Medicare reimbursement purposes in prior cost years.[51] Further, it is the Provider's position that the Part A Hours that it submitted to the Intermediary in the time studies coincide with the Part A Hours which were submitted in the Provider's 1994 cost report and are comparable to allocations that the Provider has experienced in prior years.[52]

The Provider also submitted affidavits (Provider Exhibit 40) of the physicians who provided medical director services for the Provider. In the affidavits, the physicians document that they completed the time studies requested by the Provider using the schedules and calendars that they maintained throughout the year.[53]

PROVIDER'S CONTENTIONS- MEDICAL DIRECTOR PART A HOURS:

The Provider contends that the time studies submitted by it as documentation for the Part A hours allocated on its FYE June 30, 1994 Cost Report constitute adequate, accurate and reliable documentation under the Medicare rules and regulations. The Provider refers to the regulation at 42 C.F.R. §413.20(a) which requires that "providers maintain sufficient financial records and statistical data for proper determination of costs payable under the [Medicare] program." Id.

The Provider also refers to the regulation addressing the allocation of physician compensation costs. 42 C.F.R. 405.481 (b) (redesignated as 42 C.F.R. §415.60) and provides that:

> Except as provided in paragraph (d) of this section [i.e where a provider is claiming all physician compensation costs for services to the provider], each provider that incurs physician compensation costs must allocate those costs, in proportion to the percentage of total time that is spent in furnishing each category of services between:
>
> (1) Physician services to the provider (as described in §405.480);
> (2) Physician services to patients (as described in §405.550); and
> (3) Activities of the physician ... that are not reimbursable under either Part A or Part B of Medicare.

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[51] Id. at 148.

[52] See Tr. at 125.

[53] See Tr. Insert at 146-148.

The Provider contends that based on testimony provided at the hearing and evidence included in the record, it complied with the above referenced HCFA Manual provisions and regulations when it submitted time studies as support for the Part A hours allocations documented on Worksheet A-8-2. The Provider notes that the Provider Reimbursement Manual requires that the allocation must be supported by adequate documentation and must normally be comparable to previous allocations or to similar situations in comparable providers. The Provider asserts that here, the submitted time studies were completed and signed by the physicians as documentation for the hours they spent providing Part A services.[54] The Provider contends that the physicians also submitted affidavits certifying that they maintain calendars/schedules on a daily basis on which they document their time spent in their roles as medical directors, and that they use their calendars/schedules to complete quarterly time studies of their Part A hours.[55] Therefore, it is the Provider's position that based on the evidence entered into the record at the hearing, including the physicians' affidavits, the time studies constitute adequate, accurate and reliable documentation for the Part A hours allocated on the Provider's fiscal year 1994 cost report as required by the regulations and the Provider Reimbursement Manual.

The Provider notes that the requirements for maintaining sufficient records for physician allocations are further addressed in HCFA Pub. 15-1, § 2182.3E. Section 2182.3E(l) states that "while providers have some discretion as to the types of records they maintain as to the allocation of physicians' time to services, the allocations must be supported by adequate documentation and must normally be comparable to previous allocations or to similar situations in comparable providers." Id.

Based on the above program instruction, the Provider argues that the allocations here are comparable to previous allocations. The time studies received by the Provider for FYE June 30, 1994, from the various medical directors compare similarly to previous years' allocations, which makes the time allocation between Part A - Provider/Admin hours and Part B-Professional Services hours comparable and consistent with prior years.[56]

In addition, the Provider notes that the regulations at §405.481(g) state that "...each provider that claims payment for services of physicians under this subpart must:

(1) Maintain the time records or other information it used to allocate physician compensation in a form that permits the information to be validated by the intermediary or the carrier;

(2) Report the information on which the physician compensation allocation is based to the intermediary or carrier on an annual basis, and promptly

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54 See Tr. Insert at 137-141; Provider Exhibit 34.

55 Id. at 146-148; Provider Exhibit 40.

56 Tr. at 125.

notify the intermediary or carrier of any revisions to the compensation allocation; and

(3) Retain each physician compensation allocation, and the information on which it is based, for at least four years after the end of each cost reporting period to which the allocation applies." (Emphasis added.)

Id.

Here, the Provider asserts that it complied with the regulatory record-keeping requirements by maintaining its time studies in a fashion, which permits the information to be validated by the Intermediary. The Provider also asserts that it submitted the time studies, which provided the basis for the allocation, to the Intermediary on an annual basis.

In addition to satisfying the record-keeping requirements stated in the program instructions and regulations, the Provider contends that it also satisfies HCFA's standards on time studies. The Provider refers to a HCFA letter dated April 20, 1995 (Provider Exhibit 33) which clarified HCFA's position. The HCFA letter explains that the annual requirement is two time studies of 2 weeks duration.[57] Prior to this, the Provider contends that the Intermediary had always stated that four 2 week time studies were required. Consequently, the Provider conducted four 2 week time studies of its Medical Director hours for FYE 1994.[58] Therefore, it is the Provider's position that the time studies submitted exceed the requirements set forth in HCFA's policy statement.

The Provider contends that according to HCFA Pub. 15-1 § 2182.3E(4), the maintenance of daily logs or time records to support provider services rendered by physicians is not required. However, the Provider acknowledges that adequate documentation must be maintained to support the total hours for the services to permit application of the RCE limits.[59] The Provider contends that the physicians' logs and schedules constitute the adequate documentation required by the Medicare Program to support the total hours of provider services rendered by the physicians.

The Provider also points to HCFA Pub. 15-1 § 2182.3E(5) which provides that when a provider decides to employ time study techniques to substantiate the allocation of physicians' time services, the intermediary may not require the provider to utilize the specific methodology provided in HCFA Pub. 15-1 § 2313.2E. The Provider argues that the time at which it requests the studies from the physicians and submits them to the Intermediary constitutes part of its methodology and as such, cannot be dictated by the Intermediary.

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[57] See Tr. Insert at 131-132.

[58] Id. at 132-133.

[59] See Provider Exhibit 38 for examples of logs and schedules maintained by the physicians which they use to complete their time studies.

In this case, the Intermediary contends that because the timing of the Provider's request and collecting of the time study information occurred in the latter part of the year, the acquired information should be discarded.[60] However, the Provider asserts that the Intermediary was not able to provide a citation to any statute, regulation, or manual provision which mandates the time of year during which the time study information must be collected.[61] Thus, the Provider contends that there is no basis for the Intermediary to impose this requirement. This attempt by the Intermediary to dictate the methodology is inappropriate and contrary to the program instructions. The Provider contends that it should be able to utilize its own methodology in conducting its time studies.

The Provider also points out that at the hearing, the Intermediary agreed that because the submitted time studies covered all four quarters of the fiscal year, it is reasonable to conclude that at least some of the times studies were conducted very close in time to the date on which they were requested.[62]

In addition, the Provider rejects the Intermediary's contention that it was trying to maximize reimbursement by coaching the physicians on how many Part A hours should be reported in the quarterly time studies.[63] The Intermediary references a letter in which the Provider requested time studies from a particular physician to justify this charge.[64] The Provider contends that the referenced letter serves as nothing more than a reminder to the physician of the Provider's expectations under the contract. It is the Provider's position on this issue that the Intermediary's claim of an attempt to influence the physician compensation allocations is dubious because, as illustrated in Provider Exhibit 34, the physician in question had a Part A allocation for fiscal year 1994 comparable to the Part A allocation for previous years.

As a final point in its argument, the Provider notes that it has requested and received affidavits which document that the physicians provided accurate data for the allocation of Part A Hours. (Provider Exhibit 40). The affidavits from the physicians certify that they maintain a calendar/schedule on a daily basis on which they document their time spent in their roles as medical director for the Provider. These affidavits also certify that the physicians utilize these calendars/schedules to complete the quarterly time study of medical director hours that the Provider requests for purposes of preparing its annual cost report. Thus, the physician affidavits certify that the data provided in the time studies is accurate and sufficient to support the costs. The Provider contends that the Intermediary offered no evidence to refute the reliability of the physician affidavits, which support the time studies on which the Provider relies.

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60 Tr. at 140-144.

61 Id. at 147-148.

62 Id. at 150.

63 See Tr. at.140-141, 149-150.

64 See Intermediary Position Paper at 8.

INTERMEDIARY'S CONTENTIONS-MEDICAL DIRECTOR PART A HOURS:

It is the Intermediary's position that the adjustment to remove the Part A hours was made in accordance with Medicare regulations 42 C.F.R. § 413.20, Financial Data and Reports; § 413.24, Adequate Cost Data and Cost Finding, § 415.60, Allocation of Physician Compensation Costs and HCFA Pub.15-1, § 2108.1, Professional and Provider Components.

The Intermediary refers to 42 C.F.R. § 413.24(a) which states in part:

> [p]roviders receiving payment on the basis of reimbursable cost must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors.

Id. (Intermediary Exhibit I-2)

Based on the fact that the time studies were requested on May 23, 1994 for time spent from the time period July 1, 1993 through June 24, 1994, the Intermediary questions the accuracy of the time study data and contends that the Medical Director time studies were not maintained throughout the year.

The Intermediary points out that the key regulation on this issue is 42 C.F.R. § 415.60(g) (Intermediary Exhibit I-24), which states that the Provider must "maintain the time records or other information it used to allocate physician compensation in a form that permits the information to be validated by the intermediary or the carrier." The Intermediary contends that the Provider does not meet the recordkeeping requirements. The Intermediary also contends that the Provider's records are not adequately supported by actual auditable data accumulated by the Provider during the cost reporting period.

It is also the Intermediary's position that the Provider was trying to maximize reimbursement by dictating how many Part A hours should be reported on the quarterly time studies. For example, a letter requesting time studies from a physician, the Medical Director of the Neonatal-ICU, contained the following language, "in order to ensure all of the funds paid to you by Rapid City Regional Hospital are allowed for reimbursement purposes, approximately 415 annual hours or 16 hours per two weeks would be necessary. Because the Medicaid program utilizes the Medicare cost report to calculate the final reimbursement for our Neonatal Unit, retaining all costs charged to that unit is very important to the hospital's reimbursement from Medicaid as that unit still remains on a "cost reimbursement" system."

The Intermediary asserts that it found two significant problems during its audit. The first is a series of letters that the Provider sent to about half of the physicians in question and not until the very end of the fiscal year.[65] As noted above, the Intermediary was not only concerned with the timing of the letters,

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[65] Tr. at 26.

but with the suggestions offered by the Provider as to what the proper number of hours were to include in the report. Id.

Second, the Intermediary contends that the time studies are undated and that there is a significant variation between the time period that's covered on the form and the time period in which the physician is involved.[66] The Intermediary contends that a time report for the 1st quarter of the fiscal year was not signed until the last month of the fiscal year. Id.

The Intermediary contends that this gap affects the reliability of the time studies. Id. Further, the Intermediary asserts that the supporting documentation that the physicians used to reconstruct their work effort 6 months earlier was mostly nonexistent. Id. The Intermediary acknowledged at the hearing the there may have been a fairly good record compilation for one of the physicians, however, it contends that the physicians' calendars that were submitted by the Provider to support the time studies were de minimus. Id. It is the Intermediary's position on this point that the record was never supplemented to provide auditable documentation for what was recorded on the time studies. Id.

The Intermediary contends that the Provider was not able to furnish documentation to support that the Medical Directors maintained the time studies throughout the year; therefore, it is the Intermediary's position that the time studies are only estimates of actual Part A hours spent during the year.[67] The Intermediary requests that the Board affirm its adjustment.

CITATION OF LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS:

1. Law- 42 U.S.C.:

§ 1395(x)(v)(1)(A)	-	Reasonable Cost

2. Regulations- 42 C.F.R.:

§405.1835-.1841	-	Board Jurisdiction
§ 405.481 et seq. (redesignated as § 415.60)	-	Allocation of Physician Compensation Costs
§ 412.113 et seq.	-	Other Payments
§ 413.20(a)	-	Financial Data and Reports-General

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[66] Tr. at 27.

[67] Intermediary Position Paper at 8.

§ 413.24 et seq. - Adequate Cost Data and Cost Finding

§ 413.85 et seq. - Cost of Educational Activities

3. Provider Reimbursement Manual, Part 1, (HCFA Pub. 15-1):

§ 404.2 - Costs of Approved Nursing and Paramedical Education Programs

§ 2108.1 - Professional and Provider Components

§ 2807 - Prospective Payment System for Inpatient Hospital Capital-Related Costs

§ 2182.3E et seq. - Allocation of Physician Compensation-Provider Record Keeping Requirements

§ 2313.2E - Special Allocations-Periodic Time Studies

4. Cases:

Barberton Citizens Hospital v. Blue Cross and Blue Shield Association /Community Mutual Insurance Company, PRRB Dec.No.94-D61, July 28, 1994, HCFA Admin. Decl. Rev., Medicare & Medicaid Guide (CCH) ¶ 42,587, (1994).

Butler County Memorial Hospital v. Blue Cross Association, et al , PRRB Case No. 78-D7, rev'd HCFA Admin., April 7, 1978.

Butler County Memorial Hospital v. Califano, U.S. District Court, Western District of Pennsylvania, No. 78-652-C,October 17,1979, Medicare & Medicaid Guide (CCH) ¶ 30,048, (1979).

Cleveland Memorial Hospital, Inc. v. Califano (1980 Transfer Binder ¶30,487).

Community Hospital of Indianapolis Inc. v. Califano (1979-2 Transfer Binder ¶29,999).

Los Alamitos General Hospital, Inc. v. Donnelly, 558 F.Supp. 1141 (1983).

Northwest Medical Center v. Blue Cross and Blue Shield Association of Arkansas, PRRB Dec. No. 99-D55, June 30, 1999, Medicare & Medicaid Guide (CCH) ¶80,326, Rev'd HCFA Administrator, August 31, 1999, Medicare & Medicaid Guide (CCH) ¶80,336.

St. Ann's Hospital v. Blue Cross and Blue Shield Association/Community Mutual Insurance Company, PRRB Dec.No. 93-D61, July 21, 1993, Medicare & Medicaid Guide (CCH) ¶ 41,616, (1993).

5. Other:

BCA Administartive Bulletin No. 834; Reimbursement of Nursing Education Costs in the Medicare Program, December 30, 1974.

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND DISCUSSION:

ISSUE 1: JOINT EDUCATION PROGRAM:

The Board, after consideration of the facts, parties' contentions, evidence presented, testimony elicited at the hearing, and the Provider's posthearing brief, finds and concludes that the Provider appropriately included in a pass-through cost center the costs associated with the building and maintenance of the building that the Provider provides for the Joint Education Program pursuant to its agreement with the South Dakota Board of Regents. The Board finds that the inclusion of these costs as a pass-through medical education cost under PPS is consistent with the existing Medicare regulations. The regulation at 42 C.F.R. § 412.113(b)(1) specifically allows for the payment on a pass-through basis of medical education costs for approved education activities of nurses and paramedical health professionals as described in 42 C.F.R. § 413.85. The regulations at 42 C.F.R. § 413.85 set forth the applicable principles for reimbursing the reasonable costs of educational activities under the Medicare program, and explicitly define the types of approved educational activities that are within the scope of these reimbursement principles. The Board interprets the prerequisite established under 42 C.F.R. § 412.113(b)(1) to mean that, if a provider can substantiate that its medical education activities meet the conditions set forth in 42 C.F.R. § 413.85, then the costs associated with such activities will systematically flow through the Medicare program's reimbursement process as an allowed PPS pass-through cost.

The Board finds that the Provider operated a hospital based nursing education program from 1972 to 1989. The Board also finds that in 1989, the Provider entered into an agreement with the South Dakota Board of Regents to phase out its program during the following 3 years in favor of a more cost effective arrangement with two South Dakota universities. Further, the Board finds that the Provider claimed significantly less Medicare reimbursement for the education program under the new arrangement than under the old arrangement.

The Board also finds that the Provider's program was approved by the State Board of Nursing and accredited by the National League for Nursing. In addition, the Board finds that there were two parties that were engaged in and jointly operating the education program. The two parties being the South Dakota Board of Regents (University of South Dakota and South Dakota State University) and the Provider. The Board notes that the Provider was the progenitor of the nursing education program in question, and the cost-effective consortia of the Provider and the South Dakaota Board of Regents enhanced both the quality and availability of personnel for Medicare and non-Medicare patients alike, at the Provider's facility. The Board also notes that the program in question has a direct impact on the quality of care as it supplied a critical nursing staff.

Based on its examination of the facts and evidence presented in this case, the Board concludes that the Provider has an appropriate and approved nursing education program as defined by 42 C.F.R. § 413.85(b). The Board further concludes that the Provider's program is a formally organized or planned program of study that is usually engaged in by providers in order to enhance the quality of patient care in an institution within the meaning of 42 C.F.R. § 413.85(b). The Board notes that there is no prohibition against jointly operating a program in either the regulations or the program instructions.

Addressing the Intermediary's main argument that the costs of the program were unallowable because the Provider was not the legal operator of the education program,[68] the Board finds nothing in the statute, regulations or program instructions requiring the Provider to be the "legal operator" of the program.

The Board concludes that the Provider has satisfied the regulations that it was engaged in a joint operation of an approved education program. The Board also concludes that the above uncontroverted facts, as well as other facts in the record, clearly demonstrate that the Provider did operate, to a significant extent, the nursing education program. This opinion is consistent with the logic presented in the Circuit Court's decision in the St. John's Hickey wherein the court found that the joint operation of a nursing program by a provider and university satisfied the regulatory operational requirement. In addition, the Board's ruling in this case is in accord with prior Board decisions on this issue under facts substantially similar to those found here.[69] With the approved programs recognized as

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[68] Intermediary Position Paper at 16.

[69] Northwest Medical Center v. Blue Cross and Blue Shield Association of Arkansas, PRRB Dec. No. 99-D55, June 30, 1999, Medicare & Medicaid Guide (CCH) ¶80,326, rev'd HCFA Administrator, August 31, 1999, Medicare & Medicaid Guide (CCH) ¶80,336, St. Mary's Medical Center Duluth, Minnesota v. Blue Cross and Blue Shield Association/Blue Cross and BlueShield of Minnesota, PRRB Dec.No. 97-D82, July 15, 1997, HCFA Admin. Decl. Rev.., Medicare & Medicaid Guide (CCH)¶ 45,503, (1997), Barberton Citizens Hospital v. Blue Cross and Blue Shield Association /Community Mutual Insurance Company, PRRB Dec.No.94-D61, July 28, 1994, HCFA Admin. Decl. Rev., Medicare & Medicaid Guide (CCH) ¶ 42,587, (1994).

an allowable cost, the mechanical process set forth in 42 C.F.R. § 412.113 allows for the reimbursement of approved medical education activities as pass-through costs.

Regarding the Intermediary's reference to 42 C.F.R. § 413.85(c) that costs should not be increased as a result of redistributiion of costs from educational institutions, as noted above, the Board found that the costs are significantly lower under the new arrangement with the Board of Regents than they would have been by operating a free standing nursing education program.

ISSUE 2: MEDICAL DIRECTOR PART A HOURS:

The Board, after consideration of the facts, parties' contentions, evidence presented, testimony elicited at the hearing, and the Provider's posthearing brief, finds and concludes the time studies submitted by the Provider as documentation for the Part A Hours allocated on its FYE June 30, 1994 cost report constitute adequate, accurate and reliable documentation under the Medicare rules and regulations.

The Board finds that the issue in this case is primarily one of documentation. The Board also finds that that Provider submitted physician affidavits to the Intermediary certifying that the data provided in the FYE June 30, 1994 times studies is accurate. The Board notes that the affidavits from the physicians further certify that they maintained a calendar/schedule on a daily basis on which they document their time spent in their roles as medical directors for the Provider. These affidavits also certify that the physicians utilize these calendars/schedules to complete the quarterly time studies of medical director hours that the Provider requests for purposes of preparing its annual cost report. Additionally, the Board finds that the Provider had contracts for services with the medical directors in question and with minor exceptions, the summary sheets submitted by these physicians were signed, dated and covered the appropriate period. The Board also finds that the Provider used the time studies as source documents for completing the HCFA 339.[70] The Board also notes that these physicians worked in exempt units. Consequently, the Board concludes that the physician affidavits are adequate and sufficient to support the accuracy of the submitted time studies.

The Board finds no evidence in the record or testimony at the hearing to indicate that the Intermediary reviewed or audited the time studies. Regarding the Intermediary's argument that the lateness with which the Provider sent out a letter to request time study data invalidated the data, the Board believes that the Intermediary choose to view this letter in a negative context. The Board, however, believes that the letter could be viewed in a positive context, in that it reminded the physicians, especially new ones, of their contractural obligations with respect to keeping track of their time.

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[70] Tr. at 129-130.

DECISION AND ORDER:

ISSUE 1:JOINT EDUCATION PROGRAM:

The Provider has an appropriate approved nursing program as defined by 42 C.F.R. § 413.85. The Provider's treatment of its nursing program costs as Medicare pass-though costs under PPS is correct. The Intermediary's adjustment is reversed

ISSUE 2: MEDICAL DIRECTOR PART A HOURS:

The times studies, in conjunction with the physician affidavits, submitted by the Provider in support of its FYE June 30, 1994, Part A Hours allocation constitute adequate, accurate and reliable documentation. The Provider's Part A Hours allocation is correct. The Intermediary's adjustment is reversed.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esquire
Martin W. Hoover, Jr. , Esquire
Charles R. Barker

Date of Decision: March 24, 2000

FOR THE RECORD

Irvin W. Kues
Chairman