PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
98-D19

PROVIDER -
Glendale Adventist Medical Center
Glendale, California

Provider No. 05-0239

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Blue Cross of California

DATE OF HEARING-
December 10, 1997

Cost Reporting Period Ended -
December 31, 1984

CASE NO. 91-2800M

INDEX

ISSUE:

1. Was the retroactive audit of Graduate Medical Education ("GME") costs proper?

2. Was the Intermediary's determination classifying malpractice insurance costs as administrative and general costs rather than direct GME costs proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Glendale Adventist Medical Center ("Provider") is a 463 bed acute care hospital located in Glendale, California.[1] The Provider also operates a psychiatric unit and a rehabilitation unit.[2]

On July 29, 1985, the Provider filed its Medicare cost report for the calendar year ended December 31, 1984.[3] Blue Cross of California ("Intermediary") audited the Provider's records in support of the costs and statistics shown in the cost report, and issued a Tentative Settlement on September 16, 1986.[4] The Tentative Settlement advised the Provider that the Health Care Financing Administration ("HCFA") had directed intermediaries not to issue final settlements for Medicare cost reports affected by new reimbursement rules pertaining to malpractice insurance costs, pending further instructions.[5]

On August 12, 1988, the Intermediary issued a Notice of Program Reimbursement ("NPR") for the subject cost reporting period, effectuating final settlement. The NPR advised the Provider that the amount and reason for each audit adjustment, including reference to applicable rules and regulations, were stated in the "Adjustment Report" that was part of the September 16, 1986, Tentative Settlement.[6]

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1 Provider's Position Paper Hearing on the Record at 2.

2 Intermediary's Position Paper at 1.

3 Stipulation of Facts at Exhibit 8.

4 Stipulation of Facts at Exhibit 7.

5 Id.

6 Stipulation of Facts at Exhibit 8.

On September 2, 1988, the Intermediary reopened the subject cost report in order make some corrections to the final settlement.[7] A Revised NPR reflecting the corrections was issued on December 27, 1988.[8]

On January 22, 1990, the Intermediary again reopened the Provider's cost report. This reopening, however, was made specifically to initiate a re-audit of the Provider's GME costs and statistics in order to determine the Provider's average per resident amount ("APRA") pursuant to Section 9202 of the Omnibus Budget Reconciliation Act of 1985 and Medicare regulations 42 C.F.R. § 413.86.[9] On February 27, 1991, the Intermediary sent the Provider its Notice of Average Per Resident Amount ("NAPRA"). In Part, the NAPRA reflected an adjustment made by the Intermediary reclassifying malpractice insurance costs from the intern and resident cost center to the administrative and general cost center. The effects of the re-audit and ensuing adjustment for malpractice insurance cost was a decrease in the Provider's APRA.[10]

On August 23, 1991, the Provider appealed the re-audit of its GME costs and statistics and the reclassification of malpractice insurance costs to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. § 405.1835-.1841, and has met the jurisdictional requirements of those regulations.[11] The estimated amount of Medicare reimbursement in controversy is $878,436.[12]

The Provider was represented by David L. Volk, Esquire, of Sonnenschein Nath & Rosenthal. The Provider was represented by Bernard M. Talbert, Esquire, Associate Counsel, Blue Cross and Blue Shield Association.

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7 Stipulation of Facts at Exhibit 9.

8 Stipulation of Facts at Exhibit 10.

9 Stipulation of Facts at 5 and Exhibit 13.

10 Stipulation of Facts at Exhibit 11.

11 Stipulation of Facts at 5 and Exhibit 12.

12 The Board notes that the amount in controversy affects the calculation of the APRA which, in turn, affects Medicare program payments in all subsequent cost reporting periods. Also, approximately $134,000 of the total Amount in Controversy is attributable to Issue 2, malpractice insurance. See Intermediary Position Paper at 2.

Issue 1 -- Re-Audit of GME Costs

PROVIDER'S CONTENTIONS:

The Provider contends that the Tentative Settlement issued by the Intermediary must be treated as an NPR or a final settlement of its cost report. Therefore, the re-audit of its GME base period costs is improper because the Intermediary reopened the subject cost report more than three years after the date of a "final determination" in violation of 42 C.F.R. § 405.1885.[13]

The Provider argues that use of the "Tentative Settlement" as other than an NPR in order to indefinitely keep GME base period costs open violates Medicare principles calling for finality of cost reports.[14] Medicare regulation 42 C.F.R. § 405.1803(a) explains that intermediaries must issue NPRs within a "reasonable period of time" after receipt of a cost report. The Department of Health and Human Services' policies recognize that more than one year is unreasonable. See Mt. Diablo Hospital District v. Bowen, 860 F.2d 951, 953 (9th Cir. 1988);[15] Woodruff Community Hospital v. Sullivan, 1992 WL 133087, pp. 1-2 (C.D. Cal. 1997) ("Woodruff Community Hospital.").[16] In the instant case, by use of the so-called "Tentative Settlement", the Intermediary waited more than four years after the subject cost report was filed to issue a document denominated as an NPR.

Also, the Provider argues that the Intermediary had no valid authority to issue a Tentative Settlement in lieu of an NPR.[17] The purported explanation for issuance of the Tentative Settlement, that HCFA "instructed" the intermediaries to withhold final settlements, is not a valid reason. Under the Administrative Procedure Act ("APA"), proposed substantive agency rules must be published for review and public comment before they are implemented. 5 U.S.C.
§ 553(b), (c). In the instant case, the "instruction" issued by HCFA is a substantive rule because it is a change in existing policy and removes a previously existing right. See Linoz v.

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13 Provider's Position Paper Hearing on the Record at 12.

14 Id.

15 Provider's Appendix of Authorities at 4.

16 Provider's Appendix of Authorities at 9.

17 Provider's Position Paper Hearing on the Record at 13.

Heckler, 800 F.2d 871, 877 (9th Cir. 1986).[18] That is, the "instruction" conflicts with the right of the Provider to a final determination regarding its cost reports on a timely basis after filing such reports. 42 U.S.C. § 1395oo(a)(1)(B).

The Provider argues that if the Tentative Settlement is not treated as an NPR it can be prejudiced with respect to the malpractice insurance issue in this appeal.[19] Specifically, the Provider asserts that the Intermediary may argue that insufficient documentation exists to support its position regarding its malpractice insurance claim. However, the Intermediary should be estopped from making these arguments because the delayed NPR was issued after the required date for retaining records pertaining to physicians' compensation. 42 C.F.R. § 405.481(g)(3). See also Toledo Hospital v. Shalala, 104 F.3d 791, 793 (6th Cir. 1997) ("Toledo").[20]

The Provider adds that the four year delay in issuing an NPR is "arbitrary and capricious" pursuant to the APA, 5 U.S.C. § 706, See Woodruff Community Hospital, at pp. 6-9, and that the Tentative Settlement, in the instant case, is materially no different from an NPR, i.e., it furnishes notice of the Intermediary's determination of the total amount of reimbursement due the provider. 42 C.F.R. § 405.1803(a).

Finally, the Provider contends that HCFA's re-audit regulations are inconsistent with the statutory authority upon which they are based. 42 U.S.C. § 1395ww(h)(2)(A). Therefore, the regulations are invalid and the Intermediary's re-audit of the Provider's GME base period costs was improper.[21]

The United States Supreme Court has taken up this issue for consideration in its October 1997 term. Specifically, the question before the court is as follows:

> [w]hether a provision (42 U.S.C. § 1395ww(h)(2)(A)) in 1986 legislation establishing a new Medicare payment methodology for graduate medical education ("GME") costs, which directs the Secretary of Health and Human Services ("the Secretary") to "determine," for a hospital's 1984 cost reporting year, "the average amount [of the hospital's GME costs] recognized as reasonable under this subchapter . . . for each full-time-equivalent resident," requires the Secretary to determine the average using the actual, final "amount recognized as reasonable under this subchapter" for 1984 or whether it

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18 Provider's Appendix of Authorities at 3.

19 Provider's Position Paper Hearing on the Record at 14.

20 Provider's Appendix of Authorities at 7.

21 Provider's Position Paper Hearing on the Record at 15.

> authorizes the Secretary to determine the average by re-auditing and redetermining the amount of GME costs for 1984 after the reopening and record retention periods for 1984 have expired.

St. Paul-Ramsey Medical Center v. Shalala, 91 F.3d 57 (8th. Cir. 1996), cert. granted, No. 96-1375 (1997) ("St Paul-Ramsey").[22]

The Provider asserts that the view that the re-audit regulations are unreasonable and contrary to statutory intent has been adopted in Toledo. In that case, the Court applied the two-step test found in Chevron v. Natural Resources Defense Council, Inc., 467 U.S. 1588 (1994) ("Chevron").[23] Under the Chevron test, the court assesses the statutory intent of Congress. If the statute unambiguously and clearly addresses the precise issue, then the inquiry ends, and the court applies principles of statutory interpretation to determine Congress' intent. If not, then the second step is for the court to determine whether the agency's regulatory answer is based on a permissible construction of the statute.

The Provider asserts that the court in Toledo found no ambiguity in 42 U.S.C. § 1395ww(h)(2), which prohibits the Secretary's re-audit regulations, especially in light of the fact that there existed a mechanism and regulatory scheme in place for the assessment of GME base year costs when the statute was passed. The court found that the Secretary was without authority to issue the re-audit regulations, and that she should have used the 1984 base year figure to calculate the APRA, "or informed Congress of the need for further legislation." The court also found that Congress did not allow the Secretary to re-audit the base year costs that were determined with finality.

Moreover, under the second Chevron test, the court held that the re-audit regulations are an unreasonable interpretation of the GME amendment. Specifically, the more than three year delay by the Secretary in promulgating GME regulations was found unreasonable. This is especially true because there was no notice by the Secretary that records would have to be kept beyond the four year retention period applicable to physicians' compensation.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its re-audit of the Provider's GME base period cost report was proper.[24]

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22 Provider's Appendix of Authorities at 6.

23 Provider's Appendix of Authorities at 1.

24 Intermediary's Position Paper at 4.

The Intermediary explains that the Board lacks authority to decide the validity of referenced program laws, regulations and instructions, pursuant to 42 U.S.C. § 1395oo, 42 C.F.R 405.1867 and HCFA Pub. 15-1 § 2924.6. In this regard, the Intermediary asserts that its determination was made in accordance with laws, regulations, and instructions applicable to the subject issue.

Specifically, the reopening of the GME base period cost report for the purpose of determining the Provider's APRA was made in accordance with 42 C.F.R 413.86(e)(1)(iii); no "consistency rule" (that is, the consistency of the treatment of costs between the prospective payment system ("PPS") base year and PPS transition periods) was broken since the provisions regarding the new GME payment basis prevailed over the old basis that was formerly shown in 42 C.F.R 405.421 (redesignated as 42 C.F.R 413.85); and, the provisions of 42 C.F.R 413.86 (including conforming changes in the existing related regulations and instructions) are valid and in accordance with the statutory intent.

The Intermediary contends that its position is affirmed by the decision of the United States Court of Appeals for the District of Columbia Circuit in Administrators of the Tulane Educational Fund d/b/a Tulane Medical Center v. Shalala, 987 F.2d 790 (D. C. Cir.1993), cert. denied 114 S.Ct. 740 (1994), reversing Methodist Hospitals of Memphis v. Sullivan, 799 F. Supp. 1210 (D.D.C. 1992), and several other cases.[25]

Furthermore, the Intermediary asserts that:

- Congress did not intend to reimburse the Provider on the basis of misclassified or nonallowable costs, or preclude or prohibit the Secretary from performing a corrective re-audit of the GME base period costs.

- The Secretary mandated 42 C.F.R 413.86 (including conforming changes in the existing related program regulations and instructions) on the basis of a permissible construction of the Omnibus Budget Reconciliation Act ("OBRA") of 1985 (Public Law 99-272), Section 9314 of OBRA 1986 (Public Law 99-509), and 42 U.S. C. §§ 1395ww(h) and 1395x(v).

- Congress was aware that the 3 year reopening period for the GME base period cost report may have elapsed before the governing regulations were implemented. Therefore, it is implied that Congress did not intend to preclude or prohibit the Secretary from re-auditing the GME base period cost report for past errors.

- The re-audit of GME base period costs was a result of the Secretary's reasonable interpretation of the referenced program and public laws. That is, Congress did not

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[25] Provider's Appendix of Authorities at 8. See Intermediary's Position Paper at 5 for other cases cited in support of Intermediary's position.

intend to include any misclassified and nonallowable costs in the GME base period amount.

- The Secretary established the provision to re-audit the GME base period costs through 42 C.F.R 413.86, since the referenced Medicare program laws did not include a basis for correcting erroneously allowed misclassified and nonallowable GME related costs.

- The time gap between the enactment and promulgation of the GME related amendments in the referenced Medicare program laws was not an unreasonable period for developing, proposing or permitting comments and finalizing a regulatory framework for a complex statutory scheme. Thus, even though the 3 year reopening period for the GME base period cost report may have already elapsed, the re-audit of this cost report is still a reasonable requirement.
- The re-audit of the GME base period costs for errors (even if such costs were previously found to be reasonable or allowable) would ensure that a correct or accurate base period formula will be used for future GME payments.

- The provision to re-audit the GME base period costs is neither an exercise in retroactive rule making nor impermissible. Except in the situations identified in 42 C.F.R 413.86(e)(1)(iv) and (j)(1), the process carries no impact in the actual settlement of the GME base period cost report, PPS base period cost report or any PPS transition periods. The result of the re-audit is only intended to be used to calculate future GME payments.

- The statutes, by their own silent terms, have some retroactive effect. For example, over nine months had elapsed (that is, after the beginning of the first cost reporting period to which the new GME payment methodology is to apply) when Congress enacted the new GME payment methodology in April, 1986.

- With the advent of the new GME payment methodology, Congress deliberately foreclosed the possibility of reimbursing direct medical education costs based on the previous payment methodology for cost reporting periods beginning on or after July 1, 1985. Thus, given the language of Medicare program laws and the Secretary's lack of legal authority to settle these cost reports based on the previous payment methodology, Congress clearly intended a retroactive application of the new payment methodology.

Issue 2 -- Malpractice Insurance

PROVIDER'S CONTENTIONS:

The Provider contends that the cost of malpractice insurance attributable to interns and residents is a direct GME cost. Therefore, the Intermediary's adjustment reclassifying malpractice insurance costs out of the intern and resident cost center and into the

administrative and general cost center is improper.[26]

The Provider contends that its reclassification of malpractice insurance costs to GME complies with guidelines issued by HCFA.[27] In a memorandum dated February 12, 1990, issued to all HCFA regional offices and Medicare intermediaries, HCFA stated:

> . . . if the provider purchases a policy for personal/professional malpractice coverage of the I&Rs[28] in addition to the blanket malpractice policy which covers all employees (including I&Rs), the cost of this additional personal malpractice insurance may be treated as a fringe benefit. As such, it would not be subject to the Worksheet D-8 apportionment. . . . Also, to be allowable, this fringe benefit must be reasonable, and when applicable, be reported to the IRS for tax purposes. (See PRM, § 2144.)

HCFA Memorandum, BPO-F12, February 12, 1990.[29]

With respect to these guidelines, the Provider explains that it had two insurance policies during the subject cost reporting period.[30] The first policy, which was obtained by the General Conference of Seventh-Day Adventists, and included the Provider, covered the period from June 1, 1983 to June 30, 1984. The Provider asserts that this policy specifically covered interns and residents.[31] Therefore, the Provider maintains that separate coverage was provided under a commercial policy for the professional liability of each intern and resident. The Provider adds that each intern and resident was sent a letter describing the Provider's commercial insurance policy, including the premium for each person based upon their speciality and-or subspeciality.[32]
The second policy, which covered the period beginning July, 1, 1984, through the end of the

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[26] Provider's Position Paper Hearing on the Record at 17.

[27] Id.

[28] "I&R"- acronym for intern and resident.

[29] Stipulation of Facts at Exhibit 14 at 15. Note-the information conveyed in this quoted language was included in a set of Questions and Answers issued by HCFA on November 8, 1990, to assist in the completion of the GME base period audits. See Stipulation of Facts at Exhibit 15 at Question 21.

[30] Provider's Position Paper Hearing on the Record at 6.

[31] Id. Stipulation of Facts at Exhibit 1 at Endorsements 10 and 11.

[32] See examples of letters to covered interns and residents at Stipulation of Facts at Exhibit 2.

subject cost reporting period, was obtained from a trust established by Adventist Health System United States. The Provider explains that in order to receive coverage it was required to make contributions to the trust. The contribution amount included a component reflecting coverage for interns and residents, and the cost of coverage was determined by multiplying the number of interns and residents the Provider employed times a specific rate factor. In effect, Coverage A provided general liability coverage for most of the Provider's employees, and Coverage B provided professional liability coverage for certain employees including teaching physicians and interns and residents.[33]

The Provider contends that its compliance with HCFA's guidelines is supported by the Board's analysis in Pacific Hospital of Long Beach v. Ætna Life Insurance Co., PRRB Dec. 97-D73, June 25, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,465, declined rev. HCFA Admin., August 4, 1997 ("Pacific Hospital"),[34] and Harrisburg Hospital v. Blue Cross and Blue Shield Association/ Blue Cross of Western Pennsylvania, PRRB Dec. No. 96-D9, February 15, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,058, rev'd. HCFA Admin., April 18, 1996 ("Harrisburg Hospital").[35]

In Pacific Hospital, the Provider purchased additional malpractice insurance as a fringe benefit for its interns and residents. The intermediary reclassified these costs from the intern and resident cost center to the malpractice insurance cost center. The Board determined that the Provider's evidence adequately supported the direct assignment of professional malpractice liability insurance to the intern and resident cost center even though the intermediary argued that the policies were not produced. The Board further determined that such malpractice insurance costs were paid as employee fringe benefits pursuant to Provider Reimbursement Manual, Part I ("HCFA Pub.
15-1") § 2144.1, and stated "[a]s an allowable employee fringe benefit, these costs were properly assigned to the interns and residents cost center and should be included in the Provider's GME cost pursuant to 42 U.S.C. § 1395 ww(h) and 42 C.F.R. § 413.86." Thus, the intermediary's reclassification was reversed.

In Harrisburg Hospital, the provider purchased a single insurance policy which covered various liabilities. Coverage D provided professional liability coverage for physicians and residents, while Coverage C provided coverage for all other hospital employees. The provider assigned the cost of the malpractice insurance for its residents to the administrative and general cost center, but asked the intermediary to reclassify the costs back to the GME cost center pursuant to 42 C.F.R.

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[33] See Stipulation of Facts at Exhibit 4 at C-30 and C-38, respectively.

[34] Provider's Appendix of Authorities at 5.

[35] Provider's Position Paper Hearing on the Record at 18-19. Provider's Appendix of Authorities at 2.

§ 413.86(j)(2). The intermediary refused because the Provider failed to provide required documentation within a 180 day period provided by 42 C.F.R. § 413.86(j)(2), and because the provider failed to satisfy the requirements provided for in HCFA's February 12, 1990 memorandum. The Board, however, held that the hospital satisfied the requirements provided for in both 42 C.F.R. § 413.86(j)(2) as well as HCFA's guidelines. As the intermediary had not determined the reasonableness of the malpractice premiums, the Board reversed the intermediary's adjustment, but directed the intermediary to review the costs for reasonableness and correctness.

The HCFA Administrator overturned the Board's decision because the hospital did not satisfy the documentation requirement provided for in 42 C.F.R. § 413.86(j)(2). Here, that issue is not relevant because, like Pacific Hospital, adequate proof of insurance has been presented. Moreover, in Harrisburg Hospital, the Administrator did not question the Board's conclusion that the hospital had complied with the provisions of HCFA's memorandum, which authorizes the direct costing of malpractice insurance to the intern and resident cost center.

Accordingly, the Provider relies on the Board's prior analyses of the subject issue. First, in Harrisburg Hospital, the Board held that a hospital was not required to purchase a separate insurance policy for its interns and residents in order for the costs to be charged directly to GME. To the extent separate coverage and premiums for residents can be identified, the costs may be directly assigned.[36]

The provider in Harrisburg Hospital satisfied this requirement because its regular employees received malpractice insurance coverage under Coverage C, and its physicians and residents received such coverage under Coverage D. With respect to the instant case, the Provider is also able to identify the malpractice insurance costs directly attributable to GME. First, with regard to the private insurance policy, there exists a separate endorsement for physicians and residents. There is a specific calculation of the premiums. Stipulation of Facts at Exhibit 5 at Attachment 3. Furthermore, the interns and residents were sent letters identifying the amount of premiums paid for the malpractice insurance that covered them individually.

The trust insurance in the instant case also contains separate coverage for interns and residents. Coverage A provides general liability coverage for the hospital's employees. Coverage B provides professional liability coverage for certain employees including teaching physicians and interns and residents. The Provider presents a schedule which shows the total amount of money it was required to contribute to the trust, and the total amount attributable to interns and residents.[37]

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[36] Provider's Position Paper Hearing on the Record at 22.

[37] Stipulation of Facts at Exhibit 5.

Regarding the second requirement of HCFA's February 12, 1990 memorandum, that the malpractice insurance costs applicable to interns and residents be "reasonable", the Provider explains that it does not know whether or not the Intermediary addressed this matter in its audits. However, the Provider contends that the rates it paid were the result of an extensive review and analysis that it performed in conjunction with representatives of its home office, and that the rates are consistent with the quality and price available for like providers.[38]

Regarding the third and final requirement of HCFA's memorandum, the Provider contends that the malpractice insurance costs at issue need not be reported to the Internal Revenue Service ("IRS").[39] As stated in HCFA's memorandum, such costs must be reported to the IRS as a fringe benefit only "when applicable". As the Board stated in Harrisburg Hospital:

> [t]he Board rejects the Intermediary's contention that the Provider should have reported the premiums to IRS as a fringe benefit. Malpractice insurance is a necessary prerequisite for the resident in performance of required duties. Because of this constraint, the Board finds that IRS reporting is not applicable under HCFA Pub. 15-1 Section 2144."

Harrisburg Hospital, Medicare & Medicaid Guide (CCH) ¶ 44,058 at 48111.

Having found that IRS reporting is not applicable, the Board's conclusion is not inconsistent with the HCFA memorandum.

Finally, the Provider contends that the classification of malpractice insurance costs applicable to interns and residents as direct GME costs is consistent with Medicare's principles of reimbursement and the intent of Congress.[40] Medicare's reimbursement principles call for a matching of costs with the cost centers that benefit from them. Similarly, Congress' intent in enacting section 1886(h) of the Social Security Act, calling for GME payments based upon an average per resident amount, supports placement of the subject malpractice insurance costs as direct GME costs rather than an administrative and general cost. As the Board stated in Pacific Hospital," this treatment of the malpractice costs at issue is the most accurate and equitable determination of costs for services rendered to Medicare program beneficiaries, and is consistent with the reimbursement principles established under 42 U.S.C.§ 1395x(v)(1)(A) and 42 C.F.R.
§ 413.5."

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38 Provider's Position Paper Hearing on the Record at 24.

39 Id.

40 Provider's Position Paper Hearing on the Record at 21.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its adjustment reclassifying malpractice insurance costs from the intern and resident cost center to the administrative and general cost center is proper.[41]

The Provider claimed malpractice costs of $620,302 as direct GME costs by reclassifying this amount from the malpractice premiums and paid losses cost center to the intern and resident cost center in its as-filed cost report. The Intermediary asserts, however, that these costs relate to a general malpractice insurance policy which covers the actions of all of the Provider's employees including the interns and residents, as opposed to a policy which is specifically for the personal/professional malpractice coverage of interns and residents.[42]

Accordingly, the Intermediary contends that its adjustment reclassifying these costs back to the administrative and general cost center is properly based upon the instructions contained in the answer to question number 21 of the GME "Questions and Answers" issued by HCFA on November 8,1990.[43] In part, these instructions explain that costs associated with general malpractice insurance policies that are not directly apportioned to Medicare under the 1979 malpractice rule are included in the administrative and general cost center and apportioned to the intern and resident cost center through the step-down process.

The Intermediary also contends that the Provider's circumstances do not warrant a reclassification of the subject malpractice costs as direct GME costs. Of the various situations described in the aforementioned question number 21, the malpractice costs at issue could only be considered direct GME costs if they qualify as a fringe benefit or compensation to the interns and residents, and that direct costing is made in accordance with HCFA Pub. 15-1 § 2307. The Provider, however, did not furnish sufficient information and documentation, or support its contentions, pursuant to 42 C.F.R 413.20, Financial Data and Reports, and 42 C.F.R. § 413.24 and HCFA Pub. 15-1
§ 2300ff, Adequate Cost data and Cost Finding. Therefore, the Intermediary asserts there is no basis to revise its adjustment or determination.[44]

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41 Intermediary's Position Paper at 8.

42 Id.

43 Stipulation of Facts at Exhibit 15 at 16.

44 Intermediary's Position Paper at 11.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§ 1395x(v)	-	Reasonable Cost
§ 1395oo	-	Provider Reimbursement Review Board
§ 1395ww(h)	-	Direct Medical Education Costs
5 U.S.C.	-	Administrative Procedure Act

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

§ 405.481	-	Allocation of Physician Compensation Costs
§ 405 Subpart R (405.1801 et. seq.)	-	Provider Reimbursement Determinations and Appeals
§ 413.24	-	Adequate Cost Data and Cost Finding
§ 413.5	-	Apportionment of Allowable Costs
§ 413.85	-	Cost of Educational Activities
§ 413.86	-	Direct Graduate Medical Education Payments

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

§ 2144.1	-	Fringe Benefits-Definition
§ 2307	-	Direct Assignment of General Service Costs
§ 2924.6	-	Scope of Board's Authority

4. Case Law:

Mt. Diablo Hospital District v. Bowen, 860 F.2d 951, 953 (9th Cir. 1988).

Woodruff Community Hospital v. Sullivan, 1992 WL 133087, pp. 1-2 (C.D. Cal. 1997).

Linoz v. Heckler, 800 F.2d 871, 877 (9th Cir. 1986).

Toledo Hospital v. Shalala, 104 F.3d 791, 793 (6th Cir. 1997).

St. Paul-Ramsey Medical Center v. Shalala, 91 F.3d 57 (8th. Cir. 1996), cert. granted, No. 96-1375 (1997).

Chevron v. Natural Resources Defense Council, Inc., 467 U.S. 1588 (1994).

Tulane Medical Center v. Shalala, 987 F.2d 790 (D. C. Cir.1993), cert. denied 114 S.Ct. 740 (1994), reversing Methodist Hospitals of Memphis v. Sullivan, 799 F. Supp. 1210 (D.D.C. 1992).

Pacific Hospital of Long Beach v. Ætna Life Insurance Co., PRRB Dec. No. 97-D73, June 25, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,465, declined rev. HCFA Admin., August 4, 1997.

Harrisburg Hospital v. Blue Cross and Blue Shield Association/Blue Cross of Western Pennsylvania, PRRB Dec. No. 96-D9, February 15, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,058, rev'd. HCFA Admin., April 18, 1996.

5. Other:

HCFA Memorandum, BPO-F12, February 12, 1990 (Instructions for Implementing Program Payments for Graduate Medical Education).

HCFA Memorandum, BPO-F12, November 8, 1990 (Questions and Answers Pertaining to Graduate Medical Education).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, Provider's post-hearing brief, Stipulation of Facts, and evidence presented, finds and concludes as follows:

Issue 1 -- Re-Audit of GME Costs

The Provider generally presents two arguments supporting its position that the re-audit of its GME base period cost report was improper. First, the Provider argues that a Tentative Settlement of its GME base period cost report was, in effect, a final retroactive adjustment, the same as if it were rendered as an NPR. Therefore, the GME re-audit was improper

because the Intermediary reopened the base period cost report, i.e., to perform the re-audit, more than 3 years after a final determination in conflict with 42 C.F.R. § 405.1885. Next, the Provider argues that the re-audit was improper because the enabling regulation, 42 C.F.R. § 413.86(e)(1)(iii), is inconsistent with the statutory authority upon which it is based, 42 U.S.C. § 1395ww(h)(2)(A), and, therefore, is invalid.

The Board finds the Provider's argument regarding the nature of the Tentative Settlement as having no relevance to the instant case. Regulation 42 C.F.R. § 413.86(e)(1)(iii) clearly provides for the modification of GME base year costs for the purpose of calculating a provider's APRA even if the 3 year reopening period had expired. Therefore, it is irrelevant whether or not the Tentative Settlement should be viewed as a final determination, or whether or not the Intermediary had actually issued an NPR in its place. Essentially, the Intermediary's actions would have been the same; the Intermediary would have reviewed the subject cost report and determined the Provider's APRA in accordance with 42 C.F.R. § 413.86ff.

Regarding the Provider's second argument, the Board takes judicial notice that there is a two to one split by the circuit courts regarding the validity of the GME regulations particularly regarding the re-audit provisions. In 1993, the D.C. Circuit found in Tulane that the GME re-audit regulations were valid in all respects. In January 1997, however, the GME regulations were held to be invalid in Toledo from the Sixth Circuit. A third case, St. Paul-Ramsey from the Eighth Circuit has also upheld the GME re-audit regulations.

Due to the difference of interpretation by the circuit courts, the U.S. Supreme Court has been asked to review the St. Paul-Ramsey case. Hence, the validity of the regulations is actively being litigated to resolve the issue. The Board, however, is bound by all properly promulgated Medicare regulations until there is a resolution by a court of competent appellate jurisdiction. Therefore, the Intermediary's re-audit is proper.

Issue 2 -- Malpractice Insurance

The Board finds that the Provider improperly challenged the propriety of an adjustment made by the Intermediary to the classification of its malpractice insurance costs. The Provider's challenge was not made within the 180 day period for filing appeals with the Board pursuant to 42 C.F.R.
§ 405.1841.

The Board finds that the Intermediary issued a Revised NPR on December 27, 1988, modifying an initial final settlement of the Provider's GME base period cost report, which occurred on August 12 of that year.[45] The Revised NPR reflected an adjustment made by the Intermediary reclassifying malpractice insurance costs out of the Provider's intern and

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[45] Stipulation of Facts at 4-5.

resident cost center, which is the issue disputed in this case.[46] The Board notes, however, that the Provider did not appeal this adjustment.

Subsequently, the Intermediary reopened the December 27, 1988 settlement, performed its GME base period audit and, on February 27, 1991, notified the Provider of its APRA. Thereafter, in a letter dated August 23, 1991, the Provider timely appealed the calculation of its APRA to the Board contending, in part, that the Intermediary improperly excluded the subject malpractice insurance costs from the APRA calculation.

The Board finds, however, that there is no basis for the Provider's challenge. The Intermediary properly relied upon its December 27, 1988 final settlement as the basis for its GME re-audit. In accordance with 42 C.F.R. §§ 405.1801, 1803 (1)(i) and 1807, this NPR reflected the Provider's "reasonable costs" for the subject cost reporting period. This means that the malpractice insurance costs at issue had already been reclassified out of the intern and resident cost center when the GME re-audit was performed. This also means that no revisions were made to the subject malpractice insurance costs during the re-audit and calculation of the Provider's APRA.

Medicare regulation 42 C.F.R. § 405.1889 explains that providers are granted appeal rights where "revisions" are made to a reopened cost report, as follows:

> [w]here a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been reopened as provided in § 405.1885, such revision shall be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1835, 405.1875, and 405.1877 are applicable.

42 C.F.R. 405 § 1889 (emphasis added).

The Board finds that 42 C.F.R. 405 § 1889 does not cause every item in a Medicare cost report to become subject to appeal because a final settlement is reopened and revised. Rather, the regulation is issue specific; only those items revised in a reopening may be appealed. Therefore, because no adjustment or revision was made to the subject malpractice insurance costs through the cost report reopening and GME base period audit, there is no basis for the Provider's appeal.

Accordingly, the Board finds that it lacks authority to decide the subject issue. The Provider did not submit a written request for a Board hearing within 180 days of the December 27, 1988 Revised NPR, which was the Intermediary's notice of the subject adjustment. 42 C.F.R. § 405.1841. While the Provider did timely appeal its APRA, no adjustment or revision was made by the Intermediary to the subject costs in that determination and, therefore, there is no

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[46] Stipulation of Facts at Exhibit 10 at No. 6.

basis for the Provider's challenge. The Board notes that the Provider could have requested the subject malpractice insurance costs to be reclassified back to the intern and resident cost center and included in its APRA in accordance with 42 C.F.R. § 413.86(e)(ii)(C). Furthermore, if the Intermediary would have refused such a request, that would constitute an Intermediary determination that could have been heard by the Board. However, that circumstance is not present in the instant case.

DECISION AND ORDER:

Issue 1 -- Re-Audit of GME Costs

The Board is bound by all properly promulgated Medicare regulations until there is a resolution by a court of competent appellate jurisdiction. Accordingly, the Intermediary's re-audit of the Provider's GME base period cost report is proper.

Issue 2 -- Malpractice Insurance

The Provider's appeal was not timely filed in accordance with 42 C.F.R. § 405.1841. Therefore, the Board does not have authority to decide the issue.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Teresa B. Devine
Henry C. Wessman, Esquire

FOR THE BOARD:

Irvin W. Kues
Chairman