PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

99-D13

PROVIDER -St. Mary's Hospital
Waterbury, Connecticut

Provider No. 07-0016

vs.

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

DATES OF HEARING-
December 10, 1996 and
April 17, 1997

Cost Reporting Period Ended -
September 30, 1984

CASE NO. 91-2935M

INDEX

ISSUE:

Was the Intermediary's refusal to reclassify as graduate medical education ("GME") costs certain physician compensation costs and related secretarial compensation costs originally classified as non-GME operating costs on the Provider's GME base-year cost report proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

St. Mary's Hospital ("Provider") is a 379-bed, non-profit, general acute care hospital located in Waterbury, Connecticut. As a teaching facility, the Provider administers GME programs in various specialties and subspecialties which are accredited by the Accreditation Council of Graduate Medical Education ("ACGME") or the Council of Dental Education of the American Dental Association. During its GME base year under appeal, fiscal year ended September 30, 1984, the Provider was reimbursed under the Medicare program's prospective payment system ("PPS"), under which it received payment for non-GME inpatient operating costs based on prospectively determined rates. Under PPS, reimbursement is based on prospectively determined national and regional rates for each patient discharge, rather than on the basis of reasonable operating costs. The PPS system for non-GME operating costs was phased in over a four year transition period, during which Medicare payments were made according to a "blended rate" that consisted of two components. The hospital-specific rate component reflected the hospital's costs experienced during a base-year period, while the Federal PPS rate component reflected regional and national standardized amounts. The Provider's PPS base year was its cost reporting period ended September 30, 1982.

For PPS cost years beginning prior to July 1, 1985, payments for approved GME costs were maintained as pass-through payments, and continued to be reimbursed under the Medicare program's reasonable cost principles. In order to insure that hospitals did not receive double reimbursement for costs that were initially used to determine the hospital-specific rate by subsequently reclassifying such costs as GME costs, the Health Care Financing Administration ("HCFA") adopted a "consistency rule" which required hospitals to determine their GME costs throughout the PPS transition period in a manner consistent with the treatment of these costs in the PPS base year for purposes of determining the hospital-specific rate. Under the consistency rule set forth in 42 C.F.R. § 412.113(b)(3), costs were frozen to the specific classifications adopted by the hospital during the PPS base year.

In April 1986, Congress established new payment policy for direct medical education costs for cost reporting periods beginning on or after July 1, 1985, pursuant to 42 U.S.C. § 1395ww(h).[1] Under the new methodology, Medicare pays a hospital-specific resident amount for GME activities which is determined based on a provider's average GME cost during the Federal fiscal year ended September 30, 1984 (GME base year). HCFA implemented the

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[1] Section 9202 of the Consolidated Omnibus Budget Reconciliation Act ("COBRA") of 1985, Pub. L. No. 99-272, as amended.

statute by promulgating the regulations at 42 C.F.R. § 413.86 et seq., which included a provision requiring intermediaries to reaudit and verify the accuracy GME base-year costs and to exclude any nonallowable or misclassified costs. If a hospital's GME base-year cost report was not subject to reopening after the three-year period provided under 42 C.F.R. § 405.1885, the intermediary could modify base-year costs on reaudit solely for the purpose of computing the per resident amount, but could not adjust the amount of program reimbursement for the GME base year.

In addition to providing for the reaudit of the GME base year for purposes of determining the average per resident amount ("APRA"), the regulation at 42 C.F.R. § 413.86(e)(1)(ii) also provided for adjustments of a provider's TEFRA target amount or hospital specific rate ("HSR") to account for misclassified GME costs in the TEFRA/PPS base year. Further, the provisions of 42 C.F.R. § 413.86(e)(1)(ii)(C) specifies that these costs may be included only if the hospital requests an adjustment of its TEFRA target amount or PPS HSR as described in 42 C.F.R.
§ 413.86(j)(2). With respect to the documentation necessary to support a hospital's GME base- year costs, HCFA would not apply new reimbursement principles during the reaudit but would make a determination consistent with requirements under reasonable cost reimbursement and the general statutory and regulatory scheme of the Medicare program.

On its PPS base-year cost report for FYE September 30, 1982, the Provider did not claim any teaching physician costs in the interns and residents cost center. With respect to its GME base-year cost report for FYE September 30, 1984, the Provider reclassified $63,486 of teaching physician salaries from departmental cost centers to the interns and residents cost center. Citing the lack of supporting documentation and inconsistency with the FYE September 30, 1982 PPS base year, Blue Cross and Blue Shield of Connecticut ("Intermediary") reversed the Provider's reclassification with the issuance of the Notice of Average Per Resident Amount ("NAPRA") on February 28, 1991.[2] The NAPRA advised that the Provider's APRA was determined based on total allowable GME costs of $1,983,241 and a total of 50.08 full-time equivalent interns and residents, yielding an APRA amount of $39,601.46.[3] The NAPRA further advised that an appeal to the Provider Reimbursement Review Board ("Board") must be filed within 180 days of the date of this notice if the Provider was dissatisfied with the APRA determination. The NAPRA also included the following statement:

> You may contact this office if the GME costs used in the average per resident amount determination were reduced for operating costs that were misclassified.

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[2] Exhibit A and C - Provider's Position Paper.

[3] A revised NAPRA was issued on August 23, 1991, which reduced the APRA to $39,468.27 for reasons unrelated to this appeal - See Exhibit B - Provider's Position Paper.

> If the same misclassification affected the calculation of the hospital specific portion of your prospective payment system (PPS) rate or your rate-of-increase ceiling, you may request that these rates be revised. In addition, if you believe that costs which should have been classified as GME costs in the determination of the average per resident amount were treated as operating costs in both the determination as well as the PPS or rate-of-increase ceiling calculations, you may request that we revise the per resident determination and adjust your PPS rate or rate-of-increase ceiling. As explained in Section 413.86(j)(1) and (2), your request for the review of misclassified cost must be made no later than 180 days after the date of this notice. In addition, your request must include sufficient documentation to demonstrate that the adjustment to the PPS rate or rate-of-increase ceiling is warranted.
>
> As you have 180 days to file an appeal in any case, there is ample opportunity for discussion without risk of any prejudice to your appeal rights. Appeals via either mechanism tend to be a costly and time-consuming process on everyone's part, once a formal request has been filed. I, therefore, strongly urge that you discuss with me any problems you may have prior to such filing.

Id.

In response to the NAPRA, the Provider's Administrative Director for Planning and Business Development telephoned the Intermediary's representative on or about August 26, 1991, to advise that there were problems with the APRA determination and that the Provider needed to "stop the clock and obtain a review of the entire matter."[4] Pursuant to the Intermediary's advise, the Provider filed an appeal with the Board on August 27, 1991, which included the following text:

> St. Mary's Hospital requests a hearing before the Provider Reimbursement Review Board to appeal the calculation of the FYE 1984 base-year average per resident amount. It is the Hospital's opinion that the Intermediary (Blue Cross Blue Shield of Connecticut) has inappropriately misclassified and understated allowable cost as well as overstating intern and resident full time positions for the purposes of calculating the per resident amount.
>
> Discussions are being held between the Hospital and Intermediary to resolve these issues, however, it is unlikely that all areas of concern can be addressed within the 180 day appeal limitation.

The Provider's appeal was filed pursuant to 42 C.F.R. §§ 405.1835-.1841, and the Board has determined that the jurisdictional requirements of those regulations have been met. The sole

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[4] Tr. (Dec. 10, 1996), at 56-61.

issue remaining before the Board concerns the Provider's request to increase its total base-year GME costs by about $450,000, consisting of approximately $400,000 for physician compensation costs and $50,000 for related secretarial compensation costs.[5] The Provider estimates that this increase in GME costs, including additional overhead costs, would result in an APRA of approximately $53,100, an increase of about $13,600 from the revised APRA determined by the Intermediary. The estimated effect on Medicare reimbursement is $331,000 for fiscal year 1986 (first year covered by the new GME reimbursement methodology), and a projected cumulative Medicare reimbursement effect through 1995 of about $4,700,000.

The Provider was represented by Richard P. Ward, Esquire, John H. Mason, Esquire, and Susan T. Nicholson, Esquire, of Ropes & Gray. The Intermediary's representative was Michael F. Berkey, C.P.A., Associate Counsel for the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that it incurred physician and secretarial compensation costs which qualify as GME costs pursuant to the regulatory provisions of 42 C.F.R. § 413.86 et seq.. During its fiscal year 1982 and thereafter, the Provider asserts that it employed physicians who provided teaching and supervision services for GME programs conducted at the hospital. In addition, secretaries were also employed to support the work of the teaching physicians, and that the costs associated with these teaching functions were claimed in cost centers other than the interns and residents cost center. While most of the teaching physician and related support staff costs were included in non-GME operating cost centers, the Provider regularly required its teaching physicians to execute time allocation agreements in a format developed by the Intermediary.[6]

During the 1984 GME base year, the teaching physicians executed allocation agreements showing the split between hospital services reimbursed under Part A of the Medicare program and patient services reimbursed under Part B of the Medicare program. The allocation agreements further broke down Part A time into eight distinct categories, including teaching and supervision of interns and residents. Following the Intermediary's reaudit of the GME base year, which was conducted during 1990, the Provider requested an increase to its GME costs as documented by the physician allocation agreements for fiscal year 1984. In support of this request, the Provider prepared a summary of the thirty-two physician allocation agreements which identified each teaching physician by name, department, total hours

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5 See Exhibits E and F - Provider's Position paper, as modified by testimony during hearing before the Board.

6 See Exhibit D - Provider's Position Paper and Provider Exhibit 4.

worked, total salary, and date the agreement was executed.[7] This summary consists of the sum of the percentages which physicians entered under the heading of "Teaching and Supervision of Interns and Residents " on the allocation agreements, which was then multiplied by each physician's salary to obtain a total salary cost of $404,818 for all teaching physicians.[8] Based on its analysis of allocated physician hours, the Provider estimated that 21 percent of the total physician time was devoted to GME activities.

With respect to secretarial compensation costs, the Provider presented a similar analysis which lists by name and salary the secretaries associated with the GME teaching activities during fiscal year 1984.[9] Since teaching physicians devoted approximately 21 percent of their time to GME activities during the GME base year, the Provider assumed that the secretaries supporting these physicians devoted a similar portion of their time to the same activities. Applying this percentage to the total salary costs for these secretaries, the Provider estimates that $50,378 should also have been classified in the interns and residents cost center for fiscal year 1984.

During the Intermediary's reaudit of the Provider's 1984 GME costs, the Intermediary requested supporting documentation for the $63,486 in physician compensation costs which the Provider had reclassified to the interns and residents cost center. In response to this request, the Provider informed the Intermediary that the workpapers for the reclassification were no longer available, however, copies of agreements for some of the teaching physicians were furnished to show the percentage of teaching and supervision time. Notwithstanding the fact that copies of the physician allocation agreements were already in the Intermediary's possession as part of its prior audit of the Provider's fiscal year 1984 cost report, the Intermediary issued a NAPRA which included an adjustment reversing the Provider's reclassification. As grounds for this adjustment, the Intermediary cited the lack of supporting documentation and inconsistency with the fiscal year ended September 30, 1982 base year.

The Provider argues that, at the time the NAPRA was issued, the Intermediary clearly knew that the Provider had failed to include any teaching physician compensation costs in the interns and residents cost center in fiscal year 1982, even though such costs were recoverable as GME costs rather than as general operating costs. When the Provider contacted the Intermediary on or about August 26, 1991, to discuss the NAPRA and the enclosed audit adjustment report, the Intermediary was informed that there was something "obviously wrong

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7 See Exhibit E - Provider's Position Paper.

8 The total salary cost was corrected to $400,818 based on the testimony of the Provider's witness.

9 See Exhibit F - Provider's Position Paper.

with these numbers [for both years]."[10] Further, the Intermediary explicitly relied on the "inconsistency" with fiscal year 1982 as a reason for refusing to allow the Provider to include physician compensation costs in the interns and residents cost center in fiscal year 1984. After filing its appeal with the Board, the Provider hired an outside consultant to pursue the GME and other reimbursement issues, and a meeting with the Intermediary was held on April 22, 1992.[11] At that time, the Provider made it known that it was seeking to reclassify a portion of its 1984 teaching physician compensation costs to the interns and residents cost center. In support of this proposed reclassification, the Provider was relying on the fiscal year 1984 physician allocation agreements that the Intermediary had previously used to determine the Medicare Part A and Part B split for salaried physicians. Further, the Provider advised that it was willing to conduct a current year time study to verify or corroborate these agreements. The Provider states that the Intermediary's representative responded that it would be "ok" for the Provider to conduct a present year time study,[12] however, he was unsure of the scope of his authority to make such reclassifications and would need to obtain advice from HCFA on this matter.[13]

On May 28, 1992, the Provider's outside consultant sent a draft letter to the Intermediary's representative for his signature, which requested HCFA's advice on the Intermediary's authority to allow the Provider to reclassify the misclassified teaching physician costs under the circumstances described in the letter.[14] While the letter was never sent to HCFA, it was used by the Intermediary to converse with a HCFA representative who advised that HCFA was not taking any action on reclassification requests at the time.[15] Based on his discussion with HCFA, the Intermediary's representative concluded that he had no authority to allow the Provider to reclassify any part of its physician compensation costs for purposes of determining the GME base-year APRA and, thus, took no further action on the matter.

In August of 1995, the Provider submitted its preliminary position paper in this case to the Intermediary. This submission included a summary of the Provider's 1984 physician allocation agreements as well as a summary of the 1992 physician time study which the Provider conducted to corroborate the allocation agreements. Citing legal concerns and the

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10 Tr. (Dec. 10, 1996), at 56.

11 Tr. (Dec. 10, 1996), at 333, Exhibit G - Provider's Position Paper, and Provider Exhibit 5.

12 Provider Exhibit 5.

13 Tr. (Dec. 10, 1996), at 338-340.

14 Exhibit G - Provider's Position Paper.

15 Tr. (Dec. 10, 1996) at 274-278.

lack of funding, the Intermediary conducted no review of the documents submitted with the Provider's position paper. In November of 1995, the Intermediary submitted its position paper citing the following three reasons for denying the Provider's reclassification request:

(1) Subsequent year (FY 1992) time studies could not be used to increase costs originally claimed in the interns and residents cost center;

(2) The consistency rule (42 C.F.R. § 412.113) required that GME costs which were misclassified as operating costs in fiscal year 1982 must also be misclassified as operating costs in the PPS transition years; and

(3) The Provider had not to date supplied adequate documentation to substantiate fiscal year 1982 misclassified costs.

In response to the Intermediary's position paper, the Provider submitted a supplemental position paper pointing out that the HCFA Administrator had specifically allowed a provider to use subsequent year time studies where they were used to substantiate base year allocation agreements.[16] Secondly, the Provider pointed out that the consistency rule had been revised specifically to permit corrections of GME base-year misclassifications. As to documentation for fiscal year 1982, the Provider noted that the Intermediary itself had previously recognized that no physician compensation costs had been included in the interns and residents cost center for 1982 and, hence, additional documentation was hardly needed to confirm that fact.

Notwithstanding the foregoing, the Intermediary still refused to reclassify the Provider's GME costs and, instead, cited a recently issued HCFA Administrator's decision which precluded the Provider from proceeding with its adjustment request under the circumstances of this case.[17] Relying upon the Harrisburg decision, the Intermediary for the first time raised the argument that the Provider could not proceed with this case since it failed to make any adjustment request, for either its GME base-year costs or its PPS base-year costs, within the 180-day period specified by 42 C.F.R. § 413.86(j)(2). In addition, the Provider had also failed to submit sufficient documentation to support any such adjustment request within the

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16 Abbott Northwestern Memorial Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Minnesota, PRRB Dec. No. 95-D10, December 7, 1994, Medicare and Medicaid Guide (CCH) ¶ 42,970, Aff'd HCFA Administrator, February 2, 1995, Medicare and Medicaid Guide (CCH) ¶ 43,136 ("Abbott Northwestern").

17 Harrisburg Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Western Pennsylvania, PRRB Dec. No. 96-D9, February 15, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,058, Rev'd HCFA Administrator, April 18, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,419 ("Harrisburg").

same 180-day period. The Provider denied that it failed to take any action required by 42 C.F.R. § 413.86(j)(2), and proceeded to hearing before the Board.

The Provider contends that it properly complied with the time limits contained in the GME regulations in seeking reclassification of its misclassified GME base-year costs. In determining a hospital's GME base-period APRA, the regulation states that an intermediary should:

> (C) Upon a hospital's request, include graduate medical education costs that were misclassified as operating costs during a hospital's prospective payment base year and were not allowable under § 412.113(b)(3) of this chapter during the graduate medical education base period. These costs may be included only if the hospital requests an adjustment of its prospective payment hospital-specific rate or target amount as described in paragraph (j)(2) of this section.

42 C.F.R. § 413.86(e)((1)(ii)(C) (emphasis added).

The provisions of 42 C.F.R. § 413.86(j)(2) set forth the following requirements for requesting a reclassification of GME costs:

> If costs that should have been classified as graduate medical education costs were treated as operating costs during both the graduate medical education base period, and the rate-of-increase ceiling base year or prospective payment base year, and the hospital wishes to receive benefit for the appropriate classification of these costs as graduate medical education costs in the graduate medical education base period, the hospital must request that the intermediary review the classification of the affected costs in the rate-of-increase or prospective payment base year for purposes of adjusting the hospital's target amount or hospital specific rate. For those cost reports that are not subject to reopening under § 405.1885 of this chapter, the hospital's reopening request must explicitly state that the review is limited to this one issue.

42 C.F.R. § 413.86(j)(2)(I) (emphasis added).

> The hospital must request review of the classification of its costs not later than 180 days after the date of the intermediary's notice of the hospital's base period average per resident amount. A hospital's request for review must include sufficient documentation to demonstrate to the intermediary that . . . adjustment of the hospital's hospital-specific rate is warranted.

42 C.F.R. § 413.86(j)(2)(ii) (emphasis added).

The Provider further notes that the instructions which accompanied the NAPRA provide similar instructions as follows:

> As explained in Sections 413.86(j)(1) and (2), your request for the review of misclassified costs must be made no later than 180 days after the date of this notice. In addition, your request must include sufficient documentation to demonstrate that the adjustment to the PPS rate or rate-of-increase ceiling is warranted.

Id.

In accordance with the GME regulations and the NAPRA instruction stated above, the Provider insists that the stated language plainly requires that a hospital seeking revision of its APRA must do three things within 180 days of receipt of its NAPRA:

(1) the hospital must request that its per resident amount be revised to include the misclassified GME costs;

(2) the hospital must request a review of the classification of the same costs in the PPS base year for purposes of adjusting its HSR; and

(3) the hospital must demonstrate that adjustment of its HSR is warranted.

The Provider contends that it met all three of these requirements. First, the telephone call made by the Provider's Director of Planning and Business Development to the Intermediary's representation on August 26, 1991 constitutes a timely request to revise the APRA to include misclassified costs. There is nothing in the GME regulations or the NAPRA instructions which requires the request to be in writing. Second, this telephone call also constitutes a timely request for the Intermediary to "review the classification of the affected costs in the . . . prospective payment base year for purpose of adjusting the hospital's . . . hospital specific rate" as requried by 42 C.F.R. § 413.86(j)(2)(I). By objecting to the Intermediary's treatment of physician compensation costs for fiscal year 1984, the Provider was necessarily also requesting a review of the classification of those same costs in the PPS base year. Third, the Provider also satisfied the requirement to demonstrate that adjustment of the HSR was warranted. In this case, the Intermediary already knew that the Provider had classified its teaching compensation costs as non-GME operating cost in fiscal year 1982, since the Intermediary removed similar costs from the interns and residents cost center for fiscal year 1984 to be consistent with fiscal year 1982.

The Provider argues that its case is distinguishable from the Harrisburg decision on which the Intermediary heavily relies. The provider in Harrisburg argued that the intermediary knew certain costs were not included in the interns and residents cost center because specific instructions were given during its fiscal year 1982. However, those instructions were issued

over six years prior to the GME audit. Thus, the intermediary arguably no longer had knowledge of its former instructions by the time of the GME audit. In the instant case, the Intermediary stated right in its GME audit adjustment report that the costs were being removed because no such costs were included in the interns and residents cost center in fiscal year 1982. The Provider argues that there is no principle of administrative or Medicare law that would require the submission of additional documentation to prove a fact which the Intermediary already knew and was relying upon. As to the HCFA Administrator's attempt to analogize the case in Harrisburg to end stage renal disease ("ESRD") exception request, the Provider argues that such an analogy is totally unfounded. Whereas the Board is precluded from considering evidence not submitted within the 180-day period for filing an ESRD exception request, the ESRD regulations at 42 C.F.R. § 413.170(f) expressly state that the provider must, within 180 days, specify the amount of additional reimbursement that is required, and include all materials necessary to determine if the exception is approvable. Moreover, if an ESRD provider fails to make the necessary submission within the 180 day period, it can submit another request for additonal reimbursement the following year. By contrast, a teaching hospital can file only one request for correction of misclasified GME costs, and the outcome of that request will determine the hospital's GME reimbursement from fiscal year 1986 onward. Consequently, there is a reason based on equity and fairness why the GME regulations, unlike the ESRD regulation, allows submission of supporting documentation after the 180-day period.

Where a hospital believes it has misclassified costs in its GME base year, the requirements for a review of such costs in the PPS base year is to provide a basis for reopening the PPS base year cost report which would otherwise not be subject to such reopening. Contrary to the Intermediary's position, the Provider argues that the review requirement is not to insure that a hospital prove in detail the specific amount of any proposed adjustment to its HSR within a period as short as 180 days from the hospital's receipt of its NAPRA. While the Intermediary also argues that there is a requirement to submit documentation within 180 days to support a revision of the APRA, the Provider insists that the only documentation requirement in the GME regulations applies to the hospital-specific rate or target amount. Once an appeal has been filed with the Board, the Provider believes it must follow the ordinary rules for presentation of supporting evidence. Accordingly, there is nothing in the GME regulations which would prohibit the Board from considering supporting evidence which the Provider presented to the Intermediary after the time period has expired.

Regardless of the merits of the Intermediary's time constraint arguments, the Provider contends that the Intermediary should be estopped from asserting the time limits contained in 42 C.F.R.
§ 413.86 et seq. by reason of its own action of assuring the Provider that it needed to take no further act to comply with them. As with other parties, the government may be estopped from asserting a statute of limitations where its agent has induced the alleged failure to comply, even inadvertently. In Irwin v. Dept. of Veteran Affairs, 498 U.S. 89 (1990) ("Irwin"), the Supreme Court specifically noted that it had previously allowed the equitable tolling of a

statute of limitations in suits between private parties where the complainant had been "induced or tricked by his adversary's misconduct into allowing the filing deadline to pass." The Supreme Court then held that the same equitable principles should be applied in suits against the federal government stating the following:

> A waiver of sovereign immunity cannot be implied but must be unequivocally expressed. Once Congress has made such a waiver, we think that making the rule of equitable tolling applicable to suits against the Government, in the same way it is applicable to private suits, amounts to little, if any, broadening of the congressional waiver. Such a principle is likely to be a realistic assessment of legislative intent as well as a practically useful principle of interpretation. We therefore hold that the same rebuttable presumption of equitable tolling applicable to suits against private defendants should also apply to suits against the United States. Congress, of course, may provide otherwise if it wishes to do so.

498 U.S. at 96.

Citing various court decisions, the Provider points out that the "misconduct" cited in Irwin need not be deliberate or fraud. Rather it is sufficient that the party against whom the estoppel is asserted intends that the statements or conduct be acted upon, or reasonably expects that the statements or conduct would be acted upon, and the party asserting the estoppel would be substantially prejudiced if the estoppel were denied.

In the instant case, the Intermediary's representative knew when he was contacted by the Provider on or about August 26, 1991 that the Provider was seeking a substantive review of the NAPRA that had recently been issued. He also knew that the Provider wanted to "stop the clock" and prevent any limitation period from running out with respect to the Provider's right to obtain such a review. Notwithstanding the foregoing, the Intermediary's representative did not advise the Provider about the following:

(1) The need to take some action within 180 days in addition to filing an appeal with the Board;

(2) The need to make a separate reclassification request with respect to the teaching compensation costs for fiscal years 1982 and 1984; and

(3) The need to support either request with allocation agreements or other documents in the Provider's possession.

In light of the Intermediary's failure to properly advise the Provider throughout the entire process, the Provider believes that it is plain that the principles of estoppel should be applied in this case. In support of this position, the Provider cites the Board's decision in Medical

Center Hospital of Vermont v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of New Hampshire/Vermont, PRRB Dec. No. 97-D27, January 30, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,054, Mod./Rev'd HCFA Administrator, March 31, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,232, ("Vermont"), wherein the Board stated the following:

> [T]he exclusion of misclassified GME costs from the calculation of a provider's APRA, as in the instant case, limits a provider's reimbursement in perpetuity. Accordingly, the Board finds that excluding misclassified GME costs from an APRA calculation because a provider failed to file a separate request pertaining to a PPS base period, to be a formality which results in inequitable treatment of the provider.

Id.

The Provider asserts that the government will not be prejudiced if an estoppel is applied in that the regulatory provisions of 42 C.F.R. § 413.86(j)(2) was established to avoid program overpayments during the PPS transition period. In the present case, the Provider has explicitly stated that it will avoid any such overpayment by accepting a downward adjustment in its HSR to offset any increase in its GME base-year APRA. The application of the principle of estoppel constitutes an additional and independent reason why the Intermediary's untimeliness argument should be rejected.

It is the Provider's position that the documentation it has presented in this case is more than adequate to support the reclassification requested for its teaching physician and related secretarial compensation costs. In this regard, the Provider again cites the Abbott Northwestern decision wherein both the Board and the HCFA Administrator required the intermediary to reclassify GME costs based on supporting documentation similar to that presented in the instant case. In Abbott Northwestern, the provider also saved its 1984 physician allocation agreements which reflected the time devoted by physician to the medical education activity, and had been accepted by the intermediary in settlement of the 1984 cost report. As in this case, a subsequent year (1991) physician time study was conducted to support the claimed compensation costs when the allocation agreements were deemed inadequate by the intermediary. The Board found the allocation agreements themselves constituted adequate documentation, and that the time study had not even been necessary. On appeal, the HCFA Administrator affirmed the Board's decision, albeit on somewhat different grounds. While the Administrator did not believe that the allocation agreements were adequate because they reflected estimates of the physicians' time, he held that the 1991 time study generally confirmed the accuracy of the base-year documentation. Thus, under the circumstances presented, the subsequent period documentation supported the adequacy of the physician allocation agreements as base-year period documentation.

The Provider submits that its 1984 allocation agreements constitute adequate support for the requested reclassification, and that no regulatory or manual provisions existed in 1984 which required the maintenance of further documentation to support the breakout of GME time from all other Part A time. However, should further substantiation be required, the Provider argues that its 1992 time studies, which show that approximately 20 percent of teaching physician time was devoted to GME activities, fully validate the figure of 21 percent which was derived from the 1984 physician allocation agreements. Accordingly, whether the Board's or the HCFA Administrator's decision in Abbott Northwestern is adopted, the Provider maintains that it is clearly entitled to reclassification of teaching physician and secretarial costs and a recalculation of its APRA.

In response to the Intermediary's argument that the Provider only claimed a small amount of teaching physician costs in its interns and residents cost center in subsequent years, and did not appeal the Intermediary's reclassification adjustment of such costs in the 1991 NPR issued for fiscal year 1989, the Provider argues that the Intermediary's reasoning ignores the methodology used to reimburse GME costs. Subsequent to fiscal year 1985, reimbursement for GME costs is based entirely on the amount claimed in the interns and residents cost center for fiscal year 1984. Accordingly, classification of these costs in later years is irrelevant for reimbursement purposes. Further, no subsequent GME appeals on the issue of classification of costs are in fact allowed.

As to the Intermediary criticism of the methodology used to allocate the secretarial costs, the Provider believes this contention should be disregarded because it actually results in lower reimbursement than the Intermediary's preferred method. In using an overall percentage of 21 percent based on total physicians' teaching time, the Provider determined a GME-related secretarial cost of $50,378. If the Intermediary's preferred method of matching secretaries with particular physicians had been chosen, this methodology results in a larger dollar amount for GME-related secretarial costs. Since the Provider was unsuccessful in introducing this calculation into evidence, the Board should either disregard the Intermediary's criticism or direct the Intermediary to use its preferred methodology.

The Intermediary also argued that the 1984 allocation agreements did not distinguish between the teaching of interns and residents and the teaching of medical students for purposes of computing a teaching percentage of 21 percent in computing the amount of GME costs. The Provider insists that this problem was resolved through the testimony of its witness who established that 11 percent of the physicians teaching time was spent on medical students.[18] Accordingly, the original adjustment request of 21 percent should be adjusted to 18.7 percent to account for the teaching time spent only on interns and residents.

Finally, the Provider argues that the Intermediary's attempt to discredit the 1984 allocation agreements and the 1992 time study was unavailing, and should not be given any weight.

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[18] Tr. (Apr. 17, 1997), at 50-52 and 84-85.

While the Intermediary believes that the allocation agreements cannot be relied upon because they only represent the physicians' estimates of their time, the Provider points out that this argument ignores the substantiation of the agreements by the 1992 time study. Moreover, the Intermediary had already relied on these allocation agreements as part of their regular audit of the 1984 cost report to determine the split between Part A and Part B time. As to the testimony of the Intermediary's witness for the purpose of discrediting the individual allocation agreements and time studies, the Provider contends that no weight should be given to this testimony for the following reasons:

(1) The witness had no experience auditing GME time studies and had merely employed his own standards in determining acceptability;

(2) The witness' audit approach was fundamentally unfair in that it did not include the option of asking for clarifying information or checking information; and

(3) While many of the witness' key judgements were that further guidance from his supervisor was necessary where documentation raised concerns, there was no presentation by the Intermediary as to what that guidance would have been.

Based on the evidence presented, the Provider concludes that the Intermediary should be directed to increase the Provider's base-year GME costs by the amount of teaching physician and related secretarial compensation costs requested, and make a corresponding upward adjustment to the Provider's base-year APRA.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its calculation of the Provider's APRA fully complied with the expressed provisions of the applicable regulations at 42 C.F.R. § 413.86 et seq. and other appropriate authority. In support of its position, the Intermediary cites nine primary arguments which it believes the Board must consider in denying the Provider's request for an adjustment to the APRA determination for the GME base year.[19] The first four arguments pertain to the Provider's failure to comply with the regulatory prerequisites under 42 C.F.R. § 413.86(j)(2) for requesting a reclassification of GME costs. This regulation states in part:

> (i) General rule. If costs that should have been classified as graduate medical education costs were treated as operating costs during both the graduate medical education base period and the rate-of-increase ceiling base year or prospective payment base year and the hospital wishes to receive benefit for the appropriate classification of these costs as graduate medical education costs in the graduation medical education base period, the hospital must request that the

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[19] Tr. (Dec. 10, 1996), at 29-44 and Tr. (Apr. 17, 1997), at 250-259 - See Intermediary's Hearing Chart 1.

> intermediary review the classification of the affected costs in the rate-of-increase ceiling or prospective payment base year for purposes of adjusting the hospital's target amount or hospital-specific rate.
>
> (ii) Request for review. The hospital must request review of the classification of its costs no later than 180 days after the date of the intermediary's notice of the hospital's base-period average per resident amount. A hospital's request for review must include sufficient documentation to demonstrate to the intermediary that modification of the adjustment of the hospital's hospital-specific rate or target amount is warranted.

42 C.F.R. § 413.86(j)(2).

First, the Intermediary argues that the Provider did not request a reclassification of its GME base-year cost within 180 days of the NAPRA. The Intermediary insists that the only submission by the Provider within 180 days of its NAPRA was an appeal request to the Board on August 27, 1991, one day before the 180-day time period expired. The Intermediary's second argument is that the Provider did not submit documentation to support its GME base-year reclassification request within 180 days of the issuance of the NAPRA. While the Provider attempts to get around this argument by stating that the Intermediary already had such documents (i.e., allocation agreements), the Intermediary argues that the burden for supplying the documentation lies with the Provider and that the Provider has presented no evidence that the data was submitted before the 180-day period ran out. Whether the Intermediary had some of the 1984 allocation agreements in its permanent file does not change the Provider's regulatory requirement to submit sufficient documentation with its reclassification request. The regulations do not require the Intermediary to search its records to enable the Provider to satisfy this requirement. The Intermediary's third and fourth arguments deal with the PPS base year, which in this case is the fiscal year ended September 30, 1982. Under the regulatory requirements of 42 C.F.R. § 413.86(j)(2), if a provider requests a reclassification of costs for GME purposes, then a timely request within 180 days is also required for a corollary adjustment of the PPS base year. In addition to its failure to file a request within 180 days, the Provider did not submit any PPS base-year documentation to demonstrate that such costs were misclassified in support of a consistency adjustment.

In further support of these four arguments, the Intermediary also refers to the HCFA Administrator's decisions in Harrisburg and Vermont, wherein the Administrator explicitly stated that a provider must satisfy the regulatory requirements of 42 C.F.R. § 413.86(j)(2) as a prerequisite to an appeal before the Board. In the Administrator's view, the Board improperly disregarded the requirements of 42 C.F.R. § 413.86(j), and that the Board did not have broad discretion to accept documentation during the presentation of these cases. In this regard, the Intermediary directs the Board attention to "Footnote 25" of the Administrator's Harrisburg decision which states:

> Although the Provider rejected the necessity of meeting the above requirements, the Administrator notes that a provider's right to appeal a NAPRA is strictly regulatory. Section 1878(a) of the Act, which established the Board, only references determinations regarding reimbursement under § 1816 of the Act and payment under § 1886(b) and (d) of the Act. Importantly, the NAPRA determination at issue in this case arises under the payment system set forth at
> § 1886(h) of the Act. Thus, a provider's right to appeal a NAPRA determination to the Board is only provided under the regulations at 42 C.F.R. § 413.86(e)(1)(v). In this regard, the appeal rights for a NAPRA are more like those granted under 42 C.F.R. § 413.170(h) for End-Stage Renal Disease (ESRD) exception requests. See 47 Fed. Reg. 6556, 6559 (1982). Just as the Board's scope of review is limited under ESRD exception requests, 42 C.F.R. § 413.170(h)(3)(ii), the Board review in this instance is limited by rule to whether the Provider met the necessary documentation requirements within the mandated 180-day time frame.

Id.

The Intermediary fifth argument relates to the inadequacy of the 1984 physician allocation agreements that were submitted by the Provider to support its reclassification request (Provider Exhibit P-19). In this regard, the Intermediary relied on the testimony of its witness who presented 12 reasons why the documentation would not meet auditing standards.[20] A summary of the problems identified by the witness based on his review of the allocation agreements is as follows:

(1) Physicians who have been categorized in the same department on the physician allocation summary (Exhibit E - Provider's Position Paper) were identified under different department headings on the allocation agreements.

(2) One physician categorized in the Medical Care Administration Department had a low percentage of time allocated to the administration function.

(3) Some physicians identified the use of time studies as the basis of allocation, while others indicated no basis of allocations. Thus, insufficient information was presented to support the basis of allocation.

(4) Allocation agreements for one physician appear to be transparencies. All pages are identical except for the names of the departments which have been altered.

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[20] Tr. (Apr. 17, 1997) at 126-152.

(5) Agreements covering different departments for the same physician have been altered and, thus, the validity of the agreements must be questioned.

(6) Allocation agreement for one physician has been used twice for two different departments.

(7) One allocation agreement shows no breakdown of allocation percentage.

(8) The basis of allocation was not checked off on one agreement.

(9) Information on the allocation agreements have been "whited out" with new information written in.

(10) Printing on the same form is different with numbers traced over or changed.

(11) Allocation percentage on one agreement has been crossed out with new numbers inserted.

(12) Allocation agreements shows teaching activities which included medical students as well as interns and residents.

Based on the Intermediary's analysis of the allocation agreements submitted by the Provider, the Intermediary advises that 17 of the 32 submitted would be either rejected or referred for further review.[21]

The Intermediary's sixth argument concerns the validity of the 1992 time studies which the Provider introduced as support for its 1984 allocation agreements (Provider Exhibit P-20). Again the Intermediary relies on the testimony of its witness to point out the various deficiencies and problems with these documents.[22] The following summarizes the points raised by the Intermediary as to the shortcomings of the time studies submitted as supporting documentation:

(1) Only 17 physician time studies have been furnished to validate 32 physician allocation agreements.

(2) While the Provider had approximately 50 physicians on staff during fiscal year 1992, only 17 physicians are covered by the time studies.

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[21] See Intermediary Hearing Chart 4.

[22] Tr. (Apr. 17, 1997) at 152-182.

(3) The survey period covered by the time studies ranged from 25 hours to 14 days. The GME reaudit instructions require a three-week time study.

(4) Daily logs for some time studies had no information reported and, thus, the documentation was insufficient to trace information to the summary sheets.

(5) The time study documents do not include a legend indicating the meaning of the terms used or the flow and sequencing of the documents in the study.

(6) Information reported on daily activity logs did not match with the summary data.

(7) Signatures on time study documents were not consistent suggesting that someone other than the physician prepared the documents.

(8) Notation on one time study indicated that time identified as GME may have been reported when Part B billable patient care was being rendered.

(9) Home study preparation time being systematically reported by one physician as GME time for every survey day, including days when the physician indicates working more than 14 hours at the hospital.

(10) Hourly totals for one physician's daily summary sheet have been crossed out with new numbers inserted for nearly every summary.

(11) No time reported for lunch or dinner on daily summary sheets.

(12) Daily activity logs for one physician shows large blocks of time as GME without any detailed identification of function performed.

(13) Daily activity logs were not dated.

(14) Time study data for one physician shows exactly the same data at exactly the same time for all of the days reported.

(15) Reporting of time relating to non-GME activities is inadequate.

(16) Sizeable variances noted between hours reported on daily activity logs and summary sheets.

(17) Daily activity logs merely show check marks for certain time periods without any identification that the time pertained to GME. In addition, no accounting has been shown for other patient-care functions.

The Intermediary's seventh argument is that the 1992 time studies do not support the 1984 allocation agreements which are based on estimated data. In addition to the numerous deficiencies in the time studies submitted, the Intermediary points out that the documentation furnished does not show which physicians worked in which department in which years. No explanation has been given as to why time studies have not been furnished for physicians that did teach in 1992, and the scarce information reflected in the submitted time studies are substantially inadequate as supporting documentation. As to the Provider's reliance on the Abbott Northwestern case, the Intermediary points out that there are critical differences between that decision and the instant case which would preclude its applicability. In Abbott Northwestern, the provider made a timely request for reclassification of its GME costs for both its GME base year and PPS base year, and also made a timely submission of the supporting data. In addition, the HCFA Administrator found that the time studies confirmed the allocation of the teaching physicians' efforts, whereas the 1992 time studies furnished in the instant case are incomplete and do not support the 1984 physician allocation data.

As an eighth argument, the Intermediary notes that the Provider's reporting practice for GME costs continued through fiscal year 1989, wherein the Provider was still claiming only $22,579 of teaching physician costs. Moreover, the Intermediary's reclassification of all such costs on the Provider's notice of program reimbursement issued on September 30, 1991 was not appealed by Provider. If the Provider had substantial teaching physician costs relating to its GME program, the costs associated with this effort were not reflected on its submitted cost reports.

The Intermediary's ninth and final argument concerns the Provider's allocation of costs associated with secretarial support for the teaching physicians as a lump sum percentage. The Intermediary contends that the allocation of a secretary's time should be related to the individual physician, or at least the department where the secretary was employed. The Intermediary also notes that the Provider furnished no documentation, such as job descriptions, which would prove the secretaries' involvement with the teaching activity. While the Provider indicated that it did have a more specific methodology for allocating the costs associated with the secretaries, the Intermediary believes the Provider selected a more general approach based on its preference of the results. In the absence of actual written documentation showing dates, times and activity, the secretarial costs are merely estimated amounts based on the unsupported results of the physician allocation agreements.

In summary, the Intermediary believes that its actions were consistent with the established rules for determining GME costs, and that the Provider has not met its burden of proof in this case. The Provider has not only failed to comply with the specific requirements set forth under 42 C.F.R. § 413.86 et seq., it has also failed to meet the documentary requirements established under 42 C.F.R. § 413.20 and § 413.24. The Intermediary asks that the Board look at the applicable regulations and apply them to the facts presented in this case.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§ 1395h (§ 1816 of the Act)	-	Use of Public Agencies or Private Organizations to Facilitate Payment to Providers of Services
§ 1395x(v)(1)(A) (§ 1861(v)(1)(A) of the Act)	-	Reasonable Costs
§ 1395oo(a) (§ 1878(a) of the Act)	-	Provider Reimbursement Review Board
§ 1395ww(h) et seq. (§ 1886 et seq. of the Act)	-	Payments for Direct Medical Education Costs

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

§ 405.481 (1985)	-	Allocation of Physician Compensation Costs
§ 405.481(g)	-	Record keeping Requirements
§ 405.1835-.1841	-	Board Jurisdiction
§ 405.1841	-	Time, Place, Form and Content of Request for Board Hearing
§ 405.1855	-	Evidence at Board Hearing
§ 405.1867	-	Source of Board's Authority
§ 405.1869	-	Scope of Board's Decision-Making Authority
§ 405.1885	-	Reopening a determination or decision
§ 412.113(b)(3)	-	Other Payments - Direct Medical Education Costs

§ 413.20	-	Financial Data and Reports
§ 413.24	-	Adequate Cost Data and Cost Finding
§ 413.86 et seq.	-	Direct Graduate Medical Education Payments
§ 413.86(e) et seq.	-	Determining Per Resident Amount for the Base Period - Appeal Rights
§ 413.86(j) et seq.	-	Adjustment of a Hospital's Target Amount or Prospective Payment Hospital-Specific Rate - Misclassified Costs
§ 413.170(f)	-	Payment for End-Stage Renal Disease (ESRD) Services - Procedures for Requesting Exceptions to Payment Rates
§ 413.170(h) et seq.	-	Payment for End-Stage Renal Disease (ESRD) Services - Appeals

3. Cases:

Irwin v. Dept. of Veteran Affairs, 498 U.S. 89 (1990).
Baystate Medical Center v. Aetna Life Insurance Company, PRRB Dec. No. 96-D73, September 27, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,698, Aff'd/Mod HCFA Administrator, November 25, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,966.

Abbott Northwestern Memorial Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Minnesota, PRRB Dec. No. 95-D10, December 7, 1994, Medicare and Medicaid Guide (CCH) ¶ 42,970, Aff'd HCFA Administrator, February 2, 1995, Medicare and Medicaid Guide (CCH) ¶ 43,136.

Harrisburg Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Western Pennsylvania, PRRB Dec. No. 96-D9, February 15, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,058, Rev'd HCFA Administrator, April 18, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,419.

Medical Center Hospital of Vermont v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of New Hampshire/Vermont, PRRB Dec. No. 97-D27, January 30, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,054, Mod/Rev'd HCFA Administrator, March 31, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,232.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of the facts, parties' contentions, evidence presented, testimony elicited at the hearing and post-hearing submissions, the majority of the Board finds and concludes that the Provider made a timely request for a reclassification of the GME costs at issue after the reaudit and APRA determination. The majority further finds that the documentation submitted by the Provider adequately supports the requested reclassification of the teaching physician and related secretarial compensation costs to the interns and residents cost center, as modified by the Board majority.

Under the regulatory provisions of 42 C.F.R. § 405.1867, the Board must comply with all Medicare regulations promulgated pursuant to Title XVIII of the Social Security Act, as amended. With respect to GME costs and the APRA determination, the controlling statutory and regulatory provisions are 42 U.S.C. § 1395ww(h) and 42 C.F.R. § 413.86 et seq. The GME statute was enacted for the purpose of establishing a new and more accurate reimbursement methodology which would effect the computation of an APRA based on all incurred GME costs recognized as reasonable. In implementing the statutory provision, HCFA promulgated regulations that set forth a reaudit process designed to offer a two way street for ensuring the accuracy of the GME base-period costs. The goal of the regulations was to properly determine accurate costs for the GME base-year calculation, which would include both increases and decreases of costs resulting in a correct base-year amount.

Once the intermediary computes a per resident amount which it believes is correct, the intermediary formalizes its final determination through the issuance of a NAPRA. Upon receipt of this notification, a provider's right to appeal the intermediary's NAPRA arises under 42 U.S.C.
§ 1395oo, and is provided for in 42 C.F.R. § 413.86(e)(1)(v). Under the provisions set forth in 42 C.F.R. § 413.86(e)(1)(v), a provider may appeal the NAPRA determination within 180 days of the date of the notice. The Board finds that the appeal process set forth under 42 C.F.R.
§ 413.86(e)(1)(v) is not limiting in its application, and does not change the law and regulations which govern what is appealable to the Board. In this regard, a NAPRA is no different from an intermediary's determination under an NPR, and would be subject to the same appeal process set forth in 42 C.F.R. §§ 405.1835-.1869. The regulation at 42 C.F.R. § 405.1841 establishes the general requirements for filing an appeal with the Board where a provider is dissatisfied with an intermediary's determination. With respect to additional issues which may surface during the appeal process, this regulation states that "[p]rior to the commencement of the hearing proceedings, the provider may identify in writing additional

aspects of the intermediary's determination with which it is dissatisfied and furnish any documentary evidence in support thereof." The scope of the Board's authority is further amplified under 42 C.F.R. § 405.1869, wherein the Board is granted the power to consider other modifications covered by a cost report even though such matters were not considered in the intermediary's determination. It is the majority of the Board's position that the misclassified GME costs at issue in this appeal are fully within the purview of the Board's regulatory authority.

With respect to the review and documentation requirements set forth under 42 C.F.R. § 413.86(j) et seq., the Board majority does not view this regulation section as a condition precedent to the appeal rights granted under 42 C.F.R. § 413.86(e)(1)(v). If HCFA had intended such limitations for appeals emanating from the issuance of a NAPRA, it should have included such specific appeal provisions in the GME regulations similar to those set forth under 42 C.F.R.
§ 413.170(h)(2) for appeals relating to End-Stage Renal Disease exception requests. The Board finds that the requirement under 42 C.F.R. § 413.86(j) et seq. to submit supporting documentation within 180 days after the date of the NAPRA only applies where an intermediary would effect an adjustment to a provider's APRA. However, where a provider appeals an intermediary's APRA determination to the Board, the regulation at 42 C.F.R. § 405.1855 controls the submission of supporting documentation. The regulation at 42 C.F.R. § 405.1855 states the following:

> Evidence may be received at the Board hearing even though inadmissible under the rules of evidence applicable to court procedure. The Board shall give the parties opportunity for submission and consideration of facts and arguments and during the course of the hearing should, in ruling upon admissibility of evidence, exclude irrelevant, immaterial, or unduly repetitious evidence. The Board shall render a final ruling on the admissibility of evidence.

42 C.F.R. § 405.1855.

The Board majority does not believe that a provider's timely appeal under the controlling provisions of 42 C.F.R. §§ 405.1835-.1841 and 42 C.F.R. 413.86(e)(1)(v) should fail based on the pretense that the evidence must be rejected under a regulatory provision that pertains to a separate and distinct review process conducted by an intermediary. Accordingly, it is the majority of the Board's conclusion that it has complete jurisdiction over the GME issue in dispute in this case, and that the documentary evidence is admissible in accordance with the regulations and rules governing the Board's hearing procedures.

The determinative issue in this appeal concerns the adequency of the documentation furnished by the Provider in support of its reclassification request for GME costs. Accordingly, the resolution of this request hinges on the acceptability of the submitted documentation under the general statutory and regulatory scheme of the Medicare program. Under the controlling

regulatory provisions of 42 C.F.R. §§ 413.20 and 413.24, participating providers are required to maintain sufficient financial records and statistical data for the proper determination of costs payable under the program. The general record keeping requirements of 42 C.F.R. § 413.20 require providers to maintain an adequate system for furnishing the records needed to provide accurate cost data and other information capable of verification by qualified auditors. This regulation goes on to state that "[e]ssentially the methods of determining costs payable under Medicare involve making use of data available from the institution's basic accounts, as usually maintained . . . ." The provisions of 42 C.F.R. § 413.24 further address a provider's responsibility for maintaining adequate financial and statistical records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purpose for which it is intended. Based on the substantial evidence presented, the majority of the Board finds that the Provider has complied with the documentation requirements of these controlling regulations.

The Board majority finds that the contemporaneously maintained physician allocation agreements (Providers Exhibit P-19) provide reliable and adequate substantiation of the physicians' GME teaching activities in compliance with the documentation requirements of 42 C.F.R. §§ 413.20 and 413.24. In addition, the agreements were also maintained in accordance with the specific record keeping requirements of 42 C.F. R. § 405.481(g), and were relied upon by the Intermediary during the regular audit of the Provider's 1984 cost report for the purpose of allocating physician compensation costs between Part A and Part B of the Medicare program. In reviewing these allocation agreements, the Board majority also took into consideration the problems identified by the Intermediary's witness based on his review of the agreements.[23] Of the twelve problems identified by the Intermediary's witness, the majority of the Board believes that four of the identified deficiencies are crucial factors which must be taken into consideration in determining the amount of GME costs allowable in the Provider's reclassification request. Referring to the summary of problems identified in the Intermediary's Contentions, the four deficiencies are as follows:

No. 4 - Allocation agreements for one physician appear to be transparencies.

No. 6 - Allocation agreement for one physician has been used twice for two different departments.

No. 7 - One allocation agreement shows no breakdown of allocation percentage.

No. 12 - Allocation agreements show teaching activities which included medical students as well as interns and residents.

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[23] Tr.(Apr.17, 1997), at 126-152

The Board majority traced each of the above deficiencies to the specific physician allocation agreement in question, and modified the summary data reflected in Exhibit E of the Provider's Position Paper to take into consideration the deficiencies relating to Nos. 4, 6 and 7. The deletion of physician data associated with these deficiencies reduces the physician compensation amount identified to interns and residents from $400,818[24] to $371,287. However, the estimated percentage of total physician time devoted to GME activities remained at 21 percent based on allocated physician hours. With respect to deficiency No.12, the majority relies on the testimony of the Provider's witness who established that 11 percent of the physicians' teaching time was spent on medical students.[25] Relying on the records maintained in the areas of surgery and medicine, the Provider was able to ascertain the number of medical students in these programs for the 1984 GME base period. Based on the ratio of the number of medical students to the number of medical students plus interns and residents, the Provider determined an 11 percent reduction in teaching time spent only on interns and residents. The Board majority notes that this approach was accepted by the HCFA Administrator in Baystate Medical Center v. Aetna Life Insurance Company, PRRB Dec. No. 96-D73, September 27, 1996, Medicare and Medicaid Guide (CCH) ¶ 44.698, Aff'd/Mod HCFA Administrator, November 25, 1996, Medicare and Medicaid Guide (CCH) ¶44,966. The application of this reduction would result in an adjustment to the teaching percentage from 21 percent to 18.7 percent, and would further reduce the physician compensation costs identified to interns and residents to $330,445. It is the Board majority's conclusion that the contemporaneously maintained physician allocation agreements constitute adequate support for the requested reclassification of GME costs as modified to incorporate the above deficiencies noted by the majority in its review of the documentation.

While the majority of the Board finds the physician allocation agreements to be adequate documentation, it also recognizes the existence of the 1992 physician time study which the Provider conducted to corroborate the allocation agreements. Although the 1992 physician time study was unnecessary, the majority notes that the results of this study reflected a physician allocation percentage of 20 percent relating to interns and residents teaching activities. Accordingly, this supplementary study provides further validation of the magnitude of physician compensation costs associated with the Providers' GME activities, and bolsters the accuracy of the 1984 physician allocation agreements used for the requested reclassifications of GME costs.

With respect to the secretarial support costs of $50,378 reflected in Exhibit F of the Provider's Position Paper, the majority of the Board finds the Provider's methodology and calculation to be a reasonable and appropriate approach for determining the amount of GME costs

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[24] The figure of $404,737 reported on Exhibit E of the Provider's Position Paper was subsequently corrected to $400, 818 during the hearing before the Board [Tr. (Dec. 10, 1996), at 98].

[25] Tr. (Apr. 17, 1997), at 50-52 and 84-85.

associated with this support activity. However, consistent with the Board majority's finding for the physician compensation costs, the extent of GME activity should be decreased to 18.1 percent, which would reduce the interns and residents secretarial support costs to $44,860.

DECISION AND ORDER:

The Intermediary's refusal to reclassify as GME costs certain physician compensation costs and related secretarial compensation costs originally classified as non-GME operating costs on the Provider's GME base-year cost report was not proper. The Intermediary is ordered to implement the Provider's reclassification request, as modified by the Board majority's findings and conclusions in this decision.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire (Dissenting Opinion)
Martin W. Hoover Jr., Esquire
Charles R. Barker

Date of Decision: December 01, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman

Dissenting Opinion of Henry C. Wessman

I dissent.
Calculation of the NAPRA, and the appeal rights stemming from that calculation, are specific and codified at 42 CFR § 413.86 et seq. The NAPRA process requires specific acts of both parties, intermediary and provider, with clear expectations and time lines. For the provider, the instructions for appeal of the intermediary-calculated "per resident amount" contain three imperatives: the provider 1) must request intermediary review, 2)with sufficient documentation, 3)within 180 days of notice from the intermediary. When a provider takes issue with the base-period average per resident amount [42 CFR § 413.86(e)(1)(v)], including misclassification of operating or graduate medical education costs that effect rate-of-increase ceiling or prospective payment base year, which then requires adjustments of the hospital's

target amount or hospital-specific rate, the protocol and procedure [42 CFR § 413.86(j)(1)(I) and (ii); 42 CFR § 413(j)(2)(I) and (ii)] calls for those three imperatives.

A basic tenet of administrative law requires the appealing party to "exhaust all administrative (regulatory) remedies" during each step of the process. In the instant case, in my opinion, the Provider missed all three steps, and thus did not "exhaust" its remedies at the Intermediary level. In the instant case, the NAPRA was issued February 28, 1991. On August 26, 1991, one hundred and seventy nine (179) days after the issuance of the Provider's NAPRA, the Provider allegedly "notified" the Intermediary, per telephone, that there were problems with their APRA, and that the Provider needed to "stop the clock" and obtain review of the entire matter. Tr.(Dec. 10, 1996), at 56-61.

As noted in 42 CFR § 413.86(j)(1) and (2), the burden is clearly on the Provider to request of the Intermediary, within 180 days, a review of misclassified GME costs, with sufficient documentation to demonstrate that adjustment relevant to the APRA calculation is warranted. In my opinion, a phone call that suggests "problems" sufficient enough to "stop the clock" does not rise to the level of duty fulfillment on the part of the Provider. 42 CFR § 413.86 et seq. is quite clear- the Provider knew, or should have known, the protocol to be followed to perfect its request. An uncorroborated phone call, standing naked and devoid of written verification, and unsupported by any semblance of documentation of error to be corrected, is not, I believe, what 42 CFR § 413.86 et seq. requires. Had there been strong corroboration, or contemporaneous written verification, and had there been some evidence that the substance of the issues under contention had been actually discussed, the Provider-raised theories of "detrimental reliance" and "estoppel" could possibly have been sustained, based on the theory of adequate verbal notice/documentation. But again, these contentions are moot, due to lack of corroboration/verification of the 179th day phone call by the Provider.

In addition to administrative law principles, I view the Provider's participation in Medicare to be on a contractual basis, with the regulations embodied in the CFR incorporated into that contract by reference. Both parties (the Federal government through its fiscal agent, the intermediary; and the provider) to the health care service delivery contract known as Medicare are bound by the terms of that contract, and the "conditions precedent" for adjusting certain graduate medical
education payments are that the provider must 1) request intermediary review, 2) with sufficient documentation, and 3) within 180 days of notice from the intermediary. Again, in the instant case, not only did the Provider not exhaust available administrative remedy; it also did not fulfill the terms of the Medicare contract required as a condition precedent to gain relief.

Ironically, the documentation on the issue of physicians' time (but not support staff, due to lack of job descriptions, duties, and responsibilities) presented by the Provider to the PRRB (Provider Exhibits 19 &20) would have, at least in my opinion, been of adequate persuasion to have provided the basis for some relief for the Provider, had they presented this to the

Intermediary in a timely and issue-specific manner. But the fact that the Provider, by virtue of not perfecting its right/duty to exhaust all administrative remedies in a timely manner, even on the 179th day of a 180-day window, makes those exhibits moot point under administrative law.

In the administrative law environment of the PRRB tribunal, I would sustain the adjustments made by the Intermediary to the Provider's APRA.

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Henry C. Wessman, Esq.