PROVIDER REIMBURSEMENT REVIEW BOARD HEARING DECISION

98-D26

PROVIDER -Mercy Hospital of Pittsburgh Pittsburgh, Pennsylvania

Provider No. 39-0028

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/ Blue Cross of Western Pennsylvania

DATE OF HEARING-
Various

Cost Reporting Period Ended - June 30, 1985

CASE NO. 91-2673M

INDEX

ISSUES:

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2. **Were the HCFA GME Program Instructions ("GME-PI") implementing the reaudit provisions of 42 C.F.R. § 413.86 invalid?**

3. **Was the Intermediary's adjustment reclassifying the GME costs for the Medical Library ("ML"), Department of Education ("DOE"), and Department of Continuing Education ("DCE"), to Administrative and General ("A&G") proper?**

4. **Was the Intermediary's adjustment reclassifying a portion of the teaching physicians salaries from GME to A&G proper?**

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7. **Was the Intermediary's adjustment revising the number of FTE residents used in determining the Provider's Average Per Resident amount proper?**

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9. **Should the GME clinic costs, mistakenly classified as operating costs in the base year, be included when calculating the APRA?**

10. **Should the GME laboratory costs, mistakenly classified as operating costs in the base year, be included when calculating the APRA?**

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Mercy Hospital of Pittsburgh ("Provider") is a non-profit, acute care, teaching hospital, located in Pittsburgh, Pennsylvania. During the fiscal-year ended ("FYE") June 30, 1985, the Provider operated an extensive approved Graduate Medical Education ("GME") program. The Provider's GME base-year is fiscal year ("FY") June 30, 1985.

Congress enacted section 9202 of the Omnibus Budget Reconciliation Act of 1986, P.L. 99-272, 42 U.S.C. § 1395ww(h), which significantly changed the reimbursement

methodology for GME activities. Instead of paying on a reasonable cost ("RC") basis, a new prospective rate system was created, i.e., average per resident rate amount ("APRA"). To implement this new system new regulations were promulgated[1] four years later in 1989, and Blue Cross and Blue Shield of Western Pennsylvania ("Intermediary") was required to reaudit the Provider's GME base-year. As a result, the Intermediary reopened the FY 1985 base-year making a wide variety of significant adjustments reclassifying GME costs and changing the count of interns and residents ("I&R") in the approved GME program. The APRA notice was issued on February 26, 1991. The Provider filed a timely appeal with the Provider Reimbursement Review Board ("Board") and has met the jurisdictional requirement of the regulations at 42 C.F.R. §§ 405.1835-.1841 and 413.86(e)(1)(v). The Medicare reimbursement effect in dispute is approximately $4.5 million annually with an aggregate 10 year effect of about $45 million.

The Provider was represent by Terrence J. O'Rourke, Esquire, and David W. Thomas, Esquire, of Nash & Company. The Intermediary was represented by Michael F. Berkey, C.P.A., Associate Counsel for Blue Cross and Blue Shield Association.

Relevant Medicare Statutory and Regulatory Background:

From the inception of the Medicare program until 1983, hospitals were paid for covered inpatient services on the basis of "reasonable cost" ("RC"). 42 U.S.C. § 1395x(v)(1)(A) defines RC as "the cost actually incurred," less any costs "unnecessary in the efficient delivery of needed health services." The Secretary was authorized to promulgate regulations prescribing the methods to determine RC and the items to be included. Under these RC regulation provisions, Medicare had traditionally paid a share of the net costs of "approved medical education activities[2]." 42 C.F.R. § 413.85(b) defines approved educational activities as formally organized or planned programs of study, usually engaged in by providers to enhance the quality of care in an institution and include, inter alia, approved training programs for physicians.

In 1983, Congress created the Medicare prospective payment system ("PPS")[3], where a hospital's inpatient operating costs were to be paid under a new prospective methodology, Diagnosis Related Group ("DRG"). Under PPS, providers received reimbursement for their inpatient operating costs on prospectively determined national and regional rates for each patient discharged instead of on a RC basis. To lessen the

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1 54 Fed. Reg. 40286 (1989); 42 C.F.R. § 413.86.

2 20 C.F.R. § 405.421 (1966); 42 C.F.R. § 405.421 (1977); 42 C.F.R. 413.85 (1986).

3 Pub. L. 98-21, 42 U.S.C. § 1395ww(d).

impact of this new system, Congress phased PPS in over a four-year transition period[4] paying for hospital inpatient operating costs with a "blended rate" consisting of two components. The first component was the hospital-specific rate ("HSR") reflecting an individual hospital's own cost experience during a specified base-year[5]; and, secondly, the Federal PPS rate consisting of regional and national standardized amounts. During the transition period, the Federal PPS rate increased and the HSR decreased proportionately.

Initially under PPS,[6] the costs of approved medical education activities were specifically excluded from the definition of "inpatient operating costs[7]," and they were also excluded from the blended rate, i.e., HSR and Federal PPS rates. Other costs were also excluded and collectively were known as "pass-through costs." Payment for approved medical educational activities, such as GME, continued to be made on a RC basis.[8] Since the educational costs were excluded from the blended rate, a "consistency rule" was established by the promulgation of 42 C.F.R. § 412.113(b). This regulation provided that through out the transition period, the allowable costs used in developing the HSR (PPS base-year) should also be treated consistently in the GME base-year, i.e., as either GME costs or as operating costs. This rule prevents the duplication of payment for GME costs claimed as operating costs in the HSR and again as a pass through cost under PPS. 42 C.F.R. § 413.85(c) also provides that in determining the cost of educational activities, particularly where costs were either omitted or misclassified, Medicare should not participate in any increased costs resulting from the redistribution of such costs from educational institutions or units to patient care institutions.

In 1986, Congress enacted the Comprehensive Omnibus Budget Reconciliation Act of 1986[9] (the "Act") which converted GME reimbursement from a RC pass-through basis to a prospective per-resident basis indexed to a base year. The Act further provided that the base year per-resident average amount would be adjusted for inflation and used

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4 Section 9202 of the Consolidated Omnibus Budget Reconciliation Act ("COBRA") of 1986, Pub. L. No. 99-272, 100 Stat. 82.

5 42 C.F.R. §§ 412.71 and 412.73.

6 42 U.S.C. §§ 1395ww(a)(4) and (d)(1)(A).

7 42 U.S.C. §§ 1395ww(a)(4). Pub. L. 98-21 § 601(a)(2), (1983).

8 42 U.S.C. § 1395(b).

9 Pub. L. No. 99-272, 1986, U.S.C.C.A.AN (100 Stat. 82).

to calculate GME reimbursement for future years.[10] Section 9202(a) of Public Law 99-272 amended the Social Security Act ("Act") codified at 42 U.S.C. § 1395ww, to establish this new prospective payment methodology for direct medical education costs for periods beginning on or after July 1, 1985. 42 U.S.C. § 1395ww(h)(2)(A) required the Secretary to "determine the average amount recognized as reasonable under this title" for GME costs per full-time equivalent ("FTE") resident. The statute[11] provided that:

> **the Secretary shall determine, for each hospital with an approved medical residency training program, an approved [full-time equivalent (FTE)] resident amount for each cost reporting period beginning on or after July 1, 1985, as follows:**
>
> > **(A) DETERMINING ALLOWABLE AVERAGE COST PER FTE RESIDENT IN A HOSPITAL'S BASE PERIOD ---The Secretary shall determine, for the hospital cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this title for direct graduate medical education costs for each full-time equivalent resident.**

42 U.S.C. § 1395ww(h)(2)(A) (emphasis added).

The statute also defined certain terms:

> **A. APPROVED MEDICAL RESIDENCY TRAINING PROGRAM. --- The term "approved medical residency training program" means a residency or other postgraduate medical training program participation in which may be counted toward certification in a specialty or subspecialty and includes formal postgraduate training programs in geriatric medicine approved by the Secretary.**
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> *** * ***
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> **C. DIRECT GRADUATE MEDICAL EDUCATION COSTS. --- The term "direct graduate medical education costs" means direct costs of approved medical educational activities for approved medical residency training programs.**

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[10] Section 9202(a) of the Act, 42 U.S.C. § 1395ww(h)(2)(C)-(D).

[11] Section 9202 of the Consolidated Omnibus Budget Reconciliation Act ("COBRA") of 1986, Pub. L. No. 99-272, as amended. The revised payment method applies to all hospitals regardless of their status under PPS. 54 Fed. Reg. at 40297-8.

42 U.S.C. § 1395ww(h)(5)(A) and (C). See 42 C.F.R. § 413.86(a)-(b).

The implementing regulations ("GME regulations") were promulgated three and one-half years later in 1989 at 42 C.F.R. § 413.86.[12] They were effective as of 1985 for all reporting periods beginning on, or after, July 1, 1985. Pursuant to 42 C.F.R. § 413.86(e)(1) intermediaries were required to determine a base-year amount for each hospital. In making this determination, intermediaries were to reopen[13] and re-audit the GME base-year to verify the accuracy of the GME costs and to exclude any nonallowable or misclassified costs. However, under 42 C.F.R. § 413.86(e)(1)(ii)(C), hospitals could request the reclassification of misclassified GME costs that were not allowable under § 412.113(b)(3). Such costs could be included only if the hospital also requested an adjustment to its HSR under § 413.86(j)(2) which must be made within 180 days of the APRA notice.

HCFA stated in the preamble[14] of the GME regulations that the intent of the re-audit was to ensure the reimbursement principles in effect for the GME base-year were correctly applied. Hence, no new reimbursement principles would be applied in the re-audit.

Upon completion of the re-audit and the determination of the allowable GME base-year costs, the intermediary would calculate and notify the hospital of the APRA, i.e., the new prospective payment rate for GME. In subsequent years, the base rate is adjusted for inflation and multiplied by the weighted number of FTE residents in the hospital's GME program during the applicable FY. This amount is multiplied by the hospital's Medicare inpatient load[15] to ascertain the amount of GME reimbursement. See 42 C.F.R. § 413.86 (1989).

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12 54 Fed. Reg. 40286 (1989).

13 If the GME base-year was not subject to reopening under 42 C.F.R. § 405.1885, then the base-year costs could be modified solely for the purpose of computing the per resident amount. See 42 C.F.R. § 413.86(e)(1)(iii).

14 54 Fed. Reg. at 40301.

15 Defined as the ratio of Medicare inpatient-bed days to total inpatient-bed days. See 42 U.S.C. § 1395ww(h)(3)(C).

Additional Relevant Information:

Several issues make reference to "Schedule 3"[16] (HCFA form-339) which is entitled Allocation of Physician Compensation. Schedule 3 is used to allocate physician time (contains 13 lines) which is then used to allocate physician compensation. Schedule 3 shows all of the hospital-based physician time and allocates the time as follows: lines 1-8 sub-allocates the physicians Part A time which is totaled on line 9; line 10 shows physician Part B time, i.e., services provided directly to individual patients; line 11 shows nonreimbursable time, e.g., for funded research; and line 12 shows the total of all physician time. Line 13 is a computed "Professional Component Percentage" unrelated to time per se.

The 13 lines on Schedule 3 are: 1) Supervision of technicians, nurses, etc., 2) Utilization Review, other committee work, 3) Administration, 4) Supervision of Interns/Residents, 5) Teaching, 6) Quality Control, 7) Autopsies, 8) Other, 9) Total (lines 1 thru 8) [Part A time], 10) Medical and surgical services to Individual patients [Part B], 11) nonreimbursable activities, e.g., research, 12) Total hours -All Activities (lines 9, 10, and 11), and 13) Professional Component Percentage (line 10, col. 3 - line 12, col. 3).

ISSUE NO. 1: Validity of GME regulation, 42 C.F.R. § 413.86.

Were the GME regulations at 42 C.F.R. § 413.86 valid?

PROVIDER'S CONTENTIONS:

The Provider contents that the Intermediary's adjustments, which reclassified a variety of GME costs and changed the count of I&R participating in the approved GME program, were inappropriate and impermissive because the regulatory provisions of 42 C.F.R. § 413.86 are invalid, and also because the GME program instructions ("GME-PI") implementing the reaudit provisions of the cited regulation are invalid [Discussed in Issue No. 2].

The Provider argues that 42 C.F.R. § 413.86 was invalid because the regulation:

1. **contravenes the plain language and congressional intent of 42 U.S.C. § 1395ww(h);**
2. **was an impermissible interpretation of the statute;**
3. **was arbitrary and capricious;**
4. **was otherwise unlawful and invalid;**
5. **was an unauthorized retroactive regulation;**

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[16] Provider Exhibit P-35.

6. was invalid under the standards set forth in the Administrative Procedure Act ("APA"), 5 U.S.C. § 706.

The Provider also argues that the Court of Appeals decision in the Administrators of the Tulane Educ. Fund v. Shalala, 987 F. 2nd 790 (D.C. Cir. 1993), cert. denied, 510 U.S. 1064 (1994), upholding the GME reaudit regulation was erroneous.

The Provider acknowledges (and the Intermediary agrees) that the Board does not have the authority to declare the GME regulation invalid. In view of this acknowledgment, the Provider's full contentions and arguments are hereby incorporated by reference from its Position Paper (at pp. 18-68) and the Post Hearing Brief. A synopsis is presented below. The parties also acknowledge it was inappropriate to seek, or for the Board to unilaterally grant, "expedited judicial review" ("EJR") under 42 C.F.R. § 405.1842 because there were significant interrelated factual issues for Board resolution.

The Provider states when the validity of a regulation is challenged, a reviewing court must first decide whether the regulation is consistent with the plain language of the statute before advancing to the second stage of analyzing and determining if the agency's interpretation is reasonable in order to apply the deference doctrine. Citing the following case as support:

> **If the statute is clear and unambiguous, 'that is the end of the matter, for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress. . . . The traditional deference courts pay to agency interpretation is not to be applied to alter the clearly expressed intent of Congress. In asscertaining the plain meaning of the statute, the court must look to the particular statutory language at issue, as well as the language and design of the statute as a whole. Bethesda Hospital Assn, v. Bowen, 485 U.S. 399, 403-405 (1988); Offshore Logistics, Inc. v. Tallentire, 477 U.S. 207, 220-221 (1986); K Mart Corp. v. Cartier, 486 U.S. 281, 291, (1988) (emphasis added), quoting also Chevron U.S.A. v. Natural Resources Defense Council, 467 U.S. 837, 842-43, reh'g denied, 468 U.S. 1227 (1984).**

The GME Statute at 42 U.S.C. § 1395ww(h)(2) is entitled "Determination of Hospital-Specific Approved FTE Resident Amounts," which directs the Secretary to determine "an approved FTE resident amount" as follows:

> **(A) DETERMINING ALLOWABLE AVERAGE COST PER FTE RESIDENT IN A HOSPITAL'S BASE PERIOD ---The Secretary shall determine, for the hospital cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this title**

for direct graduate medical education costs <u>for each full-time equivalent resident</u>.

42 U.S.C. § 1395ww(h)(2) (emphasis added).

The Provider states the phrase "shall determine" refers to the "average amount" for each FTE resident, and not to "the average amount recognized as reasonable under this title" for direct GME costs. Otherwise, the subsection would have been entitled "Determination of Amount to be recognized as reasonable for use in calculating the Hospital-Specific Approved FTE Resident Amounts." The Provider asserts that the title of the subsection clearly indicates the legislative intent was only to provide the Secretary with a methodology for determining the "average FTE amount" rather than the amount of costs "recognized as reasonable." The statute did not set forth an entirely new methodology or directive to redetermine how costs should be "recognized as reasonable." The Provider asserts Congress was well aware that educational costs were reimbursed on a reasonable cost ("RC") basis, and that the statute unambiguously incorporated the then existing reasonable cost principles and determinations for the base year. <u>See</u>, 42 U.S.C. § 1395ww(h)(2)(A). The GME statute was enacted in 1986 when the GME base year for most providers was in the process of being audited. Congress specifically provided that the GME per resident amount be calculated using "the average amount recognized as reasonable under this title." If Congress intended one amount to be "reasonable" in the base year, and a different amount after reaudit to be "reasonable" for future base year computations, Congress would have so stated in the statute.

The Provider asserts that Congress did not intend or authorize a reexamination, reaudit, or redetermination of an amount already "recognized as reasonable" for GME base year costs. Therefore, the Secretary made an impermissible interpretation that HHS was empowered to do all of the above acts. Congress clearly intended the Secretary to use the final GME amounts determined from the final adjustments made pursuant to the original base year audits which would be subject to the normal three-year reopenings for any necessary revisions. The fact that Congress never intended to authorize reaudits is demonstrated by the design of the GME statute as a whole. Congress instructed the Secretary to use a simple methodology of computing an "average amount" by dividing the "amount recognized as reasonable under this title" by the number of "full-time equivalent residents." The statute did not state to use an "amount that the Secretary determines to be appropriate and reasonable." Congress authorized the Secretary to "establish rules" regarding other variables but not to redetermine the amount of costs to be "recognized as reasonable."

The Provider argues that the plain language (and intent of Congress), was that the "amount recognized as reasonable under this title" was the amount already determined (or in the process of being determined) for the normal base year under the usual audit

and review procedure pertaining to the base year itself. The Secretary's reaudit regulation was based on an impermissible interpretation of the statute thereby exceeding her statutory authority rendering the regulation invalid.

The Provider further states that the reaudit regulation was also invalid under section 706 of the APA. Section 706 sets forth six separate standards whereby an agency's action may be found to be arbitrary and capricious, an abuse of discretion, or otherwise unlawful and invalid. The Secretary's actions were beyond the scope of the statute; and she relied on factors Congress did not intend for consideration while failing to consider other relevant aspects thereby making the actions arbitrary and capricious.

The entire scheme of the GME regulations and the reaudit were untimely causing an impermissive retroactive application. The Secretary promulgated the regulations three and one-half years after the statute followed by another delay of more than a year for implementing the reaudit. The reaudits typically were beyond the three-year reopening period and beyond the four-year record retention period. The reaudit instructions applied reimbursement principles that were not in effect during the original base year; and the auditing standards used were different as discussed in the next global contention in II below.

The Provider also argues that the Tulane decision was erroneous for a variety of reasons. First, the court did not properly apply the Chevron test. The court did not address the clarity of the statutory language nor the intent of Congress, i.e., that it was clear and unambiguous; and summarily concluded "that the reauditing was not an exercise in retroactive rule making at all, let alone an impermissible one." Therefore, the court erroneously advanced to Chevron's second stage to review the reasonableness of the Secretary's three and one-half year delay in promulgating an unauthorized new methodology for determining "reasonable costs in the base year." Secondly, even assuming the court could advance to the second prong of the Chevron test, the court failed to properly consider the conflict between the reaudit regulation and the reopening regulation which resulted in the unilateral abandonment of the fundamental principles of finality. Further, the court's analysis ignored the realty of the new rule's financial impact on providers which was achieved retroactively. The Tulane court merely decided the reaudit regulation "contemplated the use of past information for subsequent decision making," which was similar to a case where the use of past default rates to determine future eligibility in the student loan program was held not to be retroactive. The cited case stated a law is retroactive if it:

> **takes away or impairs vested rights acquired under existing law, or creates a new obligation, imposes a new duty, or attaches a new disability in respect to transactions or considerations already past.**

Association of Accredited Cosmetology Schools v. Alexander, 987 F. 2d 859, 864 (D.C.

Cir. 1992).

The Association case distinguished the concept of "past information for subsequent decision making" from the Georgetown I case where a vested right was impaired. The Association case stated:

> **In Bowen v. Georgetown Univ. Hosp., the plaintiff hospitals had incurred millions of dollars in expenses under the Medicaid program since 1981, for which they had a right to be reimbursed by the federal government. . . . However, in 1984 HHS issued a rule that provided for a new method of calculating the reimbursement owed under the Medicaid program, a change . . . that reduced the hospitals' 1981-84 reimbursement by more than $2 million, and then sought to recoup the overpayment. It is plain that under any definition, the plaintiff hospitals had a vested right to the Medicaid payments they had received and that the 1984 rule retroactively impaired that right.**

Association of Accredited Cosmetology Schools v. Alexander, 987 F. 2d 859, at 864 (D.C. Cir. 1992), (emphasis added), citing Georgetown I, 488 U.S. at 205-07.

The Provider and other GME hospitals subject to the reaudit regulation encountered a similar set of circumstances to Georgetown I. The Provider incurred substantial GME costs in and subsequent to the base year, and it has received reimbursement for most of those incurred expenses from 1985 to 1992. However, by the application of the reaudit, the new GME reimbursement methodology has reduced the amount of reimbursement the Provider was entitled to and had received; and now HHS seeks recoupment of the overpayment. Thus, contrary to the reasoning of Tulane, HHS has not only used past information for subsequent decision making, it has changed the past information and used it to effect recoupment on a retroactive basis.

Lastly, the court's analysis of excusable delay was based on the "complex" nature of the GME amendments which was not present. The statute only provided for a relatively simple methodology of "averaging," and it did not authorize or empower HHS to create the concept of reauditing to make a redetermination of reasonable costs, as stated above.

INTERMEDIARY'S CONTENTIONS:

The Intermediary responds to the Provider's challenge and declares that the GME regulations are valid because:

1. **42 C.F.R. § 413.86 was properly promulgated and not beyond the scope of basic statute, 42 U.S.C. § 1395ww(h)[17];**
2. **The validity of the regulation is beyond the scope of the Board's authority;**
3. **The Board has no jurisdiction over this matter;**
4. **The Board is bound by all Medicare laws enacted and regulations promulgated pursuant to 42 C.F.R. § 405.1867.**
5. **Two courts, which have also considered and rejected the Provider's contentions have upheld the GME regulations. See Tulane Medical Center Hospital and Clinic; and St. Paul-Ramsey Medical Center, Inc. v. Shalala, 91 F.3d 57 (8th Cir. 1996).**

ISSUE NO. 2: Validity of HCFA GME Program Instructions.

Were the HCFA GME Program Instructions ("GME-PI") implementing the reaudit provisions of 42 C.F.R. § 413.86 invalid?

PROVIDER'S CONTENTIONS:

The Provider argues that the HCFA GME-PI implementing the reaudit provisions of 42 C.F.R.
§ 413.86 were invalid because they:

1. **substantially changed the application of Medicare reimbursement principles and policies as well as audit standards and practices;**
2. **clearly represent substantive rules (per 1 above) and were void for failure to comply with the APA provisions under 5 U.S.C. § 553;**
3. **contravene the intent of 42 C.F.R. § 413.86 in that GME base-year costs were not verified, do not represent incurred costs, and were inherently understated;**
4. **do not provide for an accurate and proper statement of the GME costs, the Medicare statute prohibiting cost-shifting to non-Medicare patients was violated;**
5. **were otherwise unlawful since they were not in accordance with the law, violate due process, and were arbitrary and capricious.**

INTERMEDIARY'S CONTENTIONS:

The Intermediary contests the Provider's assertion that the GME Program Instructions were invalid by arguing that:

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[17] Administrators of the Tulane Educational Fund, d/b/a Tulane Medical Center Hospital and Clinic, v. Shalala, 987 F. 3d 790 (D.C. Cir. 1993), cert. denied, 510 U.S. 1064 (1994).

1. **The Board has no jurisdiction;**
2. **Provider's allegations were devoid of proof;**
3. **Differences between the procedures for a "regular" audit and the "re-audit" were reasonable under the applicable GME unique circumstances.**

ISSUE 3: Intermediary's reclassification of certain GME costs.

Was the Intermediary's adjustment (No.1) reclassifying the GME costs for the Medical Library ("ML"), Department of Education ("DOE"), and Department of Continuing Education ("DCE"), to Administrative and General ("A&G") proper?

FACTS:

The Provider had reported the costs for the ML, DOE, and DCE as GME costs since these incurred costs were necessary to maintain accreditation of its GME programs. With respect to the ML, the Intermediary disallowed these costs because 42 C.F.R. § 413.85(d) provided that such costs were not allowable as GME costs. The Intermediary did not establish that 100% of the DOE and DCE departmental costs were related to GME, and then disallowed 100% of these costs. Thus, all three of these departmental areas were fully disallowed.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's reclassification of 100% of the GME costs for all three areas was improper because:

1. **The regulation at 42 C.F.R. § 413.85(d) that excludes the Medical Library costs from GME is invalid;**

2. **A substantial portion of the two other areas are directly related to GME and should, at least, be apportioned on that basis:**

   a. 96% of the DOE was GME related

      i. A reorganization of the DOE occurred in 1985, and the financial records[18] show that 80% of the costs are directly GME related, and the other 20% relates to DCE. Since 80% of DCE was GME related (per b below), then an additional 16% must be recognized. Hence, 80% + [80% x 20%=] 16%= 96%.

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[18] Provider Exhibits P-82 and P-106.

b. 80% of DCE costs are GME related.

i. Testimony[19] of three Provider witnesses including the vice president of Medical Affairs and documentation submitted[20] establish 80% of the DCE costs are GME related.

ii. The activities conducted were required for GME accreditation including "grand rounds" and certain continuing medical education programs that all I&R were required to attend.

3. Intermediary representative testified[21] that:

a. 100% Disallowance of DOE and DCE was incorrect;

b. An allocation basis of a percentage of salaries for GME and non-GME activities would be acceptable.

c. The Provider's financial data, departmental summary (Ex. P-82) was acceptable.

d. Allocation of costs between GME and non-GME activities based upon job descriptions was acceptable. See Tr. 6/6/95 pp 169-173.

4. Failure to allocate these costs to GME violates the statutory cross subsidization provision.[22]

INTERMEDIARY'S CONTENTIONS:

The intermediary contends the reclassification adjustment was proper because:

1. a. Pursuant to 42 C.F.R. § 413.85(d)(4) there is a specific regulatory bar preventing Medical Library costs from being treated as GME costs.

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19 Tr. 6/2/95 at pp. 13-16, 19, 33, 36-37, 62-63; Tr. 6/6/95 at pp. 95, 131-132; Tr. 6/7/95 at pp. 130-131.

20 Provider Exhibits: P-36, P-82, and P-106.

21 Tr. 6/6/95 at 163, 170-171 and 174-178; Tr. 6/7/95 at 53.

22 42 U.S.C. § 1395x(v)(1)(A), Reasonable Cost

b. The Board does not have the authority to determine that this regulation is invalid; and the Board is bound by Medicare regulations properly promulgated under the provisions of 42 C.F.R. § 405.1867.

2. The Provider has not met the documentation requirements required by 42 C.F.R. §§ 413.20 and 413.24.

3. The only written documentation (Provider Exhibits P-82 and P-106) to support the claimed costs were untimely, in that they were submitted as part of this appeal's record and not submitted at the time of the re-audit.

4. The precise relationship and relevancy of Provider Exhibit P-82 is not clear since it was developed during the middle of the base-year while a reorganization was in progress. Despite the Intermediary witness' willingness to concede that P-82 was related to the base-year, the exhibit does not reflect the ultimate effect of the reorganization.

5. Provider Exhibit P-82 was also flawed in that job descriptions ("JD") were used to allocate costs between GME and non-GME activities. For example, the JD at pp 776-779 of Provider Exhibit P-82, does not relate solely to GME activities. Pursuant to an Administrator's decision, JD may not be used to allocate costs of the department between GME and non-GME functions. See In Home Health, Inc. v. Blue Cross and Blue Shield Association et al., HCFA Administrator's Dec., Aug. 4, 1996, Medicare & Medicaid Guideline (CCH) ¶ 44,594.

6. Despite the Intermediary witness' willingness to make some concessions (Tr. 6/6/95 pp 173-179) by applying a developed percentage for GME, there was insufficient documentation under the regulatory requirements regarding the remainder of the direct costs. For example, there were no JDs, invoices, or other auditable documentation to establish GME costs in the Organizational Development Department.

7. With respect to the DCE department, there was no auditable documentation.

a. The only evidence consisted of one JD in Provider Exhibit P-82 at pp 778-779 and a narrative description of the cost center in Provider Exhibit P-106 which was not sufficient.

b. The Intermediary's witness testified[23] that the cost center description for Provider Exhibit P-106 indicated the account collected costs for both GME and non-GME functions. Hence, the account is unreliable. Despite the witness's willingness to apply the same percentage developed for the Organizational Development Department (per 6 above), there was no auditable documentation.

8. The claimed costs will cause the Provider's Per Resident Amount to be substantially out of line with comparable facilities in the Provider's area. 42 C.F.R. § 413.9(c)(2).

ISSUE 4: Reclassification of Physician compensation.

Was the Intermediary's adjustment reclassifying a portion of the teaching physician salaries from GME to A&G proper?

FACTS:

The Intermediary's reaudit adjustment No. 6 reclassified a substantial portion, about $913,600, of the physician compensation reported as GME costs to A&G. The amount consisted of three separate categories of physician compensation; namely: i.) resident stipends, ii.) visiting professor fees, and iii.) GME faculty. The adjustment was made based upon the HCFA GME-PI regarding the application of Schedule 3 to segregate GME and non-GME time to determine physician compensation allocation methodology for GME and non-GME activities. Under the GME-PI, only lines 4 and 5 of Schedule 3 were considered as GME related while the time reported on all other lines of Schedule 3 were considered non-GME related. The HCFA instructions for completing Schedule 3, in the base-year, focused solely upon separating physician time into three main areas: 1) Part A, 2) Part B, and 3) any non-reimbursable activities; and Part A time was also sub-allocated into eight areas. The related instructions did not state or require any separation between GME and non-GME time.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's reclassification of the three types of teaching physician salaries were improper because:

1. All three types of teaching physician compensation were related 100% to GME:

   a. Resident stipend compensation of $14,500 was 100% GME related;

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[23] Tr. 6/6/95 at 179-186 and 197-203.

under 42 C.F.R. § 413.85(g),[24] it is an allowable GME expense; and the Intermediary had allowed 100% of the resident stipend in the Provider's original filed base-year cost report.

b. Visiting Professor fees of $4,500 were net costs of approved educational activities and were 100% GME related. The Provider's GME curriculum (and the ACGME for accreditation) required regularly scheduled conferences and seminars in the various specialties. These costs were posted to the GME physician compensation cost center[25] and reported as such. They are allowable GME costs under 42 C.F.R. § 413.85(g).[26]

c. The Provider's faculty compensation was exclusively for GME duties and was related 100% to GME. Six of the seven faculty (chairman excluded) member's compensation pursuant to their contracts was 100% GME related. (See discussion in 2 & 3 below).

2. Schedule 3 is inherently defective because it does not properly measure GME time nor was it designed to report GME time. The form is only designed to separate physician time between Part A and Part B time. Thus, it will only produce inaccurate data; and the GME-PI compounds the problem and will result in a consistent understatement of GME costs because it eliminates certain types of GME related physician time.

a. Neither residents nor visiting professors were required to complete Schedule 3 or time studies; and they were otherwise eliminated by the GME-PI.

b. All faculty physicians are exclusively (100%) GME except for the Department Chairman.

i. (a) The physician contracts[27] for six of the seven faculty represents the best evidence and clearly documents that they were 100% teaching for GME activities. Contention number 4 below is incorporated by reference.

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[24] Provider Exhibit P-22.

[25] Provider Exhibit P-133.

[26] Id.

[27] Provider Exhibit P-87.

(b) The Provider cites the case of Barnes Hosp. v. Mutual of Omaha, PRRB Dec. No. 94-D38, May 3, 1994, Medicare and Medicaid Guide (CCH) ¶ 42,420, aff'd and remanded, HCFA Adm'r, July 5,1994, ¶ 42,592. In Barnes the medical school supplied GME faculty under a contract that covered other obligations. In the base-year, the provider paid the medical school $7.8 million dollars and reported it as GME. But, on the GME reaudit, the entire $7.8 million was reclassified because the intermediary found the contract not related to GME. The Board reversed stating the contract showed the only service made was for teaching services. Id. ¶ 42,420 at p. 40,375. The HCFA Administrator affirmed the decision that the contract, as performed, established the $7.8 million payment was a GME cost. ¶ 42,592 at p. 41,422. Thus, the physician contracts were essential evidence to establish GME costs; and the regulations and manual provisions state the cost of compensating a GME instructor is an allowable GME cost pursuant to 42 C.F.R. § 413.85(g) and HCFA Pub. 15-1 § 402.2.

(c) In addition, in line with Barnes, the Provider had contracts with Department of Pediatrics, University of Pittsburgh School of Medicine (which the Intermediary agreed was 100% teaching[28]) and the Pediatric Cardiology Association to provide services that were exclusively for GME[29] and should be considered as GME.

(d) The Intermediary admits that certain physician contracts established 100% GME teaching,[30] and their representative testified that the compensation for certain physician contracts were solely GME related in the base-year.[31]

ii. The Chairman of the Department of Pediatrics testified that all of the faculty time was GME related even though required to

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28 Intermediary Exhibit I-39 at 22.

29 Provider Exhibit P-87.

30 Intermediary Exhibits I-39 and I-40.

31 See Intermediary Exhibit I-39 at 3; and Tr. 11/8/95 at 325 and Tr. 11/9/95 at 646.

participate in the administration of their respective departments.[32] Further, the Medical Staff Bylaws required as a condition of membership the providing of administrative services whether or not they were compensated by the Provider. Under Pennsylvania law,[33] bylaws approved by a hospital "are an integral part of the contractual relationship with" members of the medical staff. Thus, faculty members are required to perform such duties wholly independent of their teaching obligations pursuant to their separate teaching contracts.

iii. Due to faulty and vague instructions pertaining to Schedule 3, all of the faculty's time was reported on various lines (1 thru 8) which represents a sub-allocation of Part A time on Schedule 3 in the base-year: however, all compensation should be considered 100% GME since faculty members teach exclusively for the GME program. The GME-PI compounds the problem, as discussed in 3 below, because they improperly limit GME time to only lines 4 and 5; and the form was never designed to identify GME and non-GME time.

iv. The reasonableness of the faculty compensation was not an issue because it was reduced to the RCE limits before allocation to the GME cost center, and there was no adjustment in the original NPR for the base-year.

3. In the reaudit, the GME-PI directly caused an inaccurate and understated determination of GME costs. Thus, these instructions were invalid because they:

i) contravene the intent of 42 C.F.R. § 413.86 in that GME base-year costs will not become verified as “incurred” or “proper, reasonable, and correct” costs as both the statute and regulation were purportedly created to do; ii) violate the statutory prohibition against cost shifting to non-Medicare patients; iii) substantially changed the application of Medicare reimbursement principles and policies as well as audit standards and practices; iv) clearly represent substantive rules (per iii above) and became null and void for failure to comply with the APA provisions under 5 U.S.C. § 706; and v) were otherwise unlawful, arbitrary and capricious.

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[32] Tr. 6/7/95 at pp. 95-96.

[33] Adler v. Montefore Hosp. Ass'n, 311 A.2d 634, 643 (1973), cert denied, 94 S. Ct. 870 (1974).

a. i. The GME-PI inappropriately limited the proper determination of GME costs on Schedule 3 by stating that only lines 4 and 5 can be considered as GME related. This is improper because faculty compensation, under the base-year instructions, reported GME time on all lines of Schedule 3 including supervisory, committee and administrative time that are reported on lines (1-3) which was other than lines 4 and 5. Thus, these times are improperly omitted as GME time under the GME-PI on reaudit.

ii. As discussed in 2 above, the physician contracts clearly establish that the faculty services are entirely GME related even though some of their time may have been reported on lines 1-3. The Provider asserts, all time reported by physicians on lines 1-3 were GME related, e.g., Line 1, Supervision of Technicians and Nurses, represent staff in the GME departments who have direct contact with the interns and residents; Line 2, Committee time, relates to GME committees;[34] and Line 2, Administration, represents such time as required by their contracts, Bylaws, etc., as discussed in b. ii above. (See, "Mercy Formula" discussed in c. below).

iii. Although such time may be generally administrative in nature, as discussed in b. ii above, all the time reported on lines 1-3 was necessary to maintain accreditation and was incurred for GME activities. The time was allowable and reimbursable for GME under 42 C.F.R. § 413.85(g) and HCFA Pub. 15-1 § 402.2.

b. The GME-PI also limited the audit procedures and evidence relied upon to make GME cost determinations. Thus, there was an improper substantive change in the reaudit procedures. For example, other documentary and testimonial evidence could not be used even though it was available, would provide clear and relevant proof that the adjusted and disputed costs were, in fact, GME related activities, and it should be GME costs. The Intermediary, therefore, relied upon improper and inadequate evidence. Although available, the intermediary did not consider contracts, time studies, medical staff bylaws, committee minutes, job descriptions, or the testimony of pertinent members of the GME faculty.

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[34] For example, Committees for: Graduate Medical Education; Graduate Medical Education Planning; Task Force on Graduate Medical Education; Residency Program Directors; Medical Staff Program Directors, Residency Program Evaluation, Clinical Competency; etc. See, Provider Exhibit P-101.

c. For the GME reaudit, the GME-PI also created a new requirement; namely, the Intermediary was to use Schedule 3 as the basis for segregating physician Part A time into GME and non-GME components. This was improper because Schedule 3 does not show GME and non-GME activity since the basic instructions during the base-year did not so instruct or require this distinction. Further, the GME-PI improperly directed that only lines 4 and 5 were to be used as GME related time, and that all other lines were deemed non-GME[35] unless otherwise demonstrated with evidence.

i. This new requirement was completely at variance with the base-year regulations at 42 C.F.R. § 405.481[36] which only required that physician time be allocated in proportion to the percentage of time spent in three areas, i.e., furnishing physician services to the provider ("Part A"), to patients ("Part B"), and for funded research time since that was not reimbursable under either Part A or B. There was no requirement to segregate Part A time between GME and non-GME time.

ii. HCFA developed and published Schedule 3, but there were no directions or instructions to segregate GME and non-GME time. The Intermediary also issued instructions[37] for the completion of Schedule 3 that did not instruct providers to split Part A time between GME and non-GME time. The Provider cites the PRRB case of Good Samaritan Hosp[38] (discussed in 5 below) where the Board found that it was inappropriate for the auditor to solely rely on the HCFA form used to allocate Part A and Part B time into GME and non-GME time when there was other evidence such as physician contracts, etc.

iii. Likewise, during the base-year, the Provider Reimbursement Manual, ("HCFA Pub. 15-1") did not require or recommend that Part A time be segregated into GME and non-GME components.

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35 Provider Exhibits P-36 and P-156.

36 Provider Exhibit P- 13.

37 Provider Exhibit P-159.

38 Good Samaritan Hosp & Health Ctr. (Dayton, OH) v. Blue Cross & Blue Shield Ass'n, PRRB Dec. No. 93-D30, April 1, 1993, Medicare and Medicaid Guide (CCH) ¶ 41,399.

HCFA Pub. 15-1 § 2108.1B only required separation of physician time into Part A and B; and § 2108.3B provided for Part A time to be allocated to the same three areas stated in c. i. above. (See, Provider Exhibits P-25 and P-27). To accomplish the above stated allocations of time, HCFA Pub. 15-1 §§ 2108.11 and 2182.13 provided sample time allocation worksheets.[39] There were no worksheets for the separation of time between GME and non-GME time.

iv. The GME-PI permitted the intermediary to consider time from line 3 as GME, if there was auditable documentation. This concession was of little value since the base-year instructions did not require the distinction; and the reaudit was more than 5 years after the base-year and to find other documentation was not viable or reasonable.

v. The Provider has developed three theories (models) for determining the appropriate reaudited base-year GME costs discussed in 5 below. With respect to lines 1-3, the base-year time studies were based on the then applicable authorities governing time allocations which did not sub-segregate Part A time into GME and non-GME components. In order to allocate the mixed[40] time reported on lines 1-3, one of the Provider's models for determining the appropriate amount of GME costs for the reaudited base-year is entitled the "Mercy Formula[41]." This model allocates the mixed time on lines 1-3 to GME. This formula is expressed mathematically as:

Total time on lines 4&5	x	Total time	Proper amount
Total time on lines 4-8		reported on=	of time from
		lines 1-3.	lines 1-3 as GME.

The allocated amount of lines 1-3 is then added to lines 4 and 5 to determine total GME time. Provider Exhibit P-135 shows the results of this formula.

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39 Provider Exhibits P-26 and P-29.

40 The Provider does not concede that the time reported on any line of Schedule 3 is non-GME time.

41 A similar allocation model was used by the Intermediary (and approved by HCFA). See Intermediary exhibit I-39, Tr. 1/30/96 at 699.

4. The GME reaudit methodology is improper and defective as an auditing technique and in error as a matter of law.

   a. The Provider relies in part on the case of Cleveland Clinic Foundation v. Blue Cross & Blue Shield Ass'n, Medicare & Medicaid Guide (CCH) ¶ 42,593, PRRB Dec. No. 94-D56, July 20, 1994, rev'd in part, HCFA Adm'r., Sept 2, 1994, Medicare & Medicaid Guide (CCH) ¶ 42,746.

      i. The Provider states, in that case, the Board noted that "in 1985, when the provider prepared its cost report, it did not know that the data that it would include in its cost report would be used as base year data and used indefinitely. It is impossible to be inadvertent or careless when one does not realize the purpose for which certain costs should or should not be included."

      ii. The Provider asserts the Board, in Cleveland Clinic, held that intermediaries must properly determine a provider's allowable GME costs, including GME costs mistakenly misclassified by the Provider as operating costs in the base year.

      iii. The Provider declares it did not misclassify the base year physician compensation costs relative to adjustment No. 6. The schedule 3 was properly completed in the base year with supporting time studies and in full and correct compliance with all regulations, rules and practices governing at that time.

      iv. The Provider also states the Cleveland Clinic case was directly applicable where the Board stated: "[i]n directing intermediaries to ascertain GME time by employing Schedule 3, which does not reflect or quantify GME and non-GME time, HCFA has inappropriately limited the Secretary's intended purpose of determining proper, reasonable, and correct base period costs." Cleveland Clinic, CCH ¶ 42,593 at 41,430.

   b. In view of the inherent flaws of Schedule 3 (as discussed in 2 above) and HCFA's reliance thereon, results in a violation of both the GAAS fifth fieldwork standard and the AICPA second fieldwork standard. This causes the audit methodology and the GME-PI to be unlawfully in error.

5. HCFA's use of a form for purposes beyond the scope that the form was designed to fulfill renders the data invalid. The Provider cites the Good Samaritan Hosp & Health Ctr. (Dayton, OH) v. Blue Cross & Blue Shield

Ass'n, PRRB Dec. No. 93-D30, April 1, 1993, Medicare and Medicaid Guide (CCH) ¶ 41,399. In that case, HCFA directed the intermediary to segregate GME and non-GME time based upon the allocations made by physicians when they completed forms prescribed in HCFA Pub. 15-1 § 2108.11. These forms were only designed to segregate Part A and Part B time. The Provider states a) there were no instructions or stated requirements for this form to segregate the physician's time between GME and non-GME time; and b) the instructions for sub-allocating the Part A time into various categories were vague and indefinite and subject to misinterpretation. In Good Samaritan the holding stated it was inappropriate for the auditor to solely rely upon the HCFA form to allocate costs without further evaluation of all the documentary evidence and other persuasive proof readily available. The Provider alleges that the

result in this case and Good Samaritan was an improper reclassification of physician compensation from GME to non-GME activities.

6. The Provider contends that the Intermediary's adjustment should be reversed for the reasons stated above. In the alternative, the Provider has developed three theories (models), described below, for determining the appropriate reaudited base-year GME costs. These three models result in the reclassification of physician compensation as GME costs in the reaudited base-year in the total amounts of $2,226,100, or $1,937,900, or $1,929,100 as follows:

a) The "100% Model" allocates all the compensation paid to the GME faculty (excluding the department chairmen for the various GME departments) as base-year GME costs; and the department chairmen compensation is then allocated as a base-year GME cost pursuant to the third model, "Mercy Formula," (described in 3 v. above). This model results in the allocation of 98.493% of the total allowable Part A physician compensation in those departments as base-year GME costs, i.e., $2,226,100 of the $2,264,500. See Provider Exhibit P-133 at p. 006171.

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b) The "Contract Model" allocates 100% of compensation paid to physicians whose contracts specify GME duties exclusively; and the compensation paid all other physicians is allocated based on the "Mercy Formula" which results in 82.86% of all physician compensation paid to physicians in the subject GME departments being allocated as GME costs in the reaudited base-year, i.e., $1,937,900 of the $2,264,500 allowable Part A physician compensation. See Provider Exhibit P-134 at p. 006198.

c) Under the "Mercy Formula" physician compensation is allocated on the basis of 82.504% as GME costs for the reaudited base-year, i.e., $1,929,100 of the $2,264,500 allowable Part A physician compensation. See Provider Exhibit P-135 at p. 006225.

With respect to the Intermediary's adjustment reclassifying $913,592, the Provider states the following amounts of physician compensation should be reversed based on the three models above:

100% Model	Contract Model	Mercy Formula
$875,175	$568,991	$578,219

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the adjustment No. 6 was proper for the following reasons:

1. The Provider did not provide sufficient documentation at the time of the reaudit to justify any additional allocation of teaching physician costs to GME. The Intermediary asserts that the only documentation at the time of the reaudit was some HCFA Form 339s (Schedule 3), a few time studies, and two contracts. (See, Tr. at pp. 189-190.

2. The reclassification was based upon the GME-PI that allowed lines 4 and 5 of Schedule 3 and some on line 8. The reclassification was based upon the difference between the claimed GME costs and the audited amount. See, Provider Exhibits P-36 and P-49.

3. The Provider did not supply any additional documentation after the APRA notification on September 6, 1990.

4. The documentation and alternative theories (models) submitted by the Provider as part of this appeal in January 1995 are untimely. In addition, since this documentation was not provided when requested, it can not be considered adequately maintained for purposes of the documentation requirements of 42 C.F.R. §§ 413.20 and 413.24. See Dallas County Hospital District v. Shalala, Medicare & Medicaid Guide, (CCH), ¶ 43,917 (N.D. Tex., 1995). (Intermediary Exhibit I-47).

5. With respect to the documentation and alternative theories (3 models) submitted by the Provider as part of this appeal in January 1995, the Intermediary makes the following rebuttal statements:

a. The Provider's three model proposals were not authorized under the regulations or program instructions.

b. The models were based on unsupported and nonpersuasive estimates, opinions, and assumptions.

c. The financial data used starts with the originally filed cost report that completely disregards the Intermediary's NPR issued in August 1987.[42] This NPR made substantial adjustments that were never appealed. The Provider can not use this GME appeal to circumvent the failure to timely appeal the August 1987 NPR.

6. The claimed costs cause the Provider's Per Resident Amount to be substantially out of line with comparable facilities in the Provider's area. 42 C.F.R. § 413.9(c)(2).

ISSUE 5 -- GME Support Personnel Reclassified:

Was the Intermediary's adjustment reclassifying costs for the salaries and expenses related to GME support personnel from GME costs to A&G costs proper?

FACTS:

The Intermediary's adjustment number 3 reclassified all of the GME support staff salary and other expenses claimed by the Provider (in the GME departments of Medicine, Obstetrics & Gynecology, Pediatrics, and Surgery, and also the Graduate Medical Education office) as GME costs to A&G costs. The salaries for support personnel in these areas included technicians, non-physician medical practitioners, registered nurses, supervisors, aides, assistants, and clerical staff. This reclassification of about $609,700 was based upon the Intermediary' interpretation of the GME-PI as requiring the review of base-year job descriptions for the support staff.
The Provider maintained that the support staff job descriptions[43] made available during the reaudit were refused by the auditor. The Intermediary found that the Provider did not maintain adequate documentation regarding the job descriptions ("JD") for the claimed GME costs and determined that no support staff costs were allowable.

PROVIDER'S CONTENTIONS:

The Provider maintains that the Intermediary's adjustment was improper for the following

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[42] Provider Exhibit P-46.

[43] Provider Exhibit P-86.

reasons:

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1. All of the support staff in each GME department are necessary and proper for the achievement and completion of the particular GME functions performed in that GME program.[44] The support staff services are directly related to GME since each department is exclusively for GME activities. The support staff consist of two types:

   1) clerical staff - their activities include transcription and communication of information, maintenance of records, compilation of data, making reports, processing financial data, etc. Testimony[45] showed these activities

   were directly related to GME. (See further discussion in II 2. below which also addresses the determination of the amount of GME clerical costs.)

   2) medical support - they participate directly in the GME programs. They are directly assigned to the residency programs, provide instruction to interns and residents (under the supervision of teaching physicians), and perform other GME educational activities where the expertise of a teaching physician was not required.[46] (See discussion in II 1. below that also addresses the determination of the amount of GME medical support costs.)

2. The Graduate Medical Education office performs all administrative functions necessary and common to all the GME programs and was directly related to GME activities.

3. The reclassification pertained to support personnel costs previously determined to be reasonable and allowable GME costs in the base-year audit.

4. The support staff was related to and allowable as GME costs pursuant to 42 C.F.R. § 413.85(g) and HCFA Pub. 15-1 § 402.2.

5. The adjustment should be modified since both of the Intermediary's witnesses admitted that some of the support staff performed GME related duties. One Intermediary's witness testified that adjustment 3 should be modified since

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44 Tr. 2/1/96 at pp. 1141-42.

45 Tr. 2/1/96 at p. 1154.

46 Tr. 6/7/95 at pp. 100-01.

some of the support costs were GME costs.[47] (See, 7 e. below).

6. The adjustment was inconsistent with the purpose of the GME reaudit, i.e., the determination of actual and accurate base-year GME costs.

7. With respect to the documentation problem:

   a. The Provider supplied support staff JDs both as part of this appeal (Provider exhibit P-86) and at the time of reaudit which were refused for review.

   b. The JDs clearly establish that most of the support staff were basically GME related. However, some JDs were general in nature and did not identify specific GME program duties, and they were not tailored in a manner to segregate GME and non-GME activities as required by the new GME-PI. Nonetheless, there was other evidence to establish the relatedness to GME activities. For example, 1) JDs for secretarial positions were uniform[48] and general in nature. But, it was known that some reported to and were supervised by a teaching physician who exclusively performed GME program duties. Thus, the secretary would also perform GME related duties. (See discussion in 7 a. below). The same would be true for secretaries in specific GME program departments.
   2) the auditor had determined the relatedness by interviews and verified the Provider's internal controls of the accounting system, i.e., tracing payroll data to the GME department ledger accounts, etc.[49]

   c. Prior to the GME-PI, there was no regulation, manual or program instruction requiring definitive GME language or the segregation of GME and non-GME activities in JDs. Therefore, the GME-PI were invalid for the reasons already stated (and are incorporated by reference here) in the Provider's Contentions No. 3 for Issue 2. In particular, the GME-PI have created a new substantive requirement which violates the APA since they were not published as a rule pursuant to the APA. Moreover, the Provider cannot be expected to develop data it was not required to do under the then existing program authorities; nor can it be reasonably expected that such information would be maintained or

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47 Tr. 1/30/96 at p. 860.

48 Provider Exhibit P-96 at 003379.

49 Provider Exhibits P-173, P-184, and P-187.

available some 5-6 years later. Further, the holding in Cleveland Clinic would be applicable. In addition, the Provider can not reasonably be required to produce records that it was not required to create, much less retain, 5-6 years later. See Daughters of Miriam, and Columbia Heights.[50]

d. The GME-PI specifically acknowledge that support staff costs incurred in the performance of GME related duties are allowable GME costs[51]. The documentary evidence (JDs) submitted in Provider exhibit P-86 clearly shows the support staff in the four GME program departments perform GME functions.

e. A second Intermediary witness testified that:

i. The adjustment understated the Provider's GME costs since some of the support staff costs were GME related because of their duties;[52] and

ii. Even though JDs were not provided during the reaudit, the Intermediary had allowed GME costs based upon JDs supplied after the audit was completed[53]. Therefore, the JDs submitted as part of this appeal can be used to substantiate GME activities.

II

The Provider contends that for the above stated reasons all of the support staff costs should be an allowable GME cost.

1. With respect to the medical support personnel costs there are additional considerations.

a. The medical support staff consist of medical technicians, laboratory technicians, medical assistants/aides, registered and licensed practical nurses. This medical support staff was supervised by the GME faculty

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50 Daughters of Miriam Center for the Aged v. Matthews, 590 F. 2d 1250 (3rd. Cir. 1978), Columbia Heights Nursing Home and Hospital v. Weinberger, 380 F. Supp. 1066 (M.D. La 1974).

51 Provider Exhibit P-36 at p. 000102.

52 Tr. 2/1/96 at pp. 1366-67 and 1394.

53 Tr. 2/1/96 at pp 1333-34 and 2/2/96 at p. 1439.

physicians and performs direct GME training activities in conjunction with faculty instruction of the residents.[54] This also includes assisting and/or instructing the residents in basic medical procedures, and proper operation of sophisticated and complex medical equipment.[55]

b. The JDs of most of the medical support staff set forth specific GME related duties.[56]

c. The medical support staff duties and functions were directly related to GME activities, and are allowable GME costs under 42 C.F.R. § 413.85(g) and HCFA Pub. 15-1 § 402.2. See University of Cincinnati, 875 F. 2d at 1211-12.

d. HCFA Pub. 15-1 § 402.2 provides that the medical support staff costs should be allocated to GME on a proportional basis which reflects the amount of time spent on GME activities. The Provider asserts the Intermediary's denial of 100% was totally incorrect, it is entitled to allocate 100% of all the support staff costs accumulated in the 9900 cost center which reports exclusive GME duties as GME costs, and in the alternative the methodologies stated below comply with the manual requirement. Since the medical support staff may perform some minor Part B services, the GME portion can be determined by:

i. Allocating on the basis of the proportion of the departmental faculty GME time to the total departmental faculty time, i.e., producing the ("GME Activity Statistic" ["GME-AS"]). The Schedule 3s and the related time studies analyze the GME faculty's activities over a two week period[57]. The GME-AS is mathematically stated as:

$$\frac{\text{Total GME departmental faculty hours}}{\text{Total Number of GME faculty members X 80 hrs}}$$

This statistic measures GME activity as a proportion (%) of total activity

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54 Tr. 2/1/96 at pp. 1161-64.

55 Tr. 6/7/95 at pp. 100-101; and Intermediary Exhibit I-4 at pp. 4-5, and Provider Exhibit P-96 at p. 003403.

56 Provider Exhibit P-86 at pp. 001094, 001071; and 001132.

57 Provider Exhibits P-35 at p. 000089 and P-89 at p. 002435 (sample base-year time study).

in these GME departments.[58]

ii. The "Contract Model" identifies physician GME time and yields a GME-AS of 58.818% for the four departments.[59] This results in an allocation of $219,539 as GME costs.[60]

iii. The "Contract Model" produces a GME-AS of 49.483% resulting in an allocation of $189,895 as GME costs.[61]

iv. The "Mercy Formula" creates a GME-AS of 49.270% resulting in an allocation of $189,219 as GME costs.[62]

2. The Provider asserts there are different methodologies for allocating the clerical support staff costs to GME.

a. The GME-PI requires clerical staff cost be allocated in proportion to that staff's GME duties:

The total salaries of the teaching physicians' clerical support staff and related office expenses cannot be included in the I&R Approved Programs' cost center if such staff performs functions related to the Physician's professional services or provider services unrelated to the GME programs. In these instances, only the proportional share of the salaries and expenses associated with the training of I&Rs may be charged to GME.

The GME-PI further provided where documentation is not available to split the support staff into GME and non-GME components, then allocation should be based upon the supervisory physicians' GME time

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58 Tr. 2/1/96 at pp. 1162-63.

59 Provider Exhibit P-136 at p. 006232.

60 Id. at p. 006234.

61 Provider Exhibit P-137 at pp. 006238 and 006240.

62 Provider Exhibit P-138 at pp. 006244 and 006246.

allocation.[63] The Intermediary, in fact, considered this possibility as supported by audit workpapers identified in Provider Exhibit P-105 at p. 005835.

b. The Provider has developed three (3) models for allocating faculty physician time between GME and non-GME activities as previously describe in Issue No. 3 above.
i. The “100% Model” allocates 98.493% of the physicians' Part A time to GME activities. This would allocate $248,100 of the $274,200 direct support staff costs reclassified by the Intermediary to GME.[64]

ii. The “Contract Model” allocates 82.86% of the physicians' Part A time to GME activities. This would allocate $211,500 of the $274,200 direct support staff costs reclassified by the Intermediary to GME.[65]

iii. The "Mercy Formula" allocates 82.504% of the physicians' Part A time to GME activities. This would allocate $210,600 of the $274,200 direct support staff costs reclassified by the Intermediary to GME.[66]

The Provider concludes that the Intermediary's adjustment was improper and should be reversed. Clearly, the evidence proves that some of the support staff costs are GME costs, and that adjustment 3 should be modified so that no more than $209,046 is A&G costs.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its adjustment was correct because:

1. The Provider did not properly document the GME portion of the additional support staff costs claimed under the provisions of 42 C.F.R. §§ 413.20 and 413.24.

2. The documentation (Provider Exhibit P-86) submitted, as part of this appeal, five years after it was requested can not be considered adequately "maintained" for purposes of the regulations cited above. See Dallas County Hospital District v. Shalala.

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63 Provider Exhibit P-190 at p. 006597, item 4.

64 Provider Exhibit P-136 at p. 006234.

65 Provider Exhibit P-137 at p. 006240.

66 Provider Exhibit P-138 at p. 006246.

3. Intermediary representatives do not agree that the Provider offered job descriptions or that they were refused at the time of the reaudit as alleged by the Provider.[67]

4. The claimed disputed costs would cause the Provider's per resident amount to be substantially out of line with comparable facilities in the Provider's area under the provisions of 42 C.F.R. § 413.9(c)(2).

ISSUE NO. 6 -- Consistency Rule:

Do the Intermediary's adjustments nos. 3 and 6 violate the consistency rule stated in 42 C.F.R. § 412.113(b)(3) (1989)?

FACTS:

The original consistency rule was promulgated at 42 C.F.R. § 412.113 (1985) when the PPS reimbursement system was created. That regulation required that cost reports filed during the PPS transition period had to be consistent with the cost report filed and used as the PPS base-period.

PPS focused on the payment of a hospital's inpatient operating costs ("IOC") on a prospective payment basis. Congress created a four year transition period where hospitals were paid with a blended rate composed of two components: 1) a hospital-specific rate ("HSR") representing an individual hospital's own cost experience during a specified base-year; and 2) the Federal PPS rate consisting of regional and national standardized amounts.

For purposes of PPS, certain costs were excluded from the definition of IOC, such as educational costs, to become pass-through costs that continued to be reimbursed on a "reasonable cost" ("RC") basis. The pass-through costs were excluded from the transition blended rate because they were paid separately on an RC basis. Hence, since the costs of approved medical education activities, such as GME, were specifically excluded from the definition of IOC, they were excluded from the PPS blended rate [HSR and Federal PPS rates] because they were paid for on a RC basis.[68] Since medical educational costs were excluded from the blended rate, a "consistency rule" was established by the promulgation of 42 C.F.R. § 412.113(b). This regulation provided that through out the transition period, the allowable costs used in developing the HSR (PPS base-year) must also be treated consistently

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[67] Provider Exhibit P-205 at pp. 23-24.

[68] 42 U.S.C. § 1395f(b).

in the GME base-year, i.e., as either GME costs or as operating costs. This rule prevents the duplication of payment for GME costs claimed as operating costs in the HSR and again as a pass-through cost under PPS.

In 1989, when the GME regulation was promulgated at 42 C.F.R. § 413.86, the consistency rule was also amended. The amended regulatory consistency rule provides for an exception:

> Except as provided in § 413.86(c)(1) of this chapter, for cost reporting periods during the . . . transition period, the costs of medical education must be determined in a manner that is consistent with the treatment of these costs for purposes of determining the hospital-specific portion of the payment rate . . . .

42 C.F.R. § 412.113(b)(3) (1989) (emphasis added).

42 C.F.R. § 413.86(c) provides that GME costs be determined as of fiscal year 1986 under a new reimbursement methodology as described in § 413.86(d) through (h). This new methodology calls for the consistency rule to be applied under the new GME payment method pursuant to
§§ 413.86(e)(1)(ii)(C) and 413.86(e)(1)(iv), but it is not an absolute requirement because these sections reference §§ 413.86(j)(1) and (2). Under § 413.85(j)(1) and (2), it is possible for an Intermediary to make a unilateral determination reclassifying GME "misclassified" costs, regardless of how that category of costs was reported in the PPS base-year.

PROVIDER'S CONTENTIONS:

The Provider contends that the 1989 amendment to the consistency rule at 42 C.F.R. § 412.113(b)(3) is inter alia an impermissible retroactive application of a regulatory amendment and invalid. The Provider acknowledges that the Board is without authority to determine that a regulation is invalid since it is bound by the Secretary's regulations under 42 C.F.R. § 405.1867.

The Provider asserts the 1989 amendment allows categories of costs classified as educational costs on the GME base-year cost report to be different from how the educational costs were classified on the PPS base-year cost report. The Provider claims the amendment creates 'inconsistency' rather than consistency. Thus, the Intermediary's reclassification adjustments nos. 3 and 6, result in an invalid retroactive reclassification of GME costs because they were clearly different from the classification of these GME costs in the PPS base-year cost report.

The Provider states the Intermediary witness[69] essentially agreed that the original consistency rule made sense, was a reasonable reimbursement principle, and it was applied by the Intermediary when auditing the original GME base-year. That rule required operating costs

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[69] Tr. 1/31/96 at p. 1075-76.

and pass-through costs, like GME, to be continued as the same classification in all the PPS transition cost reporting periods. The Provider claims the rule simplified audits and facilitated the focus on the reasonableness and allowability.

The Provider states the invalidity of this new consistency rule becomes apparent from another perspective when considering that the GME reaudits applied new reimbursement principles that caused these reclassifications. The Intermediary's reclassification adjustments nos. 3 and 6 only become possible when the old consistency rule is discarded. This then permits a different classification of costs between the settled cost reports for the PPS and GME base-years.

INTERMEDIARY'S CONTENTIONS:

The Intermediary makes the following contentions:

1. That the Board has no jurisdiction to determine whether the disputed regulation at 42 C.F.R. § 412.113(b)(3) is invalid.

2. That the Board is bound by this regulation and should find that the Intermediary's adjustments meet the regulatory requirements.

3. That § 412.113(b)(3) does require the medical educations costs be determined consistently between the respective PPS and GME base-years.

4. That this regulation does provide for an exception because of the new GME reimbursement methodology starting in 1986 as described in § 413.86(d) through (h).

    a. That § 413.86(e) requires the Intermediary to verify the hospital's GME base-year costs, and to make modifications that may include nonallowable or misclassified GME costs, i.e, either as operating costs or as GME costs, previously allowed.

    b. These modifications of misclassified GME costs may be made either at the hospital's request [42 C.F.R. § 413.86(e)(1)(ii)(C)] or based on an Intermediary determination [§ 413.86(e)(1)(iv)]. These two sections reference 413.86(j)(2) and (1) respectively which provide for the consistency rule requirement under the GME system.

    c. Where the Intermediary makes a reclassification of GME costs to operating costs under § 413.86(j)(1), the Provider may obtain consistency for the PPS base-year payments if the Provider can complete two requirements:
    i) makes a timely request to the intermediary within 180-days of the

NAPRA to adjust the PPS base-year; and ii) provides adequate documentation to support that request. The Intermediary must approve the request. (The Intermediary notes that the Provider's request[70] on August 22, 1991 has not yet been evaluated on its merits.)

ISSUE NO. 7 -- Proper Determination of the number of FTE residents:

Was the Intermediary's adjustment revising the number of FTE residents used in determining the Provider's Average Per Resident amount proper?

FACTS:

Intermediary adjustment no. 12 increased the Provider's claimed FTE count for I&R from 115 to 125.88, an increase of 10.88 FTEs per the adjustment. The Intermediary, however, when computing the APRA used an FTE count of 130.36 or a difference of 4.48. Evidence submitted by the Provider[71] to potentially explain this difference shows the Intermediary's auditor determined that 4.48 FTEs related to I&R in non-approved GME programs which would have been used as a reduction of the FTEs rather than an increase. The parties disagree on the proper FTE count. The Intermediary stands by the 130.36 FTEs used in computing the APRA, while the Provider now claims the correct FTE count is 118.62.

The disputed FTE count focuses on the proper number of I&R that:

1) rotated out of the Provider's facility to other institutions;
2) were in non-approved GME programs during the base-year; and
3) actually spent time at the Provider's facility.

The estimated amount in controversy for the APRA year is $10,400 with a cumulative (1986 - 1993) Medicare amount exceeding $17.8 million.

The Provider also raised a corollary issue of whether the Intermediary properly

accounted for the costs of I&R from affiliated GME programs that were included in their FTE count?

Background:

The APRA is calculated by dividing the amount of GME costs determined as reasonable (numerator) in the base-year by the number of FTE I&R working at the hospital in the base-

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70 Providers Exhibit P-52.

71 Provider Exhibit P-174 at p. 006546.

year (denominator) in an approved GME program.[72]

The statute defines an approved GME program as follows:

> A. APPROVED MEDICAL RESIDENCY TRAINING PROGRAM. --- The term "approved medical residency training program" means a residency or other postgraduate medical training program participation in which may be counted toward certification in a specialty or subspecialty and includes formal postgraduate training programs in geriatric medicine approved by the Secretary.

42 U.S.C. § 1395ww(h)(5)(A) (emphasis added).

PROVIDER'S CONTENTIONS:

The Provider asserts that the Intermediary erroneously determined 130.36 FTEs for the base-year, and claims 118.62 FTEs was proper. The Provider makes three basic contentions to support this claim, i.e., that the Intermediary:

1. erroneously included I&Rs in unapproved GME programs;
2. failed to reduce the FTE count for I&R that rotated out of the Provider's facility to other institutions; and
3. failed to properly compute the FTE while using a ratio of months at the Provider to total months in the base year rather than the correct method of a ratio of days resulting in an understatement of the FTEs.

The Provider states the proper calculation of 118.62 FTEs should be as follows:

Intermediary determination of FTEs			130.36	
Less:	1. I&Rs in unapproved GME programs	(2.48)		
	2. I&Rs that rotated out	(11.19)		
Add:	3. Computation error; should be based on a ratio of days (understated)	1.93		
	Total correction-reduction		(11.74)	
	Proper number of FTEs in base-year			118.62

Provider Exhibit P-103 at p. 005089 presents data to support the 118.62 FTE count which is summarized as follows:

Add:	1. I&R FTEs in Provider GME programs	119.34

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[72] In subsequent years, this new prospective payment base rate for GME is adjusted for inflation and multiplied by the weighted number of FTE residents working in the hospital's GME program during the applicable FY. This amount is multiplied by the hospital's Medicare inpatient load to ascertain the amount of GME reimbursement.

	2. I&R FTEs rotating in from affiliated facilities		13.99
	Sub-total FTEs		133.33
Less:	3. I&R FTEs rotating out	9.79	
	4. I&R FTEs in unapproved programs	4.92[73]	(14.71)
PROPER FTE COUNT			118.62

I

A. The Provider states Medicare authorities only permits GME reimbursement for approved residency programs.

The Provider states that the statute and regulations governing GME reimbursement pertain only to approved residency programs. 42 C.F.R. §§ 413.85(b) and 413.86(b) provide that an approved residency program means a program that has been approved by a national organization listed in
§ 405.522(a), or that may count towards certification of the participant in a recognized specialty. Therefore, only I&Rs in an approved program can be included in the FTE count; and I&Rs in non-approved programs or that did not count toward a participant's board certification must be excluded from the FTE count.

The Provider asserts that Provider Exhibit P-174 at p. 006546 (an audit workpaper regarding non-approved programs) discloses the auditor identified 4.48 additional FTEs in non-approved GME programs which were erroneously included in the FTE count. The Provider notes, however, that 2.0 FTEs pertained to the Combined Medicine/Pediatrics program which did count toward board certification of the participants. Therefore, it would be proper to include the 2.0 FTEs in the count. Thus, the Intermediary should have reduced the FTE count by 2.48 for I&Rs in non-approved programs.

The Provider references the Intermediary witness' testimony[74] that audit adjustment no. 4 reclassified the salaries and other costs of the 4.48 I&R in non-approved programs. The Provider claims that since the costs were excluded, then the FTE count must also be excluded. However, the FTE count should only be reduced by 2.48, as discussed above; and adjustment no. 4 must be modified to increase the GME costs by $54,500 for the 2.0 FTEs properly included in the count. The Provider states the workpaper establishes $43,600 for salaries and using the 25% factor for fringe benefits yields a total of $54,500 to be added to the GME base year costs.

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[73] Provider Exhibit P-103 shows 6.92 FTEs in unapproved programs; but, Provider now recognizes the Combined Medicine/Pediatrics program did count toward I&R certification with 2.0 FTEs and should be included.

[74] Tr. 1/30/96 at pp. 883-885 and Tr. 1/31/96 at pp. 113-114.

B. Provider disagrees with the Intermediary's contentions.

The Provider disagrees with the Intermediary's contentions that 1) the 4.48 FTEs should be included in the total count because the auditor's prior determination that some programs were not approved may be questionable; and 2) the Board should reverse audit adjustment no. 4. The Provider states the auditor's workpaper clearly shows the audit work performed which formed the basis of the Intermediary's adjustments. To raise questions at this time about these workpapers is without merit and possibly misleading.

The Provider also disagrees with the continuing Intermediary assertions that records were not furnished during the reaudit particularly with respect to this issue. Provider Exhibit P-174 supra clearly demonstrates that the auditor reviewed and verified documentation including payroll registers, etc. regarding adjustment no. 4 despite the Intermediary witness' contrary assertions.

II

A. Intermediary improperly determined the FTE count by including outside rotations of residents.

The Provider contends that the Intermediary failed to exclude I&Rs that 'rotated out' of the Provider's facility to other affiliated institutions, as required by the regulations, thereby overstating the FTE count by 11.19. The regulations provide that no I&R may be counted as more than one FTE; and if an I&R works at more than one hospital, then a partial FTE is counted based upon the ratio of time worked at the hospital. The regulation states:

> (f) Determining the total number of FTE residents.
>
> * * *
>
> (ii) No individual may be counted as more than one FTE.
> If a resident spends time in more than one hospital, . . ., the resident counts as a partial FTE based on the proportion of time worked in the hospital to the total time worked. A part-time resident counts as a partial FTE based on the proportion of allowable time worked compared to the total time necessary to fill a full-time internship or residency slot.

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

This regulation and the GME PI[75] confirm that outside rotations should not be included in a provider's FTE count. The Provider notes that the Intermediary properly included 'rotations

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[75] Provider Exhibit P-36 at p. 000095.

in' to the FTE count, but did not exclude the rotations out, as stated above.

B. Intermediary's arguments on this issue are without merit.

The Provider rejects all the Intermediary arguments on this issue as being without merit. The Intermediary argued that it was permissible to include the outside rotations because: 1) the Provider initially self-disallowed the outside rotations; 2) the Intermediary's auditor relied upon Provider staff representations that there essentially were no outside rotations because the residents generally returned to the Provider's facility in the evening; and 3) the Intermediary's auditor may not have identified and pursued individual residents to the outside affiliates to determine the proper FTE count at those facilities; therefore, the FTE count at other hospitals may be incorrect and incapable of correction at this time, i.e., beyond the three year reopening.

The Provider notes that the Intermediary apparently did not perform a "resident match program" ("RMP"). A RMP is a global comparison of residents who split time between providers in the same area to ensure that a resident is only counted as one FTE.
The auditor noted on his reaudit program[76] that the RMP or "tie in with other providers needs to be completed at a later date." The Provider noted several errors were made that an RMP would have disclosed. For example, the Intermediary knew the Colon Rectal Surgery resident split time between the Provider and one other hospital.[77] Yet, the only resident for this program was listed as a full FTE for the Provider.[78]

The Provider alleges the above stated Intermediary arguments were without merit because they were not in accordance with the Medicare regulation [cited in II A. above], and the overall concept of establishing a reasonable and more accurate GME cost determination. The Provider further states:

> 1) The self-disallowance argument was faulty because any self-disallowance concept was overruled by the holding in Bethesda, supra, 108 S. Ct. at 1258-59; and the Provider made a proper request for reclassification of the outside rotation costs with a change in the FTE count which has never been acted upon.
> 2) The Intermediary auditor's reliance upon Provider staff representations was flawed because the regulations required an apportionment based upon time spent in other

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76 Provider Exhibit P-165 at p. 0006497.

77 Intermediary Exhibit I-54.

78 Intermediary Exhibit I-8 at p. 507.

facilities even if for part of a day;[79] and the auditor received and reviewed outside rotation schedules as demonstrated by Intermediary Exhibit I-8 at p. 7 and Provider Exhibit P-103 at p. 005099.
3) The Intermediary did not perform a RMP that would have ensured a more accurate FTE count for rotating residents, as discussed above.
4) The Intermediary's argument of whether the APRA of other affiliated hospitals could be reopen and corrected, if the auditor improperly accounted for the FTEs of all rotating residents, was beyond the Provider's control and irrelevant to the propriety of this Provider's APRA determination.

C. Intermediary improperly accounted for the GME costs pertaining to the outside rotations.

The Provider also asserts as a corollary issue that the Intermediary failed to properly account for the related costs for some of the outside rotations. The Provider states that:

1) a request for reclassification of these costs and a revised FTE count was made during the reaudit,[80] and the Intermediary never acted or responded to this request to date;[81]

2) the Intermediary knew about the affiliation programs operated by the Provider, and it had identified costs relative to these programs which had not been reported as GME costs.[82] The Provider rejects the Intermediary's claim that the request had insufficient documentation. The Provider counters that:
(a) the data was available during the reaudit when the request was made, (b) the Intermediary possessed all necessary documentation to make the reclassification,
(c) the reclassification request was renewed within a 180 days of the APRA which also requested the appropriate adjustments to the PPS HSR per 42 C.F.R. § 413.86(j)(1),[83]
(d) the Intermediary possessed all information necessary to make the necessary

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79 Provider Exhibit P-36 at p. 000131.

80 Tr. 2/2/96 at pp. 1485-86; and Provider Exhibit P-121 at pp. 006012-14 [affidavit] and meeting notes at p. 006023.

81 The request was repeated when a written request was made to reclassify the GME costs of the Emergency Medicine program after the APRA was issued. See Provider Exhibit P-52 at pp. 000329-37.

82 Intermediary Exhibits I-8 and I-12; and Provider Exhibits P-156 at p. 006407, P-175 at p. 006551, P-176 at p. 006553, P-177 at pp. 006554-55, P-178 at pp. 006561-67, P-179 at p. 006569, and P-180 at pp. 116570-72.

83 Provider Exhibit P-52 at pp. 000329-37.

adjustment to the PPS HSR,[84] and (e) all necessary documentation sought by the Intermediary was never precisely or timely described which unfairly prejudiced the Provider.[85]

3) failure to include these costs violates the intent of the statute and regulations to correct errors in the GME base year; and

4) failure to include the affiliated residency costs causes an impermissible cost shifting to non-Medicare patients.

1) Request for reclassification was made during reaudit.

A Provider witness testified that a request for reclassification of these costs and a revised FTE count was made during the reaudit[86], and there has never been a response. The witness also testified the auditor stated he could only move costs out of GME.[87] This comment demonstrates the narrow and rigid manner in which the reaudit was conducted.

2) Intermediary knew of the affiliation programs operated by the Provider, and failed to reclassify the identified costs relative to these programs.

The Provider asserts the Intermediary's audit work papers (identified as K-6-2-1, Provider Exhibit P-179) demonstrates that sufficient data was available to reclassify at least the physician compensation aspect of these costs to GME. The Provider stated the auditor also had other Provider books and records that enabled the reclassification of the other related costs which was confirmed by the Intermediary's witness during the hearing, at Tr. 2/8/95 at p. 177.

The Provider states that, assuming arguendo, its request did not have sufficient documentation, the period for submitting documents had been equitably tolled by the failure of all government parties to adequately and timely describe the specific documentary requirements. Further, it is inherently arbitrary to impose a documentation requirement, fail to inform providers of the requirement, and then deny reclassification due to insufficient documentation. A provider can not be faulted for incomplete documentation unless there has been prior notice of the specific requirements.

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84 Tr. 2/8/95 at p. 75-77; Provider Exhibit P-203 at p. 006723.

85 Tr. 2/8/95 at pp. 75-77; Provider Exhibit P-203 at p. 006723, line 19.

86 Id. n. 80.

87 Id.

The Provider avers the affiliated GME program costs were about $868,900 which should be reclassified as GME costs using the allocation methods identified in Issues 2 and 3 computed as follows:

Emergency Medicine Department:[88]		
Part A physician compensation	324,700	
clerical staff	73,600	
other support costs	392,500	
Sub-total		$790,800
Physical Medicine/Rehabilitation Dept:[89]		
Part A physician compensation	25,800	
clerical staff	20,100	
other support costs	32,200	
Sub-total		78,100
Total affiliated GME costs		$868,900

3) failure to include these costs violates the intent of the statute and regulations to correct errors in the GME base year.

The Provider maintains that the basic intent of the statute and the regulations, as promulgated, was to correct errors regarding GME base year costs in order to have an accurate determination of base year GME costs. The Provider states the regulation at 42 C.F.R. § 413.86(e)(1)(ii)(A) requires the intermediary to correct cost report errors and verify the base year GME costs. The case of Cleveland Clinic recognized that costs omitted can be a matter of correction in the reaudit.

4) failure to include the affiliated residency costs causes an impermissible cost shifting to non-Medicare patients.

The Provider claims the refusal to include the costs related to the Emergency Medicine and Phys/Med/Rehab GME programs in the GME base year costs causes an impermissible shifting of costs to non-Medicare patients which violates 42 U.S.C. § 1395x(v)(1)(A). In addition, under the Thomas Jefferson[90] case, this represents an improper redistribution of costs where such costs were of the type traditionally reimbursed by Medicare.

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88 Provider Exhibit P-140 at pp. 006260-64.

89 Provider Exhibit P-143 at pp. 006294-96.

90 Thomas Jefferson Univ. v. Sullivan, [1992-2 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 40,294; aff'd without opinion, DC Dec., CCH ¶ 41,575; aff'd, 993 F. 2d 879 (3d Cir. 1993).

III

The Provider contends that the Intermediary's method of computing FTEs on a monthly basis, rather than a daily basis, is improper. Residents generally work at more than one hospital in a year requiring an apportionment of the FTE. The preamble to the final regulations, 54 Fed. Reg. 40304 (1989), states the apportionment will be based on the number of days spent rather than a monthly count. 42 C.F.R. § 413.86(f) provides for the apportionment based on the proportion of allowable time worked compared to total time.

Although the calculation error of 1.93 FTEs is to the Provider's disadvantage, the Provider states the fundamental issue is the proper FTE count and the proper determination of the APRA.

INTERMEDIARY'S CONTENTIONS:

The Intermediary rejects the Provider's arguments on this issue and contends that the FTE count of 130.36 used in computing the APRA was correct. However, based on subsequent information, the Intermediary states that audit adjustment no. 4 should be reversed to be consistent with the FTE determination.

The Intermediary states the FTE count of 130.36 was accurate and makes the following arguments:

I

The Intermediary states the Provider's contention that the auditor identified 4.48 I&R FTEs in non-approved GME programs was inaccurate because:

1. There was an inconsistency in the information submitted during the reaudit (Intermediary Exhibit I-8) compared to information supplied by Provider staff;

2. There was the possibility that even if the programs were non-approved, the I&R could receive credit toward their certification which would permit the inclusion of the FTE count under the regulations. Since the auditor included the 4.48 FTEs but excluded the costs per audit adjustment no. 4, then the adjustment should be reversed; and

3. The Provider's evidence on this issue was faulty because it consisted of testimony of a witness deemed to lack credibility and written submissions that were untimely. The written evidence was untimely and impermissible because it was not submitted until the appeal in 1995. Under the regulations at 42 C.F.R. §§ 413.20 and 413.24, the information was not "maintained" by the Provider during the period in question since it was created for purposes of the appeal. Further, the Intermediary does not have to

accept the information under the holding in Dallas County (Parkland).[91] The Intermediary asserts the submission ten years after the fact makes in virtually impossible to audit and verify at this time.

II

The Intermediary argued that it was not permissible to include the outside rotations in the FTE count because:

1. Provider initially self-disallowed the outside rotations;

2. Intermediary's auditor relied upon Provider staff representations that there essentially were no outside rotations;

3. Intermediary's auditor may not have identified and tracked individual residents to the outside affiliates to determine the proper FTE count at those facilities; therefore, the FTE count at other hospitals may be incorrect and incapable of correction at this time, i.e., beyond the three year reopening. At this point, it was impossible to verify the information;

4. It is impossible to determine if the Provider received any reimbursement from affiliates that would require an offset against the Provider's GME costs;

5. The argument made in I. 3. above is incorporated by reference concerning the untimeliness and impermissiveness of the Provider's evidence; and

6. The Intermediary rejects the Provider's corollary issue relating to the proper accounting of some GME costs allegedly related to this issue because a) there was no Intermediary adjustment to appeal and, therefore, no Board jurisdiction; and b) these costs were a part of the Provider's untimely request to reclassify these costs. In fact, the Intermediary asserts the request was made to the Board as part of the Provider's initial position paper on 1/25/95.

III

The Intermediary rejects the alleged error in calculating the FTEs because of the lateness of the Provider's submissions which has interfered with the Intermediary's matching of I&R rotating to other affiliates discussed in II and I. 3. above.

ISSUE NO. 8 -- Omission of costs associated with GME programs of Anesthesiology and Radiology in the GME base year:

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[91] Intermediary Exhibit I-47.

Was the Intermediary's failure to include the costs associated with the Provider's Anesthesiology and Radiology GME programs in the GME base year proper?

FACTS:

The Provider did not include the costs associated with two of its GME programs in the GME base year, Anesthesiology and Radiology. The costs were inadvertently reported as operating costs. The Provider requested reclassification of the misclassified costs, pursuant to the GME regulations at 42 C.F.R. § 413.86(j)(2), during the reaudit and, again, after the NAPRA.[92] The Intermediary did not respond to either of these two requests. During the reaudit, the Intermediary included the residents from these two departments in the FTE count and the related resident stipend cost; but omitted all other GME direct and indirect costs of operating the two departments, such as physician compensation, clerical support, and other support costs.

The Intermediary raised jurisdictional objections to this issue on grounds that there was no Intermediary adjustment and the requested reopening was discretionary.

PROVIDER'S CONTENTIONS:

The Provider advances several contentions for the allowability of the Anesthesiology and Radiology GME programs costs:

1. Although the Provider inadvertently misclassified these costs as operating costs and did not report the costs incurred for the Anesthesiology and Radiology GME programs as GME costs in its base period cost report, a proper and timely request for reclassification of the applicable GME costs was made, as permitted under the GME regulations at 42 C.F.R. § 413.86(j)(2).

2. The GME base year costs were grossly understated resulting in an inequitably low APRA computation because the Intermediary included the number of residents from these two departments in the FTE count while omitting all related costs except for the stipend costs of the residents. The computed APRA was not based on the actual base year GME costs. The costs omitted exceeded $1 million dollars. See 5 below.

3. The omission of the subject GME costs violated the basic intent of the statute and the regulations as promulgated, namely to correct errors for an accurate determination of the Provider's base year GME costs. Further, the Intermediary failed to properly

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92 Provider Exhibit P-52 at p. 000329-37.

implement the GME regulation, as promulgated, at 42 C.F.R. § 413.86(e)(1)(ii)(A) which required the intermediary to correct cost report errors and verify the base year GME costs.

4. Failure to include the Anesthesiology and Radiology GME programs' costs causes an impermissible cost shifting to non-Medicare patients.

5. The Provider proposed that a combination of the three alternative methods of computing the allowable amount of GME related costs should be used for this reclassification, i.e., "100% Model" "Contract" and "Mercy Formula" [all previously discussed]. The proposed reclassified amounts which exceed $1 million dollars is summarized as follows:

	Anesthesiology			Radiology	
	100%	Contract	Mercy	100%	Mercy
a. Physician Comp	157,100	132,800	141,500	NA	12,200
b. Clerical Support	75,300		68,800	NA	313,400
c. Medical Supt.&Other	46,300		42,300	NA	436,800
Sub-Total	278,700	132,800	252,600		762,400
Visiting Professors	1,150	1,150	1,150		
Grand Total	278,850	133,950	253,750		762,400

I

The Provider states the two proper and timely requests to reclassify the inadvertently misclassified costs of the Anesthesiology and Radiology GME program costs were made during the reaudit,[93] and, again, on August 22, 1991 after the NAPRA.[94] The requests were made pursuant to 42 C.F.R. § 413.86(j)(2). The Provider asserts that all of the necessary information to make the reclassification was available during the reaudit which was confirmed by an Intermediary's witness at the hearing.[95] More importantly, the auditor knew of the omitted costs because he had reviewed: 1) the base year Schedule 3's for the physicians in the Anesthesiology and Radiology departments and noted that the time study had been

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93 Tr. 6/13/96 at pp. 1974-78; and Provider Exhibit P-121 at pp. 006012-14 [affidavit] and meeting notes at p. 006023.

94 Provider Exhibit P-52 at pp. 000329-37.

95 Tr. 2/8/95 at p. 77 and Tr. 1/31/96 at p. 832.

examined;[96] 2) the total base year physician compensation paid the Anesthesiologists and Radiologists;[97] and 3) the trial balance and general ledgers.[98]

The Provider avers that despite the Intermediary's knowledge of the incurred GME costs for these two GME programs, the Intermediary only made negative adjustments to remove GME costs from the base year and did not reclassify any costs to GME. The Provider maintains, as supported by its witness' testimony, that the auditor stated he could only move costs out of GME[99] which demonstrated the narrow and rigid manner in which the reaudit was conducted for this Provider. The Intermediary's witness testified at the hearing that, if the Intermediary was aware that a Provider operated a

GME program, and if no costs were reported as GME, then the Intermediary should reclassify the costs to GME.[100] However, this has not happened yet.

The Provider states the GME regulations as promulgated permit the inclusion of misclassified costs during the reaudit [See, III below].

II

The Provider claims the GME base year costs were understated by more than $1 million dollars resulting in an inequitably low APRA computation because the Intermediary included the number of residents from these two departments in the FTE count[101] while omitting all of the costs related to these departments except for the stipend costs of the residents. The Provider states that during the reaudit, the auditor was aware of these two approved programs and that the costs were not included in the base year cost report; yet the auditor failed to make any reclassification even after requested to do so.

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96 Provider Exhibits: P-94 at p. 3305 and 3314 [base year Schedule 3], and P-156 at p. 006408, lines 1-3.

97 Provider Exhibits P-177 at pp. 006556-57 (base year Schedule 1; and total physician compensation P-179 at p. 006569.

98 Tr. 2/8/95 at pp. 75-77, and Provider Exhibits P-168 at p. 006518 and P-173 at p. 006544.

99 Id. n. 80 and n. 87.

100 Tr. 2/2/96 at p. 1485.

101 Intermediary Exhibit I-8 at 1 of 7.

III

The Provider asserts the omission of the Anesthesiology and Radiology departments GME costs violates the basic intent of the statute and the regulations as promulgated which was to correct errors for an accurate determination of base year GME costs. The Provider states the GME regulation, as promulgated, at 42 C.F.R. § 413.86(e)(1)(ii)(A) required the intermediary to correct cost report errors and verify the base year GME costs. The regulation permitted the Intermediary to reclassify and include the costs of these two programs in GME costs.

The Provider cites two cases in support of the contention that these costs should have been included in its GME base year costs, i.e. Tulane and Cleveland Clinic. In the case of Cleveland Clinic Foundation v. Blue Cross & Blue Shield Ass'n, PRRB Dec. No. 94-D56, July 20, 1994,
¶ 42,593 Medicare & Medicaid Guide (CCH), rev'd, HCFA Adm'r. Sept. 21, 1994, ¶ 42,746 CCH, the Board recognized that costs omitted can be a matter of correction in the reaudit. In that case, the Board rejected the intermediary's argument that "the regulations permitted only downward adjustments in costs claimed." The Board held:

> Even though the provider did not include total GME costs in its base year cost report, the intermediary could have included the Clinic Division's costs in the APRA. The regulation at 42 C.F.R. § 413.86(e)(1)(iii) allows an intermediary to modify a hospital's base year costs solely for determining the APRA if the hospital's cost report for its GME base period is no longer subject to reopening under 42 C.F.R. § 405.1885.
>
> The regulation at 42 C.F.R. § 413.86(j)(2) allows a reclassification of GME costs if they were misclassified operating costs during the GME base period and rate-of-increase ceiling base year. . . . These [misclassified] costs should then have been classified as appropriate GME hospital costs and included in the APRA calculation.
>
> The Tulane appeals court decision supports the Board's conclusion in this case, the reclassifiable clinic costs can be included in the APRA calculation even though such costs were not included in the Provider's GME base year cost report. The court reasoned that when Health and Human Services (HHS) issued its reaudit regulations, it was hard to believe that Congress intended that misclassified and nonallowable costs continue to be recognized [as such] indefinitely. The goal of the Secretary was to properly determine costs for its base year calculation. That should include both increases and decreases of costs which should result in the correct base year amount. In this case the Provider has demonstrated that it omitted the Clinic Division's costs that were appropriate GME costs.

> Further, in Tulane, the court reasoned that the GME amendments required that discrepancies in the base period be corrected because there was no provision in the law for correcting them later. The Board agrees with this analysis and finds that all adjustments necessary to correct the base year are to be made once a cost report is no longer subject to be reopened .... The Board notes that the preamble to the regulations, requiring the APRA prospective payment, limits increases in costs to "inadvertent" omissions. Although the preamble is HCFA's discussion on how it plans to implement its regulation, it is not part of the regulation and does not have the weight of regulation. The clear language of the regulation at 42 C.F.R.
> § 413.86(e)(1)(iii) states that an intermediary may modify the hospital's base year costs solely for purposes of computing the APRA. There is nothing in the regulation addressing "inadvertent" omissions. In the light of the Tulane decision which addresses the Secretary's intent of allowing adjustments to correct errors or misclassification of costs, the preamble's limit of omissions to "inadvertent" inappropriately limits the Secretary's intended purpose of determining proper, reasonable and correct base period costs.

Cleveland Clinic Foundation v. Blue Cross & Blue Shield Ass'n, PRRB Dec. No. 94-D56

, July 20, 1994, ¶ 42,593 Medicare & Medicaid Guide (CCH), rev'd, HCFA Adm'r. Sept. 21, 1994,
¶ 42,746 CCH (emphasis added).

The Provider claims it has been established that GME costs may be increased beyond the amount claimed in the base year, to arrive at a proper, reasonable and correct base period amount.

Further, the Provider rejects the Intermediary's reliance upon the GME program instructions, rather than the GME regulations, as support for its assertion that it can never increase GME costs in the reaudit process. The Provider asserts the Intermediary's understanding of the GME program instructions, that governs the reaudit process, was to lower and retroactively limit the GME base year costs. This understanding gives further support for the Provider's contention that the GME program instructions were invalid because they conflict with the regulations. See National Medical Enterprises, 851 F. 2d at 283-84. However, the Provider believes the reaudit instructions do permit GME costs to be increased.

The Provider declares that, contrary to the Intermediary's allegation, the Intermediary's specific reference to the GME program instructions does allow GME costs under the facts of this case. The cited instructions state:

> Intermediaries are not to increase GME base period costs for these misclassified costs until it is determined whether the same misclassification

> occurred in the PPS or TEFRA base period . . . .
>
> If the hospital can demonstrate through its documentation that the same misclassification was made in the PPS/TEFRA base period, it may submit a request for an adjustment to its HSR or TEFRA target rate. Upon receipt of the request and a review of the hospital's documentation, the intermediary may increase the hospital's GME base period costs and average per resident amount, and adjust (reduce) the hospital's HSR/TEFRA target rate.

GME Program Instructions (1990) (emphasis added).

Thus, the instructions and the reaudit regulations at 42 C.F.R. § 413.86(j)(2), state a provider may request a reclassification of erroneous misclassified GME costs within 180 days of the date of the NAPRA. The Provider asserts, as discussed in I above, a timely reclassification request was made during the reaudit and again on August 22, 1991 with necessary supporting documentation of its claim. See Provider Exhibit P-52.

The Provider asserts: 1) the Intermediary's initial Position Paper at p.11 admits that the subject costs were included in the hospital's PPS base year as operating costs rather than GME costs; 2) the Provider made two reclassification requests as stated above, 3) the intermediary failed to respond in any fashion to either reclassification request, 4) the Intermediary's witness testified it had all the information necessary to make any corresponding PPS/HSR adjustments; and that once it obtained information during the GME reaudit, the Provider did not have to resubmit this information,[102] 5) the Intermediary's claim that necessary documentation was not submitted is not accurate and unfairly prejudices the Provider since the precise types of information now deemed necessary was never identified or described in a timely manner, 6) the Intermediary's dilatory practices have interfered with the verification of the costs; 7) the documentation was available and is part of the record as Provider Exhibits P-93, P-94, P-144, and P-146. Accordingly, these costs should be added to the GME base year. See V below.

The Provider also maintains that the Intermediary knew of the omitted costs, as discussed in I above, yet failed to make an adjustment reclassifying the costs as mandated by the GME regulations and related instructions. This violates the basic intent of the statute and the regulations as promulgated which was to correct errors for an accurate determination of base year GME costs.

IV

The Provider claims the refusal to include the costs related to the Anesthesiology and Radiology GME programs in the GME base year costs causes an impermissible shifting of

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[102] Tr. 2/8/95 at pp. 75-77 and Tr. 1/31/96 at pp. 1079-80.

costs to non-Medicare patients which violates 42 C.F.R. § 1395x(v)(1)(A). In addition, under the Thomas Jefferson case, this represents an improper redistribution of costs where such costs were of the type traditionally reimbursed by Medicare.

V

The Provider states that during the reaudit the Intermediary was well aware of the omission of the costs for these two departments. Nevertheless, the Intermediary failed to make any reclassification even after receiving a request to do so. The Provider claims the amount of misclassified GME related costs that should now be recognized pertains to physician compensation, clerical support, medical support, and other costs.

a. Anesthesia Department

1. Physician compensation.

The Provider states adequate documentation was submitted including the out-sourcing contract for physician services with time studies and a departmental type allocation as permitted under the GME-PI.[103] The Provider maintains that a combination of the two proposed methods [“100% Model” and “Mercy Formula”] were more applicable to this department. Under the contract with Pittsburgh Anesthesia Associates (“PAA”) all of the physician services provided were entirely related to GME activities; therefore, the “100% Model” should be used for reclassifying these costs, i.e., about $132,800 in the base year. Under the contract, any services provided to patients would be billed separately including the physician component. The department chairman's compensation should be reclassified based upon the “Mercy Formula” or 94.104%, i.e., $24,300. Thus, a total of about $157,100.[104] The same result occurs by using the "Contract Model" [$132,800] and the "Mercy Formula" for the Chairman, $24,300.

The Provider states, alternatively, the "Mercy Formula" results in an allocation of 85.981% physician compensation to GME or about $ 141,500.[105]

2. Clerical Support Staff Costs.

The Provider claims the clerical support staff is supervised by the GME faculty and, obviously, is an integral part of this GME program. Moreover, the job descriptions corroborate GME involvement such as the Departmental Secretary and Administrative

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103 See Provider Exhibits P-94 at p. 3287, P-36 at p. 104; and HCFA Pub. 15-1 § 1102.3.

104 Provider Exhibit P-144 at p. 006306.

105 Provider Exhibit P-145 at p. 006318.

Supervisor.[106] Other positions are similarly GME related.

The 100% Model results in a reclassification of about $75,300 since the GME faculty teaching percentage was 94.104%.[107] Under the "Mercy Formula", using the GME faculty teaching percentage of 85.981% makes an allocation of about $68,800.

3. Medical Support Staff GME Costs and Other Direct Departmental GME Costs.

The Provider states the support staff and other direct departmental costs of $246,000 have been properly developed pursuant to the regulations and manual provisions[108] which excludes the cost of non-GME and patient care activities. Consistent with the method of developing the reclassification of GME support costs in other GME departments, the Provider has developed a GME Activity Statistic for each of the various GME departments which was 18.821% for this department.[109]

Using the "100% Model," about $46,300 [246,000 x 18.821%] would be reclassified; and, alternatively, the "Mercy Formula" yields an activity statistic of 17.196% resulting in a reclassification of $42,300.[110]

4. Visiting Professor Fees.

The Provider maintains that the Anesthesiology program brochure evidences that the visiting professor lectures were an integral part of the GME curriculum and needed for accreditation. The ACGME site review also confirms that the visiting professor is part of the GME training program. Therefore, the entire $1,150 of cost incurred should be reclassified to GME.

b. Radiology Departments-Diagnostic and Nuclear.

The Provider asserts the Intermediary clearly knew during the reaudit that there were two Radiology GME departments, Diagnostic and Nuclear. The auditor's workpapers demonstrate the existence of these departments because they were listed on the base year approved GME

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106 Provider Exhibit P-96 at pp. 003376-77 and 003345-46.

107 Provider Exhibit P-144 at pp. 006307-08.

108 42 C.F.R. § 413.85(g) and HCFA Pub. 15-1 § 402.2.

109 Provider Exhibit P-144 at p. 006307.

110 Provider Exhibits P-144 at p. 006307; and P-145 at p. 006320.

programs,[111] the physician Schedule 3's were reviewed,[112] and the residents were included in the FTE count.[113]

The Provider avers that the amount of GME costs that should be reclassified pertains to physician compensation, clerical support, medical support, and other direct costs.

a. Physician Compensation.

In the base year, the only two radiologists that received Part A compensation were the chairmen of the respective departments who inherently perform some non-GME services. Therefore, the "Mercy Formula" was more applicable. This results in a reclassification of 82.353% of the Diagnostic department chairman's compensation or about $8,200; and 40% for the Nuclear department or $4,000.[114]

b. Clerical Support.

The Provider claims the clerical support staff was supervised by the radiologists and were an integral part of the GME program.

The radiology site reviews demonstrates that a significant amount of clerical time was devoted to GME activities.[115] The clerical support staff costs should be reclassified using the "Mercy Formula" since the only paid physicians in these departments were the respective chairmen. Thus, the allocation would use the same basis as the physician compensation, i.e., 82.353% and 40% respectively. The reclassification amount would be about $285,400 for the Diagnostic department and $28,000 for the Nuclear department.[116]

c. Medical Support Staff and Other Direct Costs.

The Provider maintains that the medical support staff was supervised by the radiologists, assisted persons directly involved in the GME training, and were themselves an integral part of the GME program in these departments. Further, the ACGME site reviews confirm their

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111 Provider Exhibit P-175 at p. 006551.

112 Provider Exhibit P-156 at p. 006408.

113 Intermediary Exhibit I-8 at p. 1 of 7.

114 Provider Exhibit P-146 at p. 006329-30.

115 Provider Exhibit P-102 at pp. 004257-409.

116 Provider Exhibits P-146 at pp. 006332-35.

involvement in the GME program.[117]

The job descriptions ("JD") in these departments clearly evidence the GME functions of the medical support staff. For example, the JDs cite specific references, such as:

1) Ultrasound Staff Technologist - "assists in instruction of the medical and x-ray resident personnel;"
2) Manager of Radiology-Diagnostic - "arranges staff education;"
3) Nuclear Medicine Technologist involved in - "ongoing staff and student clinical teaching program by presentation of lectures, journal reports or technical projects;" and
4) Radiology C.T. Scan Coordinator - "participates in staff and student training programs; coordinates work activities of the technical service personnel."[118]

Other medical support staff personnel would include CT Scan: Technologists, Angiography Technologists, Aides; and Darkroom Aides.[119]

The Provider states the support staff and other direct departmental costs have been properly developed pursuant to the regulations and manual provisions[120] which excludes the cost of non-GME and patient care activities. Consistent with the method of developing the reclassification of GME support costs in other GME departments, the Provider has developed a GME Activity Statistic for each of the various GME departments which was 37.059% and 25% respectively for each of these departments.[121] Using these activity statistics, the amount of reclassification would be about $436,800, $364,900 for Diagnostic and $98,900 for the Nuclear departments respectively.[122]

INTERMEDIARY'S CONTENTIONS:

The Intermediary makes three basic contentions:

1. The Board lacks jurisdiction over this issue;

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117 Provider Exhibit P-102 at p. 004385.

118 Provider Exhibits P-96 at pp. 003403; 003395-96; 003537; 003569;

119 Id. at pp. 003572, 003574, 003577; and 003576.

120 42 C.F.R. § 413.85(g) and HCFA Pub. 15-1 § 402.2.

121 Provider Exhibit P-146 at pp. 006331 and 006333.

122 Provider Exhibit P-146 at pp. 006332 and 006334-35.

2. The reclassification request was defective; and
3. The claimed costs would cause the APRA to be substantially out of line.

I

The Intermediary incorporates by reference its brief and motion to dismiss this issue because the Board lacks jurisdiction. In summary, there is no jurisdiction because the Intermediary made no adjustments for these costs, and the issue focuses on a request to reopen the base year GME cost report which was a matter of Intermediary discretion.[123]

II

The Intermediary claims the Provider's reclassification request was defective because it did not comply with the Medicare regulation provisions. In particular, the Provider failed to submit adequate documentation within 180 days of the NAPRA to support the timely filed request. The regulation makes four requirements:

> 1) make a request to the intermediary within 180 days of the NAPRA to adjust the GME base year, and
> 2) supply adequate documentation within 180 days of the NAPRA to support that request, and
> 3) make a corresponding request to the intermediary within 180 days of the NAPRA to adjust the prospective payment base year, and
> 4) supply adequate documentation within 180 days of the NAPRA to support that request.

42 C.F.R. § 413.86(j)(2)

The Intermediary references three cases that discuss the above requirements: Presbyterian, Providence, and Harrisburg.[124] See, Tr. 6/12/96 at p. 1797 and Tr. 6/13/96 at pp. 1908-10.

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[123] Athens Community Hospital, Inc. v. Schweiker, 743 F. 2d 1 (D.C. Cir. 1984) ("Athens II"); Good Samaritan Hospital Regional Medical Center, et al. v. Shalala, et al., 85 F.3d 1057 (2nd Cir. 1996); Saint Vincent Health Center v. Shalala, et al., 937 F.Supp. 496 (W.D. Pa 1995), affirmed without opinion, 96 F.3d 1434 (3rd Cir. 1996).

[124] Intermediary Exhibits I-35, I-48, and I-50. Presbyterian Medical Center of Philadelphia v. Ætna Life Insurance Company, PRRB Dec. 95-D41, June 15, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,487, Rev'd, HCFA Admr. CCH ¶ 43,691; Providence Medical Center v. BSBS Assn./BCBS of Oregon, PRRB Dec 95-D38, May 26, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,426, Aff'd HCFA Admr., July 30, 1995, CCH ¶ 43,690; and Harrisburg Hospital v. BSBS Assn./BCBS of Western

The Intermediary acknowledges that the Provider's request for reclassification (Provider Exhibit P-52) was timely, but the documentation was inadequate per the testimony of two witnesses at Tr. Feb. 2, 1996 at pp. 1048-49 and 1118-1122, and Tr. June 13, 1996 at pp. 1768-73.

III

The Intermediary asserts the additional disputed claimed costs would cause the Provider's APRA to be substantially out of line with comparable facilities in the area pursuant to 42 C.F.R.
§ 413.9(c)(2).

ISSUE NO. 9 -- Omission of Clinic Costs Associated with GME:

Should the GME clinic costs, mistakenly classified as operating costs in the base year, be included when calculating the APRA?

FACTS:

In the base year, resident training occurred in the Provider's Ambulatory Care Clinics located in the Provider's Health Center. The Provider did not report any clinic costs as GME costs in the base year cost report. The costs were inadvertently reported as operating costs. The Provider requested reclassification of the misclassified costs, as permitted by the GME regulations at 42 C.F.R. § 413.86(j)(2), during the reaudit.

PROVIDER'S CONTENTIONS:

The Provider essentially advances the same contentions as stated in the previous issue for the allowability of the Ambulatory Clinic costs as GME costs. The substance of those contentions are hereby incorporated by reference. In summary, the following contentions were made:

1. a) Although the Provider inadvertently misclassified these costs as operating costs and did not report the costs in the various Ambulatory Clinics as GME costs in the base period cost report, a timely reclassification request for these GME costs was made during the reaudit,[125] as permitted under the GME regulations at 42 C.F.R. § 413.86(j)(2). All necessary documentation for the reclassification was available

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Pennsylvania, PRRB Dec. 96-D9, February 15, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,058, Rev'd HCFA Admr. April 18, 1996, CCH ¶ 44,419.

[125] Provider Exhibit P-121 at pp. 006012-14 and 006023, notes from meetings; Tr. 6/13/96 at p. 1974.

during the reaudit, and in large part, had been reviewed by the Intermediary at that time. The Provider claims the Intermediary witness admitted it possessed all information from both the PPS and GME base years to make the necessary adjustments for GME and the HSR for PPS purposes.[126]

b) The regulation, at 42 C.F.R. § 413.85(g), and HCFA Pub. 15-1 § 402.2 provides for the inclusion of the net cost of approved GME activities in the base year GME costs. The following factors clearly evidence the relatedness to GME activities: i) clinical activities were required for ACGME accreditation, ii) the ACGME site reviews confirm the need for clinical education for residents, iii) Provider's GME brochures describe the clinical activities, iv) the rotation schedules of the residents demonstrate the clinics were a part of the GME training programs.

c) The costs related to those clinics were properly generated through the Provider's accounting system in the general ledger accounts of: Primary Care; Mercy Health Center: Administration, Registration, and Clinics; Family Practice; and Ambulatory: Surgical, Medical, Diabetic Care, Women's Health Unit, and Pediatrics. These accounts had been reviewed by the auditor.

d) The clinic costs were allowable and should be added as GME costs pursuant to the Tulane and Cleveland Clinic cases, as well as the University of Cincinnati, 875 F. 2d at 1210 (costs incurred to maintain accreditation are allowable GME costs); University of North Carolina v. Bowen, Medicare & Medicaid Guide (CCH) ¶ 37,432, p. 18,199 (M.D.N.C. 1988) (costs of resident clinic training are allowable), aff'd unpub. op (4th Cir. 1989); and Milton S. Hershey Medical Center, CCH ¶ 31,635 at 10,102 (all general service costs incurred to render education in clinics are allowable GME costs).

2. The computed APRA was not based on the actual base year GME costs resulting in an inaccurate and understated amount.

3. The omission of the Ambulatory Clinic costs as GME costs violated the basic intent of the statute and the regulations as promulgated, namely to correct errors for an accurate determination of the Provider's base year GME costs. The Intermediary knew of these omitted costs through its audit and the Provider's reclassification request, yet made no correction. Thus, the Intermediary failed to properly implement the GME regulation, as promulgated, at 42 C.F.R.
§ 413.86(e)(1)(ii)(A) which required the intermediary to correct cost report errors and verify the base year GME costs.

4. Failure to include the costs of the residency training in the Ambulatory Clinic as GME costs causes an impermissible cost shifting to non-Medicare patients.

5. The Provider proposed three alternative methods of computing the allowable amount of GME related costs that should be reclassified, i.e., “100% Model,” “Contract Model,” and the

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126 Tr. 2/8/95 at pp. 75-77.

"Mercy Formula." The proposed reclassified amounts range from $654,300 to $548,800 dollars is summarized as follows:

	Ambulatory clinics		
	100%	Contract	Mercy
a. Physician Compensation	10,000	10,000	9,000
b. Admin & Clerical Support	331,400	278,800	277,600
c. All Other Support costs	312,900	263,300	262,200
Sub-Total	654,300	552,100	548,800

a. Physician Compensation

During the base year, only one physician (not otherwise included in other GME programs) performed GME services exclusively in the Provider's Health Center clinics whose Part A compensation was $10,000.[127] Under the 100% and Contract Models the entire $10,000 should be allocated to GME. However, under the Mercy Formula, 90.476% would be allocated or $9,048.[128]

b. Administrative & Clerical Support

There are other GME faculty from four other departments[129] that provide residency training in the clinics; and they directly supervise the administrative and clerical support staff at the clinics. This support staff is clearly an integral part of the GME training function.

The Provider maintains that the proper method of allocation was to use the teaching percentage of the GME faculty who provide the instruction in the clinics. In this instance, a blended percentage was developed using the teaching percentage of all four departments. The blended teaching percentage uses the HCFA Form 339/Schedule 3 for the four departments. The 100% Model yields a teaching percentage of 98.493%, yielding an allocation of about $331,400.[130] The Contract Model creates a teaching percentage of 82.860% that allocates about $278,800 to GME.[131] The teaching percentage of 82.504% under the Mercy Formula

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127 Provider Exhibit P-97 at p. 003623.

128 Provider Exhibit P-149 at pp. 006341 and 006361.

129 Departments of Medicine, Pediatrics, Surgery, and Obstetrics/Gynecology.

130 Provider Exhibit P-147 at pp. 006342 and 006343-44.

131 Provider Exhibit P-148 at pp. 006352 and 006353-54.

allocates about $277,600 to GME.[132]

c. All Other Support costs

The Provider states that a blended GME activity statistic ("AS") which includes the chairmen of the four departments is appropriate for the allocation of all other support costs. The three methods result in an allocation of about: $312,900 under the 100%

Model[133] with an AS of 58.818%; $263,300 per the Contract Model and an AS of 49.483%;[134] and $262,200 by the Mercy Formula using an AS of 49.270%.[135]

For all the above stated reasons including the contentions made in the previous issue, the Provider states the clinic costs should be reclassified to GME and totally rejects all the Intermediary's contentions.

INTERMEDIARY'S CONTENTIONS:

The Intermediary makes the same three basic contentions stated in the preceding issue which are incorporated by reference. In summary these contentions were:

1. The Board lacks jurisdiction of this issue;
2. The reclassification request was defective; and
3. The claimed costs would cause the APRA to be substantially out of line.

The Intermediary makes the following additional arguments:

The Provider's reclassification request is totally defective under the regulation provisions of 42 C.F.R. § 413.86(j)(2). There was no written request and no documentation submitted. The only reclassification request was allegedly made verbally at the time of reaudit which is not within the scope of the regulation. The only written request was contained in the Provider's position paper which is inappropriate. Thus, there is no Board jurisdiction.

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132 Provider Exhibit P-149 at pp. 006362 and 006353-54.

133 Provider Exhibit P-147 at pp. 006342 and 6343-44.

134 Provider Exhibit P-148 at pp. 006352 and 006353-54.

135 Provider Exhibit P-149 at pp. 006362 and 006363-64.

ISSUE NO. 10 -- Laboratory Costs Omitted:

Should the GME laboratory costs, mistakenly classified as operating costs in the base year, be included when calculating the APRA?

FACTS:

In the base year, resident training occurred in the Provider's Pathology Department but inadvertently none of the costs for this department was reported as GME costs in the base year cost report because they were reported as operating costs. The Provider requested reclassification of the misclassified costs, as permitted by the GME regulations at 42 C.F.R. § 413.86(j)(2), during the reaudit, but the Intermediary made no adjustment.

PROVIDER'S CONTENTIONS:

The Provider essentially advances the same contentions as stated in the previous two issues for the allowability of the Pathology Department costs as GME costs. The substance of those contentions are hereby incorporated by reference. In summary, the following contentions were made:

1. a) Although the Provider inadvertently misclassified these costs as operating costs and did not report the Pathology (laboratory) costs as GME costs in the base period cost report, a timely reclassification request for these GME costs was made during the reaudit,[136] as permitted under the GME regulations at 42 C.F.R. § 413.86(j)(2). All necessary documentation for the reclassification was available during the reaudit, and the costs had been reviewed by the Intermediary at that time. For example, the Intermediary had verified the department as an approved GME program, had reviewed the rotation schedule of the I&Rs and included them in the FTE count,[137] and had reviewed the time and salaries.[138] Thus, the Intermediary was well aware this department was providing GME instruction. The Intermediary was also aware when examining the schedule showing the source of GME costs claimed, i.e., Provider's general ledger, that the Pathology department was not listed.[139] The Provider claims the Intermediary witness admitted it possessed all information from both the PPS

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136 Provider Exhibit P-121 at pp. 006012-14 and 006023, notes from meetings; Tr. 6/13/96 at p. 1974.

137 Intermediary Exhibit I-8 at 1 of 7.

138 Provider Exhibit P-179 at p. 006569.

139 Intermediary Exhibit I-12.

and GME base years to make the necessary adjustments for GME and the HSR for PPS purposes.[140]

b) The regulation, at 42 C.F.R. § 413.85(g), and HCFA Pub. 15-1 § 402.2 provide for the inclusion of the net cost of approved GME activities in the base year GME costs. The following factors clearly evidence the relatedness to GME activities: i) this department's activities were required for ACGME accreditation, ii) the ACGME site reviews confirm the need for pathology and laboratory education for residents, iii) Provider's GME brochures describe the pathology department's activities, iv) the rotation schedules of the residents demonstrate the Pathology department was a part of the GME training programs.

c) The costs related to the Pathology department were properly generated through the Provider's accounting system in the general ledger accounts which had been reviewed by the auditor.

d) The Pathology costs were allowable and should be added as GME costs pursuant to the Tulane and Cleveland Clinic cases, as well as the University of Cincinnati, 875 F. 2d at 1210 (costs incurred to maintain accreditation are allowable GME costs); University of North Carolina v. Bowen, Medicare & Medicaid Guide (CCH) ¶ 37,432, p. 18,199 (M.D.N.C. 1988) aff'd unpub. op (4th Cir. 1989) (costs of resident clinic training are allowable); and Milton S. Hershey Medical Center, CCH ¶ 31,635 at 10,102 (all general service costs incurred to render education in clinics are allowable GME costs).

2. The computed APRA was not based on the actual base year GME costs resulting in an inaccurate and understated amount.

3. The omission of the Pathology Department costs as GME costs violated the basic intent of the statute and the regulations as promulgated, namely to correct errors for an accurate determination of the Provider's base year GME costs. As stated in 1 a&b above, the Intermediary clearly knew of these omitted costs through its audit and the Provider's reclassification request, yet made no correction. Thus, the Intermediary failed to properly implement the GME regulation, as promulgated, at 42 C.F.R. § 413.86(e)(1)(ii)(A) which required the Intermediary to correct cost report errors and verify the base year GME costs.

4. Failure to include the costs of the residency training in the Pathology Department as GME costs causes an impermissible cost shifting to non-Medicare patients.

The Provider states the amount for reclassification should be:

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[140] Tr. 2/8/95 at pp. 75-77.

Physician compensation	$173,300
Clerical support	109,700
Other	635,700
Total	918,700

Physician Compensation:

The Provider states that the Pathologists perform both non-GME and GME Part A services. The Pathologist's schedule 3s report time on lines 1, 2, 3, and 7 (autopsies) as well as the basic lines 4 and 5. The "Mercy Formula" would have to be altered to include time on line 7 for autopsies as follows:

time on lines 4 & 5	X	time on lines	=	GME portion of
time on lines 4,5,6, & 8		1,2,3, & 7		time on lines 1,2,3, &7

The GME portion on lines 1,2,3, and 7 is then added to the GME time on lines 4 and 5 to calculate the total percentage of Part A GME time for each pathologist.[141] The formula results in a percentage of 31.339% x $618,400 (Pathologists Part A compensation) for a reclassification of $173,300.[142]

Support Staff:

The Provider states the above Mercy formula (31.339%) would also be applied to the support staff cost centers since the clerical staff were an integral part of the GME training and were directly supervised by the pathologists. Thus, $109,700 would be reclassified.[143]

Other Costs:

The Provider states the method consistently used for allocating "other support" costs for all other issues was a GME "Activity Statistic." For the Pathology department 18.479% results in a reclassification of $635,700.[144]

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141 Tr. 6/13/96 at pp. 1993-94.

142 Provider Exhibit P-150 at p. 006374.

143 Provider Exhibit P-150 at p. 006379.

144 Provider Exhibit P-150 at p. 006379.

INTERMEDIARY'S CONTENTIONS:

The Intermediary made the same three basic contentions stated in Issue No. 8 which are incorporated by reference. In summary these contentions were:

1. The Board lacks jurisdiction of this issue;
2. The reclassification request was defective; and
3. The claimed costs would cause the APRA to be substantially out of line.

CITATION OF LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS:

1. Law - United States Code ("U.S.C.")

5 U.S.C. Administrative Procedure Act

§ 553 et seq.	-	Rule Making
§ 706	-	Scope of Review

42 U.S.C. Public Health and Welfare

§ 1395f(b) et seq.	-	Amount Paid to Provider of Services
§ 1395x(v)(1)(A)	-	Reasonable Costs
§ 1395x(v)(1)(Q)	-	Medical Educational Activities
§ 1395hh	-	Regulations
§ 1395ii	-	Application of Certain Provisions of Subchapter II
§ 1395oo	-	Provider Reimbursement Review Board
§ 1395ww	-	Payments to Hospitals for Inpatient Hospital services.
§ 1395ww(a)(4)	-	Determinations of costs for inpatient hospital services; limitations; exemptions; "operating costs of inpatient hospital services"

defined

§ 1395ww(d)	-	PPS Transition Period; DRG Classification System; Exceptions and adjustments to PPS
§ 1395ww(h) et seq.	-	Payments for Direct Graduate Medical Educational Costs

Other Statutes:

Pub. L. 98-21 (1983), 42 U.S.C. § 1395ww(d).

Section 9202 of the Consolidated Omnibus Budget Reconciliation Act ("COBRA") of 1986, Pub. L. No. 99-272, 100 Stat. 82.

Omnibus Budget Reconciliation Act of 1987 § 4008(c), P.L. No. 100-203, 101 Stat. 1303-55, as amended by § 8402 of technical and Miscellaneous Revenue Act of 1988, P.L. No. 100-647, 102 Stat. 3798, and § 6023 of Omnibus Budget Reconciliation Act of 1989, P.L. No. 101-239, 103 Stat. 2167.

2. Regulations - 42 CFR 405, Subpart D:

§ 405.481	-	Allocation of Physician Compensation
§ 405.522(a)	-	Calculating Radiology Fee Schedules for Calendar Years After 1989. Annual Update.
§ 405.1835-.1841	-	Right to a Board Hearing
§ 405.1842	-	Expediting Board Proceedings
§ 405.1867	-	Sources of the Board's Authority
§ 405.1885	-	Reopening of a Determination or Decision
§ 412.71	-	Determination of Base-Year Costs
§ 412.73	-	Determination of the Hospital-

		Specific Rate Based on a Federal Fiscal Year 1982 Base Period
§ 412.113(b) et seq.	-	Payments Determined on a Reasonable Cost Basis. Direct Medical Education Costs
§ 413.5	-	Cost Reimbursement - General
§ 413.9 et seq.	-	Cost Related to Patient Care
§ 413.9(c)(2)	-	Cost Related to Patient Care. Application
§ 413.20	-	Financial Data and Reports
§ 413.24	-	Adequate Cost Data and Cost Finding
§ 413.85 et seq.	-	Cost of Educational Activities
§ 413.85(b)	-	Definition-Approved Educational Activities
§ 413.85(c)	-	Educational Activities
§ 413.85(d)	-	Activities Not Within the Scope of This Principle
§ 413.85(d)(4)	-	Activities Not Within the Scope of This Principle--Medical Library
§ 413.85(g)	-	Calculating Net Cost
§ 413.86 et seq.	-	Direct Graduate Medical Education Payments
§ 413.86(c)	-	Payment for Graduate Medical Education Costs
§ 413.86(e) et seq.	-	Determining Per Resident Amounts for the Base Period
§ 413.86(e)(1) et seq.	-	Determining Per Resident

Amounts for the Base Period--For the Base Period

§ 413.86(e)(1)(ii)(C)	-	Determining Per Resident Amounts for the Base Period--For the Base Period. (ii)(C) Hospital Request for Misclassified Costs
§ 413.86(e)(1)(iii)	-	Determining Per Resident Amounts for the Base Period--For the Base Period. (iii) Cost Report not subject to reopening
§ 413.86(e)(1)(v)	-	Determining Per Resident Amounts for the Base Period--Appeal Rights
§ 413.86(f) et seq.	-	Determining the Total Number of FTE Residents
§ 413.86(j)	-	Adjustment of a Hospital's Target Amount or Prospective Payment Hospital-Specific Rate
§ 413.86(j)(1)	-	Misclassified Operating Costs
§ 413.86(j)(2)	-	Misclassification of Graduate Medical Education Costs--
§ 412.113(b)(3)	-	Payments Determined on a Reasonable Cost Basis. Direct Medical Education Costs

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

§ 402.2	-	Cost of Educational Activities. Definition. Net Cost
§ 2108.1	-	Cost Related to Patient Care.

		Provider-Based Physician Services. Professional and Provider Components
§ 2108.11	-	Exhibits - Provider-Based Physicians
§ 2182.3	-	Services of Physicians in Providers. Allocation of Physician Compensation
§ 2182.13	-	Exhibits
§ 2905.1	-	Time Frame for Issuance of Intermediary Determination
§ 2924.6	-	Scope of Board's Authority
§ 2926	-	Board Hearing Decision
§ 2930 et. al.	-	Finality, Reopening, and Correction of Intermediary and Board Determinations and Decisions

Other Program Instructions:

HCFA Pub 15-1, Transmittal No. 318

HCFA GME Program Instructions

4. Federal Register

47 Fed. Reg. 43593 (1982)
48 Fed. Reg. 8901 (1983)
48 Fed. Reg. 39752 (1983)
49 Fed. Reg. 234 (1984)
50 Fed. Reg. 12740 (1985)
53 Fed. Reg. 36589 (1988) (proposed rule)
54 Fed. Reg. 40286 (1989) (final rule)
54 Fed. Reg. 40297 (1989)
54 Fed. Reg. 40301 (1989)
54 Fed. Reg. 40304 (1989)
55 Fed. Reg. 35990 (1990)

5. Legislative History:

H.R. Rep. No. 92-231 (1971)
S. Rep. No. 92-1230 (1972)

6. Cases:

Adler v. Montefore Hosp. Ass'n, 311 A.2d 634, 643 (1973), cert denied, 94 S. Ct. 870 (1974).

Administrators of the Tulane Educ. Fund v. Shalala, 987 F. 2d 790 (D.C. Cir. 1993), cert. denied, 510 U.S. 1064 (1994).

Association of Accredited Cosmetology Schools v. Alexander, 987 F. 2d 859 (D.C. Cir. 1992).

Athens Community Hospital, Inc. v. Schweiker, 743 F. 2d 1 (D.C. Cir. 1984).

Barnes Hosp. v. Mutual of Omaha, PRRB Dec. No. 94-D38, May 3, 1994, Medicare and Medicaid Guide (CCH) ¶ 42,420, aff'd and remanded, HCFA Adm'r, July 5,1994, ¶ 42,592.

Bethesda Hospital Assn, v. Bowen, 485 U.S. 399 (1988).

Bowen v. Georgetown Univ. Hosp, 488 U.S. 204 (1988).

Chevron U.S.A. v. Natural Resources Defense Council, 467 U.S. 837, reh'g denied, 468 U.S. 1227 (1984).

Cleveland Clinic Foundation v. Blue Cross & Blue Shield Ass'n, PRRB Dec. No. 94-D56, July 20, 1994, Medicare & Medicaid Guide (CCH) [1994-2 Transfer Binder] ¶ 42,593, rev'd, HCFA Adm'r., Sept. 21, 1994, CCH ¶ 42,746.

Columbia Heights Nursing Home and Hospital v. Weinberger, 380 F. Supp. 1066 (D. M.D. La 1974).

Daughters of Miriam Center for the Aged v. Matthews, 590 F. 2d 1250 (3rd. Cir. 1978).

Dallas County Hosp. Dist. v. Shalala, Medicare & Medicaid Guide, (CCH), ¶ 43,917 (N.D. Tex., 1995).

Good Samaritan Hosp & Health Ctr. (Dayton, OH) v. Blue Cross & Blue Shield Ass'n, PRRB Dec. No. 93-D30, April 1, 1993, Medicare and Medicaid Guide (CCH) ¶ 41,399.

Good Samaritan Hospital Regional Medical Center, et al. v. Shalala, et al., 85 F.3d 1057 (2nd Cir. 1996).

Harrisburg Hospital v. BSBS Assn./BCBS of Western Pennsylvania, PRRB Dec. 96-D9, February 15, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,058, Rev'd HCFA Admr. April 18, 1996, CCH ¶ 44,419.

In Home Health, Inc. v. Blue Cross and Blue Shield Association et al., HCFA Administrator's Dec., Aug. 4, 1996, Medicare & Medicaid Guideline (CCH) ¶ 44,594.

K Mart Corp. v. Cartier, 486 U.S. 281 (1988).

Milton S. Hershey Medical Center v. Blue Cross & Blue Shield Assn, PRRB Dec. No. 79-D89, July 20, 1979, Medicare & Medicaid Guide CCH ¶ 30,379; Rev'd and rem'd, HCFA Admr. CCH ¶ 30,989; PRRB Dec. No. 79-D89R, Dec. 8, 1981, [1981-2 Transfer Binder] CCH ¶ 31,635 at 10,102.

National Medical Enterprises v. Bowen, 851 F. 2d 291 (9th Cir. 1988).

Offshore Logistics, Inc. v. Tallentire, 477 U.S. 207 (1986).

Presbyterian Medical Center of Philadelphia v. Ætna Life Insurance Company, PRRB Dec. 95-D41, June 15, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,487, Rev'd, HCFA Admr. CCH ¶ 43,691.

Providence Medical Center v. BSBS Assn./BCBS of Oregon, PRRB Dec 95-D38, May 26, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,426, Aff'd HCFA Admr., July 30, 1995, CCH ¶ 43,690.

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

Saint Vincent Health Center v. Shalala, et al., 937 F. Supp. 496 (W.D. Pa 1995) 373 (Erie), Dec. 22, 1995, affirmed without opinion, 96 F.3d 1434 (3rd Cir. 1996).

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

Thomas Jefferson Univ. v. Sullivan, [1992-2 Transfer Binder] Medicare & Medicaid

Guide (CCH) ¶ 40,294; aff'd without opinion, DC Dec., CCH ¶ 41,575; aff'd, 993 F. 2d 879 (3d Cir. 1993).

University of Cincinnati v. Bowen, 875 F. 2d 1207 (6th Cir 1989).

University of North Carolina v. Bowen, Medicare & Medicaid Guide (CCH) ¶ 37,432, p. 18,199 (M.D.N.C. 1988), aff'd unpub. op (4th Cir. 1989);

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, evidence presented, testimony elicited at the hearing, and posthearing briefs, makes the following findings and conclusions, i.e., that:

GENERAL:

1. With respect to the realm of GME, the controlling statutory and regulatory provisions are 42 U.S.C. § 1395ww(h) and 42 C.F.R. § 413.86 et seq.

2. There was no persuasive evidence in the record to establish that the disputed regulation, 42 C.F.R. § 413.86, was beyond the scope of the statutory language at 42 U.S.C. § 1395ww(h); or that the regulation was otherwise invalid.

3. Pursuant to 42 C.F.R. § 405.1867, the Board is required to comply with all Medicare regulations properly promulgated pursuant to Title XVIII of the Social Security Act, as amended.

4. There was no persuasive evidence in the record to establish that the HCFA GME-PI were invalid.

5. The Intermediary applied the GME-PI in an inflexible and narrow manner which caused and resulted in an inaccurate APRA in various ways. This applied particularly to the Provider's omission and misclassification of GME costs, and to the Intermediary's inappropriate reclassification of certain GME costs.

6. The GME statute was enacted for the purpose of establishing a new and more accurate methodology of reimbursing GME costs. The APRA was to be based on all incurred GME costs recognized as reasonable. When implementing the statute through the promulgation of regulations, HCFA represented that the reaudit process was 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. In this case, the Intermediary's reaudit process disregarded this focus causing an inaccurate APRA.

7. All the documentary evidence relied upon by the Board in the record was contemporaneously maintained by the Provider and available during the reaudit as demonstrated by many of the auditor's workpapers. The record demonstrates that the auditor apparently ignored the Provider's data and information supporting the fact that GME costs had been incurred. Such costs were either omitted or misclassified by the Provider or inappropriately reclassified by the Intermediary.

8. All GME costs related to the disputed issues (except for the corollary matter in issue no.7) were properly claimed when the cost report was originally filed, and such costs had been basically allowed and reimbursed.

9. The Provider made a timely request for the reclassification of the GME costs after the reaudit and after the APRA determination which had adequate documentation; and the Intermediary improperly failed to address this request.

10. The Provider failed to properly document some of its claims for GME costs particularly in the clerical and medical support staff areas.

11. 42 C.F.R. § 412.113(b)(3) does require the medical education costs be determined consistently between the respective PPS and GME base-years. When the GME regulations were promulgated, the consistency rule was also amended in 1989 at 42 C.F.R. § 412.113(b)(3) which was valid and not an impermissible retroactive application of the regulation.

12. The Intermediary improperly used 130.36 FTEs in determining the Provider's Average Per Resident amount. The proper number of FTEs is 125.88.

13. a. In the initial as filed 1985 base year cost report, the Provider claimed GME and indirect costs of $11,450,807 with 116.62 I&Rs producing an APRA of $97,803.

b. After the audit of the initial as filed 1985 base year cost report, the approved costs would have yielded an APRA of $85,846 based on total GME costs of $9,872,263 and 115 FTEs.

c. After the reaudit of the 1985 base year cost report, the Intermediary approved GME total costs of $7,587,299 with 130.36 I&Rs for a APRA of $58,202.

d. On appeal, the Provider is claiming various GME costs that produce an APRA ranging from $114,000 to $123,000 based upon the three methodologies proposed by the Provider, i.e., "100% Model," "Contract Model," and the "Mercy Formula."

ISSUES:

ISSUE NO. 1 - Validity of GME Regulation, 42 C.F.R. § 413.86

The Board finds that in exercising its authority to conduct hearings and decide appeals, 42 C.F.R. § 405.1867 requires the Board to comply with all regulations properly promulgated pursuant to Title XVIII of the Social Security Act, as amended.

The Board finds that there was no persuasive evidence in the record to establish that the disputed regulation, 42 C.F.R. § 413.86, was beyond the scope of the statutory language at 42 U.S.C. § 1395ww(h). The Board finds there was no persuasive evidence in the record to support any of the other contentions of the Provider.

The Board notes the parties acknowledged that (1) the Board did not have the authority to declare this regulation invalid, and (2) it would be inappropriate for the Board to unilaterally grant or for the parties to seek, "expedited judicial review" ("EJR") under 42 C.F.R. § 405.1842 because there were interrelated factual issues for Board resolution.

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 reaudit provisions. In 1993, the D.C. Circuit found in the Tulane case that the GME reaudit regulations were valid in all respects. In January 1997, however, the GME reaudit regulations were held to be invalid in The Toledo Hospital v. Shalala[145] case from the Sixth Circuit. A third case, St. Paul Ramsey Medical Center, Inc. v. Shalala[146] from the 8th Circuit has also upheld the GME reaudit regulations. Due to this 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 is bound by all properly promulgated Medicare regulations until there is a resolution by a court of competent appellate jurisdiction.

ISSUE NO. 2 - Validity of HCFAs GME Program Instructions (“GME-PI”)

The Board finds that there is no persuasive evidence in the record establishing that the GME-PI are invalid.

After reviewing the GME-PI and the Provider's five basic contentions, the Board finds and concludes that (1) there is no inconsistency of the GME-PI and (2) we must disagree with all of the Provider's contentions. For example, the Board did not find that the GME-PI substantially changed the application of Medicare reimbursement (or audit) principles and policies. The Board finds that the GME-PI emphasized the need to determine that the existing Medicare reimbursement principles were properly applied to all providers in the GME base

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145 104 F. 3d 791 (6th Cir. 1997).

146 91 F.3d 57 (9th Cir. 1996), cert. granted, No. 96-1375 (1997).

period which was stated in the Federal Register at 54 Fed. Reg. 40,301 (1989).

The Board does find, however, that the Intermediary applied the GME-PI in an inflexible and narrow manner in this case which caused and resulted in an inaccurate APRA in various ways. This occurred particularly in the omission of misclassified GME costs brought to the Intermediary's attention as well as the inappropriate reclassification of certain GME costs.

ISSUE NO. 3 - Reclassification of Medical Library, Department of Education, and Department of Continuing Education

The Board finds that the portion of the Intermediary's adjustment no. 1 which reclassified costs for the Medical Library ("ML") from GME to A&G was proper; however, the portion that reclassified costs pertaining to the Department of Education ("DOE") and the Department for Continuing Education ("DCE") from GME to A&G was improper. Therefore, the Intermediary's adjustment must be modified.

Medical Library Costs:

The Board finds that with respect to ML costs there is a specific regulatory bar preventing ML costs from being treated as GME costs pursuant to 42 C.F.R. § 413.85(d)(4). Although the Provider asserts this regulation is invalid, the Board does not have the authority to determine this regulation invalid; and the Board is bound by Medicare regulations properly promulgated pursuant to the provisions of 42 C.F.R. § 405.1867.

Department of Education and Department of Continuing Education:

The Board finds the evidence submitted on this portion of the issue was compelling and persuasive in demonstrating that the reclassification adjustment no. 1 was improper. The Board also finds that the evidence was available during the reaudit, and rejects the Intermediary's arguments that the evidence did not meet the documentation requirements required by 42 C.F.R. §§ 413.20 and 413.24, or that the documentation was untimely.

The Board finds that the activities conducted in these two departments were directly related to GME. The DOE provided overall support and coordination of all departments for the entire GME program. The activities of the DCE were required for GME accreditation including "grand rounds" and certain continuing medical education programs that all I&Rs were required to attend. The Board notes that the Intermediary representatives testified[147] that the activities of these departments were related to GME, and that it was inappropriate to make a 100% disallowance of both DOE and DCE; and that it would be acceptable to make some allocation. The Board finds and relies upon the testimony of the Provider witnesses and

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147 Tr. 6/6/95 at 163, 170-171 and 174-178; Tr. 6/7/95 at 53

documentation submitted showing that 96% of DOE costs and 80% of DCE costs were related to GME.

ISSUE NO. 4 - Reclassification of Teaching Physician salaries from GME to A&G

The Board finds that the Intermediary's adjustment no. 6 reclassifying a portion of the teaching physician salaries from GME to A&G was improper.

The Board finds that the GME statutory amendments were enacted for the purpose of establishing a new and more accurate methodology of reimbursing GME costs, and that the APRA was to be based on all incurred GME costs recognized as reasonable. The GME regulation at 42 C.F.R.
§ 413.86(e)(1)(ii) provides for adjustments to reclassify GME costs misclassified as operating costs in the GME base period, and to adjust the provider's TEFRA target amount or HSR under PPS to account for these misclassified GME costs in the TEFRA/PPS base year. Although some statements in the Federal Register were directed at eliminating inappropriate costs from the GME base period, e.g., erroneously misclassified and nonallowable costs, the presumed focus was to determine accurate GME costs for the base period. Thus, the reaudit process was presented as a two-way street. The Board finds that the Intermediary's implementation was not focused in that manner; and, in fact, the audit was performed in an inflexible and narrow manner.

The Board finds that all GME costs related to this issue were properly claimed when the cost report was originally filed, and that such costs were basically allowed and reimbursed. The Board also finds that the Provider made a timely request for the reclassification of the GME costs after the reaudit and after the APRA determination which had adequate documentation; and that the Intermediary improperly failed to address this request.

The Board finds the evidence submitted on this issue was compelling and persuasive demonstrating that the reclassification adjustment no. 6 was improper; that the evidence was contemporaneously maintained and available during the reaudit; such evidence meets the documentation requirements required by 42 C.F.R. §§ 413.20 and 413.24; and that the documentation is considered timely. The Board relies on the Provider's submitted contemporaneous evidence showing (1) all the physician contracts[148] during the base year, (2) the related schedule 3s (Form HCFA-339)[149] displaying the allocation of physician time, and (3) the related physician salaries.[150] This information was restated and summarized in Provider Exhibit P-135.

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148 Provider Exhibit P-87.

149 Provider Exhibit P-89.

150 Provider Exhibit P-87.

The Board rejects the Intermediary's arguments that: i) the Provider's documentation was untimely; ii) was not provided when requested during the reaudit; iii) that it can not be considered adequately maintained for purposes of the documentation requirements of 42 C.F.R. §§ 413.20 and 413.24; and the Board is unpersuaded by the Intermediary's reliance on the Dallas County Hospital District case. As stated above, the Board finds all the evidence relied upon was contemporaneously maintained and available during the reaudit as demonstrated by many of the auditor's workpapers and that the documentation meets the requirements of 42 C.F.R. §§ 413.20 and 413.24. The record demonstrates that the auditor apparently ignored the Provider's data and information supporting the fact that GME costs had been incurred causing an incorrect APRA.

With respect to the appropriate allocation of physician compensation to GME, the Board finds that:

1. The Form HCFA-339 was originally designed to determine the appropriate split of physician Part A and B time and any non-reimbursable activity time. Hence, the form's use was never intended to gather or determine detailed GME information.

2. The thrust of the HCFA GME-PI provisions concerning the use of Form HCFA-339 appeared to be narrow in scope when only lines 4 and 5 were identified as being related to GME duties unless other documentation could demonstrate a GME relationship.

3. The Intermediary was absolutely inflexible in applying the HCFA GME-PI in this case, in that only lines 4 and 5 were used for GME duties. The GME-PI permitted the use of other lines where other data demonstrated a GME relationship.

4. It is reasonable that teaching physician time reported on lines: 1 (Supervision of technicians), 2 (Committee work), 3 (administration), were also related to GME, particularly where the teaching physician's contract was basically for GME.

5. Under the circumstances of this case, the appropriate method of allocating teaching physician salaries should be based on the Provider's "Contract Model." This Model allocates:
   1) 100% of the compensation paid to those physicians with contracts specifying exclusive GME duties, and
   2) compensation paid to all other physicians based on a portion of physician time reported on lines 1, 2 and 3. This Model results in the allocation of 82.86% of all physician compensation paid to physicians in the subject GME departments to GME costs in the reaudited base year. The Intermediary's adjustment is modified to allow an

additional $586,991 of physician compensation.

ISSUE NO. 5 - Reclassification of GME Clerical and Medical Support Personnel Salaries and Expenses from GME Costs to A&G Costs

The Board finds that Intermediary adjustment number 3 which reclassified all of the GME clerical and medical support staff salary and other expenses (about $609,700) claimed by the Provider (in the GME departments of Medicine, Obstetrics & Gynecology, Pediatrics, Surgery, and the Graduate Medical Education office) as GME costs to A&G costs was improper and must be modified.

The Board finds substantial evidence in the record to sustain the claim for clerical costs as GME. The Board finds that:

1. (a) The adjustment was clearly inconsistent with the stated purpose and intent of the GME regulations to make an accurate determination of actual base year GME costs; (b) the auditor had determined the relatedness by interviews and verified the costs through the Provider's internal controls of the accounting system; (c) the Intermediary had clearly identified the disputed costs as being GME related to the above stated GME departments, but denied the entire costs when a dispute arose regarding the furnishing of job descriptions ("JD"); and (d) the Intermediary's witnesses admitted some of the support staff performed GME related duties, and that the adjustment should be modified since some of the support costs were GME costs[151]

2. The documentary evidence (JDs) submitted in Provider Exhibit P-86 clearly demonstrates the support staff in the four GME program departments performed GME functions. In addition, they clearly indicate that the clerical staff worked directly for and under the supervision of the GME teaching physicians.

3. All the documentary evidence relied upon in the record was contemporaneously maintained and available during the reaudit as demonstrated by many of the auditor's workpapers. The record clearly demonstrates that the auditor apparently ignored the Provider's data and information supporting the fact GME costs had been incurred and the ultimate amount used for computing the APRA was understated.

4. The number of clerical FTEs in these departments were reasonable compared to the number of GME teaching physician FTEs.

5. The GME-PI [Provider Exhibit P-36 at p. 000142] state, at p. 30, Question and Answer to No. 48, that:

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[151] Tr. 1/30/96 at p. 860. Id. n. 46.

> If the clerical/support costs are attributable to teaching physicians, the allocation may be made based upon the portion of physician time allocated to GME.

6. The "Contract Model" is found to be an appropriate basis to allocate the clerical support costs pursuant to the GME-PI cited in 5 above. It allocates 82.86% of the physicians' Part A time to GME activities resulting in an allocation of $211,461 of the $274,200 direct clerical support costs.

The Board, however, finds that with respect to the medical support staff costs, there is no question that some of the costs were GME related, but there was insufficient documentation to determine the amount allowable as GME costs. The Board finds that:

1. Although the medical support staff JDs set forth some specific GME related duties, they do not indicate how much time is devoted to GME activities; and there were no time studies.

2. (a) The medical support staff activities are not directly related to the GME physician teaching time because they also perform patient care activities; (b) there was no documentation to separate these activities.

3. The Provider's creation of an allocation system based upon an "Activity Statistic" was not acceptable.

ISSUE NO. 6 - The Consistency Rule

The Board finds that the Intermediary's adjustments No's 3 and 6 did not violate the consistency rule stated in 42 C.F.R. § 412.113(b)(3) (1989).

The Board finds that § 412.113(b)(3) does require that the medical education costs be determined consistently between the respective PPS and GME base-years.

The Board disagrees with the Provider's various contentions. When the GME regulations were promulgated, the consistency rule was also amended. The Board finds that the 1989 regulatory amendment to the consistency rule at 42 C.F.R. § 412.113(b)(3) was valid because it was not an impermissible retroactive application of the regulation.

The Board finds that the new GME regulation at § 413.86(e) requires the Intermediary to verify the hospital's GME base-year costs, and to make modifications that may include nonallowable or misclassified GME costs, i.e, either as operating costs or as GME costs, previously allowed. The Board notes the modifications of misclassified GME costs may be made either at the hospital's request [§ 413.86(e)(1)(ii)(C)] or based on an intermediary determination [§ 413.86(e)(1)(iv)].

The Board finds that the new GME reimbursement methodology, described in 42 C.F.R. § 413.86(d) through (h), calls for the consistency rule to be applied either pursuant to § 413.86(e)(1)(ii)(C) [pursuant to the hospital's request] or under § 413.86(e)(1)(iv) [based upon the Intermediary's determination].

The Board also finds that in the event the Intermediary makes a reclassification of GME costs to operating costs under § 413.86(j)(1), the Provider may still obtain consistency for the PPS base-year payments by complying with two stated requirements, i.e., a timely request with adequate documentation.

ISSUE NO. 7 - Proper FTE Count of I&R

The Board finds that the Intermediary's adjustment revising the number of FTE residents used in determining the Provider's Average Per Resident ("APRA") amount was not proper because it included 4.48 FTEs related to I&R in non-approved GME programs.

The Board notes that Intermediary audit adjustment no. 12 called for a total I&R FTE count of 125.88. However, when computing the APRA, the Intermediary used an FTE count of 130.36 or a difference of 4.48 FTEs. Evidence submitted by the Provider[152] and the Intermediary[153] auditor's workpaper, shows this difference of 4.48 FTEs was related to I&R in non-approved GME programs which should have been used as a reduction of the FTEs rather than an increase. The Board also notes that audit adjustment no. 4 eliminated the costs for these FTEs. The Board finds that 125.88 FTEs (130.36 less 4.48) is the proper FTE count for computing the APRA.

The Board agrees that the FTE count ordinarily should be adjusted for the number of I&R that rotated in and out of the Provider's GME program. The Board finds, however, that the record is inconclusive regarding the proper number of rotations in and out. The Board also finds the cost evidence claimed to be associated with this aspect to be inconclusive. Thus, in view of these two findings, the claimed corollary cost issue is moot.

The Board finds the Provider's other assertions unpersuasive.

ISSUES NOs. 8-10 - Jurisdiction Objection

The Board notes the Intermediary renewed its jurisdictional objection for issues 8-10 which had been overruled prior to the hearing. The Board hereby reaffirms that ruling and incorporates it by reference. This statement is incorporated in each of these issues (no's. 8-9-

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152 Provider Exhibit P-174 at p. 006546.

153 Intermediary Exhibit I-8, last page.

10) discussed below.

ISSUE NO. 8 - Omission of Costs Associated with GME Programs of Anesthesiology and Radiology in the GME Base Year

The Board finds that the Intermediary's failure to include the omitted costs associated with the Provider's Anesthesiology and Radiology GME programs in the GME base year was improper.

The Board finds and concludes with respect to the merits of this issue that:

1. The disputed GME costs were inadvertently reported as operating costs in the base period cost report;

2. The Provider demonstrated that a portion of the omitted costs of the two departments were appropriate GME costs.

3. The Intermediary clearly knew during the reaudit that there were two approved Radiology GME departments, Diagnostic and Nuclear, because the auditor's workpapers listed the departments in the base year as approved GME programs.[154] The auditor had reviewed the physician Schedule 3's;[155] and the residents were included in the FTE count.[156]

4. The Provider timely requested reclassification of these misclassified costs, pursuant to the GME regulations at 42 C.F.R. § 413.86(j)(2), both during the reaudit and, again, after the NAPRA was issued. The request was adequately documented; the evidence submitted for the record showed it was contemporaneously maintained and available during the reaudit; such evidence meets the documentation requirements required by 42 C.F.R. §§ 413.20 and 413.24; and the documentation was considered timely.

5. The omission of these disputed GME costs violated the basic intent of the statute and the regulations as promulgated at 42 C.F.R. § 413.86(e)(1)(ii)(A), providing for the correction of errors to make an accurate determination of the Provider's GME base year costs.

6. The amount of allowable GME costs is based upon the following:

a. Physician Compensation and Visiting Professors

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154 Provider Exhibit P-175 at p. 006551.

155 Provider Exhibit P-156 at p. 006408.

156 Intermediary Exhibit I-8 at p. 1 of 7.

The Board finds that approximately $157,100 is allowable as GME costs for physician compensation in the Anesthesiology Department, $12,200 in the Radiology Department, and $1,150 for visiting professors based on the following:

i. The Board relied upon the documentation submitted in the record, particularly Provider Exhibits:

> P-93 [Physician Contracts for Anesthesiology and Radiology], P-94 [Physician Time allocations], and P-95 [Visiting Professor records]. The Board found this evidence to be persuasive, contemporaneously maintained, and available at the time of the audit. The evidence meets the documentation requirements required by 42 C.F.R. §§ 413.20 and 413.24; and the documentation was considered timely. There were supporting time studies on a departmental basis as permitted by the GME-PI.[157]

ii. The allowable amount was determined based upon the same method used in Issue No. 4, i.e., the "Contract Model" which allocates 100% of the compensation paid to those physicians with contracts that specify exclusive GME duties; and the compensation paid to all other physicians allocated based on a portion of physician time reported on lines 1, 2 and 3 of Schedule 3, i.e, the "Mercy Formula."

> (a) With respect to the Anesthesiology Department, all teaching physician services were provided under contract with Pittsburg Anesthesia Associates ("PAA") which were entirely related to GME activities. Thus, the entire contract amount of about $132,800 in the base year is allowable. The two departmental chairmen's compensation will be reclassified using the "Mercy Formula" or 94.104%, resulting in about $24,300 reclassified. A total of approximately $157,100[158] is allowable for physician compensation in the Anesthesia Department.
>
> (b) With regard to Radiology, there were two Departments-Diagnostic and Nuclear. Since the chairmen of the respective departments perform some non-GME services, the amount determined allowable is based on the "Mercy Formula." A reclassification will be $12,200 consisting of: i) 82.353% of the Diagnostic department chairman's compensation, or about $8,200, and ii) 40% for the Nuclear department, or $4,000.[159]

iii. Visiting professor lectures were found to be an integral part of the GME

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157 Provider Exhibit P-36 at p. 000104.

158 Provider Exhibit P-144 at p. 006302.

159 Provider Exhibit P-146 at p.006326.

curriculum and needed for accreditation. Further, the ACGME site review confirmed that the visiting professors were part of the GME training program. All of the visiting professors were essentially paid on a contract basis, therefore, the entire $1,150 of cost incurred will be reclassified as GME costs.

b. Clerical Support

The Board finds that although the clerical support staff was supervised by the radiologists and were an integral part of the GME program, there is insufficient documentation to support the claimed costs. The evidence indicates that the clerical support staff was engaged in both patient care and other support of the physicians. Since there were no time studies or detailed job descriptions that permitted an allocation of time, there is insufficient documentation under §§ 413.20 and 413.24 to make any allocation of costs to GME.

c. Medical Support Staff and Other Direct Costs.

The Board finds that although the medical support staff was supervised by the radiologists and was an integral part of the GME program, there is insufficient documentation to support the claimed costs. The evidence indicates that the medical support staff was engaged in both patient care and other non-GME activities of the physicians. Since there were no time studies or detailed job descriptions that permitted an allocation of time, there is insufficient documentation under §§ 413.20 and 413.24 to make any allocation of costs to GME. The Provider's creation of an allocation based upon an "Activity Statistic" was not acceptable.

ISSUE NO. 9 - Omission of Clinic costs associated with GME

The Board finds that the Intermediary's failure to include all of the omitted costs associated with the Provider's Ambulatory Care Clinics located in the Provider's Health Center in support of the GME programs in the GME base year was improper.

The Board makes the following findings and conclusions:

1-5. The Board makes and incorporates by reference the first 5 (1-5) findings and conclusions stated in Issue No. 8 above for this issue.

6. The amount of allowable GME costs is based upon the following:

a. Physician Compensation

The Board finds that $10,000 will be allowed as GME costs for physician compensation. Only one physician (not otherwise included in other GME programs)

performed GME services exclusively in the Provider's Health Center clinics whose Part A compensation was $10,000. See Provider Exhibit P-97. Consistent with the Board's decision in Issues No. 4 and 8, the entire amount is allowable since this physician's contract states the services were exclusively GME related.

b. and c. Clerical and Medical support staff costs

The Board finds that although the clerical and medical support staff was supervised by the teaching physicians and was an integral part of the GME program, there was insufficient documentation to support the claimed costs. The evidence indicated that the clerical and medical support staff was engaged in both patient care and other non-GME activities. Since there were no time studies or detailed job descriptions that permitted an allocation of time, there was insufficient documentation under §§ 413.20 and 413.24 to make any allocation of costs to GME.

ISSUE NO. 10 - Omission of Pathology Laboratory costs

The Board finds that the Intermediary's failure to include the omitted costs associated with the Provider's Pathology Laboratory costs in support of the GME programs in the GME base year was improper.

The Board finds that with respect to the merits of this issue that:

1. The disputed GME costs were inadvertently reported as operating costs in the base period cost report;

2. The Provider demonstrated that a portion of the omitted costs of this department was appropriate GME costs.

3. The Intermediary clearly knew during the reaudit that the Pathology department was an approved GME department because the auditor's workpapers listed the department in the base year as an approved GME program;[160] the auditor had reviewed the physician Schedule 3's;[161] and the residents were included in the FTE count.[162]

4. The Provider timely requested reclassification of these misclassified costs, pursuant to the GME regulations at 42 C.F.R. § 413.86(j)(2), during the reaudit. All necessary

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160 Provider Exhibit P-175 at p. 006551.

161 Provider Exhibit P-179 at p. 006569.

162 Intermediary Exhibit I-8 at 1 of 7.

documentation for the reclassification was available during the reaudit, and the costs had been reviewed by the Intermediary at that time as demonstrated in 3 above. The evidence submitted for the record was contemporaneously maintained and available during the reaudit; and this evidence meets the documentation requirements required by 42 C.F.R. §§ 413.20 and 413.24.

5. The omission of these disputed GME costs violated the basic intent of the statute and the regulations as promulgated at 42 C.F.R. § 413.86(e)(1)(ii)(A), providing for the correction of errors to make an accurate determination of the Provider's GME base year costs.

6. The amount of allowable GME costs is based upon the following:

a. Physician Compensation

The amount allowable is based upon an allocation using the GME portion on lines 1,2,3, and 7 (autopsies) of Schedule 3 added to the GME time on lines 4 and 5 to calculate the total percentage of Part A GME time for each pathologist.[163] The formula produces a percentage of 31.339% x $618,400 (Pathologists Part A compensation) for a reclassification of $173,300.[164]

b. Clerical Support

The Board finds that although the clerical support staff was supervised by the Pathologists and was an integral part of the GME program, there was insufficient documentation to support the claimed costs. The evidence indicated that the clerical support staff was engaged in both patient care and other support of the physicians. Since there were no time studies or detailed job descriptions that permitted an allocation of time, there is insufficient documentation under §§ 413.20 and 413.24 to make any allocation of costs to GME.

c. Other Costs:

Although the evidence shows there were other support costs as an integral part of this GME program, there was insufficient documentation to support the allocation of the claimed costs. The evidence indicated that both patient care and other non-GME activities were involved. Since there were no time studies or detailed job descriptions that permitted an allocation of time, there was insufficient documentation under §§ 413.20 and 413.24 to make any allocation of costs to GME.

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163 Tr. 6/13/96 at pp. 1993-94.

164 Provider Exhibit P-150 at p. 006374.

The Provider's proposed method for allocating "other support" costs was a GME "Activity Statistic" was found to be unacceptable.

DECISION AND ORDER:

ISSUE NO. 1 -- Validity of GME Regulation

The Board, in exercising its authority to conduct hearings, is required, pursuant to the provisions of 42 C.F.R. § 405.1867, to comply with all regulations properly promulgated pursuant to Title XVIII of the Social Security Act, as amended. The Board is also bound by such regulations until a court of competent appellate jurisdiction declares them invalid.

ISSUE NO. 2 -- Validity of HCFA GME-PI

The HCFA GME-PI are considered valid because they did not substantially change the application of Medicare reimbursement (or audit) principles and policies. As stated in the 1989 Federal Register, the instructions emphasized the need for intermediaries to determine that existing Medicare reimbursement principles were properly applied to all providers in the GME base period.

ISSUE NO. 3 -- Reclassification of Medical Library, Department of Education, and Department of Continuing Education

Intermediary adjustment no. 1 that reclassified costs for three departments from GME to A&G was improper and is modified as follows:

a) That portion of the adjustment pertaining to the Medical Library is affirmed; and
b) The remaining portion of the adjustment is modified to allow 96% of the Department of Education and 80% of the Department for Continuing Education.

ISSUE NO. 4 -- Reclassification of Teaching Physician Salaries

Intermediary adjustment no. 6 reclassifying a portion of the teaching physician salaries from GME to A&G was improper and is modified.

The adjustment is modified to allocate 82.86% of all physician compensation paid to physicians in the subject GME departments to GME costs in the reaudited base-year. Approximately $1,937,900 of the $2,264,500 total allowable Part A physician compensation should be classified as GME costs. The Intermediary's adjustment is modified; and the Intermediary is ordered to reclassify and allow about $586,991 of physician compensation.

ISSUE NO. 5 -- Reclassification of GME Clerical and Medical Support

The Intermediary's adjustment no. 3 reclassifying all of the clerical and medical support staff salary and related costs from GME to A&G was improper. The Intermediary is ordered to modify this adjustment to allow $211,461 for clerical support staff costs.

ISSUE NO. 6 -- The Consistency Rule

The Intermediary's adjustments No's 3 and 6 did not violate the consistency rule stated in 42 C.F.R. § 412.113(b)(3) (1989).

ISSUE NO. 7 -- Proper FTE Count of I&R

The Intermediary improperly used 130.36 FTEs in determining the Provider's Average Per Resident amount. The Intermediary is ordered to use 125.88 FTEs as the proper number in recomputing the APRA.

ISSUE NO. 8 -- Omission of Costs Associated with GME Programs of Anesthesiology and Radiology

The Intermediary's failure to include the omitted physician and visiting professor costs for the Provider's Anesthesiology and Radiology GME programs in the GME base year was improper. The Intermediary is ordered to reclassify $157,100 of physician compensation for the Anesthesiology department, $12,200 for the Radiology departments, and $1,150 for visiting professors from A&G to GME costs for these departments. There was insufficient documentation to support the claimed costs for the clerical and medical support staff costs.

ISSUE NO. 9 -- Omission of Clinic GME Costs

The Intermediary's failure to include the omitted physician compensation of $10,000 in the Provider's Ambulatory Care Clinics that was part of the Provider's GME programs in the GME base year was improper. The Intermediary is ordered to reclassify $10,000 of physician compensation from A&G to GME costs for thIs department.

There was insufficient documentation to support the Provider's claimed costs for clerical and medical support staff costs.

ISSUE NO. 10 -- Omission of Pathology Laboratory costs

The Intermediary's failure to include the omitted physician compensation of $173,300 in the Provider's Pathology Laboratory department that was part of the Provider's GME programs in the GME base year was improper. The Intermediary is ordered to reclassify $173,300 of physician compensation from A&G to GME costs for thIs department.

There was insufficient documentation to support the Provider's claimed costs for clerical and other support costs.

Board Members Participating:

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

Date of Decision: January 28, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman