PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

98-D49

PROVIDER -
St. Mary's of Nazareth Hospital Center
Chicago, Illinois

Provider No. 14-0180

vs.

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

DATE OF HEARING-
September 4, 1996 (Live) and
September 19, 1997 (Record)

Cost Reporting Period Ended -
December 31, 1984

CASE NO. 91-2824M

INDEX

ISSUES:

1) Was the Intermediary's adjustment reclassifying physician salaries for medical education from interns and residents to the administrative and general cost center proper?

2) Was the Intermediary's adjustment disallowing 50 percent of the Chicago Medical School ("CMS") faculty salaries related to teaching of undergraduate medical students proper?

3) Was the Intermediary's adjustment reclassifying the salary of a fellow from interns and residents to the adults and pediatric cost center proper?

4) Was the Intermediary's adjustment of the weighted average full-time equivalence of the residents and interns proper?

5) Was the Provider's request for Hill Burton 3 percent interest subsidy in total allowable costs proper?

6) Was the Intermediary's failure to include expenses related to graduate medical education ("GME") which were not filed on the Medicare cost report proper?

7) Should the laundry and linen statistics be adjusted to include laundry processed for residents?

8) Should the meals served statistic be adjusted to include meals consumed by residents in the GME base period?

9) Should the square footage statistic be adjusted to include residents sleeping and conference rooms?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

St. Mary of Nazareth Hospital Center ("Provider") is a 432-bed not-for-profit hospital located in Chicago, Illinois. The Provider operated and was reimbursed for GME costs in its GME base year, fiscal year ended ("FYE") 1984. In 1991, the Provider's GME costs were reaudited to determine its average cost per resident amount ("APRA"). Blue Cross and Blue Shield of Illinois ("Intermediary") conducted the reaudit and made a number of changes to the total cost allowable and to the number of interns and residents recognized. The Provider filed a timely appeal with the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841. The Medicare reimbursement effect for all of the issues is

approximately $750,000.[1]

The Provider was represented by Timothy Powell, CPA, of Powell, Powell and Associates. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross and Blue Shield Association.

The Board held a live hearing on June 4, 1996 for issues 1-4 and 6. The Board held a record hearing for issues 5 and 7-9 on September 19, 1997.

The Provider submitted a motion to add a new issue to the present case on April 25, 1997. The issue deals with the legality of the GME reaudit regulation. The request was received after the live hearing on the issues was heard before the Board, and after the record was closed for the issues to be determined on the record. The Board finds that the Provider's request was not timely and has not permitted the issue to be added to the appeal. It is noted, however, that the reaudit regulation was subsequently upheld in Regions Hospital v. Shalala, ____ U.S. ____ (February 24, 1998).

Issue 1: Reclassification of Physician Salaries

The Intermediary reclassified the portions of six teaching physician salaries, that it determined were not related to teaching responsibilities at the hospital. The physicians had submitted time sheets for allocation purposes.[2] The Intermediary reviewed the time sheets in the reaudit and changed the intern and resident costs from $358,563 to $274,980. The Provider requested permission to submit new cost studies from current years to serve as proxies for the GME base year.[3] The Intermediary refused the request because proxy measures were only to be used if documentation did not exist or was inadequate. The Intermediary found the original time studies to be reasonable and acceptable.

The Intermediary included the following categories from the time sheets to be GME functions:

A Teaching - Approved Graduate Medical Education Programs.

B Teaching - on the job training.

D Administration

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1 See Intermediary Position Paper ("IPP") at 2. The Intermediary submitted one position paper for both the live and record hearing.

2 See Provider Position Paper for the Live Hearing ("PPPL"), Provider Exhibit 3.

3 See IPP, Intermediary Exhibit 3.

E Professional supervision

The following Part A activities, although deemed allowable by the Intermediary, were reclassified from the interns and residents cost center to the Administrative and General cost center:

C Research related to patient care, ...

F Hospital Services (committee work, ...)

G Services of general benefit to patients (quality control)

H Other (autopsies, radiation/bacteria level inspections, etc.)

I Sick Time

J Jury Time

K Vacation Time

L Legal Holiday

M Personal Holiday

N Other (indicate)[4]

PROVIDER'S CONTENTIONS:

The Provider contends that these individuals are primarily engaged in teaching and that their administrative costs are merely a component of their jobs. The Intermediary is only allowing direct teaching time. The Provider notes that "I" through "M" constitute non-productive time for items including vacations and holidays. The Provider indicates that if a physician spent all of his time teaching except vacation and holidays, it would be incorrect to allocate that time to anything but teaching. At a minimum, the non-productive time should be allocated between job functions. The Provider argues that "F" and "G", dealing with committees and quality assurance activities, are engaged in by all Departments and are part of the general overhead of hospital operation. Costs are not separated out in other Departments and reclassified into administrative and general. The Provider presented illustrations that for other Part A costs in

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[4] See IPP, Intermediary Exhibit 3.

other Departments the general and administrative costs of physicians has been allocated to the Department for which the physician worked.[5]

The Provider also contends that the Intermediary's treatment of its teaching costs are inconsistent with that of the PPS base period. This is not permitted under the provisions of 42 C.F.R. § 412.113(b)(3) which state that:

> [e]xcept as provided in §413.86(c) of this chapter, for cost reporting periods during the prospective payment transition period, the cost 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 as provided in Subpart E of this part.

The Board has previously upheld the consistency rule in Good Samaritan Hospital v. Blue Cross and Blue Shield Association/Community Mutual Blue Cross and Blue Shield, PRRB Dec. No. 93-D79, August 26, 1993, Medicare and Medicaid Guide (CCH) ¶ 41,693, rev'd in part and aff'd in part HCFA Administrator, October 28, 1993, Medicare and Medicaid Guide (CCH) ¶ 41,921, rev'd in part 673 F.Supp 1063 (1994) ("Good Samaritan"). In Good Samaritan, the Intermediary had reclassified compensation paid to teaching physicians, non-physician faculty and support personnel from GME costs used to determine the APRA. The Board held "that the Intermediary improperly reclassified the teaching costs, i.e., compensation of teaching physicians, non-physician faculty and support personnel from GME to operating costs. The Intermediary's reopening of the Provider's cost report which resulted from the TIPPS review was improper because the audit adjustment violated the consistency rule of 42 C.F.R. § 412.113(b)." Id.

The Provider notes that despite the Intermediary's indication at the hearing that the rate would be adjusted, the Board lacks jurisdiction to correct the misclassification of costs for the PPS hospital specific rate adjustment because those years are not before it during this appeal.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the original time studies were adequate and accepted by the Intermediary. The only problem was a misclassification of some administrative and direct patient services such as medical education costs, which has been corrected by the reclassification. The use of proxies are only permitted when no auditable documentation existed, which was not the case at the Provider's facility.

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[5] See PPPL, Provider Exhibit 38.

Issue 2: Medical Student Costs

The Provider has an affiliation with the CMS. In Article VI of their Affiliation Agreement, it provides that medical students will be trained along with interns and residents at the Provider's facility. The budget from 1983-1984 shows that there were 44 undergraduates and 35 residents for that time period. The Intermediary viewed this as a 50/50 split and allocated 50 percent of the cost to undergraduate training.

PROVIDER'S CONTENTIONS:

The Provider presented testimony that the CMS faculty did not supervise or pay for the training of medical students. Supervision of medical students is carried out by interns and residents and is part of their job duties. Such supervision is the same as allowable supervision of nursing and other staff. The Provider claims that HCFA Pub. 15-1 § 2802(f) recognizes supervision of medical students as an allowable operating expense.

Testimony of a participant and subsequent director of the family practice residency program indicated that supervision of medical students is by residents.[6] Testimony also noted that medical students attended different lectures than those of the interns and residents of the hospital site.[7] The agreement between the Provider and the Medical School clearly identifies that the Provider is only paying for teaching of residents and resident costs and that the cost of medical students is not covered.[8]

The Provider asserts that the Intermediary's assumption that any training costs for Departments that had no residents must be for medical students was incorrect. The Provider indicates that the CMS faculty compensation for these Departments was for residents that rotated through them. Further documentation is presented that interns and residents rotated through Departments that had no teaching costs other than the CMS faculty time assigned to them.[9]

The Provider also claims that the CMS fees were considered GME costs in the PPS base year and that the same argument concerning the consistency rule as stated above for Issue 1 is applicable to CMS fees.

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6 Tr. at 42.

7 Tr. at 52.

8 See PPPL, Provider Exhibit 7 and Tr. at 19-20.

9 See PPPL, Provider Exhibit 38 pertaining to neurology and pediatric rotations.

INTERMEDIARY'S CONTENTIONS:

The Intermediary asserts that teaching of interns and residents is allowable but that teaching undergraduates is not allowable. See 42 C.F.R. § 413.85(d)(6). The Intermediary indicates that medical students are being trained during various rounds by teaching physicians. The Intermediary refers to a HCFA directive, dated November 8, 1990, that provides guidance on this subject.[10] The directive indicates that GME costs should not include medical student stipends. The medical student stipends should be adjusted out as well as the medical student portion of any activities designed to train both interns and residents and medical students.[11] The Intermediary determined that a number of teaching rounds regularly occurred for the benefit of both the interns and residents and the medical students.[12] A letter from CMS clarifies that medical students participate in programs with the interns and residents directed by the Provider's faculty and, therefore, a portion of these costs should be allocated to a non-allowable student account.[13]

Issue 3: Reclassification of Physician Costs from GME to Adult and Pediatric Cost Center

During the reaudit, the Intermediary reclassified $5,662 attributed to a fellow from the interns and resident cost center to the adult and pediatric cost center.

PROVIDER'S CONTENTIONS:

The Provider contends that the physician costs in question were not included in the GME costs as a result of the initial audit.[14] The Intermediary adjustment sought to remove these costs from GME. Since these costs had already been removed, the adjustment was improper and should be reversed. The Provider indicates that the Intermediary admitted at the hearing that an error had been made in making this adjustment.[15]

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10 See IPP, Intermediary Exhibit 16.

11 Id.

12 See IPP, Intermediary Exhibit 6.

13 Id.

14 See PPPL, Provider Exhibit 38.

15 Tr. at 141.

INTERMEDIARY'S CONTENTIONS:

The Intermediary determined that one resident was a fellow who had remained at the Provider to gain more experience. The Intermediary indicates that fellows are not part of the GME program and are covered as physician services on a reasonable charge basis. Therefore, the Intermediary's reclassification of the fellows' compensation from GME to the adult and pediatric cost center was correct.

Issue 4: Count of FTE's

The Intermediary calculated a total of 57.32 FTEs in the Provider's two GME programs. The Provider claims that the Intermediary made a number of errors in the count and overstated the count by approximately 7.5 FTEs.

PROVIDER'S CONTENTIONS:

The Provider contends that a number of errors were made by the Intermediary in calculation of its FTEs. First, the Provider notes, and the Intermediary acknowledged, that it counted as an FTE the fellow disallowed in issue 4 above. Second, the Intermediary used the CMS schedule to count FTEs, and since the Provider's family practice residents are also simultaneously listed on that schedule, they were counted twice. The Intermediary counted one month twice in two different residency programs.[16] The Provider notes that two residents were counted as more than one FTE.[17] Another error failed to note that a resident did not start until one month after originally scheduled.[18] The Intermediary also made a computational error of .995 [19] in adding up the FTEs.

The Provider also asserts that the assignment sheets used by the Intermediary for August and September were not correct,[20] and that the rotational schedule was more accurate.[21] Using the assignment sheets, numerous mistakes were made for numerous residents, for a total over-count of 3.166 FTEs. The CMS assignment sheets also included fellows who should not be

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16 Provider Post Hearing Brief ("PPHB") at 31-33.

17 Id. at 32.

18 Id. at 33.

19 Id. at 33 and 34.

20 Id. at 35 and 36.

21 Id. at 36.

in the FTE count.[22] These fellows represent approximately 3.22 FTEs. The Provider also indicates that the Intermediary's use of intern and resident salaries was not appropriate because they are paid through voucher and not through the payroll system. Records further indicate that many of the vouchers were not paid.

The Provider indicates that the fellows should not be counted in the FTE count since that was not an approved program. The Provider states that this should not effect the amount of teaching costs allowed because they would not really be in training but rather merely reporting to the Chairman and conducting rounds. Fellows are really attending physicians, unlike residents or interns. Finally, some of the resident and intern rotations were held off-site and thus .091 FTEs should be adjusted out.

In summary, the Provider asserts that with corrections for math and duplication error, adjustments for variances in rotation schedules, and removal of fellows from the count, the total FTE count should be 49.93 instead of 57.32.[23] In addition, $80,371 in GME costs for fellows should be reclassified from GME cost. The revised FTE count and GME costs should be used to determine the APRA.

INTERMEDIARY'S CONTENTIONS:

The Intermediary indicates that because of the time lag in conducting the reaudit, some records were not located, and it used the best available records. The Intermediary notes that the Provider has two GME programs, the in-house GME family practice program with 24.77 FTEs, and the GME program affiliated with CMS with 32.55 FTEs, for a total of 57.32 FTEs.

According to the Intermediary, the Provider contends that there should be 7.5 FTE less or 49.93 FTEs. Of the 7.5 FTE difference, 6.71 FTEs are for the CMS program: 3.73 FTEs for internal medicine, 0.83 FTEs for psychiatry and 2.15 FTEs for the nursery. The Intermediary claims there were errors in the number of days counted.[24] The reaudit turned up 32.32 intern FTEs versus the 35 listed by CMS.[25] The Intermediary indicates that some rotation schedules were not present and it examined the average salary of $21,257 for residents and divided it into the actual salary for CMS residents, which yielded approximately 36.6 FTEs. The Intermediary audit result of 32.32 was therefore reasonable and not overstated as indicated by the Provider.

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22 Id. at 45.

23 Id. at 55.

24 See IPP, Intermediary Exhibit 9 at 13-2,13.3, and 13.4 workpaper.

25 IPP, Intermediary Exhibit 10.

Issue 5: Hill Burton Costs

The Provider had a 3 percent Hill Burton interest subsidy. The total amount of the interest subsidy for FYE 1984 was $459,290. The Provider indicates that in reporting allowable interest costs and total claimed expenses, it reduced them by the 3 percent Hill Burton subsidy. The Provider requested that the Hill Burton loan subsidy not be offset for the GME base period.[26]

PROVIDER'S CONTENTIONS:

The Provider asserts that the Hill Burton subsidy was a grant, and that the requirement that income from grants and gifts be offset was removed for any cost reporting period on or after September 1, 1983. Therefore, the Provider is not required to offset the Hill Burton subsidy in the GME Base Period. Although the Provider indicates that it inadvertently offset the Hill Burton subsidy in its filed cost report, the Provider asserts that it properly requested that the costs be included for calculation of the GME rate.[27]

The Provider further argues that the decision in Tulane Medial Center Hospital v. Shalala, 987 F.2d 790 (1993) ("Tulane"), requires that any misclassified costs applicable to GME, whether direct or indirect, be included in the APRA.

INTERMEDIARY'S CONTENTIONS:

The Intermediary asserts that the Hill Burton interest subsidy, which was not a GME cost, cannot be introduced in the GME audit per regulations. See 54 Fed. Reg. 40,301, September 29, 1989.

Issue 6: Failure to Include Expenses Related to GME on the Cost Report

The Provider claims that certain costs should have been included in GME to determine the ARPA. These include salaries of the program director and staff, non-payroll expenses of interns and residents, and malpractice insurance for interns and residents. The Intermediary used the 1984 Cost Report.

PROVIDER'S CONTENTIONS:

The Provider claims that a number of direct costs were misclassified and should be considered direct GME costs in calculating the APRA. These include $64,521 in salary for the Program

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[26] See IPP, Intermediary Exhibit 2.

[27] See Provider Position Paper for Record Hearing ("PPPR"), Provider Exhibit 2.

Director and staff; $24,533 for non-payroll costs for interns and residents, and $22,735 for medical insurance for interns and residents.

The first misclassified cost was for the Assistant Residency Director. This individual was responsible for staffing and review of credentials and approving residency expenses. There were also two assistants to the Residency Director whose salaries were also misclassified.

The Provider indicated that it has documentation of non-payroll costs for its residents which were not included in the GME cost center.[28] These costs equaled $24,533.

The Provider indicates that in the PPS base year the GME program was allocated a portion of the malpractice costs. The Provider indicates that no similar allocation was made for the GME base year. The Provider proposed that a similar percentage of malpractice costs be allocated in the GME base year as that allocated in the base year.

INTERMEDIARY'S CONTENTIONS:

The Intermediary indicates that under the regulations the Provider is allowed to show additional costs for GME, but that it failed to support those costs with auditable documentation.[29]

Issue 7: Laundry and Linen Statistics

The Provider maintained exclusive sleeping rooms for residents and interns to be used when they were on call. The laundry and linen was changed daily in these rooms, and the Provider developed an estimate of these costs and seeks to have these costs included in the GME Cost Center. The Intermediary used the 1984 Cost Report information which did not have any special allocation of linen or laundry to GME for the call rooms.

PROVIDER'S CONTENTIONS:

The Provider indicates that interns and residents were required to be on call, and used special call rooms that were reserved exclusively for them. The Provider states that linen and laundry in these rooms were changed daily. Since the laundry for this rooms were solely for GME, the Provider asserts that these costs should be included in GME costs pursuant to 42 C.F.R. § 413.86(d). The Provider presented information indicating that 14 rooms were used for call purposes.[30] The Provider also presented details of the laundry and linen use, and indicates

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28 PPPL at 24.

29 IPP at 15.

30 See PPPR, Provider Exhibit 5.

that the laundry and linen statistic should be adjusted to reflect its use for GME purposes.

The Provider further argues that the decision in Tulane, supra, requires that any misclassified costs applicable to GME, whether direct or indirect, be included in the APRA.

INTERMEDIARY'S CONTENTIONS:

The Intermediary indicates that the Provider has not previously claimed a laundry and linen cost for GME in prior cost years, and that insufficient documentation was provided. The Intermediary claims that a review of other teaching hospitals shows that it is not usual or customary for them to claim overhead cost for laundry and linen.

Issue 8: Meals

The Provider indicates that residents and interns are given free meals during the periods that they are on call. The Provider seeks to add these meals to the existing meals that are currently allocated to GME, using a cafeteria statistic. The Provider also asserts that the allocation of cafeteria costs is incorrect because the cost of faculty, residents, and interns, who were paid by voucher, were not included in the payroll statistic used to allocate costs.[31]

PROVIDER'S CONTENTIONS:

The Provider indicates that there were two problems with cafeteria costs. First, they do not reflect the free meals provided to residents and interns while on call. Second, the Provider claims that interns, residents and faculty costs were paid by voucher and thus their FTEs were not used to allocate the cafeteria costs to GME in the ordinary step down of those costs to various cost centers. The Provider presented documentation concerning its requirements that interns and residents be on call as well as its practice of providing free meals to interns and residents while on call.[32] The Provider has also noted that the Intermediary workpaper notes that the CMS residents and faculty were not included and should be allowed if documented.[33]

The Provider further argues that the decision in Tulane, supra, requires that any misclassified costs applicable to GME, whether direct or indirect, be included in the APRA.

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31 See PRRB at 14.

32 See PPPR, Provider Exhibit 4.

33 See PPPR, Provider Exhibit 8.

INTERMEDIARY'S CONTENTIONS:

The Intermediary states that the Provider's cafeteria costs are allocated to the various departments using statistics maintained by the cafeteria The Provider is claiming an already claimed additional 38,485 meals for interns and residents in addition to the 3,534 claimed. This is 2 meals per day and is out of line with other teaching facilities. The Intermediary claims that interns and residents in other facilities scarcely use the cafeteria.

Issue 9: Square Feet Statistic

The Provider indicates that exclusive space for sleeping and conferences are maintained for the residents and interns of the GME program. The Provider seeks to increase the square footage allocated GME by these amounts. The Intermediary used the square footage amounts from the 1984 Cost Report.

PROVIDER'S CONTENTIONS:

The Provider indicates that the residents and interns were required to be on call and that they were provided special sleeping rooms for their exclusive use while on call. The Provider maintains that the square footage for GME used to calculate the APRA was understated because of the failure to properly allocate these on-call sleeping rooms to GME. The Provider presented evidence that errors had been made in allocation of the rooms,[34] and presented information to support a reallocation of 3,901 square feet to the GME cost center.[35]

The Provider further argues that the decision in Tulane requires that any misclassified costs applicable to the GME, whether direct or indirect, be included in the APRA.

INTERMEDIARY'S CONTENTIONS:

The Provider has consistently claimed 1,746 square feet for interns and residents. The additional square footage now being claimed is for sleeping quarters and the medical library. The Intermediary claims that the Provider did not provide sufficient documentation of the sleeping quarters to allow for review and adjustment, if necessary. The Intermediary also indicates that HCFA Pub. 15-1 § 2802.2(d) does not allow maintenance of a medical library as a direct medical education cost.

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[34] See PPPR, Provider Exhibit 17.

[35] See PPPR, Provider Exhibits 5, 13, 14,18, and 20.

CITATIONS OF LAWS, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§ 1395x(v)(1)(A)	-	Reasonable Cost

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

§ 412.113(b)(3)	-	Other Payments, Direct Medical Education Costs
§ 413.85(d)(6)	-	Cost of Educational Activities, Activities Not Within the Scope of this Principle
§ 413.86 et. seq.	-	Direct Graduate Medical Education Payments

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

§ 2802(f)	-	Payment Rates During Transition, Prospective Payment Computation

4. Cases:

Good Samaritan Hospital v. Blue Cross and Blue Shield Association/Community Mutual Blue Cross and Blue Shield, PRRB Dec. No. 93-D79, August 26, 1993, Medicare and Medicaid Guide (CCH) ¶ 41,693, rev'd in part and aff'd in part HCFA Administrator, October 28, 1993, Medicare and Medicaid Guide (CCH) ¶ 41,921, rev'd in part 673 FSupp 1063 (1994).

Regions Hospital v. Shalala, ____ U.S. ____ (February 24, 1998).

Tulane Medial Center Hospital v. Shalala, 987 F.2d 790 (1993).

5. Other:

54 Fed. Reg. 40,301, September 29, 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 post hearing briefs, finds and concludes as follows:

Issue 1: Reclassification of Physician Salaries

The Board notes that the record contains the time sheets of the physicians in question.[36] The Board agrees with the Intermediary that it is unnecessary to use "proxy" time studies when otherwise reasonable documentation from the time period in question is available. The Board concurs with the Intermediary that some of the activities listed in the Part A section of the time sheets are not related to the GME program. The Board finds that research, hospital services, services of general benefit to patients, and "other" were not specifically related to GME and should not be included in that Cost Center.[37] The Board agrees with the Provider that items such as vacation, sick leave, and holidays are part of the general overhead associated with an employee and should be allocated to that employee in proportion to their main activities. That is, if a physician spends most of his time in GME activities, most of the vacation and other forms of leave should be allocated to GME activities. The Board finds that the Intermediary should allow a portion of the time for items I through N to items A, B, D and E, and that this portion should equal the portion that items A, B, D and E are of the physicians' total activities.

The Board finds that the Intermediary adjustment should be modified to allow a portion of overhead costs to be included in the GME Cost Center.

Issue 2: Medical Student Costs

The Board and HCFA recognize that undergraduate medical students are often trained alongside residents and interns in GME programs.[38] The cost of medical student teaching, stipends, etc. are specifically to be excluded from the GME Cost Center. The Intermediary found that the GME program was equally for the residents and interns and the medical students and, therefore, allocated 50 percent of the costs of the faculty to the medical students whose numbers approximately equaled that of the residents and interns. The Board finds evidence in the record that the responsibility and costs of medical student education were born by the Medical School and not the Provider. The Board also finds that medical student involvement in the intern and resident programs was minor, and should not result in an adjustment that proportionately reduces the costs of the GME program.

The Provider submitted a letter from the CMS that clarifies the responsibility and costs of

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36 See PPPL, Provider Exhibit 3.

37 Id., Items C, F, G and H, respectively on the time sheet.

38 See IPP at 7, referring to HCFA guidance on excluding medical school student costs from the GME cost center.

faculty for medical students who participate in the GME program.[39] The letter indicates that the Provider permits undergraduate education at the facility "but has not been billed for nor paid any of the cost of the University undergraduate program."[40] It further indicates that the University paid all costs associated with the undergraduates and that the University faculty salaries paid for by the Provider were only for graduate medical students.[41] The letter further notes that graduate students are sometimes required to act as team leaders for undergraduate students but that at those times they were under the supervision of University faculty paid by the University.[42] In addition, there was considerable testimony that medical students were supervised and trained by interns and residents as opposed to utilizing the time and resources of the Provider's teaching faculty.[43]

The record indicates that no teaching or direct medical students costs were paid for by the Provider and that the Provider's GME program was for the interns and residents. The Provider provided medical students with an opportunity to gain clinical experience, but training courses taken by medical students were taught at the Medical School.[44]

The Board finds that the Provider teaching costs were not related to medical student education and should not be disallowed.

Issue 3: Reclassification of Physician Costs from GME to Adult and Pediatric Cost Center

The Board notes that fellowship costs should be removed from the GME center costs. Testimony and evidence in the record indicates that fellowship costs had already been removed from the GME Cost Center.[45] The Board finds that the Intermediary had already removed the fellowship costs from the base year and therefore the subsequent adjustment was improper.

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39 PPPL, Provider Exhibit 6.

40 Id. at 2.

41 Id.

42 Id.

43 See Tr. at 19 and 39.

44 See IPPL, Intermediary Exhibit 16 at 1.

45 See Tr. at 141 and PPPL, Provider Exhibit 38.

Issue 4: Count of FTE's

The Board notes that there is a dispute as to which source document should be used to count the number of interns and residents. The Provider presented evidence that a number of errors were made in counting residents and interns and that using the Provider's rotational schedule instead of the assignment sheets used by the Intermediary would result in a more accurate count. The Board is persuaded that a number of errors have been made in the computation, and that the rotational schedules are the preferred source documentation to determine the number of residents and interns.

The Provider pointed out a number of errors in the Intermediary's count of residents and interns.
First, the resident and intern count should not include Fellows who were not in approved GME programs. The assignment sheets used by the Intermediary included some of the Provider's Fellows. The Provider identified these Fellows and the number of FTEs related to them that should be removed.[46] The Provider also pointed out that the rotational schedules they proposed to use for the count did not include Fellows.[47]

Second, the Provider noted that some of its family practice residents were listed on the Medical School assignment schedule for internal medicine. As a result, some of these residents were counted twice for some months.[48]

Third, the Provider indicated that some of the assignment sheets were missing.[49] The Intermediary made assumptions concerning the missing time period.[50] As a result, some residents were counted for more than one FTE.[51] In addition, the Provider indicates that if the rotation schedules are used, a number of adjustments must be made that would further reduce the resident count. The Provider also points out that some residents are counted in two different residencies for the same month.[52]

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46 See PPHB at 46.

47 Id. at 45.

48 Id. at 31, 32 and 33.

49 Id. at 34.

50 See IPP, Intermediary Exhibit 8.

51 See PPHB at 32.

52 See Id. at 37.

Fourth, the rotation schedule that the Provider would utilize shows residents at sites other than the Provider.[53] The Provider notes that this off-site time should not be counted in its FTE count, but that is not reflected in the Intermediary's calculations.[54]

The Intermediary indicates that it reconciled the FTE counts to payroll, but the record does not reflect that this occurred, and the Provider points out that this would not have been possible due to the fact that interns and residents were paid by voucher. The Intermediary did divide the average cost per resident, $21,257, into the total actual cost for all residents in the period, $778,825, and determined that there were approximately 36.6 FTEs.[55] The Intermediary compared this number to the FTE count it obtained from the assignment sheets, 32.5, and determined that its count was not unreasonable.[56]

The Board finds that the Provider is correct in asserting that the Intermediary count, using the assignment sheets, has resulted in numerous errors. The Board also finds that the rotational schedules provided sufficient detailed information to generate a non-duplicative count of resident FTEs and should be utilized by the Intermediary in the calculation of the FTEs for the APRA.

Issue 5: Hill Burton Costs

The Board notes that the preamble to the regulation addresses the issue of whether non-GME cost issues can be raised in the reaudit related to the APRA. The guidance in the preamble states that "[a]ll other elements of the Medicare cost reports for the years in question would remain settled."[57] The Board finds that the Hill Burton interest subsidy is not related to GME costs and cannot be changed during the GME base year reaudit.

Issue 6: Failure to Include Expenses Related to GME on the Cost Report

The Board notes that the Medicare regulations allow for GME costs that were misclassified in the base year to be reclassified during the reaudit. The Provider is attempting to claim the costs of an Assistant Residency Director and support staff, non-payroll costs for residents, and a portion of its malpractice costs attributable to GME. The Intermediary indicates there is

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53 PPPL, Provider Exhibits 18 and 19.

54 See PPHB at 38 through 43.

55 See IPP at 13.

56 Id.

57 See Medicare and Medicaid Guide (CCH) ¶ 37,428, at 18,140.

insufficient auditable documentation to support these costs. The Board finds that the record does not contain sufficient documentation to permit the reclassification.

The Board notes that there was testimony concerning the role of the Assistant Residency Director and the support staff. The record does not contain job descriptions for these individuals. It is unclear if these individuals engaged in non-GME activities and to what extent they did so. The Board therefore finds that the Provider has not provided sufficient auditable documentation to support reclassification of these staff costs.

The Board notes that the Provider claims $24,533 in non-payroll expenses of its interns and residents.[58] The record does not contain documentation to support allocating these costs to the GME Cost Center. The Board, therefore, finds that the Provider has not provided sufficient auditable documentation to support reclassification of these non-payroll expenses.

The Board notes that the Provider allocated a portion of its malpractice costs to GME in the PPS base year and seeks to make a similar allocation in the GME base year. The record contains no explanation for the allocation in the PPS base year, nor why it is appropriate to utilize the ratio from the PPS base year in the GME base period. There is no malpractice policy or cost data presented to permit an allocation of malpractice costs for the GME base period. The Board finds that the Provider has not provided sufficient documentation to support reclassification of malpractice costs.

In summary, the Board finds that the Provider has not provided sufficient documentation to support the reclassification of the costs related to staffing, non-payroll costs, or malpractice costs.

Issue 7: Laundry and Linen Statistic

The Board notes that the Provider has identified some specific laundry and linen expenses related to the GME program. The Provider argues that these costs should be carved out of general laundry and linen expenses and directly allocated to the GME Cost Center. The Board finds that the Provider had not previously allocated specific laundry and linen costs to the GME Cost Center nor is it appropriate to do so without directly allocating laundry and linen costs to other hospital Departments.

Issue 8: Meals

The Board notes that the Provider identified meals that were provided to interns and residents as part of the GME program. The Provider argues that these costs should be carved out of the other cafeteria costs and directly allocated to the GME Cost Center. The Board finds that the

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[58] PPPL at 24 and PPHB at 56.

Provider has not previously identified these costs as part of the GME Cost Center, nor is it appropriate to do so without directly allocating cafeteria costs to other hospital Departments.

Issue 9: Square Feet Statistic

The Board notes that the Provider has presented documentation to support its assertion that additional square footage was used for GME. The documentation relates to on-call sleeping rooms and conference areas used solely by residents. The Board finds that the Provider has submitted adequately detailed documentation with regard to both the call rooms and resident conference areas to support their request to reclassify these areas to GME.

DECISION AND ORDER:

Issue 1: Reclassification of Physician Salaries

The Board finds that the Intermediary adjustment should be modified to allow a portion of overhead costs associated with teaching physician salaries in the GME Cost Center. The Intermediary adjustments are modified.

Issue 2: Medical Student Costs

The Board finds that the Provider costs were not related to medical student education and should not be disallowed. The Intermediary adjustment is reversed.

Issue 3: Reclassification of Physician Costs from GME to Adult and Pediatric Cost Center

The Board finds that the Intermediary had already removed the fellowship costs from the base year and therefore the subsequent adjustment was improper. The Intermediary adjustment is reversed.

Issue 4: Count of FTE's

The Board finds that the Intermediary count is incorrect and that the rotational schedules provided sufficient detailed information to generate a non-duplicative count of resident FTEs. The Intermediary is directed to utilized rotational schedules to recalculate FTEs for the APRA.

Issue 5: Hill Burton Costs

The Board finds that the Hill Burton interest subsidy is not related to GME costs and cannot be changed during the GME base year reaudit. The Intermediary's exclusion of these costs is affirmed.

Issue 6: Failure to Include Expenses Related to GME on the Cost Report

The Board finds that the Provider has not provided sufficient documentation to support the reclassification of the costs related to staffing, non-payroll costs or malpractice costs. The Intermediary's exclusion of these costs is affirmed.

Issue 7: Laundry and Linen Statistic

The Board finds that the Provider has not previously allocated specific laundry and linen costs to the GME Cost Center, nor is it appropriate to do so without directly allocating laundry and linen costs to other hospital Departments. The Intermediary's exclusion of these costs is affirmed.

Issue 8: Meals

The Board finds that the Provider has not previously identified these costs as part of the GME Cost Center, nor is it appropriate to do so without directly allocating cafeteria costs to other hospital Departments. The Intermediary's exclusion of these costs is affirmed.

Issue 9: Square Footage Statistic

The Board finds that the Provider has submitted detailed documentation with regard to both the call rooms and resident conference areas to support their request to reclassify these areas to GME. The Intermediary is directed to include these costs in the calculation of the APRA.

Board Members Participating:

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

Date of Decision: May 08, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman