PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
98-D61

PROVIDER -Doctors Hospital
Columbus, Ohio

Provider No. 36-0152

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Community Mutual Insurance Company

DATE OF HEARING-
May 6, 1998

Cost Reporting Periods Ended -
December 31, 1984 (Base Year),
December 31, 1986 - December 31, 1990

CASE NOs. 91-2894M, 92-1709, 94-1277, 94-1278, 94-1702, 94-2063

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ISSUES:

1. Should the cost incurred by the Provider's General Practice Center ("GPC") for the Family Practice Residency Program be costs of a separate outpatient cost center or costs of the interns and residents medical education cost center and included in graduate medical education ("GME") base year cost and "rate" year per resident amounts?

2. Should the salary and incentive compensation of GPC's director and assistant director be costs of a separate outpatient ancillary cost center or costs of the interns and residents medical education cost center and included in GME base year cost and "rate" year per resident amounts?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Doctors Hospital ("Provider") is non-profit, osteopathic hospital located in Columbus, Ohio. For the graduate medical education base year ended December 31, 1984 and subsequent "rate" years, the total cost amount in controversy for the above issues appealed and included in the Provider's average per resident amount ("APRA") are as follows:

ISSUE	APPEALED COST AMOUNT (BASE YEAR)	ADDITIONAL REIMBURSEMENT RATE YEARS				
		1986	1987	1988	1989	Total
1	$150,853	$58,000	$62,000	$68,000	$84,000	$272,000
2	65,331	$25,000	$27,000	$30,000	$36,000	$118,000
Totals	$216,184	$83,000	$89,000	$98,000	$120,000	$390,000

The Provider's appeals meet the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841. The Provider is represented by David C. Levine, Esquire, of Baker & Hostetler. The Intermediary is represented by Bernard M. Talbert, Esquire, of Blue Cross and Blue Shield Association.

Issue No. 1 -- General Practice Cost Center Costs

Statement of Facts

In 1978, the Provider initiated the Family Practice Residency Program ("Program") with the opening of a Family Practice Center located adjacent to the hospital's west satellite facility.

During 1980, that Family Practice Center was closed by the Provider due to low enrollment. In 1982, the Provider opened the new freestanding GPC, which the Provider also refers to as the Family Practice Residency Training Module ("Module"). This Module was established solely as a single purpose teaching facility for the residency education program. On its 1982 and 1983 cost reports, the Provider reported the costs of the GPC/Module as an outpatient ancillary service cost center called "Clinic". The Intermediary accepted the Provider's treatment as a special service or ancillary cost center and treated the costs accordingly on the finalized cost reports. Commencing with the December 31, 1984 cost report, the first year subject to the prospective payment system, the Provider reclassified the net direct expense of the GPC to the interns and residents cost center after offsetting the revenue earned by the GPC. The Intermediary reversed the Provider's reclassification and reestablished the outpatient service ancillary cost center.

The American Osteopathic Association ("AOA"), the Provider's accrediting agency, has consistently granted approval of the Program with increases in the number of resident education positions as the Program developed.[1] AOA approved eight resident positions for 1981 through 1984, 16 positions from 1985 through 1988, and 32 positions for 1989. Residents participating in the program ranged from 2 in 1981, 3 in 1982, 8 in 1983, 9 in 1984, 8 in 1985, 1986, and 1987, 9 in 1988, and 12 in 1989.

The GPC cost center included personnel, supplies, and other costs related to the operation of the Family Practice Program. The cost amount in controversy for the 1984 Graduate Medical Education base year totals $150,853 as addressed in Intermediary Adjustment #12[2] of the December 31, 1984 Notice of Program Reimbursement ("NPR"). This adjustment was also made by the Intermediary during its 1984 Graduate Medical Education base year audit. The cost, therefore, was disallowed in determining the APRA issued by the Intermediary in its February 28, 1991 Notice of Per Resident Amount ("NAPRA").[3]

The GPC patients were charged only for the supervising physicians' services, and not for the residents' services and GPC costs. These net direct education costs were transferred from the GPC to the intern/resident cost center by the Provider prior to cost finding, closing the GPC cost center. After this transfer, the Provider allocated the costs in the intern/resident medical education cost center to the revenue-producing cost centers by the step-down cost finding method stated in 42 C.F.R. § 413.24 to determine allowable medical education reimbursement. Reimbursement for allocated medical education costs was computed by the Provider for hospital routine and special care inpatient services based upon the proportion of Medicare inpatient days to total inpatient days, and for ancillary services based upon

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1 See Provider Exhibit 4.

2 See Provider Exhibit 7.

3 See Provider Exhibit 10.

Medicare ancillary charges to total ancillary charges.

PROVIDER'S CONTENTIONS:

The Provider contends that the issue in this dispute is whether its costs of interns and residents in the Provider's Family Practice Residency Program are allowable medical education costs to be reimbursed pursuant to 42 C.F.R. § 413.86. If they are, they are reimbursed on a per resident calculated amount. If not, such costs would be reimbursed on a ratio of cost to charge method. The relevant rules governing the reimbursement for medical education costs are set forth in 42 C.F.R. § 413.9 which provides in part:

> (a) Principle. All payments to providers of services must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs incurred in furnishing the services, subject to principles relating to specific items of revenue and cost.

42 C.F.R. § 413.9. (emphasis added)

42 C.F.R. § 405.522 discusses intern and resident services in approved teaching programs. It provides that Medicare recognize programs approved by the AOA. It also states that Medicare pays for the costs of approved residency programs as set forth in 42 C.F.R. § 413.85. Further, the regulation at 42 C.F.R. §§ 413.86(e)(1)(ii)(C) and (e)(1)(iii) states in part:

> [u]pon a hospital's request, include graduate medical education costs that were misclassified as operating costs during the hospital's prospective payment base year and were not allowable under § 412.113(b)(3) of this chapter during the graduate medical education base period. These costs may be included only if the hospital requests an adjustment of its prospective payment hospital-specific rate or target amount as described in paragraph (j)(2) of this section.
>
> If the hospital's cost report for its GME base period is no longer subject to reopening under § 405.1885 of this chapter, the intermediary may modify the hospital's base-period costs solely for purposes of computing the per resident amount.

42 C.F.R. § 413.86(e)(1)(ii)(C) and (e)(1)(iii).

42 C.F.R. § 413.86(j)(2) provides for reclassification of costs, as follows:

> General rule. If costs that should have been classified as graduate medical education costs were treated as operating costs during both the graduate

> medical education base period and the rate-of-increase ceiling base year or prospective payment base year and the hospital wishes to receive benefit for the appropriate classification of these costs as graduate medical education costs in the graduate medical education base period, the hospital must request that the intermediary review the classification of the affected costs in the rate-of-increase ceiling or prospective payment base year for purposes of adjusting the hospital's target amount or hospital specific rate.

42 C.F.R. § 413.86(j)(2).

The Provider further contends that several United States Court of Appeals decisions support the Provider's position that the GPC's net direct costs are allowable medical education costs. In University of Cincinnati v. Bowen, 875 F.2d 1207 (6th Cir. 1989) ("University of Cincinnati"), the court concludes that in order to be reimbursable under Medicare regulations, educational activities must:

1. be approved programs,
2. contribute to the quality of patient care within an institution, and
3. not redistribute costs from educational to patient care institutions.

In Loyola University of Chicago vs. Bowen, 905 F.2d 1061 (7th Cir. 1990) ("Loyola University"), the court found that educational activities are not required to occur either in the medical care provider or in a facility that is part of the provider in order for such activities to be deemed to be reimbursable under Medicare. In Thomas Jefferson University v. Shalala, 512 U.S. 504 (1994) ("Thomas Jefferson"), the Supreme Court interpreted the "redistribution" clause of 42 C.F.R. § 413.85 to mean:

> The Secretary interprets the regulation to allow reimbursement for costs of educational programs traditionally engaged in by hospitals, but, at the same time, to deny reimbursement for "cost(s) previously incurred and paid by a medical school." Brief for Respondent 26 (emphasis deleted); see also § 413.85(b) (defining "approved educational activities" which are eligible for reimbursement as "programs of study usually engaged in by providers in order to enhance the quality of patient care.") The Secretary's reading is not only a plausible interpretation of the regulation; it is the most sensible interpretation the language will bear.

Id.

The Provider contends that the instant case meets all of the criteria set forth in the regulations and as clarified by the courts in University of Cincinnati and Loyola University to have its resident and intern costs reimbursed by Medicare as approved medical education costs.

a. The Provider's program is approved.

The Provider's General Practice Center is a planned, integrated program of study as approved by AOA's Committee on Postdoctoral Training and Board of Trustees.[4] The AOA is an approved organization listed in 42 C.F.R. § 405.522(a). Accordingly the Provider meets the first requirement of having an approved program.

b. The Provider's program contributes to the quality of patient care within its institution.

A plain reading of the regulations cited above concludes they do not require as a component of the residents' education the direct performance of services to hospital patients to the exclusion of ambulatory care patients. The University of Cincinnati court agrees with this interpretation. The Provider's General Practice Center teaching facility is an integral part of the Provider's Family Practice Residency Program and satisfies the criteria of the Medicare regulations. The Provider's General Practice Center is a planned, integrated program of study in which the Provider's residents spend part of their time at the Provider's General Practice Center with outpatients, and part of their time rotating through several areas of the Provider working with inpatients. Accreditation of the Provider's program requires ambulatory experience and inpatient care and training. Accordingly, residents' services at the General Practice Center enhance the quality of patient care in the Provider through the transfer of skills and education from the General Practice Center residents to hospital patients when the residents rotate within the hospital. Therefore, the Provider also meets the second requirement.

c. The Provider's request will not redistribute costs from educational to patient care institutions.

The Provider's General Practice Center does not redistribute costs from educational to patient care institutions. As supported by the Thomas Jefferson court, the Provider's General Practice Center involves an educational program traditionally engaged in by hospitals, is a separate cost center of the Provider, and is not owned or operated by a college or university. All costs for which reimbursement is requested were incurred and paid by the Provider to unrelated parties. These net costs were calculated prior to any step-down cost allocations.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that cost centers deemed as ancillary must consistently be classified as such for purposes of Medicare reimbursement. Provider Reimbursement Manual, HCFA Pub.
15-1 ("HCFA Pub. 15-1"), § 2302.8 defines a cost center. Classification of a cost center is

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[4] See Exhibit 4.

further broken out as either general routine, special care, or ancillary. HCFA Pub. 15-1 § 2202.8 defines ancillary services. Based upon these definitions, the General Practice Center was appropriately treated by the Intermediary as an ancillary cost center. The services provided by the General Practice Center generated patient care related charges in accordance with aforementioned program instructions and classification as a separate cost center is proper.

The Intermediary notes that the Provider's subsequent attempt to reclassify costs to a general service cost center is contrary to HCFA Pub. 15-1 § 2203, which states in pertinent part:

> [t]he cost of those items and services specifically classified as routine in Section 2202.6 are always considered routine service costs, and the costs of those specifically classified as ancillary in Section 2202.8 are always considered ancillary service costs for purposes of Medicare reimbursement.

HCFA Pub. 15-1 § 2203.

The Intermediary further contends that the costs of medical education must be determined consistently with the treatment of such costs in the base year. The Medicare regulation at 42 C.F.R. § 412.113 requires that the costs of medical education be determined on a basis consistent with the treatment of such costs when the hospital-specific portion of the Provider's prospective payment rate is established. As previously noted, the costs for the Family Practice Center were classified in the "Clinic" cost center. Reclassification of costs to medical education would be an inconsistent practice from the base year.

Issue 2: General Practice Center Directors' Compensation

Statement of Facts

For the 1984 GME base year the Provider had a Graduate Medical Education Program which was approved by the AOA. For that year the Provider employed a full-time salaried Director and an Assistant Director of its Family Practice Residency Program, including the General Practice Center. The Director and Assistant Director were responsible for the education program of all residents enrolled in the Family Practice Residency Program. They also assisted the Director of Medical Education in coordinating and providing educational programs in family practice and other medical areas. Both General Practice Residency directors devoted 100% of their Medicare Part A time to the Program, either in a teaching or an administrative capacity. Neither of the directors owned or operated a private practice nor privately billed patients for service.

The compensation paid to the General Practice Residency Program directors included fixed salary amounts plus certain annual incentive payments. Both General Practice Residency Program directors assigned all rights relative to Medicare Part B physician service charges to

the Provider. These charges were recognized as revenue by the Provider and were offset against the direct expenses of the General Practice Center in the Provider's calculation of the General Practice Residency's net direct medical education costs.

The Intermediary reclassified $124,655 of the directors' compensation from interns and residents cost center to the general and administrative cost center via adjustment #13[5] on the December 31, 1984 NPR dated July 18, 1986.[6] The Intermediary contends that these expenses were not properly classified as medical education expenses in calculating 1982 base year costs. In its February 28, 1991 NAPRA, the Intermediary reduced the above adjustment by $10,599 via adjustment #8[7] by reclassifying the expense back to the medical education cost center.

PROVIDER'S CONTENTIONS:

The Provider contends that 100% of the GPC's Director and Assistant Director's salaries and incentive compensation should be allowable GME costs. Both directors devoted 100% of their Part A administrative and teaching time to the Provider's Family Practice Residency Program.[8] The Provider opened the GPC for the primary purpose of educating the Provider's Family Practice Residents. If the Provider's Family Practice Residency Program were eliminated, the General Practice Center would be closed.

The Provider notes the following regulations apply to this case. Educational activities are an item more specifically addressed in 42 C.F.R. § 413.85. 42 C.F.R. § 405.522 discusses intern and resident services in approved teaching programs. It provides that Medicare recognize programs approved by the AOA. Also, as noted above, all of the criteria and analysis provided by the courts in the University of Cincinnati and Loyola University cases apply to this issue.

The Provider further argues that the directors' salaries are permissible medical education costs. The analysis in Issue no. 1 illustrates that the Provider's costs associated with the GPC Program satisfy the Medicare requirements for reimbursement as medical education expenses. The evidence demonstrates that the GPC Program Director and the Assistant Director spent one hundred percent of their time working either directly or indirectly for the Residency Program. Accordingly, their salaries and incentive compensation are allowable medical education costs. Accordingly, the Provider is entitled to:

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5 See Provider Exhibit 8.

6 See Provider Exhibit 9.

7 See Provider Exhibit 11.

8 See Provider Exhibit 5.

1. Reclassification of the salaries and incentive compensation in controversy to the Intern/Resident Medical Education Cost Center for the 1984 GME base year;

2. Adjustment of the Provider's Hospital specific rate for these medical education costs for the 1984 GME base year and subsequent fiscal years which were audited by the Intermediary and appealed by the Provider and which were effected by the change in medical education payment methodology, i.e., 1986, 1987, 1988, 1989 and 1990;

3. Allocation of these medical education costs through the normal cost finding method in the same manner as other Provider medical education costs are allocated for the 1984 GME base year.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the costs of medical education must be determined consistently with the treatment of such costs in the base year for cost reporting periods beginning before October 1, 1987.

Medicare Regulations at 42 C.F.R. § 412.113(b) state the following:

> (b) Direct Medical Education Costs - Payment for the cost of approved medical educational activities as defined in Section 413.85 of this chapter is made on a reasonable cost basis (except with respect to activities defined in Section 413.85(d) of this chapter). For cost reporting periods beginning on or after July 1, 1985, but before July 1, 1986, payment for these reasonable costs is limited as described in Section 413.85(a) of this chapter. For cost reporting periods beginning before October 1, 1987, the costs of medical education must be determined consistently with the treatment of such costs for purposes of determining the hospital-specific portion of the transition payment rate In Subpart E of this part.

42 C.F.R. § 412.113(b).

The treatment of costs for the applicable cost reporting periods was handled by the Intermediary in accordance with the aforementioned regulation, which was consistent with the base year treatment. Subpart E - Determination or Transition Period Payment Rates at 42 C.F.R.
§ 412.71(d) states the following:

> (d) Intermediary's determination - The Intermediary will use the best data available at the time in estimating each hospital's base year costs and the

> modifications to those costs authorized by paragraphs (b) and (c) of this section. The Intermediary's estimate of base-year costs and modifications thereto is final and may not be changed after the first day of the first cost reporting period beginning on or after October 1, 1983, except as provided in Section 412.72.

42 C.F.R. § 412.71(d).

The regulation at 42 C.F.R. § 412.72 outlines the instances in which modifications may be made for base-year costs. Section 412.72(b)(3), which addresses administrative and judicial reviews, states:

> (3) Specifically excluded from administrative or judicial review are any issues based on data, information, or arguments not presented to the Intermediary at the time of the estimation.

42 C.F.R. § 412.72(b)(3).

The Provider timely requested a modification be made to its base-year costs in accordance with regulations at 42 C.F.R. § 412.72. However, it failed to supply adequate documentation. Accordingly, the Intermediary made adjustments which conformed with Medicare regulations concerning consistency of base-year costs.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - Title XVIII of the Social Security Act:

§ 1861(v)(1)(A)	-	Reasonable Cost

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

§ 405.522 et. seq.	-	Interns' and Residents' Services in Approved Teaching Programs
§§ 405.1835-.1841	-	Board Jurisdiction
§ 412.71(d)	-	Intermediary's Determination
§ 412.72	-	Modification of Base-Year Costs
§ 412.72(b)(3)	-	Right to Administrative and Judicial Review

§ 412.113	-	Payments to Determined on a Reasonable Cost Basis
§ 412.113(b)	-	Direct Medical Education Costs
§ 413.9	-	Cost Related to Patient Care
§ 413.24	-	Adequate Cost Data and Cost Finding
§ 413.85	-	Cost of Educational Activities
§ 413.86	-	Direct Graduate Medical Education Payments
§ 413.86(e)(1)(ii)(C)	-	For the Base Period
§ 413.86(e)(1)(iii)	-	For the Base Period
§ 413.86(j)(1)	-	Misclassified Operating Costs
§ 413.86(j)(1)(ii)	-	Request for Review
§ 413.86(j)(2)	-	Misclassification of Graduate Medical Education Costs

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

§ 2202.8	-	Ancillary Services
§ 2203	-	Provider's Charge Structure as a Basis for Apportionment
§ 2302.8	-	Cost Center

4. Cases:

Loyola University of Chicago vs. Bowen, 905 F.2d 1061 (7th Cir. 1990).

Thomas Jefferson University v. Shalala, 512 U.S. 504 (1994).

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

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the law, regulations, program instructions, facts and parties contentions finds and concludes as follows:

Issue No. 1 -- General Practice Center Costs

The Board finds that the cost center (outpatient-ancillary) established by the Provider for the general practice is proper for accumulating the costs of clinical services offered in the "clinic". Further, the Board finds that the costs, of interns and residents, included in that cost center are allowable under 42 C.F.R. § 413.85. However, the Provider's calculation of those, the "net" interns and residents' costs, i.e., costs the difference between the total cost center costs and revenues generated by the cost center, is not correct.

There is no dispute that the Provider had an approved intern and resident program at the Provider. That program was approved by the AOA. Thus, costs are allowable under 42 C.F.R.
§ 413.85. Further, as part the determination of the prospective GME rate determination, 42 C.F.R. § 413.86(j)(1) allows a hospital to request that the intermediary review the classification of costs where it believes that operating costs have been misclassified. The Board believes that this situation exists in this case because intern and residents' costs were included in the General Practice Center cost center. However, the proper determination of such costs should have been to "carve out" the actual intern and resident costs, related supervision and overhead costs in the General Practice Center cost center, and to include them in the APRA calculation. The Provider is required by 42 C.F.R. § 413.86(j)(1)(ii) to request a review of its costs and include sufficient documentation to support an adjustment to the GME or operating costs. The Provider did not provide that documentation. The Board cannot determine what intern and resident costs belong in the interns and residents cost center that were included in the General Practice cost center. Therefore, the Board denies the Provider's request for reclassification based on that lack of documentation.

Issue No. 2 -- General Practice Center Directors' Compensation

As addressed in Issue No. 1 above, the Provider is responsible for providing adequate documentation to support reclassification of operating costs to GME. The Provider has not offered that documentation for reclassifying the director's and associate director's compensation from general and administrative costs to GME costs. The Provider claims that 100% of their activities were Part A GME activity. Intermediary Exhibit I-10 states otherwise. In 1984, the Provider completed HCFA Form 339 (Allocation of Physician Compensation) which states that only 49 of 125 hours or 39% of the physicians' time was spent on supervising interns and residents. Therefore, the Provider's request for including

100% of the directors' salaries in GME is denied.

DECISION AND ORDER:

Issue No. 1 -- General Practice Center Costs

The Provider improperly calculated and documented intern and residents' costs that were included in the General Practice cost center. The Intermediary's adjustments are affirmed.

Issue No. 2 -- General Practice Center Directors' Compensation

The Provider's request to include 100% of the GPC directors' compensation in GME is denied. The Intermediary's adjustments are affirmed.

Board Members Participating:

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

Date of Decision: June 03, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman