PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2000-D28

PROVIDER -
Roswell Park Cancer Institute
Buffalo, New York

Provider No. 33-0354

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Empire Blue Cross and Blue Shield

DATE OF HEARING-
October 3, 1997

Cost Reporting Period Ended -
March 31, 1985

CASE NO. 91-2846M

INDEX

ISSUE:

Was the Intermediary's failure to include supervising physician costs in the Provider's final base-year average per resident graduate medical education amount proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Roswell Park Cancer Institute ("Provider") is a state-owned cancer research and treatment facility located in Buffalo, New York. By notice dated February 28, 1991, Empire Blue Cross and Blue Shield ("Intermediary") sent the Provider its proposed average per resident amount ("APRA") for graduate medial education ("GME") costs. On August 23, 1991, the Provider filed a timely appeal. On April 30, 1992, the Provider received a revised APRA from the Intermediary. The Provider filed a timely appeal from the revised APRA on October 23, 1992. Although the list of issues in the original and revised appeals did not include the supervisory physician cost issue, the Provider added the issue on April 26, 1994, prior to its hearing.[1] The Board determined that it had jurisdiction over this matter on March 5, 1996.[2]

Background

In 1980, Congress enacted legislation that allowed a teaching hospital to choose to be reimbursed by Medicare for its supervising physician GME costs in one of two ways. A hospital can either claim reimbursement for physician supervisory costs under Medicare Part A, and physicians can charge for patient services under Medicare Part B (the "standard election"), or the entirety of reimbursable physician costs can be paid to the hospital, if the physicians agree not to charge for their services under Medicare Part B (the "teaching election"). See § 1861(b)(7) of the Social Security Act ("Act"), 42 U.S.C. § 1395x(b)(7). A hospital is free to choose either option, and that election continues "until otherwise provided by the hospital." See Omnibus Reconciliation Act of 1980, Pub. L. 96-499, § 948(c), 94 Stat. 2643.

In 1981, the Provider chose the teaching election and its physician costs, including those related to patient service, were reimbursed to the hospital. A hospital that chooses the teaching election does not report its GME costs in the same manner as standard election hospitals, but report the salary costs of residents and interns in the GME cost center that is included as part of Worksheet A of the Medicare cost report. A teaching election hospital takes its total physician compensation costs and then excludes certain Medicare Part A activity, such as departmental administration, that is not related to teaching as well as non-reimbursable activity, such as research. This exclusion is reflected on Worksheet A of the annual cost report, using the information from Supplemental Worksheet A-8-2. The remaining costs include both the costs of providing professional services to patients (the Medicare Part B component)

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[1] See Intermediary Exhibit 30.

[2] See Provider Exhibit 18.

and the costs of supervising residents and interns (the Medicare Part A component). These costs are reported together on Supplemental Worksheet D-9 to a hospital's cost report, and are reimbursed on a reasonable cost, pass-through basis. The Provider reported its costs in this manner for twelve years, until 1993 when it chose to drop the teaching election.

The Provider dropped its teaching election due to a blue-ribbon panel report that concluded that the Provider would be unable to retain its position as one of the preeminent cancer treatment hospitals if physician salaries were not improved. The core of the problem was that the Provider, as a state-owned facility, was subject to state salary caps, and was therefore limited in the amount of salary it could offer to the cancer specialists and the other physicians employed there. By the late 1980's, the salary cap resulted in the Provider's physician salaries falling behind those of competing hospitals at an ever-increasing rate. The Provider could no longer recruit the caliber of physician it needed to fulfill its mission. At one point, the situation became so serious that the Provider was unable to fill vacancies in its clinical department chairs for Anesthesiology, Pathology, Medicine, Diagnostic Radiology, and Radiation Medicine.

The Provider secured state legislative approval that allowed it to implement a "Physician Practice Plan," pursuant to which physician salaries, although still subject to the statewide cap, could be supplemented. The Physician Practice Plan is funded through revenue for professional services, i.e., physicians are allowed to charge for patient services, and the revenue from those charges is then distributed to the physicians as a supplement to their salary.

The Physician Practice Plan was implemented on July 1, 1993, and it has been successful in attracting the top quality physicians critical to the Provider's mission as a cancer research and treatment facility. Under the Physician Practice Plan, the Provider was forced to change its reimbursement of supervisory expenses to the standard election because it is a prerequisite to reimbursement under the teaching amendment that hospital physicians agree not to bill Medicare Part B for patient services. This case arises because Congress changed the method by which GME costs were reimbursed to teaching hospitals between the time that the Provider had first elected to be reimbursed under the teaching amendment in 1981, and the time that it exercised its statutory right to cease such election in 1993. Prior to 1986, Medicare paid for its share of costs based on each hospital's historical, Medicare-allowable costs. In 1986, Congress changed this system to the payment methodology set forth in §1886(h) of the Social Security Act, 42 U.S.C. § 1395ww(h). That section provides for the determination of a hospital-specific base period per resident amount for each hospital. The per resident amount is calculated by dividing a hospital's allowable GME costs for a base period (the cost reporting period beginning in federal fiscal year 1984) by the average number of full-time equivalent ("FTE") residents working in all areas of the hospital during the base period. The base period amount is updated yearly to account for inflation, and then multiplied by the weighted average number of FTE residents working in the hospital to determine an aggregate approved amount for the period. Medicare's share of the aggregate approved GME amount is determined by the Medicare patient load as measured by the ratio of Medicare hospital inpatient days to total hospital inpatient days.

In calculating a hospital's APRA, the Secretary is instructed to determine, for the base year, "the average amount recognized as reasonable under this title for direct graduate medical education costs of the hospital for each full-time-equivalent resident." 42 U.S.C. § 1395ww(h)(2)(A). Physician supervision cost is a direct GME cost that is to be reimbursed under the new methodology.

The Health Care Financing Administration ("HCFA") published its proposed rules implementing the new GME reimbursement methodology in 1988 and final rules not until 1989. See 53 Fed. Reg. 36589 (1988) and 54 Fed. Reg. 40286 (1989). These rules instruct Medicare intermediaries to re-open and audit each provider's base-year cost report to determine its APRA.

In 1990, HCFA issued "further clarification" with respect to its audit instructions to intermediaries. See 55 Fed. Reg. 35990, 36063 (1990). HCFA noted that to support the allocation of physician compensation costs in the areas of teaching and supervision, providers are generally required to furnish a written physician allocation agreement to the intermediary that specifies the respective amount of time a physician spends in furnishing his or her services to the provider and to patients. Id. At the same time, HCFA realized that in 1990 and 1991, when the APRA audits were being performed, "physician allocation agreements, time records and other information may no longer exist" for the base year period. Id. Thus, as an "equitable solution to the problem of the nonexistence of physician allocation agreements," it allowed providers to furnish documentation from cost reporting periods subsequent to the base period in support of the allocation of physician compensation costs in the base year. Id. In the event that the provider had no auditable documentation for any subsequent cost reporting period, providers were allowed to perform a three-week time study of all physicians' time. Id. at 36064.

In July 1990, the Provider received from the Intermediary revised instructions relating to the Intermediary's audit of its base-year cost report.[3] The instructions noted that the revisions were intended to "provide relief to a provider that for 1984 is unable to furnish physician allocation agreements . . . and auditable and verifiable documentation, i.e., calendars, diaries, logs, schedules of rounds, etc."[4]

The instructions provided that hospitals that were unable to produce time records for the base year, and that could not produce such information for a more current period could request permission to perform a three-week time study of their supervising physicians. The instructions were specific as to when these studies were to be conducted (i.e., the first three weeks of August 1990), and they included work sheets to take account of changes to a hospital's GME program since the base year. These instructions were the same for all providers unable to produce physician allocation agreements and other time records from 1984. The instructions stated that the time studies were to be "summarized and

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[3] See Provider Exhibit 10.

[4] Id. at 1.

forwarded to your Blue Cross audit manager" and that "[a]udits of the time studies will be scheduled to begin shortly thereafter."[5]

Pursuant to these instructions, the Provider formally requested permission from the Intermediary to conduct a three-week time study, and that request was approved on August 1, 1990.[6] The letter from the Intermediary again instructed the Provider that "the studies are to be summarized" and forwarded to the provider.[7]

The Provider conducted its three-week time study in August 1990 using the forms prescribed by the Intermediary. As instructed, the Provider summarized the studies and sent the results to the Intermediary. The Intermediary never conducted an audit of the underlying time studies, although they remain available to it to do so.

The Intermediary notified the Provider of its proposed APRA for the base period by notice dated February 28, 1991. The APRA did not include the results of the 1990 time study or any other method of capturing the costs associated with physician supervision of residents and interns. On August 23, 1991, the Provider timely filed an appeal from the proposed APRA calculation. A List of Issues ("LOI") was filed on January 2, 1992, and the case was scheduled for a hearing. The Provider received a revised notice of the APRA on April 30, 1992. The Provider filed an appeal from that determination on October 23, 1992, along with a revised LOI that specifically reserved the right to modify the list of issues prior to the hearing.

The original LOI filed on January 2, 1992, and the revised LOI submitted on October 23, 1992, did not include the Intermediary's failure to include physician supervisory costs in the APRA. At that time, the Provider was still exercising its election under the teaching amendment; accordingly, the costs associated with physician supervision of residents and interns was reimbursed on a reasonable cost, pass-through basis. If those costs had also been included in the APRA, the Provider would have been reimbursed twice, albeit under different methodologies, for the same services.

With the July 1, 1993 change of election, the exclusion of physician supervisory costs from the APRA had an effect on the Provider, because implementation of the Physician Practice Plan precluded the Provider from continuing its teaching election, the exclusion of physician
teaching costs were wholly uncompensated. Because the base year calculation determines GME reimbursement in all subsequent years, the exclusion of these costs from the base-year calculation is of lasting significance.

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5 Id.

6 See Provider Exhibit 11.

7 Id.

Prior to the APRA hearing, the Provider added the physician supervisory costs issue to its appeal. The Provider used the approved 1990 time studies to demonstrate that, on a weighted departmental basis, almost 22 percent of physician compensation was attributable to supervision of residents and interns. Applied to the 1985 physician salaries--which totaled $7,433,520--the Provider calculated that it had incurred $1,614,013 in recognizable GME expenses that had not been included in the calculation of its APRA.

By letter dated June 17, 1994, the Intermediary requested that the case be dismissed for lack of jurisdiction on the ground that its failure to include physician supervisory costs in the APRA had not been raised previously. In a decision dated March 5, 1996, this Board held that the Provider's appeal from its APRA "was filed within 180 days of the issuance of the APRA as required by 42 C.F.R. §§ 413.86(e)(1)(v) and 405.1835-.1841."[8] The Board additionally noted that pursuant to 42 C.F.R. § 405.1841(a), a provider is permitted to add an issue to the appeal prior to the commencement of the hearing proceeding.[9] Consequently, the Board determined that it had jurisdiction over the appeal.

The Provider was represented by Charles A. Miller, Esquire, and Caroline M. Brown, Esquire, of Covington and Burling. The Intermediary was represented by Michael F. Berkey, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS

The Provider contends that the Intermediary improperly excluded physician supervisory costs from its base year APRA. The Provider contends that physician supervisory costs should be included in its APRA because those costs were legitimately incurred in the base year, were reported as required on Supplemental Worksheet D-9 of its cost-report, and were recognized as reasonable by HCFA, which reimbursed them. The Provider does not contend that it suffered any injury from exclusion of physician supervisory costs prior to July 1, 1993.

The Provider contends that the 1989 preamble language relied upon by the Intermediary is only an "interpretative rule" and as such "do[es] not have the force and effect of law and [is] not accorded that weight in the adjudicatory process." Shalala v. Guernsey Memorial Hospital, 514 U.S. 87, 99 (1995). The Provider argues that, while this Board is bound by the Secretary's regulations, it is not bound by a preamble. Augustina Hospital and Health Care Center v. Blue Cross and Blue Shield/Health Care Services Corporation, PRRB No. 88-Dll (1987, Medicare and Medicaid Guide (CCH) ¶ 36,779, aff'd, HCFA Administrator, February 29, 1988, Medicare and Medicaid Guide (CCH) ¶ 37,022.

In the instant case, the Provider contends that the preamble should be disregarded as contrary to the actual regulations, which provide that a hospital's APRA is to include GME costs that were

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[8] See Provider Exhibit 18.

[9] Id.

"misclassified" as operating costs. 42 C.F.R. § 413.86(e)(ii)(C). The Provider claims that, because of the unusual method of reimbursement under the teaching election, its physician supervisory costs were "misclassified" as operating costs on its base year cost report and should be re-classified as GME costs properly includible in the APRA calculation.

The Provider also contends that the preamble language is inconsistent with § 1861(b)(7) of the Act, 42 U.S.C. § 1395x(b)(7), which allows a teaching hospital to "elect" to be reimbursed its physician supervisory costs on a reasonable cost, pass-through basis or to have those costs reimbursed as GME costs. The Provider argues that Congress did not intend the election, once made, to be irrevocable. Under the framework set forth in the 1989 preamble, however, a hospital that had elected to be reimbursed under the teaching amendment in 1984 is required to continue reimbursement under that election forever, or else it forgoes all reimbursement for the costs associated with physician supervision of interns and residents. The Provider claims that a literal application of the preamble to preclude a hospital from withdrawing the teaching election would result in retroactive rulemaking in the Medicare program in violation of the Supreme Court's decision in Bowen v. Georgetown Hospital, 488 U.S. 204 (1988).

The Provider further contends that the reasons that the preamble gives for denying a hospital reimbursement for its physician supervision costs are clearly not applicable in this case. The Provider argues that it did not withdraw its teaching election in order to increase Medicare Part B reimbursement. Instead, the hospital was obliged to drop the election as an unintended consequence arising from implementation of the Physician Practice Plan, which was necessary to continue the hospital's mission of providing its patients top-quality cancer treatment. The Provider contends that the hospital itself did not benefit from changing its reimbursement election except to the extent that its reputation has been preserved by its ability to attract qualified physicians despite the state salary cap.

Finally, the Provider contends that HCFA is incorrect in its assumption, stated in the preamble, that it is impossible to make an adjustment to the APRA to reflect physician supervisory costs if the provider was reimbursed under the teaching election in the base year. The Provider claims that it can substantiate the costs of supervising residents and interns in the base year through its 1990 time allocation study, a method which HCFA itself proposed and has accepted as a valid means of calculating GME costs for those hospitals that do not have auditable and verifiable documentation from the base year. Thus, the Provider concludes, to the extent that the preamble can or should be given any weight at all, it should not govern in a situation where a hospital can reliably establish its physician supervision costs in the base year GME program.

The Provider claims that the 1990 time study reliably establishes that roughly 22 percent of physician time--which corresponds to $1,614,013 of 1985 physician compensation--is spent supervising residents and interns, and that these costs should have been included in its APRA calculations. The Provider contends that the Intermediary's interpretation of HCFA's 1990 audit instructions to preclude use of the 1990 time studies to allocate physician costs when those costs will not otherwise be reimbursed, is contrary to the statutory and regulatory intent that a hospital's APRA be "an accurate

reflection of legitimate GME costs incurred during the fiscal year 1984 base year." 54 Fed. Reg. 40286, 40288 (1989).

The Provider contends that it is not using the 1990 time studies to "increase or add" to its claimed GME costs, as the Intermediary claims, but only to segregate out legitimately incurred physician supervision costs from the combined total that it was required to report on Supplemental Worksheet D-9 as a result of its election to be reimbursed under the teaching amendment. According to the Provider, the Intermediary is incorrect in its position that the Provider claimed nothing in GME physician supervisory costs in the base year. The Provider claims that these costs were reported, together with the cost of "Part B" professional services, on Supplemental Worksheet D-9 to its base year cost report. The Provider also claims that the Intermediary can measure whether it is seeking to "increase or add" to its GME costs by reference to the time allocation estimates completed by physicians in the base year as part of the allocation reported on HCFA Form 339.

Finally, the Provider contends that it was not required to seek an adjustment to its TEFRA target amount simultaneously with the appeal of its APRA. The Provider claims that no adjustment of the hospital's target amount is warranted, as the costs associated with physician supervision of residents and interns are not included in the costs used to determine its target amount. The Provider claims that, because it was still under its teaching election when its target amount was set, all costs associated with physician supervision of residents, as well as the costs of professional services rendered to patients, were eliminated from the operating cost centers prior to calculation of its target amount.

INTERMEDIARY'S CONTENTIONS

The Intermediary contends that there are four jurisdictional and four substantive reasons to deny the Provider's request to include supervisory physician costs in its APRA. [10]

The first Intermediary jurisdiction contention is that this Board is without jurisdiction to review this dispute because the Provider did not appeal the Intermediary's failure to include its physician supervisory costs within 180 days of the issuance of the original or revised notice of the Provider's APRA. The Intermediary asserts that there were two notices of APRA given to the Provider. The first in February of 1991 and then a second in October of 1991. The Intermediary asserts that the Provider had to raise this issue in the appeal of the second 1991 APRA notice, but that they did not do so until 1994, when as a result of their change in election concerning supervisory physician costs, this issue first presented itself.

The second Intermediary jurisdiction contention is that the APRA contains no adjustment related to supervisory physician costs. The Intermediary claims that because there was no claim for these costs on the cost report, the Provider cannot add this issue after 180 days under 42 C.F.R. §405.1841.

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[10] See Intermediary hearing chart number 1.

The third Intermediary jurisdiction contention is that the Provider may not appeal the effect of a 1993 event on its APRA through an appeal filed in 1991 or 1992. And the fourth Intermediary jurisdiction contention is that the Provider did not raise the issue of including physician supervision costs in the APRA within 180 days of the "precipitating event" that caused those costs to be reimbursed, which it defines as the implementation of the Physician Practice Plan on July 1, 1993.

Assuming that the Board has jurisdiction, the Intermediary argues that under the preamble to the final rules issued by HCFA, 54 Fed. Reg. 40286, 40309 (1989), there can be no APRA accommodation for providers that withdraw their teaching election after the base year. According to the Intermediary the decision in Guernsey, supra, holds that you don't have to publish every rule as a regulation and that the Secretary may use manuals or preambles to set policy. The preamble provided clear notice of the Secretary's intention that she was not going to change the APRA with a change of election and that if there is a change providers should bump up the level of activity for these teaching physicians and make them attending physicians and they could bill for everything they do under Part B. The preamble further states that one of the reasons a teaching hospital would want to drop the cost election for physicians, direct medical and surgical services would be to institute fee-for-service billing for physician services furnished to Medicare patients. This would apply both to services personally performed by the physician and those which he or she furnishes within the context of an attending physician relationship. The only classification of costs for which a teaching hospital would not be paid would be the less intensive role of supervising residents in the care of individual patients where no attending physician relationship is established. The preamble states that:

> [t]he teaching hospital could address any shortfall from not recognizing the supervisory services of teaching physicians in the care of individual patients by upgrading the physicians' involvement to that of an attending physician role. The supervisory role of the physician would then be recognized through reasonable charge billing under Medicare Part B, and we believe that this would have been the whole purpose of changing to a fee-for-service situation.

54 Fed. Reg. 40286, 40309 (1989).

The Intermediary contends that this language prohibits it from including physician supervisory costs in the Provider's APRA.

Third, the Intermediary contends that the Provider has not submitted timely and adequate documentation under 42 C.F.R. § 413.86(j)(2) to support its allocation of the costs of physician supervision of residents and interns in the base year. The Intermediary claims that the Provider's attempt to use its 1990 time study to allocate costs in the base year is contrary to HCFA's 1990 audit instructions, which provide that "[i]n no event will the results obtained from the use of the records from a cost reporting period later than the base period serve to increase or add physician compensation costs to the costs used to determine the per resident amounts." 55 Fed. Reg. 35990, 36064 (1990).

The Intermediary also claims that the 1990 time studies were never submitted and that the Provider should have submitted any time studies that it had completed in 1988 instead.

Finally, the Intermediary contends that no adjustment can be made to the Provider's APRA because the Provider did not simultaneously request an adjustment to its TEFRA target amount. The Intermediary argues that the Provider has shown that it had supervisory costs and that any potential duplication of payment for shifting these costs to GME has to be accomplished through a TEFRA adjustment.

CITATIONS OF LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS

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

§ 1395x(b)(7)	-	Inpatient Hospital Services
§ 1395ww(h) et seq.	-	Direct Medical Education Costs

Omnibus Reconciliation Act of 1980, Pub. L. 96-499, § 948(c), 94 Stat. 2643

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

§§ 405.1835-1841	-	Time, Place, Form, and Content of Request for Board Hearings
§ 413.86 et seq.	-	Direct Medical Education Costs

3. Case Law:

Augustina Hospital and Health Care Center v. Blue Cross and Blue Shield/Health Care Services Corporation, PRRB No. 88-D11 (1987, Medicare and Medicaid Guide (CCH) ¶ 36,779, aff'd, HCFA Administrator, February 29, 1988, Medicare and Medicaid Guide (CCH) ¶ 37,022.

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

Shalala v. Guernsey Memorial Hospital, 514 U.S. 87 (1995)

4. Other:

53 Fed. Reg. 36589 (1988)
54 Fed. Reg. 40286 (1989)
55 Fed. Reg. 35990 (1990)
60 Fed. Reg. 38400 (1995)

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 brief, finds and concludes that:

The Board notes that the Provider properly claimed costs under the teaching election and that the costs associated with supervising interns and residents were not included in determining its APRA. The Provider now seeks to change their election which is permitted under the Medicare statutes and have their APRA adjusted to include these costs. The Board finds that these costs were not in the GME cost center used to create the APRA and thus any adjustment to put them back in the APRA for 1993 FYE periods forward will not result in a duplication of payments. The Board notes that the preamble to the final GME regulation provides different and unequal remedies for providers that change their election. The Board indicates that the proposed remedy of "upgrading" supervisory teaching to the status of attending physician costs and billing for them under Medicare Part B appears to conflict with HCFA policy and still may not cover all of a provider's GME costs that would be provided by a proper APRA adjustment. The Board finds that the remedy specified in the preamble does not provide relief for otherwise allowable costs to be reimbursed under the APRA or as reasonable costs and therefore conflicts with the purpose of the GME regulation to ensure that all costs would be included. The Board finds that adequate data exists to allow an adjustment to be made to the Provider's APRA. Finally, the Board finds that the Provider was not required to petition for adjustment of its TEFRA target rates.

The Board notes that there is no disagreement that the Provider had the teaching election in place during the GME base year and as a result certain costs associated with supervising interns and resident were properly excluded from their APRA. The Board also notes that the possibility of providers changing their election after the effective date of 1886(h) of the Act was addressed in a comment and response in the preamble to the final GME regulations. See 54 Fed. Reg. 40286, 40309 (1989). The comment notes the existence of the cost election for reimbursement of physician's direct medical and surgical services in teaching hospitals available under §1861(b)(7) of the Act and that the proposed regulations for GME allows the APRA to be adjusted if providers decide to make the election, for the first time, after the beginning of the effective date of 1886(h) of the Act. The comment suggest that a similar APRA adjustment be permitted for providers that withdraw their election, after the beginning of the effective date of 1886(h) of the Act. The response to the comment acknowledges that providers may withdraw their election, but indicates it would not be possible to make the necessary adjustments to the APRA for providers that withdraw their teaching election. The comment indicates that under the teaching election the costs for supervision of residents and interns were never separately identified and cannot now be identified to adjust the APRA. In lieu of making an adjustment to the APRA, the comment suggests that the unrecognized supervisory services of teaching physicians be "upgraded" to an attending physician role and that these costs be reimbursed under Medicare Part B.

The Board finds that the proposed method for upgrading teaching physician supervisory time to attending is not specified and appears to conflict with existing policy on what constitutes attending for

reimbursement purposes. The Board refers to proposed regulations, 60 Fed. Reg. 38400 (1995), which raised doubts as to whether one of the most common responsibilities of a teaching physician can be raised to the attending physician level. It states that:

> [w]e are clarifying that services of teaching physicians that involve the supervision of residents in the care of individual patients are payable under a physician fee schedule only if teaching physician is present during any portion of the service. If a teaching physician is engaged such activities as discussion of the patient's treatment with a resident but is not present during any portion of the session with the patient, we believe that the supervisory services furnished is a teaching service as distinguished from a physician service to an individual patient.

Id. at 38410.

The Board also agrees with the Provider's assertion that even if one could upgrade supervision to the attending level and have physicians reimbursed under Medicare Part B, the associated operating costs of the provider would not be compensated.[11] The Board concludes that the methodology specified in the preamble does not provide relief for otherwise allowable costs to be reimbursed under the APRA or as reasonable costs and therefore conflicts with the purpose of the GME regulation to ensure that all GME costs be included.

The Board also disputes HCFA's assumption, stated in the preamble, that it is never possible to make an adjustment to the APRA to reflect physician supervisory costs if the provider was reimbursed under the teaching election in the base year. The Board agrees with the Provider that a hospital that has withdrawn its teaching election must be given the opportunity to establish an allocation of its physician compensation costs in the base year and that the preamble should govern, if at all, only if no such allocation can reliably be made.

The Board rejects the Intermediary's argument that only GME costs reported in the GME cost center may be included, in the APRA. The Board finds that the Providers's physician supervisory costs, while not part of its GME cost center, are in fact included in two of the figures reported in its base year cost report: once on Worksheet A as part of the ancillary cost centers with which each physician was associated, and once on Supplemental Worksheet D-9 as part of the combined total of professional services to patients and physician supervisory costs.

The Board also finds that it is possible to reallocate these costs to the GME cost center for inclusion in the APRA. Supplemental Worksheet D-9 of the base year cost report reveals that $4,196,349 of total physician compensation in the base year was spent either directly caring for patients or supervising

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[11] See Provider Position Paper, Supplement at 25 and 26.

residents and interns. That figure already excludes costs that Medicare does not reimburse (such as research) or costs reimbursed solely under Medicare Part A (such as departmental administration). Thus, the only remaining question is how to allocate costs between direct patient care and physician supervision in the GME program. The Board finds that, under HCFA's audit instructions, such an allocation can reliably be achieved by means of the three-week time study conducted in the summer of 1990. See 55 Fed. Reg. 35990, 36063-64 (1990). The Board finds that the Provider in this case is not seeking to use the 1990 time study to "increase or add" to its base year GME costs, but only to segregate out legitimately incurred physician supervision costs from the combined total that it was required to report on Supplemental Worksheet D-9 as a result of its election to be reimbursed under the teaching amendment.

The Board finds that adequate data was presented to allow an adjustment to be made to the Provider's APRA. The Board points out that the Provider kept the same type of Part A and Part B split time records that other providers kept at that time and that a subsequent time study to reallocate costs as suggested by the Provider, using 1990 data, is an acceptable method of determining the extent of changes to the Provider's APRA.[12] The Board concludes that the time studies, subject to audit, should be used to reallocate GME costs claimed under the teaching election in the base year to the GME cost center and that an adjustment to the APRA be permitted for the 1993 time period forward.

Finally, the Board finds that the Provider was not required, under 42 C.F.R. 413.86(j)(1), to petition for adjustment of its TEFRA target amount for Medicare inpatient rates because the costs associated with physician supervision of residents and interns are not included in the costs used to determine the provider's target amount. The Provider was still under its teaching election when its target amount was set, all costs associated with physician supervision of residents, as well as the costs of professional services rendered to patients, were eliminated from the operating cost centers for reimbursement purposes. The removal of these costs can be seen on Worksheet A and Supplemental Worksheet A-8-2 of the provider's 1988 cost report, which served as the basis for determining the hospital's TEFRA target amount.

In summary, the Board finds that an adjustment to the Providers APRA should be made to properly compensate them for GME costs as a result of their decision to change their teaching election under § 1861(b)(7) of the Act. The Board finds adequate data exists to allow the Intermediary to adjust the Provider's APRA.

DECISION AND ORDER:

The Intermediary's failure to include physician supervisory costs in Provider's average per resident GME amount was improper. The Intermediary's determination not to audit such costs for inclusion in Provider's APRA is reversed.

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[12] See Provider Position Paper, Supplement at 26 and 27.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esq. (Dissenting)
Martin W. Hoover, Jr., Esq.
Charles R. Barker

Date of Decision: March 8, 2000

FOR THE BOARD:

Irvin W. Kues
Chairman

Dissenting Opinion of Henry C. Wessman, Esq.

I am troubled by this case, and the Majority decision, and chose to dissent.

In my mind, PRRB jurisdiction over this controversy has not been distilled. I am not convinced that this is an appeal from the original NAPRA. The issue here did not arise until the Provider chose to "deselect" the GME "teaching election" in 1993, some twelve (12) years after the initial election. As near as I can understand, there were no "misclassified", or disputed costs relevant to supervising physician costs that went into the analysis, and calculation, of the Provider's initial NAPRA of February 28, 1991. Thus the appeal submitted by the Provider on August 23, 1991, while technically "timely", appears to be devoid of the critical "case or controversy" element that makes an appeal an appeal.

I proudly admit that I come at my PRRB membership with a clinical mentality, and an upper Midwestern ethic. Unlike my learned colleagues, I am admittedly not steeped in the finer points of health care financing. But having a thirty year experience in health care education and clinical service, I believe that there are certain responsibilities, and concomitant decisions, that each practitioner/facility makes in the name of quality care, and the privilege to "teach" apprentices, along with providing care. Roswell made such an informed decision in 1981, when they chose to opt for the less-rigorous "teaching election" methodology of GME reimbursement. That system apparently served the facility, and the physicians, well, until the late '80's, when the state-imposed salary cap on practitioners made recruitment and retention of quality clinicians difficult, if not impossible. At that juncture, the clear alternate pathway, allowed by HCFA, and chosen by the Provider, was to disavow the "teaching election", particularly its limitation on Medicare Part B billing for physicians, and to move to a more physician-lucrative "Physician Practice Plan"; such plan intending, and accomplishing, the retention of quality practitioners on the staff of the Provider. I note, with interest, incidentally, that at the time of the "deselection", the Preamble to the final rules (54 Fed.Reg. 40309) made it clear that "deselection" did not, for what appear to be obvious reasons (i.e., that at least a portion of the new costs, the "supervising physician costs", have already been calculated into the base NAPRA), give the Provider the option to recalculate that base. In my opinion, the Provider was put on clear notice as to the absence of recalculation and appealability, just as they were also given a workable alternative strategy (i.e., to bill appropriately through Medicare Part B).

Perhaps I am too simplistic in my view, but it appears to me that the Provider can not have it both ways. To say, or infer, that "everyone" else has secured high practitioner incomes via Part B, while at the same time secured all conceivable supervising physician costs via GME, is not justification for supporting the Provider's appeal. Who benefits from those additional costs to be paid by Medicare? The Provider? The physician? Who is being harmed here? The Provider, with it's acknowledged quality staff and touted care? The physician practitioner/teacher, with the higher incomes via Part B? No, methinks its Medicare.

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