PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2001-D55

PROVIDER –
Mercy Catholic Medical Center
Philadelphia, PA

Provider No. 39-0156

vs.

INTERMEDIARY –
Blue Cross/Blue Shield Association/
Veritus Medicare Services

DATE OF HEARING-
January 19, 1999

Cost Reporting Period Ended -
Various

CASE NO. 91-2902M, 95-1677

INDEX

ISSUES:

1. Was the Intermediary's failure to recognize and reclassify certain operating costs as graduate medical education ("GME") proper?

2. Was the Intermediary's failure to add misclassified operating costs to the Provider's Prospective Payment System ("PPS") hospital specific rate ("HSR") and TEFRA target amount ("TA") proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Mercy Catholic Medical Center ("Provider") is an acute care hospital located in Philadelphia, Pennsylvania. In fiscal year ("FY") 1985, the Provider also operated a PPS-exempt distinct part psychiatric unit on two campuses in Philadelphia County and Delaware County, Pennsylvania. On December 21, 1989, the Provider received a notice[1] from Independence Blue Cross ("Intermediary IBC")[2], stating that the Intermediary was reopening FYs ended June 30, 1985, 1986, 1987 and 1988 to perform a re-audit of GME as required by the Health Care Financing Administration's ("HCFA") regulation at 42 C.F.R. ' 413.86.[3] This regulation implemented Section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA 1986"), which amended the Social Security Act ("SSA") to add ' 1886(h), codified at 42 U.S.C. ' 1395ww(h). Subsection 413.86(f) required the Intermediary to conduct a re-audit of GME costs in the Provider's base year (FY ending June 30, 1985) for purposes of establishing an Average Per Resident Amount ("APRA").

The base year previously had been audited by the Intermediary IBC,[4] through its subcontractor Johnston, Young & O'Fria ("JYO") and the FY was no longer subject to reopening. As originally audited by the Intermediary IBC in 1985, the base year costs would have produced an APRA of $81,574.50. The Intermediary IBC, through JYO, conducted the GME Re-Audit during the Fall of 1990. The final audit report, dated February 26, 1991, substantially reduced GME costs. The Intermediary IBC issued a NAPRA of only $73,657 on February 28, 1991.[5]

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[1] Provider Exhibit P-1

[2] Subsequently replaced by Veritus Medicare Services as the Intermediary.

[3] Provider Exhibit P-2.

[4] Independence Blue Cross ("IBC") served as intermediary during the course of the GME Re-Audit and thereafter until July 31, 1997; Veritus Medicare Services ("VMS") succeeded IBC.

[5] Provider Exhibit P-3.

During the GME Re-Audit,[6] the Intermediary IBC:

1) refused to accept re-audit documentation that supported an increase in GME base year costs,[7] even though the Provider performed time studies for all its physicians ("1990 Time Studies") based upon FY 1990 data; 2) reclassified certain costs originally reported as GME costs to operating costs[8]; and 3) refused to make appropriate adjustments[9] to the Provider's PPS hospital specific rate ("HSR") and TEFRA target amount ("Target Amount"), to take into account the proposed increase in reclassified costs, despite repeated requests during the course of the GME Re-Audit and thereafter.

On August 26, 1991, the Provider appealed the NAPRA to the Provider Reimbursement Review Board ("PRRB")[10] and has met the appropriate jurisdictional requirements. See 42 C.F.R. ' 405.1835-.1841. The Provider simultaneously requested that the Intermediary reopen its fiscal years 1986-1990 for purposes of adjusting its HSR, TEFRA Target Amount and GME costs for misclassified operating and GME costs in accordance with 42 C.F.R. ' 413.86(j)(1)(2). Id. By separate letter to the Intermediary IBC, dated August 26, 1991, the Provider requested the reopening and adjustment to the HSR and Target Amount to account for operating costs that truly had been misclassified in 1985 as non-GME expenses;[11] and a copy of the Notice of Appeal was also included.

Relevant Medicare Statutory and Regulatory Background:

From the inception of the Medicare program until 1983, hospitals were paid for covered inpatient services on the basis of "reasonable cost" ("RC"). 42 U.S.C. ' 1395x(v)(1)(A) defines RC as "the cost actually incurred," less any costs "unnecessary in the efficient delivery of needed health services." The Secretary was authorized to promulgate regulations prescribing the methods to determine RC and the items to be included. Under these RC regulation provisions, Medicare had traditionally paid a share of the net costs of "approved medical education activities."[12] 42 C.F.R. ' 413.85(b) defines approved educational activities as formally organized or planned programs of study, usually engaged in by

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6 Provider Exhibit P-4.

7 Provider Exhibit P-5.

8 Provider Exhibit P-4.

9 Provider Exhibit P-5.

10 Provider Exhibit P-6.

11 Provider Exhibit P-7.

12 20 C.F.R. ' 405.421 (1966); 42 C.F.R. ' 405.421 (1977); 42 C.F.R. 413.85 (1986).

providers to enhance the quality of care in an institution and include, inter alia, approved training programs for physicians.

In 1983 Congress created the Medicare prospective payment system ("PPS"),[13] where a hospital's inpatient operating costs were to be paid under a new prospective methodology, Diagnosis Related Group ("DRG"). Under PPS, providers received reimbursement for their inpatient operating costs on prospectively determined national and regional rates for each patient discharged instead of a RC basis. To lessen the impact of this new system, Congress phased PPS in over a four-year transition period[14] paying for hospital inpatient operating costs with a "blended rate" consisting of two components. The first component was the hospital-specific rate ("HSR") reflecting an individual hospital's own cost experience during a specified base-year;[15] and, secondly, the Federal PPS rate consisting of regional and national standardized amounts. During the transition period, the Federal PPS rate increased and the HSR decreased proportionately.

Initially under PPS,[16] the costs of approved medical education activities were specifically excluded from the definition of "inpatient operating costs,"[17] and they were also excluded from the blended rate, i.e., HSR and Federal PPS rates. Other costs were also excluded and collectively were known as "pass-through costs." Payment for approved medical educational activities, such as GME, continued to be made on a RC basis.[18] Since the educational costs were excluded from the blended rate, a "consistency rule" was established by the promulgation of 42 C.F.R. ' 412.113(b)(3). This regulation provided that throughout the transition period, the allowable costs used in developing the HSR (PPS base-year) should also be treated consistently in the GME base-year, i.e., as either GME costs or as operating costs. This rule prevents the duplication of payment for GME costs claimed as operating costs in the HSR and again as a pass through cost under PPS. 42 C.F.R. ' 413.85(c) also provides that in determining the cost of educational activities, particularly where costs were either omitted or misclassified, Medicare should not participate in any increased costs resulting from the redistribution of such costs from educational institutions or units to patient care institutions.

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

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

15 42 C.F.R. '' 412.71 and 412.73.

16 42 U.S.C. '' 1395ww(a)(4) and (d)(1)(A).

17 42 U.S.C. '' 1395ww(a)(4). Pub. L. 98-21 ' 601(a)(2), (1983).

18 42 U.S.C. ' 1395(b).

In 1986, Congress enacted the Comprehensive Omnibus Budget Reconciliation Act of 1986[19] (the "COBRA 1986") which converted GME reimbursement from a RC pass-through basis to a prospective per-resident basis indexed to a base year (codified at 42 U.S.C. ' 1395ww). The Act further provided that the base year per-resident average amount would be adjusted for inflation and used to calculate GME reimbursement for future years.[20] Section 9202(a) of Public Law 99-272 amended the Social Security Act ("SSA"), codified at 42 U.S.C. ' 1395ww, to establish this new prospective payment methodology for direct medical education costs for periods beginning on or after July 1, 1985. The SSA, codified at 42 U.S.C. ' 1395ww(h)(2)(A), required the Secretary to "determine the average amount recognized as reasonable under this title" for GME costs per full-time equivalent ("FTE") resident. The Act[21] provided that:

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

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

The statute also defined certain terms:

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

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

20 Section 9202(a) of the Act, 42 U.S.C. ' 1395ww(h)(2)(C)-(D).

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

* * *

C. DIRECT GRADUATE MEDICAL EDUCATION COSTS. --- The term "direct graduate medical education costs" means direct costs of approved medical educational activities for approved medical residency training programs.

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

The implementing regulations ("GME regulations") were promulgated three and one-half years later in 1989 at 42 C.F.R. ' 413.86.[22] They were effective as of 1985 for all reporting periods beginning on, or after, July 1, 1985. Pursuant to 42 C.F.R. ' 413.86(e)(1) intermediaries were required to determine a base-year amount for each hospital. In making this determination, intermediaries were to reopen[23] and re-audit the GME base-year to verify the accuracy of the GME costs and to exclude any nonallowable or misclassified costs. However, under 42 C.F.R. ' 413.86(e)(1)(ii)(C), hospitals could request the reclassification of misclassified GME costs that were not allowable under ' 412.113(b)(3). Such costs could be included only if the hospital also requested an adjustment to its HSR under ' 413.86(j)(2) which must be made within 180 days of the APRA notice.

HCFA stated in the preamble[24] of the GME regulations that the intent of the re-audit was to ensure the reimbursement principles in effect for the GME base-year were correctly applied. Hence, no new reimbursement principles would be applied in the re-audit.

Upon completion of the re-audit and the determination of the allowable GME base-year costs, the intermediary would calculate and notify the hospital of the APRA, i.e., the new prospective payment rate for GME. In subsequent years, the base rate is adjusted for inflation and multiplied by the weighted number of FTE residents in the hospital's GME program during the applicable FY. This amount is multiplied by the hospital's Medicare inpatient load[25] to ascertain the amount of GME reimbursement. See 42 C.F.R. ' 413.86 (1989).

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[22] See 54 Fed. Reg. 40286 (1989).

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

[24] 54 Fed. Reg. at 40301.

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

CONTENTION OF THE PARTIES

Issue No. 1

Was the Intermediary=s failure to recognize and reclassify certain operating costs as graduate medical education ("GME") proper?

PROVIDER'S CONTENTIONS

The Provider contends that it incurred teaching physician and secretarial compensation in three approved GME residency departments which qualify as GME costs pursuant to the regulatory provisions of 42 C.F.R. ' 413.86 et seq.-but such costs were erroneously misclassified as general operating costs ("OC") in the GME base-year. The costs for all of the other GME residency programs were properly classified as GME.

The Provider asserts that the subcontractor auditors and the Intermediary were well aware of the existence of these 3 omitted GME departments and erroneously refused to reclassify these costs as GME. The Provider maintains that the GME re-audit adjustments and the resulting determination of the average per resident amount (AAPRA@) for the prospective payment method of reimbursing GME costs are in error. The Provider also claims the auditors and the Intermediary had adequate documentation of all costs during the original audit; and that adequate documentation of contemporaneous records were furnished during the re-audit including 1990 time studies making appropriate allocations of GME time and costs.

The Provider contends that it has fully complied with all the regulatory requirements for the GME reclassification and the revision of the hospital specific rate and/or TEFRA target amount per issue no. 2. The Intermediary refusal to make any revisions is contrary to the Medicare statute and regulations.

The Provider contends the Intermediary improperly refused to increase it's GME costs for certain misclassified operating expenses in FY 1985, which included 1) teaching physician compensation of the OB/GYN, Radiology and Laboratory departments, 2) secretarial and clerical support costs, and 3) departmental costs related to teaching. The Provider maintains it complied with the Intermediary's request for documentation of these teaching costs by submitting time studies for all its physicians ("1990 Time Studies") including the physicians in the departments at issue. Despite this documentation, the Intermediary refused to consider them to increase GME, (Transcript pages ("Tr. pp.___") 116, 159, and 180), because the Intermediary erroneously stated the costs of these physicians were not originally claimed in the Interns and Residents ("I/R") Cost Center.

The Provider states that in FY 1985, the Provider utilized Form 339 Physician Allocation Agreements to track all physician time reported on the cost report whether or not the time was reported in the I/R Cost Center. (Tr. p. 115). The Provider asserts at the time of FY 1985 audit, time studies were not required by the Intermediary. (Tr. p. 161). Although Form 339 separated Part A and Part B expenses, the time for administration, supervising and teaching was combined under Part A. However, the GME Re-Audit required that the teaching portion be separated. (Tr. p. 115). The Provider asserts the 1990 Time Studies would enable that separation.
The Provider asserts the 1990 Time Studies were developed in conjunction with and approved by the Intermediary in order to determine the most accurate allocation of costs. (Tr. pp. 30 and 155). They tracked in one half hour intervals or less the time spent by all physicians involved in teaching-related activities which enabled their compensation to be apportioned between teaching time, departmental administration and supervision, and direct patient care.

The Provider states that the 1990 Time Studies were not used evenhandedly as the statute and instructions provided. Instead, the Intermediary utilized them only for one purpose -- to support the disallowance and reclassification of costs originally claimed in the I/R Cost Center, i.e, decrease the GME costs. The Provider maintains that as a result of the 1990 Time Studies, the GME costs originally misclassified as operating costs by the Provider were found to be physician compensation for teaching and were properly identified as GME costs. Yet, the Intermediary's re-audit Subcontractor, JYO, testified that he was instructed not to increase the I/R Cost Center for costs that were not originally claimed in the I/R Cost Center even though contemporaneous records and the 1990 Time Studies indicated that they should rightfully be classified as GME. (Tr. pp. 161 and 164.).

The Provider contends the GME re-audit results violate the regulations and announced HCFA policy and supports its position as follows:

a. The GME Regulations Require That The GME Re-Audit Be Used To Determine As Accurately As Possible The Provider's Allowable Average Cost Per Resident In The GME Base Year.

The Provider asserts the plain meaning of the regulations and preamble is that the purpose of the GME Re-audit is accuracy (Provider Exhibit P-16). In adopting the GME regulation, HCFA stated:

> in establishing the base period per resident amount for a specific hospital based on [FFY] 1984 GME costs, it is important that the amount determined be an accurate reflection of legitimate GME costs incurred during the [FFY] 1984 base period.

As justification for reopening the base year to reassess the allocation of GME costs, HCFA took the position that errors in GME costs were likely to occur, because:

> The GME base period under ' 1886(h) of the Act was also the first period under the prospective payment system, a period in which many changes were occurring in the Medicare Program. The costs that were classified as cost of approved educational activities did not always receive the scrutiny they should have. Several instances of misclassified costs have come to our attention, and we believe that it is necessary to correct these errors before incorporating these [FY] 1986 costs into the per resident amounts that will not be revised again except by an update factor. Because of this, we believe that it is imperative that we do our best to ensure that these amounts are correct.

54 Fed. Reg. 40303 (Sept. 29, 1989).

The Provider asserts that in order for the GME cost determination to be accurate and correct, HCFA adopted a regulatory "presumption" that costs misallocated to either GME or operating expenses during the base year should be reclassified so as to obtain a more correct and accurate cost allocation.

Specifically, operating costs might have been erroneously assigned to GME cost centers, or GME costs might have been erroneously designated as operating costs. HCFA made it clear that both types of misallocation were to be reviewed and corrected during the GME Re-Audit process. See 42 C.F.R. ' 413.86(e)(ii)(C); (Provider Exhibits P-2 and P-16).

54 Fed. Reg. 40289 (Sept. 29, 1989).

b. Adequate Documentation Evidence Has Been Shown To Support A Reclassification From Operating Costs to GME

(1) The Costs Were Accepted As Auditable And Verifiable In The original FY 1985 Audit.

The Provider states all of the expenses at issue were previously allowed by the Intermediary as either operating or GME costs during the original contemporaneous FY 1985 audit. There are no previously disallowed or unclaimed costs involved. (Tr. pp. 49, 101, and 116). Thus, the Intermediary's initial contemporaneous audit accepted the validity of the costs in question, following on-site review of all of the Provider's supporting data and records. Once the initial audit was accepted and attested to by Robert Patterson of JYO, the agent of the Subcontractor, the validity and legitimacy of the expenses was established. At this point, the Provider merely seeks to reallocate some of these costs from an operating to a GME cost component based on the same time studies the Intermediary relied on to reclassify certain other of the Provider's GME costs in the opposite direction.

(2) HCFA's Own Instructions Properly Interpreted Allow Reclassification Of Expenses as GME.

The Provider states that in 1990, HCFA issued an Addendum dated, June 22, 1990 ("Addendum"), to the Instructions (defined below) clarifying procedures for the GME Audit. (Provider Exhibit P-17). Recognizing that the regulations in place during 1985 did not require maintenance of the sort of records that would address the re-audit issues, and to the extent contemporaneous records might have been lawfully discarded in the interim (because providers had no reason to presume a need for their retention beyond that required by the controlling regulations), HCFA allowed providers "to furnish documentation from cost reporting
periods subsequent to the base year in support of the allocation of physician compensation cost in the GME base period" for accurately determining the APRA.

The Provider asserts that in the event an Intermediary concluded that a provider no longer had the necessary auditable documentation pertaining to events in FY 1985, HCFA's Instructions dated February 22, 1990 ("Instructions") contemplated that a provider could perform a time study of a subsequent cost reporting period for the Intermediary's review. (Provider Exhibit P-29). The Intermediary could then use this information as persuasive evidence as to what the allocations of physician compensation to teaching should be if the time study was deemed reliably done in accordance with HCFA's guidelines. At all times, the beacon of the re-audits should have been accuracy in the determination, of the APRA. See Tulane Educational Fund v. Shalala, 987 F.2d 790 (1993), cert. denied, 510 U.S. 1064 (1994), cited with approval in Regions Hospital v. Shalala, 1998 W.L. 71823 (U.S. Feb. 24, 1998). (Provider Exhibits P-9 and P-10).

The Provider asserts that instead of seeking accuracy, the Intermediary used the re-audit data only where it served to reduce GME costs. The Provider maintains that it is arbitrary and capricious to utilize the 1990 Time Studies -- i.e., those which the Provider performed for all physicians engaged in teaching activities in 1990 to determine teaching physician time allocations for purposes of determining the Provider's APRA -- only to the extent that the time studies support a reduction of GME costs originally included in the I/R Cost Center. The Provider claims the Intermediary failed to incorporate into the APRA certain misclassified GME costs previously reported as operating costs, but now shown, correctly and accurately, to be GME costs by the GME Re-Audit. In fact, the Intermediary refused to even look at them. (Tr. p. 116).

The Provider states the Intermediary's refusal to use the 1990 Time Studies to reclassify the previously reported operating costs as GME was purportedly based on the fact that HCFA's Addendum provided that "in no event will the results obtained from the use of 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 amount." The Provider asserts the Intermediary misreads this sentence; and, if it does not, then the instruction should be rejected by the PRRB as arbitrary and capricious. As noted above, HCFA has, in duly promulgated legislative rules, made it very clear that the purpose of the GME Re-

Audit is to achieve the most accurate results possible. To that end, HCFA specifically provided for correction of historic costs misallocations that improperly assign GME costs to operating cost centers or operating costs to GME cost centers. If the quoted sentence were construed to mean that such corrective reallocations could not occur, it would be directly contrary to the GME regulations themselves, and to well-established canons of construction, that is preferring a construction of a regulation that gives meaning to all of its components.

As the Board recognized in Presbyterian Medical Center of Philadelphia v. Aetna Life Insurance Companies, PRRB Dec. No. 95-D4, June 15, 1995, Medicare and Medicaid Guide &43,487. Rev'd, HCFA Adm'r., Dec. August 7, 1995, Medicare and Medicaid Guide & 43,691, summary judgement granted in Presbyterian Medical Center v. Shalala, 1998 VVL 199963 (D.D.C. April 21, 1998) (opinion not reported) (Exhibits P-21 and P-22), the sentence can be interpreted in a manner fully consistent with the GME regulations as follows:

> a Provider cannot use a later period time study to support the inclusion of additional physician compensation costs that were not originally claimed somewhere on the hospital's base year cost report.

Id.

In this case, in FY 1985, the Providers' physician compensation costs were claimed (albeit in the instances relevant here as operating costs) on its GME base year cost report. Thus, properly interpreted, the purported prohibition simply does not apply.

As the HCFA Instructions themselves recognize, the unavailability of physician allocation agreements in 1990 for the OB/GYN, Laboratory and Radiology physicians should not be fatal to Provider's request for reclassification based on the 1990 Time Studies. Under the specific rules governing physician allocation agreements at 42 C.F.R. ' 405.481 (Provider Exhibit P-18), the Provider was required in FY 1985 to maintain either contemporaneous time studies "or other information" in support of the I/R Cost Center allocation. The Provider was required to report that information to the Intermediary (which presumably reviewed this mandatory information when it did the original audit), and was required to retain that data and back-up materials only until June 30, 1989. In addition, the Provider has produced ample contemporaneous documentation of the nature of the OB/GYN, Radiology and Laboratory physician compensation as GME. The Provider avers that the 1990 Time Studies were accepted by the Intermediary in the absence of physician allocation agreements for all the other physicians.

The Provider states the manual at PRM-1 ' 2182.3 (Provider Exhibit P-20) reinforces the four-year retention rule; and it required the Intermediary to satisfy itself that data and information "used to allocate physician compensation [was presented] in a form that permits [validation]" in 1985. The provisions of PRM-1 ' 2182.13 (Provider Exhibit 20) expressly prescribed the form of physician allocation agreement and accompanying documentation required in 1985. The Intermediary certified the date, and

has not nor can it deny that the requisite data was supplied. Another plausible potential reading of this sentence is that the re-audit cannot result in the recognition of additional I/R costs that increase the total amount of GME above the total amount of GME costs as determined during the audited base-year.

The subcontractor and the Intermediary had audited and approved all these costs in FY 1985 when the NPR was issued. In fact, the Subcontractor reviewed all physician allocation agreements, contracts, work papers, payroll records and general ledgers at that time. (Tr. p. 156). The Intermediary was provided with all the necessary documentation at the time of the original audit and, as such, the Intermediary certified the audit. (Tr. p. 156). The Subcontractor for the Intermediary stated he was familiar with the documentation of the Provider (Tr. p. 160) with respect to physician compensation, and that he found it to be adequate and accurate documentation for cost reporting purposes in fiscal year 1985. (Tr. p. 160). To the extent that such documentation still exists, in contracts, or contemporaneous memos, these were provided to the Board at hearings along with the 1990 Time Studies. (Provider Exhibits: P-3, P-23, P24, P-24, P-25, P-27, P-28, P-31, P-32, P-37, P-38, P-39, P-45, P-46, and P-47).

(3) Use of Subsequent Year Time Studies Was Proper And Is Supported by Case Law.

The use of subsequent year time studies for purposes of allocation when contemporaneous documentation is inadequate (or no longer exists) has been consistently validated. St. Mary's Hospital vs. Blue Cross and Blue Shield Association, PRRB Dec. No. 99-D13 Dec. 1, 1998 Medicare & Medicaid (CCH) &80,150, Rev=d HcfA Adm=r Dec. (Feb. 2, 1999) Medicare & Medicaid (CCH) &80,170; Abbott Northwestern Memorial Hospital v. BCBSA of Minn., PRRB Dec. No. 95-D10, aff=d HCFA Adm'r. Dec. (Feb. 2, 1995) (Medicare & Medicaid Guide (CCH) ' 43,136.

See Provider Exhibits P-11 and P-12

In Abbott, the Provider claimed that base year GME costs in cost centers other than the I/R Cost Center should be included as GME costs for purposes of calculating the APRA. The Provider submitted contemporaneous documentation to the Intermediary, including physician allocation agreements, which the Board deemed to be dispositive for purposes of calculating the GME costs. The HCFA Administrator, in finding that the physician allocation agreements were of themselves not adequate documentation, endorsed the use of subsequent period time studies to support allocations of previously claimed physician costs.

In St. Mary's, the Board also commented on the adequacy of documentation that must be provided to support a reclassification request for GME costs. Under 42 C.F.R '' 413.20 and 413.24, providers are required to maintain sufficient financial records and statistical data for the proper determination of costs payable under the program. Under 42. C.F.R '413.20, the provider must maintain an adequate system for furnishing the records needed to provide accurate cost data and other information capable of verification by qualified auditors. The Board found that contemporaneous physician allocation

agreements provide reliable and adequate substantiation of the physician's GME teaching activities in compliance with the regulations. The Board noted that a subsequent time study performed corroborated the physician allocation agreements and bolstered their accuracy.

In the instant case, the Subcontractor for the Intermediary testified that all sufficient and necessary documentation was provided to certify the original FY 1985 audit. (Tr. p. 156). This included documentation such as physician allocation agreements for all physician, contracts, work papers, payroll records and general ledgers (Tr. p. 156). The 1990 Time Studies corroborated the contemporaneous evidence that the OB/GYN, Laboratory and Radiology physicians performed teaching duties and identified the misclassified costs in the OB/GYN, Laboratory and Radiology Departments. The 1990 Time Studies indicate, as did the contemporaneous documentation, that expenses previous reported by the Provider as operating expenses were properly GME. (Tr. pp. 159 and 161).

B. The 1990 time studies corroborate contemporaneous documentation and identify the expenses previously reported as Operating Costs (AOC@) should have been reported as GME in the OB/GYN, Laboratory and Radiology Departments.

1. The OB/GYN Department

The Provider states that in the OB/GYN Department, various documents still existing were presented at the hearing that indicate certain expenses were claimed as operating expenses which should have accurately been claimed as GME. Contracts were provided for two OB/GYN physicians (Provider Exhibit P-28) that support the fact that the two physicians in question performed teaching and were compensated for teaching interns and residents as part of their duties for the Provider. Work papers reflect the number of doctors trained by the Provider in the Department of Internal Medicine, of which the OB/GYN Physicians were a part. Furthermore, the Provider's program was listed in the Index of Accredited Physician Training Programs and was fully accredited as evidenced by an accreditation letter (Provider Exhibit P-26). The standards for accreditation of a program (Provider Exhibit P-27) support the fact that substantial time was required to be devoted to OB/GYN teaching in the Department of Internal Medicine.

The 1990 Time Studies (Provider Exhibit P-25) were submitted in the GME Re-Audit to evidence the GME allocation for the OB/GYN physicians. These time studies support the Provider's contention that approximately 29% of the costs for physicians' salaries in the OB/GYN Department were allocable to teaching internal medicine residents during the OB/GYN rotations and as such should be reclassified to the I/R Cost Center to achieve a fair and accurate result.

2. Laboratory

The Provider states that physician compensation in the Laboratory Department was also misclassified as operating costs; and it was documented for and audited by the Intermediary in the original FY 1985

audit together with sufficient contemporaneous documentary support provided to the Intermediary to verify these expenses. The Provider avers it has presented contracts with laboratory physicians (Provider Exhibit P-31) to the Board which provide for administrative, supervision and teaching services. In addition, work papers of the Intermediary as well as internal work papers generated at the time of the FY 1985 audit demonstrate verification of the physician compensation (Provider Exhibit P-24), through payroll records and general ledger entries. The Provider also states its program was listed in the Index of Accredited Physician Training Programs and is the subject of an accreditation letter. (Provider Exhibit P-26). The standards of accreditation demonstrate that substantial physician time was required to be devoted to medical education. (Provider Exhibit P-27).

The 1990 Time Studies (Provider Exhibit P-25) indicate that 48% of the costs for physician salaries in the Laboratory are allocable to teaching residents. Expenses including 50% of secretarial expenses and 5% of other expenses incurred by the Laboratory were also claimed as operating expenses in fiscal year 1985 but should have been claimed as GME. The 1990 Time Studies of the Laboratory physicians, the audit work papers of the Intermediary (Provider Exhibit P-46), its audit report and the absence of any disallowance of these expenses support their existence in the FY 1985 base year. Secretarial time such as typing evaluations, preparing schedules and setting conferences, as well as meals and supplies, were obviously utilized by residents.

3. Radiology

The Provider avers that in the Radiology Department, Part A physician compensation costs were also claimed as operating expenses in the FY 1985 audit as certified by the Intermediary. Audit work papers as well as Provider work papers generated contemporaneously with the FY 1985 reports reveal data that ties into the FY 1985 cost report. The 1990 Time Studies along with a 1985 memorandum (Provider Exhibit P-32) break down the physician compensation costs allocated to teaching. The time studies show that 52% of the costs of physician salaries were allocable to teaching residents and should have been reclassified to GME. This program is also listed in the Index of Accredited Physician Training Programs and the subject of an accreditation letter. (Provider Exhibit P-26 and P-27). The standards for medical accreditation support the contention that substantial physician time was devoted to medical education including 50% of secretarial and 5% of other expenses which were incurred by the Radiology Department. This included the salaries for two full-time secretaries. These expenses were documented and claimed as operating expenses in the FY 1985 audit. The Provider states sufficient contemporaneous documentation was provided to the Intermediary verifying these expenses. Work papers and audit reports of the Intermediary along with copies of the Provider's internal work papers have been submitted for the record at the hearing. (Provider Exhibits: P-13, P-23, P-24, P-37, P-38, P-39, P-45, P-46, and P-47). The 1990 Time Studies (Provider Exhibit P-25) further support the physician GME allocation and the allocation of secretarial expense and departmental overhead to GME.

The Provider claims that the 1990 Time Studies are the "best evidence" of the actual percentage of time devoted to teaching. The Provider states the Intermediary's position that there was a fictional

assumption that no teaching time was spent and that trained doctors magically appeared without the intervention of Provider's paid medical staff, is indefensible.

INTERMEDIARY=S CONTENTIONS:

The Intermediary makes three (3) primary contentions:

1. With respect to the Provider=s claim of misclassified GME costs, the Intermediary contends that the Provider has not submitted any documentary evidence of these costs as required by the regulations at 42 C.F.R. ' 413.86(j)(2), per the previous Issue.

2. The Intermediary contends the Provider was unable to supply any physician time studies from FY 1985 to support the GME physician costs claimed as misclassified.

3. a) The published regulations, in 55 Fed. Reg. 36063, 1990, granted an exception for using data from periods after the GME base year. Although time studies from periods subsequent to FY 1985 could be used, they were only admissible for the limited purpose of "establishing base period physician compensation cost allocations for purposes of determining per resident amounts...." Thus, the Intermediary asserts that in no event will the results obtained from the use of records from a subsequent cost reporting period be used to increase or add physician compensation costs to the costs in determining the APRA. (Intermediary Exhibit I-16).

b) The Intermediary acknowledges that it used the Provider=s 1990 time studies in the GME re-audit of physician time in the base year. However, the 1990 time studies could not be used to increase the Provider=s claimed GME physician teaching costs beyond the amount originally claimed on the base year cost report on the Intern and Resident line per the Medicare instructions referenced above per Intermediary Exhibit I-16.

c) In support of its position, the Intermediary cites the case of Presbyterian Medical Center of Philadelphia v. Aetna Life Insurance Companies, PRRB Dec. No. 95-D41, June 15, 1995, Medicare and Medicaid Guide & 43,487. Rev=d, HCFA Adm=r Dec, Aug. 7, 1995, Medicare and Medicaid Guide & 43,691. In that case, the HCFA Administrator ruled that the use of substituted documentation from later periods was solely to verify that costs originally claimed as GME costs had been properly classified. Time study results from a later year could not in any case be used to >increase or add= physician compensation costs to the originally amount designated in the GME cost center.

Issue 2 - Failure to adjust the HSR & TEFRA rates:

Did the Intermediary err in not revising the Provider=s base year for its:
a) Prospective Payment System ("PPS") Hospital Specific Rate ("HSR"), and
b) TEFRA target rate?

FACTS:

The regulations provide that a hospital may request the Intermediary to review the classification of base year costs for both the PPS HSR and TEFRA target rate within 180 days after the date of notice of the hospital=s graduate medical education (AGME@) average per resident amount (AAPRA@). This request must include sufficient documentation to demonstrate to the Intermediary that an adjustment to the HSR or target rate is warranted.

42 C.F.R. ' 413.86(j)(1)(ii).

The parties agree that a timely request was made, but disagree with respect to the requirement that sufficient documentation was submitted with the request. The Intermediary determined there was inadequate documentation to support a revision, and it did not make any revision in the respective rates as requested.

PROVIDER'S CONTENTIONS:

The Provider contends (contrary to the Intermediary's assertion) that sufficient documentation was made available to the Intermediary during the GME re-audit when a verbal request was made; and subsequently with the written request. In addition, the Provider states documentation was submitted as Exhibits for this hearing.

The Provider submitted the affidavit (Provider Exhibit E) of Carol Primavera, the current Assistant Vice President of Finance since 1988, who was the Manager of Cost Accounting and Reimbursement, during the FY 1985 audit and was directly involved during the GME re-audit. This affidavit refutes the allegations of the Intermediary=s Audit Manager, Mr. Koons; and stated that he was not present during the re-audit, and in paragraph 6 disagrees with the alleged factual allegations of hearsay statements attributed to the auditor, Mr. Patterson. The affidavit supports the basic arguments by the Provider on both issues.

1. The Provider Had Made an Appropriate Request for Review of its HSR and Target Amount.

Pursuant to 42 C.F.R. ' 413.86, a provider that wishes to reclassify costs misclassified as operating costs in the base year to GME costs must request that the Intermediary review the classification of affected costs in the TEFRA rate-of-increase ceiling or PPS base year for the purposes of adjusting the hospital's target amount or HSR. In the present situation, the Provider made an appropriate request to the Intermediary for reclassification as well as its appeal to the PRRB. These requests were made during the GME Re-Audit and were both verbal and written. (Provider Exhibits P-5, P-6, P7, P-15; Tr. pp. 7, 34, 35, 43, 44, 46, 47, 162, 163, 164). The Board itself, in a letter dated February 6, 1998

addressed to counsel for the Provider and Intermediary, found that the Provider had made the appropriate request. (Provider Exhibit P-52).

2. The Intermediary's Contention That the Provider Did Not Submit Adequate Documentation to Support the Reclassification Within 180 Days Is Not Supported By Case Law.

The regulation at 42 C.F.R. ' 413.86(j)(2) states that a hospital's request for reclassification of its GME costs that were treated as operating costs during the base year requires "sufficient documentation to demonstrate to the Intermediary that modification of the hospital HSR or target amount is warranted" be submitted to the Intermediary within 180 days. The Intermediary contends that the Provider failed to comply with this regulation and that such failure is an appropriate basis for the denial of the Provider's request for reclassification. This Board's own decisions do not support this contention.

In the case of St. Mary's Hospital vs. Blue Cross and Blue Shield Association PRRB Dec. No. 99-D13 (1998) (Exhibit P-3), the Board dealt with issues similar to the case at hand. In this matter, the provider had appealed to the PRRB to have compensation costs that it incurred for physician and secretarial compensation costs reclassified as GME. The Board found that the provider made a timely request for reclassification on the GME costs at issue after the re-audit and APRA determination. The Board stated that the GME statute was "enacted for the purpose of establishing a new and more accurate reimbursement methodology" which would effect the computation of an APRA based on all incurred GME costs recognized as reasonable, and that HFCA had promulgated regulations that were designed to offer a "two way street" for ensuring the accuracy of the GME base-period costs. The goal of the regulation was to properly determine accurate costs for the GME base-year calculation, which would include both increases and decreases resulting in a correct base-year amount. Id.

The Board found that the review and documentation requirements set forth under 42 C.F.R. '413.86 et seq. are not a condition precedent to appeal rights granted under 42 C.F.R. '413.86(e)(1)(v). The Board reasoned that if HCFA had intended such limitations for appeals emanating from the issuance of a NAPRA it would have included such specific appeals provisions in the GME regulations. The requirement under 42 C.F.R. '413.86 et seq. applies only to supporting documentation submitted within 180 days after the date of the NAPRA when an intermediary would effect an adjustment to Provider's APRA. However, if a provider appeals an intermediary's determination of APRA to the Board, the regulations of 42 C.F.R '405.1855 controls the submission of supporting documentation and evidence for a Board hearing. See St. Mary=s.

The case of Fletcher Allen Health Care, Inc. v. Shalala, 2 F. Supp. 2d 313 (D.C. Vt. 1998); Medical Center Hospital Of Vermont. v. BCBS Assoc., PRRB Dec. No. 97-D27 Jan 30, 1997 Medicare & Medicaid Guide &45,034, modified in part; Medical Center of Vermont v. BCBS Assoc., HCFA Adm'r Dec. (March 31, 1997) Medicare & Medicaid Guide &45,232. (Provider Exhibits P-50, P-35, P-36), are instructive on this point. The court held that an intermediary should review a provider's request to include misclassified operating cost as GME, but there is no requirement that a Provider

request a review of its HSR within 180 days after receiving the APRA. The court held that the regulations merely require a hospital to request an adjustment of its HSR within 180 days of receiving a NAPRA which includes reimbursement amounts which have been reclassified as GME costs. In other words, only when the provider receives a NAPRA that includes GME costs that were misclassified as operating costs in its APRA, must it request an adjustment of its HSR. The request must be made within 180 days of this NAPRA or the provider must forego inclusion of those costs in its APRA. The Fletcher Allen court found, with respect to the costs that were the subject of judicial review, the triggering event was a NAPRA that included misclassified GME costs that had not yet occurred. The Provider asserts this is the very situation in which it now finds itself, i.e., with respect to its request for reclassification of certain OB/GYN, Laboratory and Radiology Costs.
Although Fletcher Allen involved a provider's request for review [the timeliness of which is not at issue here], it is also equally applicable to the timeliness requirement for providing documentation.

The Provider avers that there is no dispute that the 1990 Time Studies were supplied to the Intermediary in a timely manner (i.e., during the course of the GME Re-Audit). The Provider disputes the Intermediary's contention that the documentation necessary to make the corresponding (downward) adjustments to Provider's HSR and TEFRA Target Amount were not supplied to them in a timely manner. The Provider states there was testimony that in the course of performing the 1990 Time Studies all physicians performing the 1990 Time Studies were "crosswalked" to a corresponding teaching physician position in 1985. (Tr. pp. 31-33). In addition, since FY 1983 was the PPS base year, the Provider was also required to demonstrate that it treated its GME costs consistently from FY 1983 to FY 1985. The Provider also asserts it is undisputed that it's medical educational costs remained relatively constant and consistent from FY 1983 to FY 1985 (Tr. p. 123). In addition, the Intermediary made findings of consistency with respect to costs claimed in I/Rs Cost Center between FYs 1985 and 1984 and between FYs 1984 and 1983, respectively. (Tr. p. 123). The consistency determination was corroborated by the crosswalk performed from June 30, 1983 to June 30, 1985 in which the physicians were matched and compared in the two years. (Provider Exhibits P-37 and P-38). This crosswalk showed that the positions in 1985 were the same as 1983 even though the same physician may have not been performing the duties. (Tr. p. 75). Moreover, the Subcontractor testified that the Provider's documentation "was better than most" other medical centers. (Tr. pp. 160-161). Nonetheless, the Subcontractor was under instructions from the Intermediary not to allow for GME costs not originally claimed in the base year as GME. (Tr. p. 159).

The Provider argues that since the Intermediary failed to follow HCFA's instructions, it should be estopped from contending the Provider failed to supply adequate documentation. Furthermore, when the Intermediary did not increase the Provider's I/R costs, the Intermediary failed to submit any written explanation of the facts and conclusions to support its refusal as required by the Addendum. (Provider Exhibit P-17). The Addendum set forth a specific process for intermediaries to evaluate the documentation produced by a Provider, e.g., a later period time study:

> We would stress that the use of documentation from the current year or a subsequent year is, at best, persuasive evidence rather than conclusive evidence. Accordingly, if the Intermediary believes that any of the changes or modifications distorts the reliability of the data, it will make whatever adjustments are necessary to ensure an accurate cost allocation. In addition, the Intermediary will prepare a written statement documenting the facts and its conclusions concerning how the information distorts the reliability of the data and why the data should not be relied upon. Also, the Intermediary will explain why its adjustments are appropriate. This statement will become part of the record as it may be used to support any action taken in subsequent reviews and appeals.

55 Fed. Reg. 36064 (Sept. 4, 1990), (emphasis added.) (Provider Exhibit P-17).

The Provider argues that since the Intermediary failed to provide the required explanation, it should be estopped from questioning the historic evidence; and the Provider's 1990 Time Studies must be accepted as support of the reclassification in its physician teaching costs requested by the Provider.

The Provider states the Intermediary had in its possession at the relevant time period all the information necessary to assure itself of consistency with the PPS Base Year (1983) and to make the appropriate adjustments to the HSR, Target Amount and GME.

Even if the Provider had discarded any of the documentation pursuant to the time-retention requirements of the regulations, the Intermediary's Subcontractor was in possession of a voluminous amount of relevant records. The Subcontractor testified at the Board hearing that he was in possession of Provider's records reviewed in the course of audits that contained documentation from 1983 to the early 1990s, until he shipped them back to the Intermediary around July 1996. These records were stored in large archive boxes (Tr. p. 166) and included multiple boxes containing the PPS Base Year, GME Base Year, and the 1990 GME Re-Audit records. (Tr. pp. 165-168). The Provider argues that these boxes of documents were not provided as part of its discovery requests. At the hearing, it was revealed that the Intermediary never requested this information from nor asked the Subcontractor to respond to the Provider's discovery request. (Tr. p. 168).

The Provider asserts the Subcontractor testified he received all necessary documentation during the GME Re-Audit in order to reclassify and adjust Provider HSR and Target Amount (Tr. p. 162); and that enough documentation was provided to prove that certain OB/GYN, Laboratory and Radiology operating costs should have been designated as GME. (Tr. p. 161). Further, the Subcontractor was aware of Provider's timely appeal within 180 days (Tr. p. 168), and that adequate documentation was received prior to and after the NAPRA (Tr. p. 168) as well as on-site during the GME Re-Audit. (Tr. p. 162). The Board noted the Provider's request in its letters to the parties' counsel. (Provider Exhibit

P-52). Additionally, the Provider produced at hearing a document, Provider Exhibit P-37, that was a crosswalk of all physician costs in the three departments: OB/GYN, Laboratory and Radiology departments between FYs 1983 and 1985. This crosswalk document demonstrates conclusively that these costs were treated consistently in the PPS and GME base years.

The Provider contends it has presented unrebutted evidence consistent with the regulations, the Instructions, and the Addendum that reclassification of its physician teaching costs was appropriate.

3. Adjustments Made To Base Period GME Costs By Reason Of Their Alleged Character As Misclassified Operating Costs Were Not, But Should Have Been, Added By The Intermediary To The Provider's HSR And The TEFRA Target Amount.

The Provider requested pursuant to 42 C.F.R. ' 413.86 that the Intermediary review the classification of the affected costs in its rate-of-increase ceiling or prospective payment base year for the purpose of adjusting its HSR and its Target Amount upward to account for costs that were reclassified as general operating expenses as a result of the GME Re-Audit. The Intermediary had refused to make these adjustments, despite the fact there was auditable and verifiable data to support the adjustment. (Tr. pp. 116 and 160). In fact, the Subcontractor testified that the Intermediary had sufficient documentation at the time of the GME Re-Audit to show the consistency required to make any reclassification of the HSR and the Target Amount. (Tr. p. 162). The Provider states this refusal was not only improper under the statute and regulations, but it is against public policy because it eliminates the Medicare Program's obligation to pay its fair share of those expenses as either GME or general operating costs and results in an improper cost shifting.

The costs of OB/GYN physicians were reported as GME in FY 1983, but were reclassified by the Provider in FY 1985 as operating costs due to the incorporation of their functions into the Internal Medicine Department. The Intermediary accepted this reclassification in fiscal year 1985.

a. The Provider Made An Appropriate Request For Increase of Its HSR and Target Amount

The Provider contends that: 1) it requested these increases, verbally during the GME Re-Audit (Tr. pp. 42 and 43), and 2) in writing in the Notice of Appeal (Provider Exhibit P-6, Tr. p. 103). In addition, the Provider sent a letter, dated August 26, 1991, notifying Mr. Robert Koons of the Intermediary (Provider Exhibit P-7) of its appeal of the APRA and also requested reopening pursuant to 42 C.F.R. ' 413.86.

The Provider states the Intermediary ignored all the Provider's requests, i.e, 1) the verbal request during the GME Re-Audit (Provider Exhibit P-5), 2) in its Notice of Appeal (Provider Exhibit P-6), and 3) the letter of August 26, 1991 to Robert Koons of the Intermediary (Exhibit P-7); as well as all subsequent attempts by letter or telephone (Provider Exhibit P-5) to make adjustments to the HSR and the Target Amount. In fact, on January 29, 1992, Robert Koons, of the Intermediary, assured the Provider that its

HSR rate would be adjusted. (Tr. pp. 43 and 44). Carol Primavera, of the Provider, contemporaneously documented this assurance. (Provider Exhibit P-52).

b. The Provider Submitted Adequate Documentation to Support Its Request.

The Provider contends it submitted adequate documentation in support of its request. The Provider asserts the Intermediary only needed to assure that the costs in the 1985 GME base year and the 1983 PPS and TEFRA target base year were relatively comparable. The Provider states there is no disagreement with the fact the misclassified operating costs were auditable and verifiable consistent with 42 C.F.R. '' 413.20 and 413.24 for both FYs 1983 and 1985. Furthermore, the Provider's GME Programs remained constant and consistent between the 1983 PPS base year and Provider's 1985 GME base year. (Tr. pp. 59, 123, and 162). In fact, the Intermediary through its Subcontractor made a finding of consistency with respect to the costs claimed in the I/R Cost Center between 1984 and 1985. (Exhibit P-38 & Tr. p. 123). In addition, the Provider witness testified that the same finding of consistency was made with respect to the cost claimed in the I/R Cost Center in fiscal years 1983 and 1984. (Tr. p. 123).

The Provider contends there is no question of comparability presented as to the Provider's TEFRA limit because the Provider established its distinct part psychiatric unit in 1985; and the cost impact pertaining to the Target Amount was only for FY 1986 and subsequent years. Since 1985 was both the Provider's TEFRA and GME base year, there was no need to "cross-walk" the Provider's operations from 1985 to 1983 except as to the HSR calculation. (Provider Exhibit P-30).

The Instructions (Provider Exhibit P-29), make clear HCFA's expectations of intermediaries during the course of the GME Re-Audit with respect to adjusting the HSR or Target Amount. The Instructions state at pp. 10 and 11:

> [I]n conjunction with the review of GME based period costs and the determination of each hospital's average per resident amount, Intermediaries are responsible for the following: advising the hospital of all operating costs which were misclassified as GME costs during its GME base period ... This would include all misclassified operating costs identified during a review of GME costs pursuant to these instructions ... A description of these costs is to be included in the adjustment report sent to the hospital with the notice of average per resident amount. However, auditors working on site at a hospital should advise the hospital of misclassified operating costs as soon as they are identified. This may allow the hospital to provide the auditor with documentation pertaining to its PPS/TEFRA base period, which the auditor could verify before concluding the on site review... in order to determine if an adjustment should be made to a hospital's HSR or TEFRA target rate,

> Intermediaries may use any or all of the following means: request additional documentation from the Provider; rely upon prior audit work papers; perform an on site review of the hospital's PPS or TEFRA base period records. Intermediaries should complete the reviews of the Provider's HSR and TEFRA target rate adjustment requests as soon as possible; however, in no case shall this determination be made later than the Intermediary's next regularly scheduled review of the Provider.

Id. (Emphasis added.)

The Provider states IBC, which no longer serves as an intermediary, totally failed to follow these instructions. Although the Provider protested the removal of certain costs from GME without a corresponding increase in its HSR or Target Amount, the Intermediary refused to honor the Hospital's request to make the corresponding adjustments and review. (Provider Exhibit P-5). IBC did not make the adjustments on site at a time and place where work papers and other documentation were readily available, including historic work papers that previously had been provided to the Intermediary. (The Subcontractor testified that he was in possession of these documents until 1996 when they were shipped back to the Intermediary) (Tr. p. 157). The Provider claims that: 1) IBC, in contravention of HCFA Instructions, directed its Subcontractor not to make the required adjustments; 2) IBC assured the Provider the required calculation would be performed when all appeal issues were settled. (Tr. pp. 43 and 44); 3) the Intermediary only raised the documentation issue shortly before the hearing; and 4) most of the documentation was already in the Intermediary's possession.

The Provider avers that although it should hardly have to do so at this stage, given IBC's refusal in 1990 to review the Provider's proffered FY 1983 data, the Provider submitted further evidence at the hearing that confirms the consistency in its GME programs and operating costs in fiscal years 1983 and 1985 (Provider Exhibits P-15, P-37, P-38, P-39 and P-45). The Provider further attested to such comparability between FYs 1983 and 1985 under oath at the hearing. (Tr. p. 123).

The Provider rejects the Intermediary's position that the Provider's failure to submit "supporting documentation" to the Intermediary within 180 days of the NAPRA pursuant to 42 C.F.R. '413.86(2)(ii) justified its failure to adjust the Provider's HSR and TEFRA Target Amount. The Provider avers that this claim fails entirely regarding the Target Amount. As demonstrated at Provider Exhibit P-30, the Intermediary in fact performed the calculation using documentation in its possession at the time of the GME Re-Audit; yet has failed, without any supportable reason, to make the corresponding adjustment to the Provider's reimbursement in its TEFRA base year (FY 1985) or subsequent cost years.

With respect to HSR, the Provider claims sufficient documentation in the form of work papers, ledgers and internal documents was available on site or already in the possession of the Subcontractor during the GME Re-Audit for the Intermediary to respond to Provider's requests for adjustments to the HSR

and to assure itself of consistency between the GME base year and the PPS base year. The Intermediary's insupportable position is that the Provider is trying to shift the burden of documentation to the Intermediary. To the contrary, it is the Intermediary that failed to follow the HCFA instructions quoted above, and to make the necessary adjustments within the prescribed time period (i.e. no later than the next regularly scheduled review by the Intermediary).

In light of IBC's failure to make the necessary adjustments as contemplated by the Instructions, even when documentation from both the GME and PPS base year was most readily available, the Provider properly appealed the Intermediary's determination to the Board. In support of its claim, the Provider has "crosswalked" each disputed adjustment made in the course of the GME Re-Audit to demonstrate that the classification of such costs was consistent in both the GME base year and the PPS base year, supplying supporting work papers with as much detail as possible even these many years following the original audits and required record retention period. (Provider Exhibit P-39). Moreover, such a demonstration was hardly necessary when the Intermediary itself made the same finding in the course of its FYs 1985 and 1984 audits.

The Intermediary's assertion that the regulations require that documentation be formally submitted to the Intermediary within 180 days, as a precondition to making the HSR adjustments, is inconsistent with the decision in Hospital of Saint Raphael, PRRB Dec. No. 97-D68 June 19, 1997 Medicare & Medicaid Guide &45,454, Rev'd HCFA Adm'r. Dec. August 13, 1997 Medicare & Medicaid Guide &45,723. (Provider Exhibits P-40 and P-41). The Board found in Saint Raphael that documentation regarding consistency in the GME and PPS base years in support of an adjustment to the HSR may be submitted at the Board hearing which will satisfy the sufficient documentation requirement. The Intermediary in that case was ordered to audit such costs and to adjust the HSR, despite the Intermediary's assertion that 42 C.F.R 413.86(j)(2) required that such documentation be supplied within 180 days of the NAPRA. The Board found that the regulatory requirement of 180 days applies only in cases in which an Intermediary would make the requested adjustment. See also Harrisburg Hospital v. BCBSA, PRRB Dec. No. 96-D9 Feb. 15,1996 Medicare & Medicaid Guide &44,058, rev'd HCFA Adm'r. Dec. (April 18, 1996) Medicare & Medicaid Guide &44,419, Medical Center of Vermont v. BCBSA, supra, Fletcher Allen Healthcare Inc. v. Shalala, 2 F. Supp. 2d 313 (D.VT 1998). (the PRRB did not find the 180 day time period determinative in allowing an adjustment to GME for misclassified costs). (Provider Exhibits P-33, P-34, P-35, P-36 and P-30).

INTERMEDIARY=S CONTENTIONS:

The Intermediary contends that the written requests did not contain any documentary evidence, much less to demonstrate that an adjustment was warranted, as required by the regulations. The Intermediary acknowledges that the Provider=s request made various assertions together with a computation of the mathematical impact; but the Intermediary asserts the computation was not supported by any

documentation. The Intermediary contends the request was only an allegation with no support. At best, it was an arbitrary speculation of the reimbursement impact which had no factual basis, and it was an attempt to improperly shift the responsibility to the Intermediary. The Intermediary simply states the Provider failed to supply any documentation to support its request for a revision of the subject rates.

The Intermediary also submitted an affidavit (Intermediary Exhibit I-7) of its Director and Manager of Medicare Hospital Payment and Audit Department that refutes all the Provider=s allegations on this issue. The Director states: 1) in paragraph 15, that "... the Provider has never submitted to anyone , either at the Board or at the Intermediary, the sufficient documentation required ... ."; 2) in paragraph 17, "that the August 26, 1991 letter is really a request for " consistency adjustments" under 42 C.F.R. ' 413.86(j)(1) rather than a reclassification adjustment under 42 C.F.R. ' 413.86 (j)(2), which has never been made;" and 3) in paragraph 19, that a) the Intermediary has never refused to make a reclassification adjustment because no formal request has been made, and b) that if the August 26, 1991 letter could be construed as a reclassification request, it does not have adequate supporting documentation as required by the regulations.

The Intermediary states this case is similar to the Harrisburg Hospital v. Blue Cross and Blue Shield Association/Blue Cross of Western PA, PRRB Case No. 96-D9, February 15, 1996, Rev=d by the HCFA Adm=r Dec., April 18, 1996. (Intermediary Exhibits I-14 and I-15). In that case, a timely request for reclassification was made, but inadequate documentation had been submitted.

The Intermediary concludes that the Provider=s failure to submit adequate documentation as required by the regulations under 42 C.F.R. ' 413.86(j)(2) substantiates its determination not to revise either the HSR or the target rate.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law-42 U.S.C.

' 1395h (' 1816 of the Act)	-	Use of the Public Agencies or Private Organizations to Facilitate Payment to Providers of Services
' 1395x(v)(1)(A) (' 1861 (v)(1)(A) of the Act)	-	Reasonable Costs
' 1395oo (' 1878(a) of the Act)	-	Provider Reimbursement Review Board

' 1395ww et seq. (' 1886 et seq. of the Act)	-	Payments for Direct Medical Education Costs

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

' 405.481	-	Allocation of Physician Compensation Costs
' 405.481 (g)	-	Record Keeping Requirements
' 405.1835-.1841	-	Board Jurisdiction
' 405.1841	-	Time, Place, Form and Content of Request for Board Hearing
' 405.1855	-	Evidence at Board Hearing
' 405.1867	-	Source of Board=s Authority
' 405.1869	-	Scope of Board=s Decision-Making Authority
' 405.1885	-	Reopening a determination or decision
' 412.113(b)(3)	-	Other Payments-Direct Medical Education Costs
' 413.20	-	Financial Data and Reports
' 413.24	-	Adequate Cost Data and Cost Finding
' 413.85 et seq	-	Cost of Educational Activities
' 413.86 et seq.	-	Direct Graduate Medical Education Payments

' 413.86 (e) et seq	-	Determining Per Resident Amount for the Basic Period - Appeals Rights
' 413.86 (j) et seq.	-	Adjustment of a Hospital=s Target Amount or Prospective Payment Hospital-Specific Rate-Misclassified Costs

3. Other:

54 Fed. Reg. 40302 (Sept. 29, 1989)
55 Fed. Reg. 36063 (Sept. 4, 1990)
55 Fed. Reg. 36064 (Sept. 4, 1990)

4. Cases:

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

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

Tulane Educational Fund v. Shalala, 987 F.2d 790 (1993), cert. denied 510 U.S. 1064 (1994).

Regions Hospital v. Shalala, 1998 W.L. 71823 (U.S. Feb. 24, 1998).

Presbyterian Medical Center of Philadelphia v. Aetna Life Insurance Companies, PRRB Dec. No. 95-D41, June 15, 1995, Medicare and Medicaid Guide & 43,487. Rev=d, HCFA Adm=r Dec., Aug. 7, 1995, Medicare and Medicaid Guide & 43,691.

St. Mary=s Hospital vs. Blue Cross and Blue Shield Association, PRRB Dec. No. 99-D13 Dec. 1, 1998 Medicare & Medicaid (CCH) &80,150, Rev=d HCFA Adm. Dec. (Feb. 2, 1999) Medicare & Medicaid Guide &80,170.

Fletcher Allen Health Care, Inc. v. Shalala, 2 F. Supp. 2d 313 (D.C. Vt. 1998).

Medical Center Hospital of Vermont v. Blue Cross and Blue Shield Association, PRRB Dec. No. 97-D27, (Jan. 30, 1997) Medicare & Medicaid Guide & 45,034 mod=d in part HCFA Admin. Dec. (March 31, 1997), Medicare & Medicaid Guide &45,232.

Hospital of Saint Raphael, PRRB Dec. 97-D68 June 19, 1997 Medicare & Medicaid Guide &45,454 Rev=d HCFA Adm=r Dec. (Aug. 13, 1997) Medicare & Medicaid Guide &45,723.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of the facts, parties contentions, evidence presented, testimony elicited at the hearing and post hearing submission, the Board finds and concludes that although the Provider made a timely request for reclassification of misclassified operating costs to GME costs, there was not sufficient documentation to support the request.

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

Once the intermediary computes a per resident amount which it believes is correct, the intermediary formalizes its final determination through the issuance of a NAPRA. Upon receipt of this notification, a provider=s right to appeal the intermediary=s NAPRA arises under 42 U.S.C. '1395oo, and is provided for in 42 C.F.R. ' 413.86(e)(1)(v). Under the provisions set forth in 42 C.F.R. ' 413.86(e)(1)(v), a provider may appeal the NAPRA determination within 180 days of the date of the notice.

Th Board makes the following findings:

Issue No. 1 - Misclassified GME costs:

1. Mercy Catholic Medical Center (the AProvider@) is a hospital provider with a distinct part psychiatric unit.

2. Independence Blue Cross (the AIntermediary@) audited and certified Provider=s cost report for fiscal year 1985.

3. The Congressional intent expressed in the statute and as promulgated in new GME regulations required the GME Re-Audit to determine as accurately as possible the Provider=s Allowable Average Cost Per Resident (AAPRA@) in the GME base year.

4. The statute and the preamble state that any misclassified GME costs are to be corrected. This permitted a " two way street" of changing erroneously claimed GME costs to operating costs (" OC") and vice versa, i.e., to change erroneously claimed OC to GME costs.

5. In 1990, the Intermediary performed a re-audit of Provider=s graduate medical education (" GME") costs for fiscal year 1985 (the " GME Re-Audit").

6. During the GME Re-Audit, the Intermediary reclassified costs, found to be misclassified as GME in fiscal year 1985, as operating costs.

7. No adjustments were made by the Intermediary to Provider=s hospital specific rate ("HSR") and TEFRA target amount ("Target Amount") as a result of costs that were reclassified from GME to operating costs.

8. HCFA allowed Provider=s documentation from cost periods subsequent to the base year (ie., the 1990 Time Studies) in support of allocation of expenses in the GME base period to accurately determine APRA.

9. The Provider prepared time studies for all physicians including OB/GYN, Laboratory and Radiology physicians (the "1990 Time Studies").

10. The Intermediary used the Provider=s 1990 Time Studies to reduce GME costs.

11. In fiscal year 1985, the Provider conducted GME teaching programs in its OB/GYN, Laboratory, and Radiology Departments.

12. Through the original 1985 audit, the Intermediary=s NPR determined that all claimed costs were allowable and reasonable.

13. During the GME Re-Audit, the Provider performed a crosswalk from 1985 to 1990 with respect to all physicians for whom the Provider performed the 1990 Time Studies and claimed GME costs (including OB/GYN, Laboratory and Radiology Physicians.)

14. Pursuant to 42 C.F.R. ' 413.86(e) and (j), HCFA made it clear that both over and under misallocations to GME could be corrected during the GME Re-Audit.

15. The HCFA instructions reinforced this concept; however, an addendum consisting of questions and answers was incorrectly interpreted by the Intermediary as meaning that no new GME costs could be added by the re-audit from OC.

a. The Intermediary, IBC, wrongfully instructed the audit subcontractor not to increase the GME costs by reclassifying any misclassified OC.

16.

1. There was insufficient evidence in the record for the Board to reclassify any OC costs to the GME cost center.

2. Specifically, there was insufficient evidence regarding forms 339 and physician allocation agreements.

3. The Board does notes that there were unaudited 1990 time studies available in the record.

Issue No. 2 - Revision of HSR/TEFRA Target Amount:

The Board finds the record in this case is incomplete as to whether adequate information was ever presented in writing to the Intermediary as required by the regulations.

1. The Provider made a timely request for a review of the misclassified GME costs and a revision of its HSR and TEFRA target amount.

2. (a) This request showed Aenclosures@ were submitted; but such documentation was never specifically identified in the record. (b) The declarations (at Provider Exhibits P-5 and P-15) indicated the enclosures probably were the letters identified in Provider Exhibit P-4.

3. The second letter in Provider Exhibit P-4 pre-dates the official request, and does request reclassification of additional Ateaching costs@ which would encompass physician compensation support cost, and overhead costs. Attached thereto was a schedule of Aadditional GME physician costs requested@ which listed and named physicians, their compensation, hours, and percentage. There were no extensions of the additional amounts, or any totals.

4. Despite testimony that evidence of the reclassification amounts were submitted both verbally and in writing to the Intermediary, the only written evidence found was Provider Exhibit P-51 which was submitted in January 1992, considerably after the regulatory 180-day time requirement.

5. The subcontractor testified it had received adequate information for such revisions to the HSR/TEFRA target amount; but this was not part of, and hence, beyond the scope of, its authority. Such information had to be made directly to the Intermediary.

The Board concludes that:

Issue No. 1 - Intermediary=s failure to recognize and reclassify certain operating costs as graduate medical education (AGME@) costs.

Although the subcontractor and Intermediary did not follow the provisions of the Medicare statute, regulation (preamble), and GME re-audit instructions which permitted misclassified GME costs to be corrected, there is no evidence in the record permitting a correction by the Board.

There is no creditable evidence in the record to reclassify the misclassified OC to GME costs because of the lack of form 339's and the fact that the 1990 time studies were not audited by the Intermediary nor is there adequate documentation in the record regarding these time studies.

Issue No. 2 - Revision of HSR/TEFRA Target Amount:

Based on the findings above, the Intermediary is not required to make any revision in the HSR or TEFRA Target Amount.

DECISION AND ORDER:

Issue No. 1 - Intermediary=s failure to recognize and reclassify certain operating costs as graduate medical education (AGME@) costs.

The Intermediary=s refusal to reclassify the physician compensation and related secretarial and support staff costs in three GME departments originally classified as non-GME costs can not be changed based upon the lack of evidence in the hearing=s record. The Intermediary=s GME determinations stand.

Issue No. 2 - Revision of HSR/TEFRA Target Amount

The Intermediary is not required to make any revision in the HSR or TEFRA Target Amount.

BOARD MEMBERS PARTICIPATING:

Irvin W. Kues
Henry C. Wessman, Esquire

Stanley J. Sokolove

Date of Decision: September 28, 2001

FOR THE BOARD

Irvin W. Kues
Chairman