PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2000-D39

PROVIDER -
Fairfax Hospital
Falls Church, Virginia

Provider No. 49-0063

vs.

INTERMEDIARY -Blue Cross and Blue Shield Association/ United Government Services

DATE OF HEARING-
October 1, 1999

Cost Reporting Periods Ended -
December 29, 1984
December 31, 1986
December 31, 1988, 1989 & 1990

CASE NO. 91-2592M
94-0951
94-0952
94-0953
94-1386

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ISSUES:

1. Whether the Intermediary properly omitted all of the pathology teaching costs incurred in the Graduate Medical Education ("GME") base year from the GME costs used to compute the Provider's average per resident amount ("APRA")?

2. In the alternative, whether the Intermediary properly included the 4.42 full-time equivalent ("FTE") residents who worked in the approved pathology program during the GME base year in the resident count used to compute the APRA?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Fairfax Hospital ("Provider") is a non-profit, general, short-term, teaching hospital located in Falls Church, Virginia. The issues appealed by the Provider arise from the Intermediary's[1] issuances of the Notices of Average Per Resident Amounts ("NAPRA") for each of the fiscal years ("FYs") in contention. In addition to the appeal of the 1984 GME base year under Case No. 91-2592M, the Provider has appealed the same issues for subsequent cost reporting periods as follows: FY 1986 Case No. 94-0951; FY 1988 - Case No. 94-0952; FY 1989 - Case No. 94-0953; and FY 1990 - Case No. 94-1386. In each of the appeals for the subsequent fiscal years, the Provider seeks only to have the results of the final administrative or judicial decision entered for the GME base year appeal applied as well to the calculation of the GME payments to the Provider for the subsequent cost reporting periods.

The Provider appealed the Intermediary's NAPRA determinations to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§405.1835-.1841 and has met the jurisdictional requirements of those regulations. The Medicare effect of the Intermediary's determination for the 1984 GME base year is approximately $125,000. The amount of Medicare reimbursement in controversy for the four subsequent fiscal years appealed by the Provider averages approximately $215,000 per year. The Provider was represented by Christopher L. Keough, Esquire, of Powers, Pyles, Sutter & Verville, P.C. The Intermediary's representative was Bernard M. Talbert, Esquire, of the Blue Cross and Blue Shield Association.

During its GME base year under appeal, fiscal year ended December 29, 1984, the Provider was reimbursed under the Medicare program's prospective payment system ("PPS"), under which it received payment for non-GME inpatient operating costs based on prospectively determined rates.

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[1] The Intermediary for this case is the Blue Cross and Blue Shield Association and its sub-contracting plan. The initial subcontracting plan which issued the NAPRAs for the years in contention was Blue Cross and Blue Shield of Virginia. In 1995, Trigon Blue Cross and Blue Shield replaced Blue Cross and Blue Shield of Virginia. The formal name of the subcontracting plan currently responsible for the cases in this decision is United Government Services.

Under PPS, reimbursement is based on prospectively determined national and regional rates for each patient discharge, rather than on the basis of reasonable operating costs. The PPS system for non-GME operating costs was phased in over a four year transition period, during which Medicare payments were made according to a "blended rate" that consisted of two components. The hospital-specific rate component reflected the hospital's costs experienced during a base-year period, while the Federal PPS rate component reflected regional and national standardized amounts. The Provider's PPS base year was its cost reporting period ended December 31, 1982.

For PPS cost years beginning prior to July 1, 1985, payments for approved GME costs were maintained as pass-through payments, and continued to be reimbursed under the Medicare program's reasonable cost principles. In order to insure that hospitals did not receive double reimbursement for costs that were initially used to determined the hospital-specific rate by subsequently reclassifying such costs as GME costs, the Health Care Financing Administration ("HCFA") adopted a "consistency rule" which required hospitals to determine their GME costs
throughout the PPS transition period in a manner consistent with the treatment of these costs in the PPS base year for purposes of determining the hospital-specific rate. Under the consistency rule set forth in 42 C.F.R. § 412.113(b)(3), costs were frozen to the specific classification adopted by the hospital during the PPS base year.

In April of 1986, Congress established a new payment policy for direct medical education costs for cost reporting periods beginning on or after July 1, 1985, pursuant to 42 U.S.C. § 1395ww(h).[2] Under the new methodology, Medicare pays a hospital-specific resident amount for GME activities which is determined based on a provider's average GME cost during the Federal fiscal year ended September 30, 1984 (GME base year). HCFA implemented the statute by promulgating the regulations at 42 C.F.R. § 413.86 et seq., which included a provision requiring intermediaries to reaudit and verify the accuracy of GME base year costs and to exclude any nonallowable or misclassified costs. If a hospital's GME base-year cost report was not subject to reopening after the three-year period provided under 42 C.F.R. § 405.1885, the intermediary could modify base -year costs on reaudit solely for the purpose of computing the per resident amount, but could not adjust the amount of program reimbursement for the GME base year.

In addition to providing for the reaudit of the GME base year for purposes of determining the APRA, the regulation at 42 C.F.R. § 413.86(e)(1)(ii) also provided for adjustments of a provider's TEFRA target amount or hospital specific rate ("HSR") to account for misclassified GME costs in the TEFRA/PPS base year. Further, the provisions of 42 C.F.R. §413.86(e)(1)(ii)(C) specify that these costs may be included only if the hospital requests an adjustment of its TEFRA target amount or PPS HSR as described in 42 C.F.R. § 413.86(j)(2). With respect to the documentation necessary to support a hospital's GME base-year costs, HCFA would not apply new reimbursement principles

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[2] Section 9202 of the Consolidated Omnibus Budget Reconciliation Act ("COBRA") of 1985, Pub. L. No. 99-272, as amended.

during the reaudit but would make a determination consistent with requirements under reasonable cost reimbursement and the general statutory scheme of the Medicare program.

In order to provide the Board with a clear understanding of the material facts pertaining to the issues in dispute, the parties executed the following joint stipulations:

Stipulations of the Parties

The Provider, Fairfax Hospital, and the Intermediary, Blue Cross and Blue Shield Association and its subcontracting plan, Trigon Blue Cross and Blue Shield, hereby stipulate and agree as follows:

1. The Provider contests two issues involving the Intermediary's determination of the Provider's average per resident amount ("APRA") for purposes of the prospective payment method for graduate medical education ("GME") established under Section 1886 (h) of the Social Security Act. The APRA was determined by the Intermediary in a final Notice of Average Per Resident Amount ("NAPRA") issued to the Provider on February 26, 1992.

2. The issues involve the omission of the teaching physician compensation costs and the administrative support costs attributable to teaching and supervision of residents in the Provider's approved residency training program in Pathology during its GME base year, the fiscal year ending December 31, 1984. Those portions of the total physician compensation costs and the administrative support costs of the Department of Pathology costs are referred to below as the "Pathology teaching costs."

3. Specifically, the issues in this appeal are:

   (1) Whether the Intermediary properly omitted all of the Pathology teaching costs incurred in the GME base year from the GME costs used to compute the APRA; and

   (2) In the alternative, whether the Intermediary properly included the 4.42 full-time equivalent ("FTE") residents who worked in the approved Pathology program during the GME base year in the resident count used to compute the APRA.

4. The Pathology teaching costs incurred by the Provider during its prospective payment system ("PPS") base year, the fiscal year ending

December 31, 1982, were included in the Provider's Laboratory cost center and classified as an operating cost.

5. Under the consistency rule in effect during the GME base year, 42 C.F.R. § 412.113(b) (1985), the Pathology teaching costs had to be, and were, also classified as operating costs for the GME base year.

6. The costs incurred by the Provider during the GME base year in connection with other approved residency programs were claimed and allowed as GME costs on the original audited cost report for that period. Those costs included $121,419 of salary expense the Provider paid to family practice residents, $569,721 of compensation the Provider paid to teaching physicians for Part A Services, $42,231 of malpractice costs incurred by the Provider, $1,978,334 of payments made for residents' salary expenses and other administrative costs associated with residency programs operated jointly by the Provider and two other teaching hospitals in the area, and $331,869 in clerical salary expenses and other administrative costs incurred by the Provider in connection with the approved residency programs other than Pathology.

7. In 1990, the Intermediary began a reaudit of the Provider's base year GME costs solely for the purpose of computing its APRA. At that time, the Provider did not have physician time allocation records for the GME base year. The GME base year was no longer subject to reopening under 42 C.F.R. §405.1885. In addition, the four-year record retention period for physician time allocation records, 42 C.F.R. § 405.481 (1985), expired on December 31, 1988.

8. In connection with the GME reaudit, the Provider conducted a three-week time study in 1990 for the purpose of determining the proportion of physician compensation cost that should be classified as GME cost in the calculation of the Provider's APRA. In addition, in compliance with the requirements of 42 C.F.R. §§413.86 (e) (1) (ii) (C) and (j) (2) (i) - (ii), the Provider timely requested a reclassification of the Pathology teaching costs that were misclassified as operating cost for the GME base year and the PPS base year, for the purposes of both computing its APRA and adjusting its PPS hospital-specific rate. The Provider's request was accompanied by documentation meeting the requirements of 42 C.F.R. § 413.86 (j) (2) (ii).

9. The Intermediary accepted the three-week time study for the purpose of determining the proportion of teaching physician compensation cost and administrative support costs attributable to teaching and supervision of residents in all approved programs of the Provider, other than Pathology, during the GME base year. As a result, the Intermediary reduced the amounts of physician compensation costs and administrative support costs that were classified as GME and attributed to teaching and supervision of residents in those programs for the GME base year. Specifically, the Intermediary reclassified $286,020 of physician compensation cost from the GME cost center to other operating cost centers in adjustment number 5 on the adjustment report accompanying the Intermediary's determination of the Provider's APRA, and also reclassified $78,496 of administrative support costs from the GME cost center to other operating cost centers in adjustment number 6 on that adjustment report.

10. With respect to the Pathology program, the physician time studies conducted by the Provider in fiscal years 1989-1995, copies of which are included in Provider Exhibits 6-12, reflect that the teaching physicians in the Department of Pathology spend an average of 30% of their time teaching or supervising residents in the approved Pathology program. These physician time allocation records are auditable and verifiable documentation for the Pathology teaching costs attributable to GME for fiscal years 1989-1995. In addition, the average teaching percentage (30%) reflected on those physician time allocation studies is an accurate and reliable proxy for the percentage of the total physician compensation costs and administrative support costs incurred by the Department of Pathology during the GME base year. There is no dispute that the Provider's Pathology program was accredited during the GME base year, that teaching physician supervision and instruction of the residents was an essential requirement for accreditation of the Pathology program, and that the Provider employed teaching physicians in the Department of Pathology during the GME base year. Further, the parties agree that the size and structure of the Pathology residency program remained consistent from 1984 to 1990. The numbers of teaching physicians employed in the Department of Pathology and FTE residents employed in the Pathology program did not change significantly from 1984 to 1990. The number of teaching physicians decreased by only one from 1984 to 1990, and six of the ten physicians employed in the Department of Pathology in 1990 were also employed in the Department in 1984. In addition, the number of

residents employed in the Pathology program was consistently in the range of 4 to 5 FTE residents.

11. Nevertheless, the Intermediary believes that it lacks the authority to reclassify any portion of the Provider's Pathology teaching costs as GME for the GME base year because it is bound by a policy established by the Health Care Financing Administration in 1990, stating, in pertinent part:

> As an equitable solution to the problem of the nonexistence of physician allocation agreements, time records, and other information, we are allowing providers to furnish documentation from cost reporting periods subsequent to the base period in support of the allocation of physician compensation costs in the GME base period. . . . In 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 determined the per resident amounts.

55 Fed. Reg. 36063-64 (September 4, 1990).

12. The Provider contends that the policy quoted above is inapplicable here and that it is arbitrary and capricious and otherwise contrary to law as applied in this case. The Provider submits that 30% of the total physician compensation cost ($333,283) and 30% of the total administrative support cost ($218,211) that were claimed in the Provider's Laboratory cost center for the GME base year and are classified as allowable operating costs of the Department of Pathology for the GME base year should be reclassified as GME costs and included in the GME costs used to compute the Provider's APRA. This would offset the Intermediary's reclassification of physician compensation costs from the GME cost center to various operating cost centers in adjustment number 5 by $99,985 (i.e., $333,283 x .30), thus reducing the reclassification from $286,020 to $186,035. It would also offset the Intermediary's reclassification of administrative support costs from the GME cost center to operating cost centers in adjustment number 6 by $65,463 (i.e., $218, 211 x .30), thus reducing the Intermediary's reclassification from $78,496 to $13,033. The parties agree that if these Pathology teaching costs are reclassified as GME cost for the purpose of determining the Provider's APRA, then 30% of

the total physician compensation cost and the total administrative support cost incurred by the Department of Pathology and claimed in the Laboratory cost center for the PPS year should be reclassified as GME cost for that year and a corresponding adjustment should be made to the Provider's PPS hospital - specific rate.

13. In the alternative, the Provider submits that if the Intermediary's application of the above-quoted policy is upheld here, then the 4.42 residents who worked in the Pathology program during the GME base year should be removed from the count of FTE residents used to compute the Provider's APRA for the GME base year. The Provider submits that the omission of the Pathology teaching costs from the GME costs used to compute the APRA and the inclusion of the Pathology residents in the FTE residents count used to compute the APRA is arbitrary and capricious, contrary to the intent of Section 1886 (h) of the Act and otherwise contrary to law. The Intermediary believes that it lacks the authority to remove the Pathology residents from the FTE residents count for the GME base year because 42 C.F.R §413.86 (e) (1) (i) (B) requires the Intermediary to include the "FTE residents working in all areas of the hospital complex" for the GME base year.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's determination of its APRA is fundamentally wrong because it excluded all of the pathology teaching physicians' compensation costs and the administrative support cost attributable to an approved residency training program from the computation of the APRA. This problem is further compounded by the inclusion of the pathology residents' time in the FTE resident count in the denominator of the APRA calculation. As to the first issue concerning the exclusion of pathology teaching costs from the GME costs included in the numerator of the APRA calculation, the Provider notes that the Intermediary relies solely on HCFA's 1990 policy regarding the use of subsequent-period records to support physician compensation costs attibutable to GME for the base year. The Intermediary believes that the 1990 policy precludes it from including such costs unless the Provider can produce physician time allocation records from the 1984 base year. The Provider argues that the Intermediary's determination is invalid as a matter of law, and cites six independent reasons as to why the 1990 policy cannot be sustained.

First, the Provider contends that the application of HCFA's 1990 policy constitutes the impermissible retroactive application of rules that were not in effect during the GME base year. Neither the Physician allocation agreements prescribed on HCFA Form 339, nor any other regulation or instruction in place during the base year, required providers to maintain contemporaneous physician allocation records to support the allocation of physician compensation to GME. The applicable 1984 regulations at 42

C.F.R. § 405.481 did not require providers to maintain information supporting such allocations on a contemporaneous basis. Moreover, the 1983 preamble to that regulation stated that the allocation should be based on a reasonable estimate, and that historical records are appropriate for this purpose.[3] Further, the HCFA Form 339 did not require the use of current physician time allocation records but, rather indicated that estimates or other information sufficed.[4] Furthermore, the instructions at § 2182 ff of the Provider Reimbursement Manual ("HCFA Pub. 15-1") allow for allocations based on experience in other hospitals instead of documentation of actual time spent by physicians furnishing various activities to the hospital.[5] The Provider concludes that HCFA's 1990 policy conflicts both with the cost reimbursement principles in effect during the GME base year and with the four-year record retention requirement prescribed by 42 C.F.R. §405.481(g)(3) (1985). Additionally, the impermissible retroactive application of rules is also supported by the court decisions in Bowen v. Georgetown Univ. Hosp., 488 U.S. 204 (1988) and University of Iowa Hospitals & Clinics v. Shalala, 180 F. 3d 943 (8th Cir. 1999).

Second, the Provider argues that the application of HCFA's 1990 policy violates the public protection provisions of the Paperwork Reduction Act, 44 U.S.C. § 3512.[6] This act prohibits a federal agency from imposing a penalty upon, or withholding a benefit from, any person who fails to comply with a collection of information, including a record-keeping requirement, that has not been approved by the Office of Management and Budget ("OMB"). HCFA submitted to OMB, and OMB approved, a four year record retention period for information supporting allocations of physician compensation. Therefore, absent approval by OMB, HCFA's requirement that the Provider produce 1984 physician time allocation records to determine an APRA based upon a 1990 reaudit of the base year cannot be applied in a manner that penalizes the Provider or deprives it of the benefit of an accurate APRA. Due to HCFA's lengthy delay in promulgating the implementing regulations, the regulatory time period for retaining supporting documentation expired long before the reaudit was conducted. Since its failure to comply with an unauthorized record retention requirement may not be grounds for withholding a benefit or imposing a penalty, the Provider believes that HCFA must instead permit the Provider to prove the pathology teaching costs attributable to GME in some other reasonable manner. The requirement for contemporaneous time records is not a reasonable means, and the best the Provider could hope for was to use subsequent-year records to keep the physician compensation costs that had already been recognized as reasonable GME costs through the original audit of the base year cost report. However, under HCFA's 1990 policy, the Provider could not add to its GME base year costs, but could only have the physician compensation costs reduced for each department. The inequity of this policy is exacerbated by the fact that the reason the pathology teaching costs were not classified as GME on the

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[3] See Provider Exhibit P-18.

[4] See Appendix H to Provider's Post Hearing Brief.

[5] See Appendix I to Provider's Post Hearing Brief.

[6] See Provider Exhibit P-16.

base year cost report was that the Provider complied with HCFA's consistency rule that was ultimately repealed for purposes of the base year reaudit. Because the Provider had reported its pathology teaching costs as operating costs in its PPS base year, HCFA's consistency rule precluded it from reporting those costs as GME costs in 1984. Absent contemporaneous time records that were not even required in 1984, the Provider believes the Intermediary's position that it must live with the misclassification ad infinitum is an unjust and absurd result that cannot be sustained.

Third, the Provider contends that the application of HCFA's 1990 policy conflicts with the GME statute's requirement that the Intermediary and HCFA must calculate an accurate APRA. It is undeniable that the Provider incurred Medicare allowable and reimbursable pathology teaching costs during the base year. In support of this argument, the Provider cites the circuit court's decision in Administrators of Tulane Educational Fund v. Shalala, 987 F. 2d 790, 792 (D.C. Cir. 1993),[7] ("Tulane") wherein the court observed that "Congress would not likely have wished misclassified. . . costs inadvertently [excluded from GME costs] for the fiscal year 1984 to be "cemented into the base year amount and indefinitely carried forward in the formula for further reimbursement." The court further noted that "the statute directs the [HCFA] to 'determine' the 'average amount' of GME costs per FTE resident recognized as reasonable." The court also indicated that " [t]his activist language" insures accuracy by allowing "elbow room for adjustments based on prior miscalculations or errors." The Provider proclaims that the Intermediary's position erroneously "cements" prior misclassified costs in future GME payments, and should be rejected.

Fourth, the Provider contends that the application of HCFA's 1990 policy violates the statutory proscription against cross-subsidization because it results in no reimbursement for allowable pathology teaching costs. The requirement that the Intermediary determine the Provider's APRA based upon the "reasonable" GME costs incurred in the base year incorporates the reasonable cost standard established under 42 U.S.C. § 1395x (v)(1)(A). The application of the 1990 policy requires the exclusion of all of the pathology teaching costs from the GME costs used to compute the APRA, while all of the pathology teaching costs are also excluded from the standardized PPS rates paid to providers for operating costs of inpatient hospital services furnished after 1988. As a result, application of the 1990 policy precludes Medicare payment for any of the Medicare reimbursable and allowable pathology teaching costs incurred after 1988. In the instant case, there is no "federal" component of the APRA since it is entirely a hospital - specific rate, which presently excludes the pathology teaching costs. This leads to a impossible result in which the Provider cannot be reimbursed for costs that are clearly allowable . Consequently, the Intermediary's application of the 1990 policy violates the Medicare Act because it necessarily shifts the pathology teaching costs incurred in all years since 1988 to non-Medicare patients.

Fifth, the Provider argues that the application of the 1990 policy is arbitrary and capricious because it irrebuttably presumes that no pathology teaching costs were incurred in the 1984 GME base year despite the undisputed evidence and stipulated facts in this case. HCFA's 1990 policy places the

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[7] See Appendix B to Provider's Post Hearing-Hearing Brief.

burden of proving otherwise on the Provider, while simultaneously prohibiting the Intermediary from considering the Provider's undisputed evidence. Accordingly, application of the 1990 policy renders the Provider's right to appeal the APRA calculation meaningless because contemporaneous physician time allocation records from the base year were not required, and were not required to be available by the time HCFA implemented the 1986 GME statute. The Provider notes that the requirement to make an impossible factual showing was flatly rejected in the court's decision in Atlanta College of Medical and Dental Careers, Inc v. Riley, 987 F.2d 821 (D.C. Cir. 1993).[8]

Sixth, the Provider points out that, even assuming arguendo that the 1990 policy is valid, it does not apply in this case. The 1990 policy precludes only the use of subsequent-year records to increase or add physician compensation costs to the amount used to determine the per resident amount. The Provider asserts that its pathology teaching costs were claimed and reimbursed as operating costs during the 1984 GME base year in compliance with the consistency rule in effect at that time. The Provider only seeks to use the later-year records to verify the costs it claimed on the base year cost report, not to add to those costs. The only issue created by the Provider's request for adjustment is how much the Intermediary ultimately will have subtracted from the GME costs used to compute the APRA on the basis of subsequent-period records. Moreover, the parties have stipulated that reclassifying the pathology teaching costs would merely offset the Intermediary's reclassification of physician compensation costs and administrative support costs from the GME cost center that has already occurred. Since the use of later-year records sought by the Provider does not add to, or increase, the physician compensation costs used to compute the APRA, the 1990 policy does not apply.

Regarding the second issue, the Provider alternatively argues that, if the pathology teaching costs are to be excluded from the numerator of the APRA calculation, then the pathology residents must be excluded from the denominator. In order to bear any semblance to reality, the costs included in the numerator of the equation must be reasonably matched with the number of residents included in the denominator. In this case , the Intermediary excluded all of the pathology teaching costs from the numerator of the APRA calculation, but included the entire FTE number of pathology residents in the denominator. This calculation improperly dilutes the resulting average such that it does not accurately reflect the actual average per resident costs the hospital incurred during the base year, and undermines the averaging principle set forth under 42 U.S.C. §1395ww(h)(2)(A). The Provider cites the Eleventh Circuit Court's decision in Charter Peachford Hosp. v. Bowen, 803 F.2d 1541 (11th Cir. 1986),[9] wherein the court reversed HCFA's attempt to exclude adolescent educating costs from the pool of costs apportioned to Medicare on the basis of an average cost per diem. In that decision, the court explained:

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[8] See Appendix E to Provider's Post Hearing Brief.

[9] See Appendix F to Provider's Post-hearing Brief.

> The averaging technique is meant to work out fairly for the individual providers. Individual exclusion of the cost of services not used by Medicare beneficiaries , would destroy the balance upon which the regulatory averaging principle depends. . . .

The Provider contends that, to maintain the balance contemplated by the statute, either pathology teaching costs must be included in the numerator, or the pathology residents' salaries must be excluded from the numerator and their time must be excluded from the denominator. Absent such an adjustment, the calculation of the APRA violates the averaging principle employed by the statute, and cannot be sustained. The Provider requests that the Board order the Intermediary to issue revised NAPRAs calculated in accordance with its decision and make prompt payments of the additional amounts due the Provider for each of the fiscal years under appeal.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that it was correct in not reclassifying the pathology teaching physicians' costs into the GME cost center for the years in contention. During the reaudit of the GME base year cost report data, the Intermediary determined that costs associated with physicians and support services in the pathology department cost center were included in the laboratory department cost center, and that this treatment was consistent with the handling of such costs in prior years' cost reports.

The Intermediary notes that the Provider was unable to produce documentation to support the allocation of the pathology physicians' costs in any department as required under 42 C.F.R. §405.481. Under this regulation, providers claiming reimbursement for the compensation of physicians must be able to document the allocation of that cost among all of the services furnished by the physicians. Further, the documentation supporting the allocation must be current, auditable, and retained by the providers for at least four years from the end of the cost reporting period to which the allocation applies. At the time of the GME audit, the Provider did not have the actual 1984 documentation needed to support the allocation of physicians' costs to the teaching activities in the GME cost center. In the absence of such supporting documentation, the Provider requested permission to use a subsequent period time study (July, 1990) in support of the allocation of GME costs.

In view of the time lapse between the GME base year and the GME base year audits, HCFA recognized that providers may have a legitimate reason for not having sufficient auditable documentation available to support the allocation of physician compensation in the base year cost reports due to the expiration of the four-year record retention period. In the September 4, 1990 Federal Register,[10] HCFA stated the following:

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[10] See Intermediary Exhibit I-11.

> As an equitable solution to the problem of the nonexistence of physician allocation agreements, time records, and other information, we are allowing providers to furnish documentation from cost reporting periods subsequent to the base period in support of the allocation of physician compensation costs in the GME base period.

55 Fed. Reg. 36063.

In accordance with the above-stated HCFA policy, the Intermediary approved the use of the July, 1990 time studies prepared by the Provider. Consistent with the method of allocating GME costs to the other departments, the Provider submitted a written request to reclassify a porton of pathology costs for teaching activities and related administrative costs from the laboratory cost center to the GME cost center based on the July, 1990 time studies. However, since the cost in the pathology cost center had never previously been reported as allowable GME pass-through costs, the Intermediary denied the Provider's request based on its determination that subsequent period time studies cannot be used for this reclassification. In support of its determination, the Intermediary again cited the September 4, 1990 Federal Register which states:

> In 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 amount.

55 Fed. Reg. 36064.

Contrary to the Provider's argument, the Intermediary states that the absence of the 1984 time studies is not the sole reason for not allocating pathology costs into the GME cost center. The use of subsequent period time studies can be a viable solution to the lack of contemporaneous GME base year documentation if an assumption can be made about the similarity of the activites for the subsequent fiscal years involved. The Provider's failure to classify any pathology physician costs as GME costs in the GME base year cost report negates any assumption about the similarity of the activities for the years in contention. This factor, combined with the lack of any contemporaneous documentation for allocating such costs in the base year, is the basis for the Intermediary's determination. The Provider's arguments require the Intermediary to make a leap-of-faith determination about the allowability and propriety of pathology department physicians and support staff GME costs which the Intermediary is not willing to make. The Intermediary insists that the cited provisions of the September 4, 1990 Federal Register specifically address the fact that subsequent period time studies cannot be used to "add to or increase" physician compensation costs allocated to the GME cost center. In further support of its position, the Intermediary cites the HCFA Administrator's decision in Presbyterian Medical Center of Philadelphia v. Aetna Life Insurance Company, PRRB Dec. No. 95-D41, June 15,

1995, Medicare & Medicaid Guide (CCH) ¶43,487, Rev'd HCFA Administrator, August 7, 1995, Medicare & Medicaid Guide (CCH) ¶43,691.[11]

As to the second issue, the Provider argues that if the costs related to the teaching services of pathology physicians are not allocated to the GME cost center, then the pathology residents must be excluded from the APRA calculation. The Intermediary disagrees with this assertion because the Provider does not have an option where the counting of residents is concerned. The Intermediary contends that the counting of residents must include all residents working at the hospital in an approved program pursuant to the methodolgy set forth in 42 C.F.R § 413.86 (e) (1) (i).[12] Since the Provider had adequate documentation for determining the correct count of pathology residents, as well as the actual amount of salaries paid to the pathology residents, the Intermediary believes it was correct in using this documented data for determining the Provider's APRA. The Intermediary interprets the intent of the regulations to mean that the best available data (i.e., all GME costs documented as allowable, reasonable and proper, and all FTE residents in approved programs as prescribed by the regulations), should be included in the data used for the APRA calculation. Compliance with the regulations may result in instances in which allowable costs in the numerator of the formula may not exactly match the count of FTE residents included in the denominator. Since the Intermediary followed the requirements set forth in the regulations, the Provider's argument is an attack on the controlling regulations. However, if the Provider's argument on the second issue prevails, then the Intermediary argues that all salary costs relating to the residents that were reclassified to the GME cost center, must be eliminated from the numerator.[13]

The Intermediary concludes that it properly performed its audit responsibilities in accordance with the governing regulations and implementing instructions promulgated by HCFA in determining the Provider's APRA. After consideration of the relevant law, regulations and facts, the Intermediary respectfully requests that the Board affirm its adjustments.

CITATION OF LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS:

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

42 U.S.C. § 1395ww(h) (Section 1886 (h) of the Act)	-	Payment for Direct Graduate Medical Educational Costs

[11] See Intermediary Exhibit I-12.

[12] See Intermediary Exhibit I-5.

[13] Tr. at 34-35.

42 U.S.C. § 1395x(v)(1)(A) (Section 1861(v)(1)(A) of the Act	-	Reasonable Costs
44 U.S.C. § 3512	-	Public Printing and Documents - Public Protection

Other Statutes:

Section 9202 of the Consolidated Omnibus Budget Reconciliation Act ("COBRA") of 1985, Pub L. No. 99-272, as amended.

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

§ 405.481 et seq.	-	Allocation of Physician Compensation Costs
§§ 405.1835-.1841	-	Board Jurisdiction
§ 405.1885	-	Reopening a Determination or Decision
§ 412.113 et seq.	-	Other Payments - Direct Medical Education Costs
§ 413.86 et seq.	-	Direct Graduate Medical Education Payments

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

§ 2182ff	-	Services of Physicians in Providers

4. Federal Register:

55. Fed. Reg. 36063 & 36064 (September 4, 1990).

5. Cases:

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

University of Iowa Hospitals & Clinics v. Shalala, 180 F.3d 943 (8th Cir. 1999).

Administrators of Tulane Education Fund v. Shalala, 987 F.2d 790 (D.C. Cir. 1993).

Atlanta College of Medical and Dental Careers, Inc. v. Riley, 987 F. 2d 821 (D.C. Cir. 1993).

Charter Peachford Hosp. v. Bowen, 803 F. 2d 1541 (11th Cir 1986).

Presbyterian Medical Center of Philadelphia v. Aetna Life Insurance Company, PRRB Dec. No. 95-D41, June 15, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,487, Rev'd HCFA Administrator, August 7, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,691.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After a comprehensive analysis of the controlling law, regulations, and statements cited from Federal Registers, consideration of the facts, parties' contentions, documentary evidence, statements presented at the hearing, and post-hearing submissions, the Board finds and concludes that the pathology teaching costs at issue should be included in the Provider's GME costs for purposes of calculating the Provider's APRAs for the GME base year and the subsequent cost reporting periods included with this decision.

The records for the appeals before the Board and "Stipulations of the Parties" provide compelling and persuasive evidence that the Provider had an accredited pathology teaching program during the GME base year; that teaching physician supervision and instruction of the residents was an essential requirement for accreditation of the pathology program; and that the Provider employed teaching physicians in the Department of Pathology during the GME base year. The Board further notes that the parties agree that the size and structure of the pathology residency program remained consistent from the 1984 GME base year to fiscal year 1990 when the three-week physician time study was conducted for the purpose of determining the proportion of physician compensation costs that should be classified as GME costs. With the exception of the pathology program, the Intermediary utilized the three-week time study for determining the proportion of teaching physician compensation costs and administrative support costs attributable to teaching and supervision of residents in all of the other approved teaching programs of the Provider during the GME base year. Whereas the Intermediary excluded the pathology teaching costs from the APRA calculation, the Board finds it noteworthy that the Intermediary did reclassify the salaries of the residents in the pathology training program from operating costs to GME costs for the GME base year based on its determination that these costs were initially misclassified.[14] In addition, there is no dispute between the parties that the Provider incurred pathology teaching costs during the PPS base year and the GME base year, and that these costs were included in the Provider's laboratory cost center and classified as operating costs.

The crux of issue before the Board is the Intermediary's belief that it lacks the authority to reclassify any portion of the teaching physician compensation costs and administrative support costs relating to the

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[14] Tr. at 45-51. See Provider Exhibit P-13.

pathology program as GME costs for the GME base year because it is bound by a policy established by HCFA in a 1990 Federal Register which states in pertinent part:

> In 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 amount.

55 Fed. Reg. 36064.

The Board finds the Intermediary's interpretation of the 1990 Federal Register to be inconsistent with the statute, regulations, and the circuit court's decision in Tulane. The GME statutory amendments at 42 U.S.C. §1395ww(h) were enacted for the purpose of establishing a new and more accurate methodology for reimbursing GME costs, and that the APRA was to be based on all incurred GME costs recognized as reasonable. The GME regulation at 42 C.F.R. § 413.86 (e)(1) provides for adjustments to reclassify GME costs misclassified as operating costs in the GME base period, and also provides for adjustments to the provider's TEFRA target amount or PPS HSR to account for these misclassified GME costs in the TEFRA/PPS base year. While some statements in the Federal Register were directed at eliminating inappropriate costs from the GME base period, e..g., erroneously misclassified and nonallowable costs, the presumed focus was to determine accurate GME costs for the GME base period. Accordingly, the reaudit process was presented as a two-way street. The Board finds that the Intermediary's implementation was not focused in that manner and, in fact, the audit was performed in an inflexible and narrow manner which denied the Provider proper reimbursement of GME costs incurred in its GME base year.

The Board finds that all of the GME costs relating to the Provider's pathology teaching program were accurately claimed when the GME base year cost report was originally filed, and that such costs were basically allowed and reimbursed as operating costs. The Board further finds that the Provider made a proper request for the reclassification of such costs to the GME cost center, and that its request was supported by appropriate documentation meeting the requirements of 42 C.F.R. § 413.86(j)(2). The Intermediary's refusal to reclassify the GME costs in dispute because the Provider did not have contemporaneous records for the GME base year was incorrect, and directly conflicts with the provisions of 42 C.F.R. §413.86 ff and the Tulane decision which require an accurate determination of GME costs, and allow for an appropriate reclassification when such costs are misclassified. Contrary to the Intermediary's presumption, there is no requirement under the provisions of 42 C.F.R. §§ 413.86(j)(1)(ii) or 413.86(j)(2)(ii) for submission of base year documentation, contemporaneous or otherwise, with a provider's request for modification of misclassified costs.

The Board notes that the 1990 Federal Register recognized that providers who followed HCFA's record retention requirements under 42 C.F.R. §405.481(g)(3) would no longer have key GME base year documentation and, thus, it was appropriate to allow providers the opportunity to use later period proxy data to support its GME base period costs. The Board finds that the instructions at 55 Fed.

Reg. 36064 (1990) allow for increases in costs up to the physician compensation amount claimed in the GME base year. While the instructions limit costs used to determine the per resident amount, this limitation does not include adjustments where physician costs related to the teaching of residents were included in the cost report but were misclassified. It is the Board's finding that this interpretation conforms with the above cited statutory and regulatory requirements for determining GME costs accurately in accordance with the intent of Congress. Accordingly, the Board concludes that the Provider's APRA should be recalculated to include the proportion of physician compensation costs and administrative support costs attributable to the teaching and supervision of residents in the Provider's approved residency training program in pathology consistent with the percentage ("30 percent") set forth in the "Stipulations of the Parties." A revised APRA should be calculated for the Provider's GME base year and each of the subsequent fiscal years appealed by the Provider as part of this decision.

It is the Board's finding that the inclusion of the Provider's pathology teaching costs in the calculation of the APRA is the most accurate determination of the Provider's GME costs, and that this ruling on Issue No. 1 obviates a ruling on the alternative computation of the APRA presented for Issue No.2.

DECISION AND ORDER:

Issue No. 1 - GME Costs Included in APRA:

The Intermediary improperly omitted all of the pathology teaching costs incurred in the GME base year from the GME costs used to compute the Provider's APRAs. The Intermediary is directed to recompute the Provider's APRAs in accordance with the Board's finding and conclusions.

Issue No. 2 - Exclusion of FTEs from APRA:

The Board's decision on Issue No. 1 renders Issue No. 2 moot.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esquire
Martin W. Hoover, Jr., Esquire
Charles R. Barker
Stanley J. Sokolove

Date of Decision: March 28, 2000

For The Board

Irvin W. Kues
Chairman