PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2004-D28

PROVIDER –
Children's Hospital & Regional Medical Center – Seattle, WA

Provider No: 50-3300

vs.

INTERMEDIARY –
Blue Cross Blue Shield Association/ Trispan Health Services

DATES OF HEARING-
June 17, 2004,
June 29 - July 1, 2004

Cost Reporting Periods Ended -
September 30, 2001 and September 30, 2002

CASE NOs. 04-1640 and 04-1641

INDEX

ISSUE:

Were the Intermediary's adjustments to the provider's intern and resident full-time equivalents ("FTEs") counts used for calculating children's hospital graduate medical education ("CHGME") payments proper?[1]

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The Department of Health and Human Services ("HHS" or the "Department") makes payments to children's hospitals for their expenses "associated with operating approved graduate medical residency training programs." 42 U.S.C. § 256e(a). The program, under which these payments are made, called the CHGME payment program, is administered by the Health Resources and Services Administration ("HRSA") within HHS. Under the CHGME program, children's hospitals receive payments for both direct medical education ("DME") expenses and indirect medical education ("IME") expenses. 42 U.S.C. § 256e(a). These payments depend, in part, on a hospital's FTE count of residents. 42 U.S.C. § 256e(b)(1), 256e(c)(1)(B), 256e(d)(2)(A). The FTEs for calculating CHGME payments are based on a three-year rolling average. 66 Fed. Reg. at 37982.

Children's Hospital and Regional Medical Center (the "Provider" or "Seattle Children's"), is a not-for-profit entity located in Seattle, Washington. The Provider is the primary teaching site for pediatric specialty and subspecialty residents in approved graduate medical education ("GME") residency programs sponsored by the University of Washington's School of Medicine ("UW"). The Provider receives CHGME program payments for both its IME and its DME costs.

This case arises from a dispute over the FTE counts for fiscal years ending September 30, 2001 and September 30, 2002, both of which are used to determine the Provider's 2004 CHGME program payment. The Intermediary issued its CHGME Program Payment Assessment of Full-Time Equivalent Resident Counts for the 2004 payment year on April 16, 2004.

The provider filed its application for Federal Fiscal Year (FFY) 2004 CHGME funding on July 15, 2003. In that application, the provider claimed 140.28 unweighted and 121.5 weighted Full Time Equivalent (FTE) residents for Fiscal Year Ending (FYE) 2001, and 139.93 unweighted and 119.62 weighted FTEs for FYE 2002. The Intermediary adjusted the Provider's FTE count of residents to exclude 11.73 weighted FTEs and 20.15 unweighted FTEs that the Intermediary believed were insufficiently documented by the Provider. The estimated impact on the Provider's CHGME program payment of the initial disallowances was approximately $424,642.[2]

[1] The Provider laid out five issues in its Supplemental Position Paper filed on June 8, 2004. As described in further detail below, all of the issues other than this one were resolved through agreement of the parties.

[2] The Provider also appealed several other issues related to the Intermediary's determination of the Provider's FTE count for fiscal years 2001 and 2002 that have been resolved by stipulations between the parties. The Intermediary has agreed to include 0.90 weighted and 1.09 unweighted FTEs that were disallowed because the residents were enrolled in an eligible but unaccredited program (approximate payment impact of $ 25,502); 0.15 weighted and 0.30 unweighted FTEs representing time spent beyond the initial residency period (approximate reimbursement payment impact of $6,100); and 0.79 weighted and 0.95 unweighted FTEs for assignments that initially overlapped with another provider but were resolved by both providers during the audit period (approximate payment impact of $22,210). The Provider has dropped its claim to 2.05 weighted and 1.98

The Provider appealed the Intermediary's adjustments to the Provider Reimbursement Review Board ("Board" or "PRRB") and has met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-1841. The Provider was represented by Stephanie A. Webster, Esquire, and Ronald S. Connelly, Esquire, of Powers, Pyles, Sutter & Verville, P.C. The Intermediary was represented by Mark McGinnis, Esquire, HHS, Office of the General Counsel, Public Health Division.

STATUTORY AND REGULATORY BACKGROUND:

CHGME Payment Program

Enacted in 1999 by P.L. 106-129, the CHGME program provides funds to children's hospitals to address the disparity in the level of Federal funding that results from Medicare funding for graduate medical education. The law authorizes payments out of an annual appropriation for both DME and IME costs to eligible hospitals based on their number of residents as determined by applicable provisions of Medicare, primarily § 1886(h)(4) of the Social Security Act (SSA). 42 U.S.C.§256e. The law was amended shortly thereafter by the Children's Health Act of 2000, which authorized the Secretary to promulgate rules, tightened eligibility criteria, and extended the program until 2005. P.L. 106-310 § 2001.

In order to receive CHGME funds, a children's hospital must file an application for the funds. 66 Fed. Reg. 12,942 (March 1, 2001); 66 Fed. Reg. 37,988 (July 20, 2001). Congress appropriates a capped amount of federal funds to be distributed to children's hospitals each federal fiscal year ("FFY") through the CHGME program. 42 U.S.C. § 256e(b)(2)(A). The available funds are distributed *pro rata* to the hospitals that apply to receive funds under the program. 42 U.S.C. § 256e(b)(2)(B). HRSA makes interim payments to children's hospitals throughout the fiscal year, in 26 equal installments, based on the number of residents reported in the hospital's most recent Medicare cost report filed prior to the application date for that FFY's program payments. 42 U.S.C. § 256e(e)(1). When making interim payments, HRSA withholds up to 25 percent of the total payments to be made for the year to ensure that a hospital is not overpaid for the year. 42 U.S.C. § 256e(e)(2).

HRSA must, "prior to the end of each fiscal year," determine the final amount due to each children's hospital that has applied for payments under the program. 42 U.S.C. § 256e(e)(3); 67 Fed. Reg. at 60,241-42 (Sept. 25, 2002). HRSA makes this determination through a "reconciliation" process through which it determines any necessary changes to the number of FTEs reported by a hospital in its application for CHGME payments. 42 U.S.C. § 256e(e)(3); 66 Fed. Reg. 12,941 (Dec. 3, 2001). "Reconciliation applications" are released during the third quarter of the FFY (April 1-June 30) and must be returned by the hospitals within 30 days. 67 Fed. Reg. 60,242. Hospitals are notified of the Secretary's final reconciliation payment determination during the fourth quarter (July 1–September 30) of the FFY for which payments are being made. Id., 67 Fed. Reg. 60,242.

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unweighted FTEs representing the net effect of various changes that the Intermediary made to resident rotation dates (approximate payment impact of $49,971).

Incorporation of Medicare Rules into CHGME Program

The CHGME program is directly tied to Medicare. While recognizing "fundamental differences" between CHGME and Medicare, HHS has "incorporated applicable Medicare rules and regulations" into the CHGME program. 66 Fed. Reg. 37,981 (July 20, 2001).[3] Participating hospitals must, in fact, have a Medicare provider agreement and be excluded from the Medicare prospective inpatient payment system pursuant to 1886(d)(1)(B)(iii) of the Social Security Act. 42 U.S.C § 256e(g)(2). Hospitals may also dispute final program payment determinations before the Provider Reimbursement Review Board. *Id.* at § 256e(e)(3).

There are, however, important differences. Of perhaps the most programmatic significance is CHGME's reliance on annual appropriations, which must be divided among all eligible hospitals prior to the end of each fiscal year. *Id.* at § 256(e)(f). This differs dramatically from Medicare's Trust Fund payment process, which can take years to fully settle, even absent disputes. It also significantly differs from Medicare in dividing a fixed pool of funds among all eligible hospitals, rather than fixing individual hospital's payments independent of other providers. CHGME funding is a shared resource; adjustments to one hospital necessitate adjustments to others.

In determining the number of full-time equivalent (FTE) residents for CHGME DME, Congress mandated that the Department use the same methodology that is used for counting DME resident FTEs in the Medicare program. 42 U.S.C. § 256e(c)(1)(B); see 42 U.S.C. § 1395ww(h)(4). Congress gave the Department discretion to determine how to reimburse children's hospitals for IME expenses, 42 U.S.C. § 256e(b)(1)(B), (d), but HHS has determined that residents will be counted for IME in the same manner as for DME. 66 Fed. Reg. 37,984.[4]

HHS prefers to use a hospital's settled Medicare cost report as the basis for determining the FTE count. See 66 Fed. Reg. 37,980-82 (July 20, 2001).[5] The CHGME Intermediary is allowed to

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[3] The cited differences are:

> (1) The CHGME program includes children's hospitals that span the spectrum of pediatric patient care, including acute, rehabilitation, oncology, orthopedics, and long term care;
> (2) The CHGME program includes resident training that occurs in all areas of the hospital complex for both CHDME and CHIME;
> (3) The CHGME program is bound to the FFY [Federal Fiscal Year] in which appropriated funds must be distributed without the opportunity to reconcile funding across FFYs;
> (4) The Medicare GME payments are associated with treatment of Medicare patients;
> (5) The Medicare patient population is primarily non-pediatric; and
> (6) The Medicare program monies come from a trust fund.

[4] HHS has stated in the *Federal Register* that the CHGME program will use the caps and rolling averages from the Medicare IME regulations at 42 C.F.R. § 412.105(f), but will replace the IME method of counting residents in 42 C.F.R. § 412.105(f) with Medicare's DME methodology in 42 C.F.R. § 413.86(f)(1)(ii). 66 Fed. Reg. 37,984-85. In addition, like with Medicare DME, children's hospitals may count time spent by residents working in all areas of the hospital complex. Id. at 37,984. Hospitals may also count all time that residents spend in research at the hospital and research at non-hospital sites if that research involves direct patient care. Id.

[5] HHS has not placed its CHGME rules in the Code of Federal Regulations. The rules for counting CHGME resident FTEs are found in the July 20, 2001 *Federal Register*. 66 Fed. Reg. 37,980. HRSA has clarified these regulations through program guidance. See, e.g., Children's Hospitals Graduate Medical Education Payment Program Guidance: FTE Resident Count Acceptance for Hospital's Initial Application (July 3, 2003) ("CHGME

determine the FTE count only if a settled Medicare cost report is unavailable. 66 Fed. Reg. 37,981-82. Even children's hospitals that do not file Medicare cost reports are required to follow Medicare standards in counting and documenting resident FTEs. 66 Fed. Reg. at 37,982. Consistent with this Medicare-based approach, in response to a question about how fiscal intermediaries would determine preliminary FTE counts for CHGME purposes, HHS referred in the *Federal Register* to CMS manuals "which outline the standards and definitions used in preparation and review of Medicare cost reports." Id. at 37,982.

With respect to resident FTE documentation, CHGME documentation standards are the same as Medicare. To claim a resident's time toward its CHGME FTE count, HRSA has instructed hospitals to follow the documentation requirements of the Medicare DGME program. See 66 Fed. Reg. 12,944 (March 1, 2001) (noting that the CHGME statute requires FTE resident counts to be determined in accordance with 42 U.S.C. § 1395ww(h)(5) and 42 C.F.R. § 413.86).

Medicare Documentation and Audit Requirements

The Medicare documentation requirements, which are set forth at 42 C.F.R. § 413.86(j), read as follows:

> To include a resident in the FTE count for a particular cost reporting period, the hospital must furnish the following information. The information must be certified by an official of the hospital and, if different, an official responsible for administering the residency program.
>
> (1) The name and social security number of the resident.
> (2) The type of residency program in which the individual participates and the number of years the resident has completed in all types of residency programs.
> (3) The dates the resident is assigned to the hospital and any hospital-based providers.
> (4) The dates the resident is assigned to other hospitals, or other freestanding providers, and any non-provider setting during the cost reporting period, if any.
> (5) The name of the medical, osteopathic, dental, or podiatric school from which the resident graduated and the date of graduation.
> (6) If the resident is [a foreign medical graduate], documentation concerning whether the resident has satisfied [certain testing requirements].
> (7) The name of the employer paying the resident's salary.

The Medicare regulations also address general documentation requirements for providers. The Medicare regulations state that standard definitions, as well as accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields, must be followed. 42 C.F.R. § 413.20(a). In addition, the Medicare regulations do not require

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FTE Guidance"); Children's Hospitals Graduate Medical Education Payment Program (CHGME PP) Documentation Guidance ("CHGME Documentation Guidance").

any changes to these practices and systems to determine Medicare costs and state that "the methods of determining costs payable under Medicare involve making use of data available from the institution's basic accounts, as usually maintained, to arrive at equitable and proper payment for services to beneficiaries." Id. Medicare regulations addressing provider documentation incorporate standard accounting practices. 42 C.F.R. § 413.24.

PARTIES' CONTENTIONS:

This dispute centers on the application of Medicare documentation requirements and deadlines to the CHGME program.

Timeliness of Evidence

While conceding that Medicare documentation requirements apply to CHGME audits, the Intermediary contends that the Board should not consider any documents not submitted by the Provider to the Intermediary before the Intermediary's final assessment deadline of April 8, 2004. In defending its position, the Intermediary argues that beginning in FFY 2003, CHGME established a comprehensive assessment process to ensure accurate funding for all hospitals in a timely manner by contracting with Blue Cross/Blue Shield Association to perform assessments of participating hospital resident counts within the timeframe required by the CHGME statute. *See* 68 FR 60396, 60397-98 (Oct. 22, 2003). The Intermediary claims that the program attempted to educate the provider community on the FTE assessment process since many had not been subject to such audits before and none were used to the more rigorous deadlines. In particular, CHGME issued a 2003 guidance document to all participating hospitals concerning the FTE assessment process and the time lines that must be adhered to for efficient functioning of the program. Intermediary Exhibit D-4. Regarding timeframes the document stated:

> The assessment must occur within a six-month period of time in a given FY to allow for reconciliation within the appropriation year for which payments are made. This time frame differs markedly from the Medicare program, which allows for resolution of FTE counts for a given year to occur over subsequent years. However, this time frame is an improvement of the time frame available to children's hospitals under the Medicare PMs in FY 2001 and FY 2002, when assessment took place within a period of eight weeks. Any changes to FTE resident counts in the CHGME PP affect the distribution of dollars among hospitals in the fixed payment pool. Therefore, there is a priority to resolve all discrepancies in FTE resident counts within the six-month time frame available to adjust payments in the CHGME PP. Id. At 5-6
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> The assessment of resident FTE counts reflected in participating children's hospitals' initial applications by CHGME FIs will occur within a six-month period of time following the beginning of the FY for which payments are being made, but not later than April 1 of the same FY. The CHGME FI will work closely with each

> participating children's hospital and the Medicare FI, where appropriate, throughout this process and will report his/her findings to the hospital and the CHGME PP. During the third quarter of each FY (March 1—June 30) for which payments are being made, reconciliation applications will be made available to participating hospitals to provide them the opportunity to report changes in the resident FTE counts previously reported in their initial applications for CHGME PP funding. The April 1st BCBSA deadline will afford hospitals ample time to complete and submit their reconciliation applications utilizing BCBSA FTE assessment data by the May 1st CHGME PP reconciliation application deadline. *Id. at. 7.*

The Intermediary concedes that the CHGME program has not established absolute deadlines for submission of documentation to auditors. Although proper functioning of the program would be impossible if each hospital could set its own assessment schedule, most hospitals have followed the direction: "The reconciliation process requires that participating hospitals comply with the requests from the CHGME PP [payment program] FI." 68 FR at 60397.

The Intermediary asserts that CHRMC first received a request for documentation from the Intermediary on October 10, 2003. The provider received additional requests for information on November 10, including a request for rotation schedules of sponsoring institutions or CHRMC rotation schedules accompanied by a signed statement from the home hospital attesting that CHRMC schedules were accurate. Provider Exhibit P-23. The provider did its best to comply with these new requests and was granted an extension of time by the Intermediary.

The Intermediary wrote for additional documentation and clarifications on December 22, 2003. Unable to meet the deadlines for submission of these documents the hospital appealed to HRSA and the deadline was extended to February 6. On February 9, HRSA convened a conference call with CHRMC to discuss what the hospital believed were burdensome documentation requests. CHGME disagreed with the provider that such documentation requests were greater than that for other providers. Intermediary Exhibit D-10. Still, the program extended the hospital's deadline twice more until March 25 to submit additional documentation.

The Intermediary raises several arguments as to the submission of new evidence not presented during the audit period. In its initial position paper, reply brief and supplemental motions made before the Board, citing several Board decisions, the Intermediary argued that the program's deadlines for furnishing documentation established through guidance documents are binding on the Board. Intermediary Position Paper at 7-8. The Intermediary argues that allowing the submission of new evidence to the Board is not only unauthorized, but is also inequitable as to other hospitals, which operate within deadlines and which receive funding from the same shared appropriation. Finally, the Intermediary argues that allowing new evidence to be submitted after the audit period will undermine the program and disrupt Board functioning.

The Provider argues that the Intermediary's position limiting the evidence the Board should consider effectively deprives it of the PRRB review guaranteed by the CHGME statute. The Provider contends that the Intermediary based its case solely on its timeliness argument and did

not address the merits of the Provider's documentation arguments, or clarify the Intermediary's disallowances, until late in the hearing process relying on the time-limited availability of the CHGME funds. The Provider argues that the Intermediary's position is untenable for several reasons.

First, the CHGME and PRRB statutes do not enable the PRRB to accept the Intermediary's invitation to ignore the Provider's evidence and arguments. Under 42 U.S.C. § 1395oo(d), "a decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the Intermediary and such other evidence as may be obtained or received by the Board." (Emphasis added.) The Provider refutes case law cited by the Intermediary arguing that they do not address the Board's authority to review evidence not reviewed by the Intermediary and contends that the Intermediary's approach would deprive the Provider of the Board proceeding to which it is entitled under the CHGME statute. 42 U.S.C. § 256e(e)(3); see 42 U.S.C. § 1395oo.

Second, the Provider asserts that it submitted adequate documentation under applicable Medicare rules. Therefore, it contends that deadlines for the submission of the requested documentation that was not required were meaningless.

Third, the Provider claims that it is incorrect to characterize the Provider as having missed deadlines. The Provider believes that it made good-faith efforts to comply with the Intermediary's evolving requirements, and the Provider communicated regularly with the Intermediary about the difficulty it was having in understanding and meeting the Intermediary's changing expectations. As a result, as the Intermediary has acknowledged, the Intermediary repeatedly extended documentation deadlines.

Fourth, the Provider contends that the Intermediary exaggerates the time sensitivity of these determinations. Under the CHGME statute, HRSA is required to determine the final amount due to each children's hospital that has applied to payments under the program "prior to the end of each [federal] fiscal year," 42 U.S.C. § 256e(e)(3); 67 Fed. Reg. 60,241-42. HRSA makes this determination through a "reconciliation" process through which it determines any necessary changes to the number of FTEs reported by a hospital in its application for CHGME payments. Id.; 66 Fed. Reg. 12,941. "Reconciliation applications" are released during the third quarter of the FFY (April 1-June 30) and must be returned by the hospitals within 30 days. 67 Fed. Reg. 60,242. Hospitals are notified of the Secretary's final reconciliation payment determination during the fourth quarter (July 1–September 30) of the FFY for which payments are being made. The Provider contends that the Provider and the Board are still within the regulatory time period during which reconciliations occur, and not yet into the calendar quarter in which the final determinations must be made. Therefore, it asserts that reconciliation with the Provider at this juncture is therefore appropriate under the CHGME statutory and regulatory scheme.

Home Hospital Information

With respect to the individual adjustments at issue, the Intermediary contends that each adjustment was correct given the information available at the time of the audit. In particular, the Intermediary asserts that it could not rely on the CHRMC's master rotation schedule as sufficient for purposes of resident validation for visiting fellows and other residents claiming it could not

be reliably traced through sampling the master rotation schedule. Therefore, the Intermediary performed a 100% audit of those residents and made several adjustments as no documentation beyond the schedule as to the time particular residents spent in a rotation was proffered at the time of the audit. The Intermediary counters the Provider's claims of misleading information requests and confusion by pointing to faxes and other documents in the record stating what it believes was exactly what was required of the provider. The Intermediary also asserts that this audit received more oversight than any other children's hospital during this CHGME funding cycle.

The Provider contends that the Intermediary imposed upon the Provider documentation requirements that were unreasonable and contrary to law. The Provider argues that it furnished the available schedules and documents to meet the Intermediary's apparently evolving requirements. The Provider asserts that the Intermediary's expectations and reasons for disallowances were unclear, both during and after the audit. The Provider claims that the Intermediary failed to comply with the requirement in CMS Transmittal A-01-141 that an auditor's work papers "must stand on their own without the need for supplemental explanation or documentation." The Provider believes that the FTEs under appeal were disallowed because: (1) the Provider did not submit documentation from the residents' or fellows' home hospitals; or (2) the documentation that the Provider furnished to support the resident assignments was compiled after fiscal years 2001 and 2002.

The Provider disputes the Intermediary's determinations as to the reliability of certain types of evidence and urges the Board to view the evidence as a whole. The Provider contends that neither the CHGME statute nor the Medicare statute mandates the type of documentation that a provider must furnish to include a resident in its GME resident count and that the Intermediary erroneously maintains that 42 C.F.R. § 413.86(j) requires the Provider to submit corroborating evidence from a resident's or fellow's home hospital. For all claimed FTEs, the Provider submitted its master rotation schedule created and updated by Seattle Children's based on information submitted to Seattle Children's from home hospitals and used to track all residents and fellows that rotate through Seattle Children's. The Provider contends that the Intermediary failed to consider this evidence in evaluating the Provider's contested FTE claims.

Second, the Provider argues that section 413.86(j) must be read in conjunction with other Medicare regulations stating that the Medicare program should not require changes in a provider's recordkeeping practices to make cost determinations. 42 C.F.R. § 413.20(a). The Provider maintains that teaching hospitals do not commonly maintain the kind of home hospital rotation documentation demanded by the Intermediary. Therefore, the Intermediary's disallowances for lack of home hospital rotation documentation dictate a change to the Provider's (and potentially other providers') record keeping practices, which are otherwise consistent with common practice in the hospital industry. The Provider contends that because neither the Medicare nor the CHGME rules require home hospital information apparently expected by the Intermediary, the Intermediary has no basis for its disallowances.

Non-Contemporaneous Documentation

The Provider asserts that the Medicare statute and regulations governing documentation of a provider's resident count also allow the use of non-contemporaneous documentation to

supplement a provider's resident count information and cites various examples of the Board and CMS's acceptance of non-contemporaneous evidence as acceptable evidence of Medicare costs.

The Provider contends that it has submitted sufficient evidence to convince a reasonable person that the residents at issue should be included in the CHGME resident counts. CMS Transmittal A-01-141 states that audit findings must be based on the "best evidence available." In instances where the Provider could not obtain a rotation schedule, the Provider claims that it furnished the Intermediary with the best evidence that was available to it.

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND DISCUSSION:

The Board, after consideration of the evidence, the parties' contentions, testimony and applicable law and regulations, finds and concludes as follows:

The Board notes that GME documentation is generally complex and extensive. In the course of a GME audit, questions will inevitably arise, and both the provider and the intermediary will require clarifications during the course of an audit. These inherent difficulties are further exacerbated here because CHGME is a new program, and although it follows Medicare principles, the CHGME funding mechanism results in a more compressed timeframe for an audit and Board appeal than would occur with a Medicare audit.

This case does not involve, for the most part, whether residents' time may be counted by the Provider. Rather, this case centers on the difficulty in quantifying the portion of a resident's time that the Provider may count for CHGME payment purposes. The Board finds the witnesses for both parties to be very credible and that this case does not involve a situation where the Provider or the Intermediary was uncooperative or unreasonable.

The Provider furnished information responsive to the Intermediary's initial requests for documentation, but there was disagreement or misunderstanding as to what the Intermediary's documentation requirements were. In addition, the documentation submitted by the Provider raised additional questions.

Both the Provider and the Intermediary in this case were dealing with massive amounts of documentation. Though the provider furnished information responsive to the Intermediary's initial request, there was disagreement or misinterpretations about what else was required. Subsequent documentation submitted raised even more questions about allowable FTEs. The Intermediary believed that it did not receive some of this information within the timeline given to it by HRSA. The Provider acknowledges that it was scrambling for data during a very busy time and under tight deadlines. The Provider believed that information that it was gathering had to be sent by organizations over which it had no control. As a result, the Intermediary received much information in a piecemeal fashion with little explanatory material that it then took apart and reorganized to suit its needs.

The Intermediary's audit had to be done in conjunction with other work for different providers, tight timelines, and at a distance that allowed little opportunity to meet with the Provider to resolve questions. Attempts to resolve questions by telephone are for the most part undocumented, and each party has a different appreciation of those discussions.

The Intermediary urges the Board not to consider any documentation furnished after the audit period, which ended on April 8, 2004. The Intermediary argues that it gave the Provider more time than allotted in HRSA guidelines.

The Board finds that, practically speaking, it is impossible to determine with certainty what documentation was sent when. To decide the issues raised in this appeal, the Board must therefore consider all of the evidence before it. In any event, the Board does not have the legal authority to impose the limitations on evidence urged by the Intermediary. There are no regulations governing the CHGME program that address timelines for furnishing documentation. HRSA has only issued guidelines governing the CHGME program that do not have the force of law.

On the other hand, the statute creating the CHGME program incorporated the entire PRRB appeal procedures, procedures that are designed to fit Medicare funding mechanisms. There are drastic differences between the CHGME and Medicare programs, and the Board has therefore tried to adapt its procedures. The Board understands HRSA's need for all documentation to be submitted in time for a decision to be made within the funding period. The Board's regulations, however, contemplate that documentation can be furnished during the appeal process. The regulations even permit a new issue to be added up to the day of a hearing. Unless regulations are issued that impose time limits specific to CHGME appeals, the Board does not have the authority to impose the limits requested by the Intermediary.

The Board understands that some documents may have been kept by the Provider for purposes other than the FTE count, but that the collection of these documents for other purposes does not make that information less reliable. All of the Board's determinations were made based on the totality of the evidence; no single document or class of documents was discounted automatically. For example, the Intermediary stated that it had sampled the Master Rotation Schedule and found discrepancies between the schedule and corroborating evidence. The Board agrees with the Intermediary's position that it could not rely solely on the Master Rotation Schedule but the Board concludes that it should be considered in conjunction with other corroborating evidence. The Board's final determination as to each FTE hinged on whether the Board believed it could reasonably rely on the information collected, given all the circumstances.

The Board reviewed the documentation submitted for each resident whose time was in dispute. The Board's decision with respect to each resident is detailed below, and stipulations by the parties during the course of the testimony are noted where applicable.[6] To ensure a complete record and to avoid potential remand to the Board after Administrator review, the Board also notes, where appropriate, what its decision would have been had it reviewed only the documentation submitted by the Provider during the audit period. For the sake of clarity, the Board also sets forth the results of the stipulations into which the parties entered without the necessity of Board review.

[6] The Board initially announced its decisions on these FTEs on the record during the course of the hearing. After hearing arguments made by the Provider in closing, the Board revisited the decisions it had previously announced on the record and decisions it had made but not announced, but the Board found that no modifications to those determinations were necessary.

Board Findings

Ileana Calinoiu (Tab 3). During the course of testimony, the Intermediary stipulated that it would allow the 0.2521 weighted and 0.2521 unweighted 2002 FTEs claimed for Ileana Calinoiu based on information submitted after the audit period. Consistent with this stipulation, the Board allows the FTEs for Ileana Calinoiu. With respect to information submitted during the audit period, a factual dispute exists as to what documents were sent at what time. A system error in the University of Washington's Resident Tracking and Billing System (RTBS) initially caused confusion about whether this resident should be included in the Provider's resident count. The Intermediary may have been given acceptable RTBS information, but another document submitted by the Provider gave the Intermediary the impression that Calinoiu was not on RTBS.

Joanne Band (Tab 4). The Board finds that the 0.0384 weighted and 0.0384 unweighted FTEs for Joanne Band should not be included in the Provider's 2001 FTE count. Discrepancies in the dates of rotations for this resident exist in the various documents supplied by the Provider.

Buck, Charles; Desverreaux, Robert; Gregory, Timothy; Hoefle, Jeffrey; Vreeland, Matthew (Tabs 5-9). During the course of testimony, the Intermediary stipulated that it would allow the 0.4218 weighted and 0.4218 unweighted 2001 FTEs claimed for these residents based on information submitted after the audit period. Consistent with this stipulation, the Board allows the FTEs for these residents. The Board would also allow these FTEs based solely on documents submitted during the audit period. Confusion exists over what was sent during the audit period. The Provider believed it had sent a schedule that the Intermediary claims that it did not receive. The Provider, not knowing that the Intermediary's continued disallowance was made without having the document in question, sent a follow-up clarification after the audit period that was unsigned. The document originally submitted by the Provider was sufficient documentation for these residents.

Panthagani, Prasad (Tab 18). The Board finds that 0.374 weighted and 0.7479 unweighted FTEs should not be included in the Provider's 2002 FTE count. The Board notes that fellows programs by their nature involve less structured assignments and finds that more detailed records of where this fellow spent her time are needed. The documents received during and after the audit period fail to detail when and if Dr. Panthagani was working at the Provider's facility.

Kim, Samuel (Tab 19). During the course of testimony, the Intermediary stipulated that it would allow the 0.1671 weighted and 0.1671 unweighted 2002 FTEs claimed for this resident based on information submitted after the audit period. Consistent with this stipulation, the Board allows the FTEs for this resident. The Board would not allow the FTEs for this resident based solely on documents submitted during the audit period because these documents did not indicate specific dates that Dr. Kim worked at the Provider's facility.

Countouriotis, Athena (Tab 21). The Board finds that 0.0767 weighted and 0.0767 unweighted FTEs for this resident should be included in the Provider's 2002 FTE count. The Provider had a good-faith misunderstanding about what documents the Intermediary would accept, and, as a result of this misunderstanding, the Provider did not submit key documents until after the audit period. The Board would not allow the FTE for Dr. Countouriotis based solely on documents

submitted during the audit period because these documents insufficiently establish how her time was actually spent.

Brown, Julie (Tab 22). The Board finds that 0.374 weighted and 0.7479 unweighted FTEs for this fellow should not be included in the Provider's 2001 FTE count. Documents submitted by the Provider indicate that Dr. Brown was pursuing a master's degree at the same time as her fellowship, and no submitted document quantified the allowable time for Dr. Brown.

Reuter, David (Tab 23). The Board finds that 0.0722 weighted and 0.1444 unweighted FTEs for Dr. Reuter should be included in the Provider's 2001 FTE count. The Board would also allow this time based solely on documentation submitted during the audit period because testimony during the hearing demonstrated that during the audit period, the Intermediary did not realize that the Provider had submitted documents that would have allowed the Intermediary to quantify the allowable time for Dr. Reuter.

Kostic, Ana; Manley, Thomas; Pang, Jenny; Rosario, Emelda (Tabs 24-27). The Board finds that 0.1342 weighted and 0.2683 unweighted FTEs for these fellows should not be included in the Provider's 2002 FTE count. The Provider is entitled to some time for these fellows, but the documents submitted do not provide information sufficient to quantify their allowable time.

House, Nicole (Tab 28). The Board finds that 0.0425 weighted and 0.0849 unweighted FTEs, representing Dr. House's clinic time during December 2000, should be included in the Provider's 2001 FTE count. The Board bases this finding on documents submitted by the Provider during the audit period. With respect to Dr. House's research time, a majority of the Board finds that all research time should be disallowed, even when documents submitted after the audit period are considered, because there are no contemporaneous documents to show the location of the research at the Provider's facility.

Chairperson Cochran dissents as to the Board's finding on Dr. House's research time. An attestation that the Provider submitted during the audit period documented the activities of several fellows. When this attestation is viewed as a whole, it makes a clear distinction as to whose research time was at the University of Washington as opposed to the Provider's facility. Those fellows shown as working at the University of Washington were not claimed by the Provider. Chairperson Cochran finds the attestation to be reliable and would allow the research time for Dr. House.

Kollman, Tobias; Lewis, Karyn; Way, Sing Sing; Weissman, Scott (Tabs 29-32). During the course of testimony, the Intermediary stipulated that it would allow the 0.4988 weighted and 0.9149 unweighted 2001 FTEs claimed for these residents based on information submitted after the audit period. Consistent with the Intermediary's stipulation, the Board allows the FTEs for these residents. The Board would also allow these FTEs based on page 1622 of Provider Exhibit 130, which was submitted during the audit period. The Board notes that a dispute exists about whether this document was submitted during the audit period. This document was developed in response to overlapping claims with other providers. The document does reconcile these overlaps, and the information came directly from the department where the physicians were working.

Kollman, Tobias; Lewis, Karyn; Pozos, Tamara; Way, Sing Sing; Weissman, Scott (Tabs 33-37). During the course of testimony, the Intermediary stipulated that it would allow 0.4535 weighted and 0.5781 unweighted 2002 FTEs claimed for these residents based on a "call schedule" submitted during the audit period. Consistent with this stipulation, the Board allows the FTEs for these residents. The Provider also claimed time for these residents representing one-half day per week at an HIV clinic during part of the year. The only support for this time is an internally generated document submitted after the audit period. The only reference to the HIV clinic is a note stating that the fellows worked one-half day per week at the clinic, and this is insufficient documentation for the claimed time at the HIV clinic.

Faizan, Khurrai; Gillespie, Robert; Gordon, Carrie; Hingorani, Sangeeta; Lin, Fangming; Okamura, Daryl; Smith, Jodi (Tabs 38-44, FY 2001). Faizan, Khurrai; Gillespie, Robert; Gordon, Carrie; Hingorani, Sangee; Okamura, Daryl; Smith, Jodi; Yonekawa, Karyn (Tabs 45-51, FY 2002). During the course of testimony, the Intermediary stipulated that it would allow the 0.9194 weighted and 1.8392 unweighted 2001 FTEs and 0.8353 weighted and 1.6705 unweighted 2002 FTEs for these residents based on information submitted after the audit period. Consistent with the Intermediary's stipulations, the Board allows the FTEs for these residents.

The Board would not allow the FTEs for these residents based solely on documents submitted during the audit period. These documents show subsets of residents that indicate that clinic "days" claimed may be actually half days, which would substantially reduce the FTEs claimed. No source documentation was submitted for the attestations, and the Board cannot reconcile the attestation numbers claimed with an email explanation that was also submitted during the audit period.

With regard to extra documentation for Hingorani, Okamura, and Smith that was submitted during the audit period in support of the fellows' 2002 FTEs, the Board still finds that the time should not be allowed because there are discrepancies between this document and the amount claimed. This document raised even more questions as to the reliability of the information.

Debley, Jason; Hoffman, Jason (Lucas); McKinney, Martha; Moskowitz, Samuel (Tabs 52-55, FY 2001). Debley, Jason; Hoffman, Jason (Lucas); McKinney, Martha (Tabs 56-58, FY 2002). During the course of testimony, the Intermediary stipulated that it would allow the 0.7205 weighted and 1.4411 unweighted 2001 FTEs and the 0.4974 weighted and 0.9945 unweighted 2002 FTEs claimed for these residents based on a complete tracking document submitted after the audit period. Consistent with the Intermediary's stipulations, the Board allows the FTEs for these residents.

During the course of testimony, the Intermediary also stipulated that it would allow a portion of the claimed FTEs based on a single page of the tracking document that was submitted during the audit period. The tracking document was contemporaneous and therefore the best evidence of actual time spent. There were discrepancies between the tracking document and other documents that were not contemporaneous with the activity and on which the claim was based. The Board finds that those non-contemporaneous documents, in light of the discrepancies, were not reliable.

Cusick, Robert (Tab 60). The Board allows the 0.37395 weighted and 0.7479 unweighted 2001 FTEs based solely on documentation submitted during the audit period. No one document establishes all of the data needed to substantiate the claim, but all documents read together, including the Provider's Master Rotation Schedule, furnish reliable evidence of the dates of service.

Kim, Stephen (Tab 61). The Board allows 0.1055 weighted and 0.2109 unweighted 2001 FTEs based on documents submitted during the audit period. The allowed FTEs represent the Provider's original claim for Dr. Kim, less two weeks for a neonatology rotation.

Weidner, Bryan (Tab 62). The Board allows 0.4383 weighted and 0.8767 unweighted 2001 FTEs based on documents submitted during the audit period. The allowed FTEs represent the Provider's original claim for Dr. Weidner, less two weeks in August and the entire month of April. Evidence shows that Dr. Weidner was training at another facility during those periods.

Philips, Grace (Tab 64). During the course of testimony, the Intermediary stipulated that it would allow the 0.126 weighted and 0.2521 unweighted 2002 FTEs claimed for Dr. Philips based on information submitted after the audit period. Consistent with the Intermediary's stipulation, the Board allows the FTEs for Dr. Philips. The Board agrees with the Intermediary's position that documents submitted during the audit period do not sufficiently establish the dates of service and percentage of allowable FTEs for Dr. Philips.

Heathcock, Brian; Mersol, Joe; Phinney, Alexi; Pontius, Michelle (Tabs 65-68). During the course of testimony, the Intermediary stipulated that it would allow the 0.5972 weighted and 0.5972 unweighted 2001 FTEs claimed for these residents based on information submitted after the audit period. Consistent with the Intermediary's stipulations, the Board allows the FTEs for these residents. The Board would not allow these FTEs based solely on documents submitted during the audit period.

White, Cheryl (Tab 69). The Board allows 0.0822 weighted and 0.0822 unweighted 2001 FTEs. This allowance is based on the call schedules as supplemented by other documents submitted during the appeal and by Ms. Pound's testimony during the hearing. The allowance represents the Provider's original claim adjusted to agree with the actual days shown on the November, January, and February schedules. There is no allowance for December because there was no schedule in the record for that month. The Board would not allow FTEs for Dr. White based solely on documents submitted during the audit period.

The Board's findings are summarized in the tables below.

FTEs to Be Added to the Provider 2001 FTE count:

	Weighted FTEs	Unweighted FTEs
Buck, Charles (Tab 5)	0.0849	0.0849
Desverreaux, Robert (Tab 6)	0.0849	0.0849
Gregory, Timothy (Tab 7)	0.0822	0.0822

Hoefle, Jeffrey (Tab 8)	0.0849	0.0849
Vreeland, Matthew (Tab 9)	0.0849	0.0849
Reuter, David (Tab 23)	0.0722	0.1444
House, Nicole (Tab 28)	0.0425	0.0849
Kollman, Tobias (Tab 29)	0.2082	0.4164
Lewis, Kaeryn (Tab 30)	0.0809	0.1616
Way, Sing Sing (Tab 31)	0.0822	0.0822
Weissman, Scott (Tab 32)	0.1275	0.2547
Gillespie, Robert (Tab 39)	0.3333	0.6667
Gordon, Carrie (Tab 40)	0.0958	0.1916
Hingorani, Sangeeta (Tab 41)	0.3582	0.7165
Lin, Fangming (Tab 42)	0.0287	0.0575
Okamura, Daryl (Tab 43)	0.1034	0.2069
Debley, Jason (Tab 52)	0.2534	0.5068
Hoffman, Jason (Lucas) (Tab 53)	0.0438	0.0877
McKinney, Martha (Tab 54)	0.2096	0.4192
Moskowitz, Samuel (Tab 55)	0.2137	0.4274
Cusick, Robert(Tab 60)	0.37395	0.7479
Kim, Stephen (Tab 61)	0.1055	0.2109
Weidner, Bryan (Tab 62)	0.4383	0.8767
Heathcock, Brian (Tab 65)	0.137	0.137
Mersol, Joe (Tab 66)	0.1534	0.1534
Phinney, Alexi (Tab 67)	0.1534	0.1534
Pontius, Michelle (Tab 68)	0.1534	0.1534
White, Cheryl (Tab 69)	0.0822	0.0822
Total 2001 Board's Findings for Provider:	4.27235	7.3612

FTEs to Be Added to the Provider 2002 FTE count:

	Weighted FTEs	Unweighted FTEs
Calinoiu, Ileana (Tab 3)	0.2521	0.2521
Kim, Samuel (Tab 19)	0.1671	0.1671
Countouriotis, Athena(Tab 21)	0.0767	0.0767
Lewis, Karyn (Tab 34)	0.0411	0.0822
Pozos, Tamara (Tab 35)	0.0411	0.0822
Way, Sing Sing (Tab 36)	0.3288	0.3288
Weissman, Scott (Tab 37)	0.0425	0.0849
Faizan, Khurrai (Tab 45)	0.0383	0.0766
Gordon, Carrie (Tab 47)	0.3180	0.6360
Hingorani, Sangee (Tab 48)	0.0096	0.0192
Okamura, Daryl (Tab 49)	0.3238	0.6475
Smith, Jodi (Tab 50)	0.0383	0.0766
Yonekawa, Karyn (Tab 51)	0.1073	0.2146
Debley, Jason (Tab 56)	0.1932	0.3863
Hoffman, Jason (Lucas) (Tab 57)	0.2295	0.4589

McKinney, Martha (Tab 58)	0.0747	0.1493
Philips, Grace (Tab 64)	0.126	0.2521
Total 2002 Board's Findings for Provider:	2.4081	3.9911

Stipulations by the Intermediary in Advance of Testimony

The Intermediary stipulated, prior to the presentation of evidence, that the following FTEs would be added to the Provider's 2001 CHGME FTE count:

	Weighted FTEs	Unweighted FTEs
Cartwright, Victoria (Tab 59)	0.5	1.0
Deora (Duncan), Mona (Tab 70)	0.1671	0.1671
Caruncho, Maria (eligible programs issue)	0.1512	0.1512
Davis, Elizabeth (eligible programs issue)	0.0756	0.1512
Eisses, Michael (IRP issue)	0.0748	0.1496
Frigon, Chantal (IRP issue)	0.0748	0.1496
Resolved Overlaps[7]	0.73	0.90
Total 2001 Intermediary Stipulations:	1.7722	2.6660

The Intermediary stipulated that the following FTEs would be added to the Provider's 2002 CHGME FTE count:

	Weighted FTEs	Unweighted FTEs
Davenport, Nathaniel (Tab 10)	0.0767	0.0767
Garr, Elizabeth (Tab 1)	0.0384	0.0767
Goldin, Adam (Tab 63)	0.126	0.2521
Hawley, Tina (Tab 16)	0.0425	0.0849
Henkle, Esther (Tab 11)	0.0356	0.0356
Larson, Kristen (Tab 12)	0.0767	0.0767
Palanti, Mamatha (Tab 14)	0.0077	0.0154
Ramsey, Ellen (Tab 2)	0.0479	0.0959
Nicholson, Laura (eligible programs issue)	0.0373	0.0747
Hood, Bradley (eligible programs issue)	0.0017	0.0017
Reysio-Cruz, Marc (eligible programs issue)	0.0849	0.0849
Doherty, Daniel (eligible programs issue)	0.0068	0.0136
Total 2002 Intermediary Stipulations:	0.5822	0.8889

Stipulations by the Provider in Advance of Testimony[8]

Prior to the presentation of evidence, the Provider withdrew its claim to the following FTEs for fiscal year 2001:

[7] See Provider Exhibit 102 for a list of residents whose FTEs were included in this issue.

[8] The Provider also withdrew its claim to several other FTEs prior to the commencement of the hearing in this matter. See Provider's Supplemental Position Paper at 1 n.1.

	Weighted FTEs	Unweighted FTEs
Bergelson, Elise (Tab 15)	0.0575	0.0575
Rotation Changes	0.63	0.55
Total 2001 Withdrawn:	0.6875	0.6075

The Provider also withdrew its claim to the following FTEs for fiscal year 2002:

	Weighted FTEs	Unweighted FTEs
Lebl, Martin (Tab 13)	0.0103	0.0103
McCain, Greg (Tab 20)	0.0137	0.0137
Miller, Daniel (Tab 17)	0.0374	0.0748
Rotation Changes[9]	1.42	1.43
Total 2002 Withdrawn:	1.4814	1.5288

DECISION AND ORDER:

The Board orders, consistent with the Board's findings as to disputed FTEs and the parties' stipulations as to other FTEs, that the Intermediary add 6.04455 weighted and 10.0272 unweighted FTEs to the Provider's 2001 FTE count, and 3.5396 weighted and 5.4951 unweighted FTEs to the Provider's 2002 FTE count to be used for purposes of 2004 CHGME payments. Based on the old evidence and parties' stipulation, the Board orders that the Intermediary add 3.8770 weighted and 6.3718 unweighted FTEs to the Provider's 2001 FTE count, and 1.8746 weighted and 2.4274 unweighted FTEs to the Provider's 2002 FTE count to be used for purposes of the 2004 CHGME payments.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire, Chairman
Elaine Crews Powell, CPA
Anjali Mulchandani-West

DATE: July 14, 2004

FOR THE BOARD:

Suzanne Cochran
Chairperson

[9] See Provider Exhibits 104 and 105 for a list of the residents whose FTEs were included in this issue.