PROVIDER REIMBURSEMENT REVIEW BOARD

2024-D29

PROVIDERS –
Vanderbilt University Medical Center
and
Saint Thomas Health FFY 2015 Wage Index Calculation CIRP Group

PROVIDER NOS. –
44-0039, 44-0053, 44-0082, 44-0133, and 44-0218

vs.

MEDICARE CONTRACTORS –
Palmetto GBA (J-J)
and
Cahaba GBA c/o National Government Services, Inc. (J-M)

HEARING DATE –
September 21, 2023

FISCAL YEAR END –
09/30/2015 for all

CASE NOS. –
15-1470
15-1471GC

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ISSUE STATEMENT:

Whether the Medicare Contractor and the Centers for Medicare & Medicaid Services ("CMS") improperly disallowed certain wage data from Vanderbilt University Medical Center ("VUMC") when the wage index for Federal Fiscal Year ("FFY") 2015 was calculated?[1]

DECISION:

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board" or "PRRB") finds the Medicare Contractor and CMS properly disallowed certain wage data from VUMC when the wage index for FFY 2015 was calculated.

INTRODUCTION:

This case involves an individual appeal and a group appeal. VUMC appealed CMS' determination of the wage index applicable to it in FFY 2015 which was assigned to Case No. 15-1470. Four other commonly-owned hospitals also appealed CMS' determination of the wage index applicable to them in FFY 2015 which was assigned to a common issue related party ("CIRP") group under Case No. 15-1471GC. The CIRP group appeal consists of the following four hospital participants: Saint Thomas Rutherford, Saint Thomas West, Saint Thomas Midtown, and Saint Thomas Hospital for Spinal Surgery (hereinafter the "CIRP Group Participants").[2] The Board will refer to VUMC and the CIRP Group Participants, collectively, as "the Providers."

The designated Medicare contractor[3] for Vanderbilt is Palmetto GBA (J-J) ("Palmetto"), and the designated Medicare contractor for the CIRP Group Participants is Cahaba GBA c/o National Government Services, Inc. ("Cahaba"). The Board will refer to Palmetto and Cahaba, collectively, as "the Medicare Contractors."

The Providers in these appeals are challenging "the exclusion of certain wage and wage-related costs from the wage data used to calculate the final wage index for the Nashville-Davidson-Murfreesboro-Franklin ("Nashville"), Tennessee core based statistical area ("CBSA") for [FFY] 2015."[4] The Providers timely requested hearings before the Board and met the jurisdictional requirements for both appeals. Accordingly, the Board held concurrent, in-person hearings on September 21, 2023. The Providers were represented by Stephanie A. Webster, Esq. of Ropes & Gray, LLP. The Medicare Contractor was represented by Joseph Bauers, Esq. of Federal Specialized Services, LLC.

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[1] Transcript of Proceedings (hereinafter "Tr.") at 5 (Sept. 21, 2024).

[2] The group including the Individual appellant and the CIRP Group Participants are referred to, in total, as "Providers."

[3] CMS's payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate and relevant.

[4] Providers' Final Position Paper (hereinafter "Providers' FPP") at 1 (Jun. 23, 2023).

STATEMENT OF LAW AND FACTS:

A. RELEVANT LAW REGULATIONS AND POLICY

In general, Medicare pays hospitals for inpatient services through the IPPS.[5] The IPPS provides Medicare payments for hospital inpatient operating and capital related costs at predetermined, specific rates for each hospital discharge.[6] The rates are based on average costs that consist of a labor related portion and a non-labor related portion.[7] The labor related portion is adjusted by the wage index applicable to the geographic area where the hospital is located.[8] The wage index is intended to reflect the relative hospital wage level in that geographic area, as compared to the national average hospital wage level.[9] It is calculated by dividing the average hourly wage ("AHW") in each CBSA area by the national average hourly hospital wage.[10]

CMS is required to update the wage index annually and bases that update on a survey of wage-related costs taken from cost reports filed by each hospital paid under the IPPS.[11] The FFY 2015 wage index was based upon wage data "obtained from…Medicare cost report[s] for cost reporting periods beginning on or after October 1, 2010, and before October 1, 2011."[12] Hospitals report wage and wage-related costs data on Worksheet S-3, Parts II and III of the Medicare cost report.[13]

CMS publishes the wage data at intermittent intervals so that hospitals can review it for accuracy. If the hospital disagrees with the accuracy of the data, a hospital may request corrections to errors and re-computation of the wage index. A hospital requesting a correction must access the Public Use File ("PUF") online.[14]

The wage index correction process for FY 2015 took place from September 2013 through June 2014.[15] During that time VUMC made three wage index correction requests on the following dates: (1) November 20, 2013;[16] (2) February 28, 2014;[17] and (3) April 15, 2014.[18] The requests were timely as they were received by the deadline dates for such requests as specified in the wage index correction process for FY 2015.[19] The Medicare Contractor responded to VUMC's wage index correction requests on January 27, 2014,[20] and on April 7, 2014.[21]

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[5] *See* 42 U.S.C. § 1395ww(d).
[6] *Id.*
[7] 42 C.F.R. § 412.64(h).
[8] *Id.*
[9] 42 U.S.C. § 1395ww(d)(1)(H).
[10] 42 C.F.R. § 412.64(h).
[11] 42 U.S.C. § 1395ww(d)(3)(E).
[12] 79 Fed. Reg. 49854, 49964 (Aug. 22, 2014).
[13] *Id. See also* Provider Reimbursement Manual, CMS Pub. 15-2 ("PRM 15-2"), § 4005.2.
[14] Available at https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/wage-index-files-items/fy-2015-wage-index-home-page (last accessed Sept. 19, 2024).
[15] Exhibit (hereinafter "Ex.") at P-1.
[16] Ex. P-6 at P0320. Note that all Bates numbering on the exhibits for this record are alphanumeric and have a dash separating the alphabetical letter and the numbers (*e.g.*, P-0320). However, to minimize confusion, the Board is dropping the dash from the Bates numbers (*e.g.*, P-0320 becomes P0320).
[17] *Id*. at P0190.
[18] *Id.* at P0136.
[19] Ex. P-1.
[20] Ex. P-6 at Tab D (beginning at P0194).
[21] *Id.* at Tab B (beginning at P0151).

B. OMB CIRCULAR A-21

OMB Circular A-21 was issued on May 10, 2004 to address "Cost Principles for Educational Institutions." Specifically, it identifies its purpose as "establish[ing] principles for determining costs applicable to grants, contracts, and other agreements with educational institutions." It further states that "[t]he principles are designed to provide that the Federal Government bear its fair share of total costs, determined with generally accepted accounting principles, except where restricted or prohibited by law."

Significantly, OMB Circular A-21 has a section entitled "Applicability" to define the following circumstances to which it is applicable:

> a. All Federal agencies that ***sponsor research and development, training, and other work*** *at educational institutions* shall apply the provisions of this Circular in determining the costs incurred for such work. The principles shall also be used as a guide in the pricing of fixed price or lump sum agreements.
>
> b. In addition, Federally Funded Research and Development Centers associated with educational institutions shall be required to comply with the Cost Accounting Standards, rules and regulations issued by the Cost Accounting Standards Board, and set forth in 48 CFR part 99; provided that they are subject thereto under defense related contracts.[22]

Thus, OMB Circular A-21 applies to Agency-sponsored work with educational institutions (*e.g*., research and development and training) under agreements with the Federal Government that the Circular refers to as "sponsored agreements."[23] Significantly, the "Applicability" statement does not encompass determining costs under of a provider for purposes of reimbursement under the Medicare program even when the provider is an educational institution. Also important to note is the fact that research costs are non-reimbursable on the Medicare cost report, and time spent in research must be carved out of both physician and resident time when those reimbursements are calculated on the cost report. Thus, the Circular applies to the costing of activities for which Medicare does not reimburse.

As noted in OMB Circular A-21, Public Law 97-638[24] authorizes the use of predetermined rates in determining "indirect costs" which the Circular refers to as "facilities and administrative costs" or "F&A" costs.[25] Specifically Public Law 97-638 states:

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[22] Ex. P-3 at P0013 (emphasis added).
[23] *Id.* at P0016 (describing the "Objectives" as: "This Attachment provides principles for determining the costs applicable to research and development, training, and other sponsored work performed by colleges and universities under grants, contracts, and other agreements with the Federal Government. These agreements are referred to as sponsored agreements.").
[24] 76 Stat. 437 (1962).
[25] Ex. P-3 at P0019, P0031.

AN ACT

> To provide for a method of payment of indirect costs of research and development contracted by the Federal Government at universities, colleges, and other educational institutions.
>
> *Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled*, That hereafter provision may be made in cost-type research and development contracts (including grants) with universities, colleges, or other educational institutions for payment of reimbursable indirect costs on the basis of predetermined fixed-percentage rates applied to the total, element thereof, of the reimbursable direct costs incurred.

OMB Circular A-21 describes the objective of this statute as "to simplify the administration of cost type research and development contracts (including grants) with educational institutions, to facilitate the preparation of their budgets, and to permit more expeditious closeout of such contracts when the work is completed."[26] Thus, the scope of use for F&A pre-determined rates is limited to sponsored agreements (consistent with the applicability of OMB Circular A-21).

The OMB Circular A-21 defines "facilities and administrative costs" or "F&A" costs as "costs that are incurred for common or joint objectives and, therefore, cannot be identified readily and specifically with a particular sponsored project, an instructional activity, or any other institutional activity."[27] It states that "the overall objective of the F&A cost allocation process is to distribute the F&A costs described in Section F to the major functions of the institution in proportions reasonably consistent with the nature and extent of their use of the institution's resources."[28] It further states that an institution may elect to treat fringe benefits as F&A charges and that, when such an election is made, "such costs should be set aside as a separate grouping for selective distribution to related cost objectives."[29]

C. The Parties' Positions

The Providers argue that CMS has "erroneously excluded $139 million in certain wages, benefits, and contract labor costs..."[30] for VUMC, which "were for a range of administrative services…including, for example, payroll, computer support, and security" for VUMC.[31] This, in turn, excluded certain wage data from the Nashville-Davidson-Murfreesboro-Franklin, Tennessee CBSA.[32] VUMC claims it properly identified these costs on its Worksheet S-3 and properly allocated the costs "using common and accepted cost accounting principles that were both sophisticated and data driven and supported by admittedly 'voluminous' documentation."[33] VUMC explains that it "allocated its indirect wage costs from Vanderbilt University and

[26] *Id.* at P0031.
[27] *Id.* at P0019.
[28] *Id.* at P0024.
[29] *Id.* at P0025.
[30] Providers' Post Hearing Brief (hereinafter "Providers' PHB") at 1 (Nov. 20, 2023).
[31] *Id.*
[32] *Id.*
[33] *Id* at 2.

Vanderbilt's Medical Center Administration ("MCA") using allocation methods that are consistent with the methods approved for apportioning Medicare home office costs and for federal contracting and grant programs."[34]

The Providers point out that the costs at issue were allowable (and remained) on the cost report as "other" costs but were not permitted to be included as wage-related costs for the wage index. The Providers assert the removal from Worksheet S-3 of $139 million in costs is contrary to Medicare statute and rules, and also arbitrary and capricious because the Medicare Contractor did not explain why it rejected VUMC's allocation methods,[35] and failed "to consider how its exclusion of those wage costs flouts the purpose of the wage index and CMS's stated emphasis on consistency."[36]

In its third request for wage index correction dated April 15, 2014, VUMC alleges that several errors and omissions were made by the Medicare Contractor during the wage data correction process. In this letter, VUMC requested intervention by CMS "to address several significant errors in the information submitted for Vanderbilt University Hospitals and Clinic…"[37] VUMC claims the Medicare Contractor failed to "allow sufficient time to complete an adequate desk review of the Corrections Requests submitted in November 2013 or the Correction Requests submitted February 28, 2014…"[38] VUMC sought CMS intervention to address five specific issues:

1) Failure to Adjust Hours,
2) Adjustments Made Subsequent to January 29, 2014,
3) MCA Benefits
4) Overhead Department Costs, and
5) Contract Labor.[39]

The Providers contend that VUMC was operated as a separate health-related division of Vanderbilt University, and Vanderbilt University wholly-owned VUMC.[40] The Providers add that MCA was also a separate health-related division which provided support services to other health-related divisions of Vanderbilt University.[41] VUMC explains that it did not file a home office cost report for FY 2012 because "it was the only hospital within Vanderbilt and not part of either a hospital chain or network."[42] The Providers have submitted a chart at Exhibit P-12 illustrating the relationship between VUMC, MCA and Vanderbilt University.

The Providers are asking that "approximately $139 million in wage costs relating to Vanderbilt and [MCA] be included in the costs used to determine the FFY 2015 wage index."[43] This amount of $139 million includes "$41 million in wage costs relating to Vanderbilt departments that

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[34] *Id.*
[35] *Id.*
[36] *Id.*
[37] Ex. P-6 at P0137.
[38] *Id*. at P0138.
[39] *Id*. at P0139 – P0145.
[40] Providers' PHB at 13. *See also* Ex. P-12.
[41] Providers' PHB at 13. *See also* Ex. P-12.
[42] Providers' PHB at 14.
[43] *Id.* at 16.

serviced all divisions of Vanderbilt,"[44] including the medical center and VUMC, and "$98 million in wage costs relating to Vanderbilt's [MCA]."[45] It is the Providers' position that the exclusion of the $139 million from the wage index calculation resulted in the loss of millions of dollars in payment to the hospitals in the Nashville CBSA.[46]

This dispute centers on how the $139 million costs at issue were allocated. The Providers argue these costs should have been included as wage and wage-related costs attributable to Vanderbilt and MCA for purposes of the wage index because the costs were identified on Worksheet S-3, and they were "properly allocated using common and accepted cost accounting principles consistent with the [Provider Reimbursement Manual]'s home office approach and a method approved by HHS for purposes of federal grants."[47]

The Providers assert the wage and wage-related costs at issue must be included in the wage index calculation, consistent with 42 U.S.C. § 1395ww(d)(3)(E)(i) which requires that "the Secretary shall adjust the proportion…of hospitals' costs which are attributable to wages and labor-related costs…for area differences in hospital wage levels" in the wage index.[48] The Providers also cite to 42 U.S.C. § 1395x(v)(1)(A) which defines "reasonable costs" of provider services as including both direct and indirect costs.[49] The Providers claim that the Medicare Contractor has violated these statutes and their implementing regulations by excluding VUMC's indirect wage-related costs, and that the Medicare Contractor has also violated CMS rules and cost reporting instructions.[50]

The Providers claim that that the Medicare Contractor's disallowance is inconsistent with the home office instructions in Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1") which allow direct and indirect cost allocation.[51] Regarding direct allocation, the Providers cite to PRM 15-1 § 2150.3(B) which states "[t]he initial step in the allocation process is the direct assignment of costs to the chain components," and "[a]llowable costs incurred for the benefit of, or directly attributable to, a specific provider or nonprovider activity must be allocated directly to the chain entity for which they were incurred.[52] When utilizing direct allocation, the home office "may simplify the allocation of costs to the chain components in the cost finding process by transferring the costs which are directly allocable to the components through the intercompany accounts."[53] With regards to indirect cost allocation approach, the Providers cite to PRM 15-1 § 2150.3(D) which states "all chain components will share in the pooled home office costs in the same proportion that the total costs of each component (excluding home office costs) bear to the total costs of all components in the chain."[54] The Providers explain that VUMC utilized both direct and indirect cost allocation for the $98 million in MCA costs which benefited VUMC.[55]

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[44] *Id.* at 17. *See also* Ex. P-6 at P0909.
[45] *Id.* *See also* Ex. P-6 at P0895-97.
[46] *Id.* at 17-18. *See also* Exs. P-2, P-13; Tr. at 33.
[47] Providers' PHB at 26.
[48] *Id.* at 27. *See also* 42 C.F.R. § 412.64(h).
[49] Providers' PHB at 27. *See also* 42 C.F.R. § 413.9(c)(3); PRM 15-2, Ch. 40, § 4005.2 (CMS Form 2552-10).
[50] Providers' PHB at 28.
[51] *Id*. at 29.
[52] *Id.* at 30 (quoting PRM 15-1 § 2150.3(B)).
[53] *Id.*
[54] *Id*. at 30 (quoting PRM 15-1 § 2150.3(D)).
[55] *Id*. at 30. *See also* Ex. P-14 at P1487, P1597-610; Ex. P-6, Tab G at P0895-97; Ex. P-20 at P1893; Tr. at 101.

The Providers contend the allocation method used for VUMC's $41 million of wage costs was also consistent with home office cost report instructions.[56] The Providers explain that consistent with PRM 15-1 § 2150.3(D), "VUMC's share of the total Vanderbilt costs (akin to the pooled home office costs) is 58.17 percent," and the "percentage was properly applied to allocate Vanderbilt wage-related overhead between VUMC and other components of Vanderbilt."[57] The Providers claim the total $139 million costs at issue ($98 million from MCA and $41 million from Vanderbilt University) "are reasonable and should have been included in the Providers' wage index calculation."[58]

The Providers explain that VUMC employed the methodology contained in OMB Circular A-21[59] to allocate $78 million in MCA wage costs and $41 million in Vanderbilt University wage costs.[60] The Office of Management and Budget issued OMB Circular A-21, entitled "Cost Principles for Educational Institutions.[61] The Providers describe the Circular as "govern[ing] the determination of costs applicable to *federal grants*, contracts, and other agreements between the federal government and academic institutions."[62] The Providers further explain that VUMC applied the approach used by Vanderbilt University when it negotiated Facilities and Administrative rates for its federally sponsored research and grants "in preparing the indirect cost proposal that it furnished to the MAC and CMS."[63] VUMC applied the 25.9 percent benefits percentage that HHS approved in Vanderbilt's research and grant programs rate agreement to determine benefits related to VUMC for its Medicare cost report.[64]

With regards to Vanderbilt University personnel salaries, VUMC states that "[it] divided its total costs by Vanderbilt's total costs to arrive at a percentage of 58.17 percent and then used that rate to determine its portion of Vanderbilt's general wage costs."[65] At hearing, the Providers' witness explained that this percentage of 58.17 was calculated as follows:

> We took the modified total direct costs of the hospital and clinics, 1.5 billon, and divided by the total for the University, 2.6 billion, which makes the 58.1 percent. It's a strict cost to cost ratio.[66]

The Providers claim this method is common and permitted by CMS.[67] VUMC allocated $11.2 million for police wage costs "based on the square footage of the buildings in areas that the police and security patrolled, excluding parking garages, to arrive [at] a square footage statistic of 30.8045 percent,"[68] and applied the 25.9 percent benefits rate applied to MCA wage costs.[69]

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[56] Providers' PHB at 31.
[57] *Id.* at 32.
[58] *Id.*
[59] Ex. P-3.
[60] Providers' PHB at 32-33.
[61] Ex. P-3.
[62] Providers' PHB at 33 (citing to Ex. P-3 at P0019-20 (OMB Circular A-21 §§ B.4, C.4.d.3)) (emphasis added).
[63] *Id.* at 34. *See* Ex. P-6, Tab H (beginning at P0903).
[64] Providers' PHB at 34-35.
[65] *Id.*at 35. *See* Ex. P-6, Tab H at P0909, P1161; Ex. P-22.
[66] Tr. at 64.
[67] Providers' PHB at 35. *See also* Tr. at 109.
[68] Providers' PHB at 36. *See* Ex. P-6, Tab H at P0908-09, P0911.
[69] Providers' PHB at 36. *See* Ex. P-9 at P1293; Tr. at 208, 211-12.

The Medicare Contractor's position is that VUMC did not properly document "in an auditable fashion, the various allocation methodologies of costs from 'related organizations'."[70] The Medicare Contractor asserts there are two wage-related costs being challenged by VUMC. The first cost is "$41,552,327 in wage and wage[-]related costs… related to University departments that serviced all divisions of the University including the Provider."[71] The second cost is "$98,904,720 in wage[-]related costs and associated benefits allocated from the MCA to [VUMC]."[72]

In connection with the $41,552,327 in wage and wage-related costs included in the allocation from Vanderbilt University to VUMC, the Medicare Contractor summarizes VUMC's allocation method as follows:

> …the University identified $117.2 million in overhead costs in its trial balance attributable to other departments that service all divisions of the University. Provider Exhibit 6, tab H at 184. VUMC excluded costs relating to cost centers that either had no benefit to the Hospital (e.g., costs relating to alumni programs) or were non-reimbursable under Medicare. The remaining $70.4 million in overhead costs support all divisions of the University, including VUMC. Those costs were then allocated among the VUMC and other divisions of the Vanderbilt, as described below. Provider Exhibit 6, Tab H at P-912 – P-921.
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> The indirect cost proposal utilized "modified total direct costs" to allocate these overhead costs to the Hospital. *See* OMB Circular A-21 § G2, Provider Exhibit 3 at P-31. In particular, the University divided the total costs of the Hospital, which was determined to be $1,562,658,482, by the total costs of the University (including the Hospital), which was determined to be $2,686,377,823, yielding a percentage of 58.17 percent to be applied to the University overhead costs at issue here. Provider Exhibit 6, Tab H at P-1161.
>
> Of the $70.4 million in overhead costs, Vanderbilt determined that $48.2 million [was] related to salaries and wages. Provider Exhibit 6, Tab E at P-346.
>
> Applying the percentage derived above (58.17 percent) to the $48.2 million in salary and wage cost yielded a total of $28 million in salary and wage cost allocable to the VUMC. *Id.*
>
> Vanderbilt then applied a benefit rate of 25.9 percent to that $28 million in salary costs to determine the amount of benefits, (*e.g.,* health insurance and pension) that related to the salary cost discussed above. That 25.9 percent benefits rate is the rate that is applied to salary cost under the University's agreement with the

[70] Medicare Contractors' Post Hearing Brief (hereinafter "Medicare Contractors' PHB") at 11 (Nov. 20, 2023).
[71] *Id.* at 3.
[72] *Id.*

> Federal government. Applying that 25.9 percent benefits rate to the $28 million in salary costs identified above yielded $7.3 million in benefits, for a total of $35.3 million.
>
> Finally, $3.3 million in contract labor costs was also allocated to VUMC (relating, *e.g.,* to legal fees for outside counsel and IT consulting) by applying the percentage (58.17 percent) derived above to the total contract labor cost of approximately $5.745 million. *Id.* at P-348. Accordingly, VUMC requested an adjustment to its wage and wage-related costs of $41,552,328 to account for costs relating to Vanderbilt University departments that serviced all portions of Vanderbilt, including VUMC.[73]

The Medicare Contractor disagrees with the method VUMC used to allocate University costs to VUMC as the method was "based upon the HHS method related to *educational grants* to the University."[74] The Medicare Contractor argues "that allowable costs and allocations used for grant requests are not the same as requesting Medicare cost reimbursement," and the negotiated rates used in the applied method "have no place in the realm of Medicare reimbursement."[75] The Medicare Contractor alleges "this unorthodox method [of allocation] was not preapproved by the MAC and the MAC was not consulted. No adequate source data or support for the percentage used was provided to the MAC."[76] The Medicare Contractor claims VUMC "had no system in place to record and track the services that University personnel allegedly performed on behalf of the Provider," and that wage-related costs "require *contemporaneous* records to document time spent, for what purposes, and by whom."[77] The Medicare Contractor concludes that VUMC failed to document that the allocation percentages were appropriate.[78]

The Medicare Contractor describes VUMC's allocation of $98 million in MCA salaries as follows:

> For the $98 million in costs related to salaries from the MCA, the salaries were directly charged to the Provider through monthly entries on the Provider's trial balance as "other" costs. The Provider reclassified the allocated MCA expense from 'Other' to 'Salary' through Worksheet A-6 adjustments. In addition, the Provider requested that the wage related expense and contract labor expenses be added to Worksheet S-3, Part II.
>
> The Provider used various statistical basis (e.g., effort %, FTEs, Patient Revenue, Space, Machine Time, etc.) to determine a ratable share of the overhead cost to be transferred to the departments supported by the MCA. However, this was done for the purpose of financial reporting, budgeting and management reporting. *P-20 at*

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[73] Medicare Contractors' PHB at 4-5.
[74] *Id.* at 6 (emphasis added).
[75] *Id.*
[76] *Id.*
[77] *Id.* (emphasis added).
[78] *Id.*

> *P- 1893, TR. at page 53 and 163-4.* The MCA includes traditional 'overhead' cost in departments necessary for Provider's operation (e.g., HR, IT, Patient Accounting). The salary and other expenses for these overhead departments are recorded in distinct cost centers and then further allocated via general ledger journal entries to the benefiting departments. The Provider extolls that this process of shared cost allocation ensures that all entities and the departments receive a ratable share of the MCA overhead cost for internal budgeting and reporting purposes. *P-20 at P-1891.*
>
> The MCA allocations were determined internally by the University finance committee and based on the committee's best efforts and estimates to allocate these costs to the various departments. The committee looks at what is the best way to allocate these costs. *TR at page 75.*

The Medicare Contractor noted that upon review of VUMC's documentation, there appeared to be costs included that should not be shared by VUMC.[79] The Medicare Contractor asserts there "were cost items that were deemed non- reimbursable per Medicare cost report regulations…"[80] and "the allocation percentage of 58.17% could not be properly tracked back through the supplied documentation to its source, and the ICP report that the Provider documented was not reconcilable to the working trial balance."[81] The Medicare Contractor concludes that the "actual cost from the related party could not be accurately determined."[82]

The Medicare Contractor alleges VUMC did not maintain proper records and documentation regarding wage-related costs allocated from the University to MCA. The Medicare Contractor states, "many discussions and exchanges of information" took place and many efforts were made to resolve this issue.[83] The Medicare Contractor argues that the documentation and data provided by VUMC is "mainly of testimonial styled evidence that is self-serving and not capable of a MAC audit for Medicare reimbursement."[84]

DISCUSSION, FINDINGS OF FACT AND CONCLUSIONS OF LAW:

After considering the Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds the MAC and CMS properly disallowed certain wage data from VUMC when the wage index for FFY 2015 was calculated.

The Board finds the allocation method VUMC used to allocate costs from the University and MCA was not supported by sufficient financial records and statistical data. Providers are required to "maintain sufficient financial records and statistical data for proper determination of costs payable under the [Medicare] program."[85] Providers must also make such records and data available to the

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[79] *Id.* at 8.
[80] *Id.*
[81] *Id.*
[82] *Id.*
[83] *Id.* at 10. *See* Tr. at 184.
[84] Medicare Contractors' PHB at 10.
[85] 42 C.F.R. § 413.20(a). *See* Ex. C-15 at C0148.

Medicare contractor as necessary to (i) assure proper payment; (2) receive program payments; and (3) satisfy program overpayment determinations.[86]

Adequate cost data is defined at 42 C.F.R. § 413.24 (a) and (c) as follows:

> (a) *Principle.* Providers receiving payment on the basis of reimbursable cost must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting…
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> ****
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> (c) *Adequacy of cost information.* Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which is it intended. Adequate data capable of being audited is consistent with good business concepts and effective and efficient management of any organization…[87]

Providers have the "burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue," pursuant to 42 C.F.R. § 405.1871(a)(3).

The Board notes that the *sole* witness presented by the Providers began her employment with VU in September 2014, as evidenced by the resume included at Exhibit P-26. However, the witness has no first-hand or direct knowledge of the FY 2012 Wage Index review and audit process because it all occurred *prior to* when she started her VU employment. Specifically, she was not originally involved in the Wage Index preparation or review, as the FY 2012 cost report was filed in November 2012, nor was she involved in the FY 2012 Wage Index review and audit process as that process occurred from September 2013 to July 2014, with the final rule, including the publication of the wage index and any agreed-upon corrections, being published in August 2014.[88] Thus, her testimony and the underlying observations and analyses are not contemporaneous with the FY 2012 Wage Index review and audit process but rather appear to be based upon *post-hoc* review and experience with the organization. Given her lack of direct information on the FY 2012 Wage Index review and audit process, the Board carefully reviewed her testimony but declines to give it much weight or value as described below.

A. Background on How and When the Costs at Issue Were Identified

To put the nature of the dispute in its proper context, it is helpful to first discuss how and when the costs at issue were identified. The Board notes that there are two categories or "buckets" of costs in contention. The first bucket pertains to related party costs allocated down from

[86] 42 C.F.R. § 413.20(d)(i)-(iii). *See* Ex. C-15 at C0148.
[87] *See* Ex. C-16 at C0151.
[88] *See* Ex. P-17 (FYE Jun. 30, 2012 as-filed cost report dated Nov. 29, 2012). *See also* Ex. P-1 (FY 2015 Hospital Wage Index Development Timetable).

Vanderbilt University to VUMC. This bucket reflects total costs of $41.6 million, per VUMC's Exhibit P-6. This Exhibit contains a schedule on pages P0289 – P0298 which is titled "Vanderbilt University/Medicare Indirect Cost Report/Establish GA [General Administrative] Cost Pool." This 9-page schedule identifies costs by numerous centers and divisions, identifies the FY 2012 MTDC [Modified Total Direct Cost], adjusts this cost in some cases, excludes some centers (based on whether they "benefit Hospital/VHCS" or not), and arrives at an MTDC to allocate. Further columns identify "Payroll $" and "Payroll Hours" presumably related to the MTDC being allocated. After application of the "Hospital % of G&A" (58.17 percent), and the "UC Staff Benefits Rate" (25.9 percent), the calculations result in a total allocation of $41,552,327 in costs the hospital seeks to allocate to VUMC's Worksheet S-3, Part II, line 14.[89] The actual breakdown of these costs is shown below:

Hospital Gen & Admin. Payroll $ (58.17%)	$28,059,881
Hospital Calculated Benefits (25.9%)	$ 7,267,509
Hospital Portion of Univ. Contract Labor	$ 3,341,978
Hospital Police Allocation (different basis 30.80%)	$ 2,289,881
Police Calculated Benefits (25.9%)	$ 593,079
TOTAL VU G&A ALLOCATION TO VUMC	$41,552,327 (rounded)[90]

The Board notes that this expense was ***not*** included on VUMC's *originally* filed cost report as part of the Wage Index data on Worksheet S-3; but rather, was a "correction request" made in November 2013 by VUMC's consultants during the wage index review process.[91] In Exhibit P-6, at Tab E, VUMC has provided its "Summary Sheet of Proposed Hospital Wage Index Adjustments" which shows an increase from Home Office Salaries of $0 "Per "Input" Data" to $55,406,454 "As Adjusted."[92] Home Office paid hours have also increased from 0 to 1,011,044.[93] Further, while VUMC argued that this allocation was included in the FY 2011 as-filed cost report, the Board notes that VUMC's Exhibit P-6 includes its comparison of the FY 2011 Final Wage Index PUF, the FY 2012 As Filed Worksheet S-3, and the "Provider Correction Requests" for FY 2012. In this comparison analysis, VUMC notes that the FY 2011 Final PUF contains $7,205,550 in "Home Office Salaries and Wage Related Costs," while FY 2012 was filed with $0, as noted above, and then VUMC requested $55,406,454 be added to this line.[94] While *some* home office costs was included in FY 2011, the amount requested as a correction by VUMC in FY 2012 was more than seven times the amount from FY 2011. VUMC presented the Medicare Contractor with a major adjustment, adding almost 10 percent in additional overhead expenses to its Worksheet S-3 costs for wage index, and increasing the prior year amount by over 600 percent, describing it as a "correction," although it was an *unclaimed* home office cost (*i.e.*, unclaimed as it was not presented in this line on the original as-filed cost report). Through this *belated* presentment, VUMC was essentially requesting that the Medicare Contractor conduct a *full* review of a new *and* material amount of costs, and then evaluate any associated allocation methodologies, during the abbreviated wage index review cycle notwithstanding the fact that the

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[89] Ex. P-6 at P0297.
[90] *Id.*
[91] *Id.* at P0322 (email stating "Attached are corrections submitted for the 6/30/2012 Wage Index for the following provider: Vanderbilt University Hospitals & Clinics" dated Nov. 20, 2013.)
[92] *Id.* at P0328.
[93] *Id.*
[94] *Id.* at P0147.

Medicare Contractor must perform wage index reviews for ***all*** of its assigned hospitals at the same time.

The second category reflects $98 million in disputed costs and pertains to overhead allocations from MCA to VUMC. As a result of monthly transfers from the MCA to VUMC (using a shared expense account, 81025), these allocations were reported on VUMC's general ledger and trial balance, and therefore, its cost report, as "other" expenses.[95] As part of its cost report, VUMC made a reclass on Worksheet A-6 to move these costs from "other" to "salary" (column 2 to column 1), so that it could be included in the Wage Index calculation on Worksheet S-3. At hearing, VUMC's witness essentially argued that this expense was "natively" a salary expense and the reclassification simply moved it to where it belonged:

> Because the general ledger had this mechanism through which they ran these adjustments if, you know – these entries each month. It made it lose its native natural class of salary. It was . . . it's natively salary. And so, we moved it back where it belonged. When [the] trial balance came in for the cost report, it was sitting in Other – properly sitting in Other because 81025 is not a salary account. But when you look at what was sitting in 81025 for MCA, natively it was salary expense. So, we wanted to move back. And that's the whole purpose of reclass K on A-6 was about, was putting it back where it belonged."[96]

Exhibit P-16 shows VUMC's accumulation of these "Shared Allocations for FY2012." This Excel schedule identifies the expense and related paid hours/FTEs by center and cost report line. The final amount, which is shown as an increase to Salary Expense and a decrease to Other Expense, is $78,212,021.[97] VUMC also includes, as part of Exhibit P-6, a schedule titled "Wage Index Review: Shared Service Reclass – Fringe Benefits," which accumulates Fringe Benefit cost, by center, that relates to the salaries being reclassed. The "UC Staff Benefits Rate" of 25.9 percent, applied to the University Overhead bucket, as discussed above, was not used for these expenses. As a result, VUMC has identified $20,692,660 in Fringe Benefit cost, of which $151,553 was assigned to Excluded Areas.[98] The breakdown is shown below:

Total MCA Salaries Reclassed from "other"	$78,212,060
Total Shared Reclass Benefits	$20,692,660
Total MCA Shared Allocation/Reclass	$98,904,720[99]

During the hearing, VUMC's witness confirmed that Exhibit P-14 contains a summary, by shared center, to show how costs were allocated to the various entities by MCA. Each page shows the 2012 budgeted expenses, compares them to the FY 2011 forecast and budget, and then shows how they are allocated. It reflects allocations to various entities, some of which "roll up" to a Total Hospital allocation. (This group of entities includes Hospital, TVC, DOT Children's Hospital,

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[95] Tr. at 124.
[96] *Id.* at 125.
[97] Ex. P-16 at P1635.
[98] Ex. P-6 at P0311.
[99] *Id.*

VPH, VMG Bus, and VHVI.)[100] This summary allocates cost on a variety of bases, based on the type of cost. A sampling of the descriptions of these bases, from just the first page, include "Net Patient Revenue, FTEs w/o Faculty, FTEs, 2nd tier Net Pt rev, Discharges – Adult/VHVI only, ER visits – Adult/VHVI only."[101] As VUMC's witness stated, the "composite, summarized, weighted average, or whatever you want to call it. Composite would be [ ] the 67 [percent]."[102] Thus, overall, 67.16 percent of MCA's costs were allocated to VUMC.

In addition, Exhibit P-14 contains a schedule at a higher level of data which shows the percentages used to allocated costs in each shared center to the various related entities.[103] This schedule also shows a variety of percentages used, as well as some areas noted "Not shared" or "Manual Calc."[104] While VUMC did include this reclass of costs/hours with its filed cost report, it is also clear the related benefits of $20.7M were *not* included for wage index purposes, as VUMC's November 20, 2013 wage index correction request also includes a workpaper detailing these Fringe Benefit costs, which is identified as "Schedule prepared by VU [Vanderbilt University]. Annotated by CFT [Core Finance Team.", and states, "Shared service expense is reported on the trial balance and the salaries and hours are recognized on the as-filed wage index, however the fringe benefit expense was not included. This adjustment corrects to include fringe benefit expense on S-3 II, L17 & L19."[105] Again, in essence, VUMC sought the Medicare Contractor's review, for the first time, of a *belatedly*-presented, major change as part of its wage index review. The Board further questions whether there is any duplication in the allocation of overhead from the University, such as General & Administrative Costs, along with any other similar costs which may be directly reported on VUMC's cost report, but is unable to address these concerns based on the record.

B. Fatal Flaws with the Documentation

There is no argument that VUMC provided voluminous documentation to the Medicare Contractor and CMS. Indeed, the record contains numerous exhibits from both Parties. The Providers' witness testified that "from our perspective we gave them voluminous, significant support for how those, you know, allocations [for VUMC] were made."[106] Similarly, the Medicare Contractors state, "[VUMC] has taken it upon itself to deluge the MAC with voluminous documentation and data in order to persuade the MAC to resolve these issues. Indeed, from the beginning of the Appeal Review with the Medicare Contractor and CMS, its FY 2012 AHW does appear to have been increased from $30.70 to $34.90.[107] Notwithstanding, VUMC (and the other Providers) are not satisfied and seek additional costs that the Medicare Contractor and CMS excluded from Worksheet S-3, Part II. However, the Board agrees with the Medicare Contractor that "the record is void of any source data or documentation to serve as a check on the accuracy of the Provider's contentions."[108] In this respect, the issue is not whether there was or was not documentation, but

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[100] Ex. P-14 at P1563-610.
[101] *Id.* at P1563.
[102] Tr. at 132-33.
[103] Ex. P-14 at P1489-90.
[104] *Id.*
[105] Ex. P-6 at P0332.
[106] Tr. at 33.
[107] Ex. C-25 at C0334. *See also* C-7 (Medicare Contractor workpapers detailing VUMC wage data that was added to Worksheet S-2, Part II as a result of the Wage Index review and audit process for FY 2012).
[108] Medicare Contractors' PHB at 10.

whether the documentation properly supported the conclusions it was provided to support. As a result, the Board finds that VUMC's request to have the costs at issue added to Worksheet S-3 (University Overhead) and/or reclassified via Worksheet A-6 (MCA monthly allocations) to be reflected on Worksheet S-3 as salary costs is fatally flawed as there is insufficient or no source data to support VUMC's proposed allocation methodology.

The record shows that the Medicare Contractor did request specific documentation, via an email, on January 8, 2014, directed to Bruce Baldwin of Core Financial Services, the Provider's Wage Index consultant. The email states:

> [P]lease provide the below-listed documentation:
>
> 1. Regarding the **58.17% allocation amount** used to allocate **University services**, please provide **detailed documentation to support the determination of this allocation amount** (i.e. time studies, salaries, etc.).
>
> 2. Regarding the **67.16% allocation amount** used to allocate the **MCA shared services**, as above, please provide **detailed documentation to support the determination of this allocation amount**.[109]

VUMC did provide additional documentation, in response to the Medicare Contractor's request, which is included in the record for the instant appeal. However, through its review, the Medicare Contractor identified several concerns with the sufficiency of that documentation, and the proposed methodology of allocation and, as a result did not allow the requested allocations of these costs. The Medicare Contractor's workpapers document the following concerns:

1. Insufficient documentation for the Vanderbilt University allocation methodology relating to the $41.6 million in the first bucket.—

> In order to support their request, the provider submitted the following documentation: 1) their allocation spreadsheet of the University's A&G (see **Exhibit H**); 2) the provider-prepared 'Medicare Indirect Cost Report' to support their allocation amount (see **Exhibit I**); 3) the Vanderbilt University Trail Balance (see **Exhibit J**); and 4) the provider's summary of the University's Contract A&G Labor (see **Exhibit K**). Per review of this documentation, however, the Auditor noted the following: 1) Based on a scan of the University A&G items to be allocated per Exhibit H, the Auditor noted items that do not appear to be costs that should be shared by the Medical Center, such as 'Chancelor Special Assistant Beasley Office' and 'Procurement/Disbursement Services'. 2) *More importantly, the allocation percentage of 58.17% could not be properly traced back through the provided documentation to its source, nor could the actual cost to the Related*

[109] Ex. C-25 at C0261 (emphasis in original).

> *Party be accurately determined*. Since both the University A&G and Contract A&G Labor were based on the same allocation methodology that could not be definitively verified through the documentation submitted, the Auditor cannot allow these amounts to be included on W/S S-3, Part II, Line 14. Therefor the Auditor will deny the provider's request of their addition of their Related Organization costs. [110]

2. <u>Insufficient documentation for the MCA allocation methodology relating to the $98 million in the second bucket</u>.—

> [P]er the correspondence with the provider (see Exhibit C), the Auditor noted that though the provider had described the provider's method of allocation for the MCA shared services as "pro-rations of booked costs based upon management's best estimates of usage for shared services utilizing various allocation methodologies such as effort reports and net patient revenue," *the provider could <u>not</u> definitely provide specific auditable documentation to support the provider's allocation methodology*. Without more specific documentation for the MCA allocation methodology, the Auditor cannot assure that the provider is appropriately allocating costs to the Medical Center. Additionally, the Auditor noted several non-allowable, non-hospital-related costs (such as Alumni, Commencement, and various Marketing Outreach costs) that the Auditor cannot assure were not allocated to the Medical Center (see **Exhibit D**). Therefore, since the Auditor cannot confirm the provider allocation methodology, the Auditor cannot allow the Provider's request to add the MCA Wage Related Costs to W/S S-3, Part II, Lines 17-25.[111]

Upon review of the record in this case, the Board finds that the Providers have not presented any additional evidence or documentation that sufficiently addresses the Medicare Contractor's bases for denial.

First, the Board identified various anomalies in the data, both in the amounts being allocated and in the underlying support for both statistics and allocations, during the hearing. For example, in the University Overhead bucket, the Board noted that salary amounts for wage index inclusion for Cost Center 1551201 (Management Information Systems Development Group) were $2,377,726 when the "modified total direct costs" and the amount to be allocated were only $1,597,247.[112] When questioned on this issue, the Providers' witness responded, "I have a really good, you know, *speculation* as to why that's the case. But I *agree* with you that *looks a little odd*."[113] This is not the only example of this in this bucket of allocations, but is certainly one of the larger

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[110] Ex. C-7 at C0040 (bold emphasis in original and underline and italics emphasis added).
[111] Ex. C-7 at C0039-40 (bold emphasis in original and underline and italics emphasis added).
[112] Ex. P-6 at P0344.
[113] Tr. at 154 (emphasis added).

examples.[114] In addition to the Medicare Contractor's cited concerns with non-allowable types of expenses being allocated, the Board also notes many expense centers on Exhibit P-6 that would seemingly be able to be allocated directly, rather than using a pooled allocation to the entire University. Campus Planning and Construction, Architectural Services, Leadership Academy, Vanderbilt Temporary Services Fees and Operating Expenses, Recruiting and Staffing, Trademark Licensing, and the Office of General Counsel are all areas in which it should be possible to identify the recipient of such services/expense directly, yet this is not done. Instead VUMC relied upon a pooled cost statistic in all of these varied areas for allocation.[115] The Board also notes a large amount of Expense related to several centers for the Vanderbilt Human Research Protection Program which is being allocated as University Overhead.[116] The Board is unable to determine how this expense should be treated for VUMC purposes; for example, it seems as though it could easily be directly assigned, and it is likely it is research-related, and therefore, non-reimbursable for Medicare purposes, but there is no supporting detail and VUMC is expected to receive 58.17 percent of this $3.4 million in expense.

In the MCA monthly allocations bucket, the Board noted situations where direct allocations were made of 100 percent of certain costs to only VUMC, *i.e.*, the hospital.[117] The Providers' witness indicated that this situation occurred in such cases as patient accounting, insurance management, and charge integrity,[118] but the Board notes there were several such situations. Many other MCA expenses were allocated, per Exhibit P-14, on a functional basis, using a variety of statistics (FTEs, Net Revenue, Usage, Effort, Opportunity/Usage, Agreement, etc.). The basis is described/named in Exhibit P-14, but the underlying data, or the actual statistics, are not provided.[119] Thus, the MCA allocations were not all one particular method or one particular statistical basis, and the documentation provided was detailed, but no summary was provided to identify all the various methods, and what type of expenses were allocated using which methods, *et cetera*, which would have clearly facilitated the Medicare Contractor's ability to sample a variety of allocations, rather than having to make a detailed analysis to identify what was being done before determining how to audit it. The Board also notes that 100 percent of the MCA expense for Vanderbilt Heart and Vascular Marketing, and 81.20 percent of MCA expense for Marketing and Med Center Strategic

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[114] *See* Ex. P-6. (On page P0340 alone, IDS Tax Allocation has salaries of $219,827 being allocated with a MTDC of only $198,581. Similarly, the Office of Conflict of Interest & Commitment Management, Claims and Medical Center Risk Management, and the Office Expense for the Vice Chancellor and General Counsel all are allocating salary amounts for wage index which exceed their MTDC. This problem recurs on page P0343, where 5 out of 6 centers in the Finance Division are allocating salaries which exceed the total MTDC, by over $2 million. The problem arises again on page P0346, when University Services Executive Administration salaries of $3,011,342 are being allocated when the center's MTDC is only $2,805,973.)

[115] *See* Ex. P-6 (Campus Planning & Construction, Architectural Services, Leadership Academy, and Vanderbilt Temporary Services centers are all on P0345, Recruiting & Staffing is on P0344, Trademark Licensing and Office of General Counsel are on P0340.)

[116] Ex. P-6 at P0339.

[117] *See* Ex. P-14. (Patient Accounting, Patient Accounting – Admission, Patient Accounting – ER Registration, Patient Accounting – Insurance Management, and Patient Accounting – Charge Integrity, all at P1597; all of the various components of the CNO (Chief Nursing Officer) are allocated only to hospital units at P1598; Patient Education at P1600; Hardware for Hospital/Clinic at P1602; VUMC Parking Facilities at P1603; Parking Principal, Disease Management and Au Bon Pain at P1605; Plant Operations for Blakemore (Physician Eye), Crystal Terrace, and Dayami Center at P1607)

[118] Tr. at 142-44.

[119] Ex. P-14 lists an Allocation Basis ("AB") with each grouping of allocations, but there are no actual numbers or calculations included, just narratives, such as "AB = Net Pat Rev; 2nd Tier: TVC – Net Pt Revenue; VMG – Net Revenue."

Marketing were allocated to VUMC.[120] The Board is concerned as Marketing is a non-allowable expense for Medicare, and more importantly not allowed for wage index, and it is unclear from this schedule as to whether it was allocated to a reimbursable area or not.

In the hearing, when asked about the underlying data to support the various MCA allocation percentages, the Providers' witness referred to the summary of allocated costs and said:

> It says the allocation **basis** for each one of the centers. And you could select from this, you know, shared sheet. You could say, okay. I want to audit number 72, Audit Compliance and Corporate Integrity. The allocation basis then is effort. And so, then they could say, okay. Pull the effort reports for them. And we could do it. But we were never asked to do anything like that.[121]

For both the $41.6 million and the $98 million buckets, the Providers' witness suggested providing such data or doing further analysis/review of the allocation as part of a post-hearing brief, or in the future,[122] thus conceding that such data was *not* readily identifiable in the record, and that such work was *not* done (by the Medicare Contractor or the Provider) at the time of the wage index review. The Providers' witness agreed, during the hearing, that there may have been issues with the data provided, stating:

> [Y]ou're doing a really great job here auditing this work and take it out. And – but the answer is still not zero. I mean, take all those out that you don't like on there, it's still not taking the whole thing out. Zero can't be the right answer.[123]

Another issue which must be addressed is the fact that VUMC self-identified all MCA costs as "other" (meaning, not salary) on its trial balance, and then proposed a reclass to move their ***estimated*** salary amounts to be reported as salaries, for purposes of inclusion in the wage index calculations.[124] VUMC further argues that this was accepted in prior years.[125] The Board notes that it is not unlikely for an "other" cost to contain salary amounts. Indeed, a specific, and wage index-related, example is contract labor. For example, certain services are outsourced to third parties, such as legal services, or auditing, as well as other overhead services like housekeeping or laundry. However, it is a requirement of wage index review to properly support any contract labor amounts which are included in "other," that a provider wants to include in salaries and hours. The cost reporting instructions for the wage index Worksheet S-3 (Parts II through V) can be found at PRM 15-2 § 4005.2 through § 4005.5. The "General Instructions for Contract Labor" are included in § 4005.2 provide the following instructions on how to handle contracted labor:

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[120] Ex. P-14 at P1603.
[121] Tr. at 141. (Underline/bold emphasis added).
[122] *See* Tr. at 155-156 (the witness stated "But yes, I can go back, and we can – I have a really pretty clear idea of what that is. And I can get that and we can add that to the brief." – in reference to University Overhead allocations which exceeded the total MTDC). *See also* Tr. at 222 (witness stated "I'd be happy to roll up my sleeves and sit down and go through it with anybody that wants to look at it. I'm sorry I wasn't here at the time to be able to do that, I would've; but I'm happy to do it at this time and see if we can get it resolved.")
[123] Tr. at 155.
[124] Tr. at 31-33.
[125] *Id.* at 32.

> Only contract labor costs reported on the provider's trial balance and, therefore, on Worksheet A, column 2 [other costs] are included on Worksheet S-3, Part II. Do not include contract labor wages and hours on Worksheet S-3, Part II, line 1. *Contract labor costs not reported in the proper cost center are disallowed from the wage index calculation*. If hours cannot be accurately determined, the contract labor costs must not be included in the wage index calculation. In general, for contract labor, the minimum requirement for supporting documentation is the contract itself. If the wage costs, hours, and non-labor costs are not clearly specified in the contract, other supporting documentation is required, such as a representative sample of invoices that specify the wage costs, hours and non-labor costs. Attestations or declarations from the vendor or hospital are not acceptable in lieu of supporting documentation for wages, hours, wage-related costs, and non-labor costs. Hospitals must be able to provide such documentation when requested by the contractor.

VUMC included its MCA costs as "other" costs. In order for the Medicare Contractor to review such costs to ensure they were reported "in the proper cost center" (and thus, not to be "disallowed from the wage index calculation") a detailed explanation of all costs and the supporting documentation to support the monthly allocations would have been necessary. A discussion of this allocation occurred during the direct examination of the Providers' witness:

> MS. WEBSTER: You talked about the 81025, and you talked about the monthly entries, but I just wonder if you could explain that in a little bit more detail.
>
> THE WITNESS: Each and every month, at the time, our Finance Department was allocating the salaries from MCA to the individual departments. The allocation bases for it was determined in a rigorous budgeting process by our senior leadership to determine what was the very best and most appropriate allocation basis that would provide a fair allocation, an appropriate allocation to each of the areas.[126]
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> * * * *
>
> MS. WEBSTER: And was this cost, were the cost allocation methods that you used solely for the purposes of the Medicare Cost Report or were they used for other purposes? I wonder if you could describe how these were developed and why.
>
> THE WITNESS: Again, they were developed according to that, you know, letter you saw –

[126] Tr. at 37-38.

MS. WEBSTER: Uh-huh.

THE WITNESS: – in one of the exhibits. They were developed as part of the budgeting process. And really their primary purpose for these allocations is management reporting.[127]

The Board finds that this allocation methodology was *not* set up for cost reporting purposes and may or may not have had cost reporting requirements as part of the consideration when it was developed. These related party costs are similar to contract labor costs, *especially when brought over as a monthly budgetary allocation, and reported as an "other" cost*. Budgeting is ***very*** *different* from operations, and no mention was made as to whether any "reconciliation" of the budgeted amounts was ever made to reflect the actual costs at the end of a year, or whether changes in operations were reflected mid-year with new budgeted allocations or just on an annual basis. A similar concern is whether the costs were allocated each month with a new statistic (or varied in some but not others). The record is unclear on that fact.

The above information gaps highlight the open questions and concerns regarding the documentation supporting the allocation methodology for both the $41.6 million and $98 million in costs at issue. The Board notes that a home office cost report, with allocation bases approved by the Medicare Contractor beforehand (consistent with PRM 15-1 §§ 2307[128] and 2312[129]) would have avoided such an issue and, thereby, avoided the time constraint issues associated with trying to conduct a home office audit in the midst of a wage index review.

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[127] *Id.* at 52-53.

[128] PRM 15-1 § 2307 addresses the "Direct Assignment of General Service Costs" and states:

> The costs of a general service cost center need to be allocated to the cost centers receiving service from that cost center. This allocation process is usually made, for Medicare cost reporting purposes, through cost finding using a statistical basis that measures the benefit received by each cost center. Alternatives to cost finding as described below may be used where appropriate after obtaining intermediary approval. The provider must make a written request to its intermediary and submit reasonable justification for approval of the change no later than 90 days prior to the beginning of the cost reporting period for which the change is to apply. The intermediary must respond in writing to the provider's request, whether approving or denying the request, prior to the beginning of the cost reporting period to which the change is to apply.
>
> When the request is approved, the change must be applied to the cost reporting period for which the request was made, and to all subsequent cost reporting periods unless the intermediary approves a subsequent request for a change by the provider. The effective date of the change will be the beginning of the cost reporting period for which the request has been made.

[129] PRM 15-1 § 2312 addresses "Changing Cost Finding Methods" and states:

> Should a provider (other than a free-standing home health agency) desire to change cost finding methods (regardless of whether the desired change is to be a more or less sophisticated method), the request to change must be made to the intermediary in writing and must be submitted to the intermediary 90 days prior to the end of the cost reporting period to which the request for change applies. See §2313 for provider and intermediary responsibilities when a request is submitted or if a cost report is filed without a prior approval.
>
> Intermediary determination of a provider's request to change methods will be furnished to the provider in writing within 60 days and will be considered binding on the provider as of the date of the intermediary's written notice.
>
> Where the intermediary approves the provider's request to change methods, the provider must use this method for the cost reporting period to which the request applies and for all subsequent cost reporting periods, unless the intermediary approves a subsequent request by the provider to change cost finding methods.

C. The Allocation Methods Are Not Sufficiently Supported

As noted above, the provider has identified various bases/statistics for the monthly allocation of MCA expenses, but has not provided the underlying data or calculations to support the percentages derived from those bases which were used to make the allocations of the $98 million in alleged MCA salary and benefits costs. The summaries are all Excel spreadsheets, but the record contains no reconciliations of the percentages to audited/auditable data or other support which could be used to confirm the allocation percentages which lead to the amounts being allocated. As part of Exhibit P-14, VUMC included a letter explaining the "Annual Approval Process of Medical Center Administration Shared Administrative Expenses," which states:

> The process begins with the Finance staff compiling statistics and direct allocations to assign the Medical Center Administration shared departmental expenses. The *prior period's statistic* and the current year's *budget* expenses for each department are input into a detailed spreadsheet. This spreadsheet calculates how the budgeted expenses should be shared among the divisions listed above based on the allocation methodologies. . . . Following the approval and review process, the budgeted percentage/directly assigned expenses are used during the monthly final close process to assign the actual expenses incurred to each of the respective divisions.[130]

The Medicare Contractor was not provided with the underlying data of the statistics used (which appear to be prior year data, not contemporaneous data) or the explanations for why some expenses would be directly allocated. The final product was presented, leaving the Medicare Contractor to spend time analyzing it to determine what further support was necessary, to perhaps audit or sample it. Even when the Medicare Contractor clearly asked for "detailed documentation to support the determination of the allocation amount (i.e. time studies, salaries, etc."[131] only summaries and descriptions were provided. On appeal VUMC has not filled this gap to support the $98 million in alleged MCA salary and fringe benefits expense.

Similar issues exist with the $41.6 million in the alleged Vanderbilt University salary expense. VUMC has used a single, pooled cost statistic for the allocation of all Vanderbilt University overhead, as discussed *supra*. The support provided for this percentage can be found in an Excel spreadsheet at Exhibit P-6. Modified Total Direct Costs (MTDC) are accumulated for various entities within the Vanderbilt University, adjustments are made (notably, one is to bring on $1,562,912,461 in Hospital/Clinic expense, and then the adjusted costs are used to develop percentages used to allocate the Vanderbilt University's overhead cost.[132] The Hospital/Clinic expenses tie, in total, to the Audited Financial Statements, at $1,780,178,699,[133] but adjustments are made to exclude certain costs such as Depreciation/Amortization, O&M Costs, IDS, etc.[134] It is not possible to determine if other entities in the calculation have had such cost removed, nor to

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[130] Ex. P-14 at P1487.
[131] Ex. C-25 at C0261.
[132] Ex. P-6 at P0922 (NOTE—the adjusted Hospital/Clinic MTDC of $1,562,912,461 is 58.179% of the adjusted MTDC total of $2,686,377,823, which reflects the single stat used for University Overhead allocation to VUMC.)
[133] *Id.* at P1140.
[134] *Id.* at P0922.

verify the various other amounts involved in the calculation. It is also not certain that no more accurate allocation, be it direct or functional, could have been used for any, or all, of these costs.

Additionally, with respect to the University Overhead bucket ($41.6 million), the allocation method used for fringe benefits by VUMC contained in OMB Circular A-21 is an educational institution cost principle *used for federal grants* (as discussed *supra* in **Subsection B** of the STATEMENT OF LAW AND FACTS) and is ***not*** based in Medicare cost reporting principles and reimbursement. VUMC has relied on OMB federal grant rules, but the principles for allocating costs *for federal grant purposes* do not carry over to Medicare cost report accounting and the principles governing that accounting. The Circular itself indicates that the "Subject" is "Cost Principles for Educational Institutions."[135] It further explains the purpose as "[t]his Circular establishes principles for determining costs applicable to grants, contracts and other agreements with educational institutions."[136] While a hospital *may* be an educational institution, it is not always the case, and certainly all educational institutions are not hospitals. Either way, this Circular is not for the purpose of Medicare reimbursement, nor can it be relied upon as such.

Similarly, even if it were proper for VUMC to use the fringe benefits rates negotiated with HHS pursuant to this Circular, VUMC did not correctly apply those rates as it assumed that only one fringe benefit rate applied to *all* of the relevant salaries underlying the $41.6 million at issue. The fringe benefits rates negotiated with HHS for Agency-sponsored research and development and similar work included 9 different "rate groups":

Type	From	To	Rate (%) – Location	Applicable To
Fixed	7/1/2011	6/30/2012	22.20 Medical Cntr	NonClin Fac/Sr Staff
Fixed	7/1/2011	6/30/2012	22.40 Medical Cntr	Clinical Fac 1 (1)
Fixed	7/1/2011	6/30/2012	17.60 Medical Cntr	Clinical Fac 2 (2)
Fixed	7/1/2011	6/30/2012	10.70 Medical Cntr	Clinical Fac 3 (3)
Fixed	7/1/2011	6/30/2012	20.90 Univ Central	Fac/Sr Staff/Summer
Fixed	7/1/2011	6/30/2012	26.80 Medical Cntr	Staff
Fixed	7/1/2011	6/30/2012	25.90 Univ Central	Staff
Fixed	7/1/2011	6/30/2012	9.90 All	Part-time/Temporary
Fixed	7/1/2011	6/30/2012	13.70 All	Supplemental
Final	7/1/2012	Until amended		Use same rates and conditions as those cited for fiscal year ending June 30, 2012

(1) Clinical Faculty l means annual compensation of less than $170,000
(2) Clinical Faculty 2 means annual compensation greater than or equal to $170,000 but less than $300,000.
(3) Clinical Faculty 3 means annual compensation equal to or greater than $300,000.[137]

If the description of these rates is accurate *for purpose of Medicare program cost allocation*, there are multiple rates that would be applicable to the Vanderbilt University, namely:

1. 20.90 for Univ. Central applicable to "Fac/Sr Staff/Summer"

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[135] Ex. P-3 at P0013.
[136] *Id.*
[137] Table with footers reproduced from Ex. P-9 at P1296

2. 25.90 for Univ. Central applicable to "Staff"
3. 9.90 for all locations applicable to "Part-time/Temporary"
4. 13.70 for all locations applicable to "Supplemental"[138]

In providing the various rates, the rate agreement clearly intended that VUMC analyze salary expenses to determine which rate is appropriate. Significantly, VUMC selected the *highest* of these four (4) rates to apply across the board to the salary costs at issue, notwithstanding the fact that the salary cost underlying the $41.6 million at issue likely included all of these four (4) categories (in particular, it should have included Senior Staff at the 20.90 percent rate as well as Part-Time or Temporary Staff at 9.90 percentage rate). Indeed, since VUMC ***only*** applied the *highest* fringe benefit rate, it is clear that the across-the-board usage of that rate as proposed by VUMC would result in an *overestimation* of fringe benefit costs as it relates to the salaries underlying the $41.6 million at issue in the University Overhead bucket.

Similarly, it is not clear from what year(s) the data and assumptions used to set the percentage for the Rate Agreement used for 2011/12 grants were obtained, or whether they are still relevant and applicable to FY 2012. The Medicare Contractor has no ability to audit or verify those assumptions since it was not involved in setting those rates and any information upon which those rates were set was not provided to the Medicare Contractor or made a part of this record.

Further, the Board finds it telling that the Provider is able to specifically identify the fringe benefits associated with the MCA monthly allocations, in some form, as the allocations of the fringe benefits on Exhibit P-16 are not all the same percentage and do *not* reflect the 25.9 percent from the HHS rates negotiated through the Circular.[139] VUMC is apparently able to identify fringes on the MCA monthly allocations much more specifically than those on the University Overhead. The handling is not consistent, nor is the supporting documentation provided in any way for the various amounts/percentages used for the MCA monthly allocations. The allocation methods are not properly supported and it is therefore not possible to tell, from the record, if they are appropriate or reasonable.

D. VUMC Should Have Filed a Home Office Cost Statement for FY 2012.

In its workpaper reviewing the February Public Use File ("PUF") data correction requests made by VUMC, the Medicare Contractor states:

> Per review of the provider's documentation and discussion with the provider's consultants, it appears that the provider wishes to

[138] Note that the rates posted by Vanderbilt University on its website include an additional category of "Medical Faculty/Senior Exempt Staff" for which there is no applicable percentage, meaning the percentage rate is zero (0) percent for this group. Ex. P-9 at P1293. It is unclear whether this is an additional fringe benefit rate that could be applicable to some of the salary expenses at issue.

[139] *See* Ex. P-16 at P1651-55. (The salaries are accumulated by Destination Center and tie, in total, to the reclass being made for MCA on page P1655. However, the total fringe column on P1655 reflects 26.46 percent of those salaries, and each Destination Center has a different fringe percentage, compared to its salary amount. For example, on P1651, Destination Center 2016600000 has $3,923,777 in fringes on $14,005,204 of salaries, which is 28.02 percent, while Destination Center 2090150000 has $576,983 in fringes on $2,082,897 of salaries, which is 27.70 percent. Both of these exceed the 25.9 percent used from the HHS rates in the allocation of the University Overhead bucket, as is the overall percentage of 26.46 percent on the entire MCA allocation bucket.)

> treat their parent organization (Vanderbilty [*sic*] University) as their 'Home Office' and allocate costs to the provider to the extent of the benefit that the provider receives from the 'Home Office' and other related organizations. However, Vanderbilt University is not considered a 'Home Office' and does not complete a Medicare Home Office Cost Statement (HOCS). If the provider wishes to allocate costs from it's various related organizations, the provider would either need to begin completing a HOCS for Vanderbilt University and allocate costs via that method or would need to identify the actual costs that directly benefit the provider and provide the documentation for the identification of these actual costs (such as specific time studies). The Auditor does not agree with the provider's requests to allocate multiple service costs to the provider from related organizations using one statistical basis per related organization, as the Auditor believes that one statistical basis cannot be applied to multiple, separate services being offered from each related organization.[140]

The Board notes that an email from VUMC's Consultant, dated December 18, 2023, details the "requested wage index adjustments." In that list of requests, #4 is described as "[t]o include salaries, benefits, contract labor and hours associated with home office (University) services, consistent with [Worksheet] A-8-1."[141] Also, in VUMC's Exhibit P-6 (the CMS Intervention Request dated April 15, 2014), VUMC includes its analysis of the Wage Index Worksheet S-3, comparing the wage data from FY 2011 Final PUF file with that from the FY 2012 as-filed cost report. The Board Notes that, in Column 4 of Worksheet S-3, Part II, VUMC reported $7.2 million in "Home Salaries and Wage Related Costs" on Line 14 for FY 2011 and $0 for FY 2012; however, later as part of its November 21, 2013 "Provider Correction Requests," VUMC requested to ***add*** $55.4 million to this same line for FY 2012.[142] This request represented more than a 7-fold increase in the Line 14 Home Office salaries and wage-relates costs from FY 2011 to 2012. Similarly, in Column 4 of Worksheet S-3, Part II, VUMC reported $31.2 million for FY 2011 in Line 15, "Home Office Physician Part A," but the amount increased slightly to $32.3 million for FY 2012.[143] Notwithstanding the magnitude of these home office costs, when asked in the hearing, "Was any consideration given to filing a home office cost report at any time prior to 2012?," VUMC's witness asserted that "we didn't have any basis to file a home office cost report at that time because we only had one hospital one license."[144]

Further testimony during the hearing did elicit the fact that Vanderbilt began filing a Home Office Cost Report *nine (9) years later* in 2021, after the purchase of additional hospitals.[145] However, the Board notes that there were other separate, and distinct Medicare-participating health care entities owned and operated by Vanderbilt during the year at issue (*i.e.*, FY 2012). The witness identified that there was "a home health agency and there's long-term care, but both of them are

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[140] Ex. C-4 at C0012.
[141] Ex. C-5 at C0030.
[142] Ex. P-6 at P0147.
[143] *Id.*
[144] Tr. at 117.
[145] Tr. at 177-78.

not hospital-based. They're both separate and independent."[146] The Medicare Contractor's witness also identified that the excluded Inpatient Psychiatric Facility ("IPF") had its own provider number ("CCN"). The existence of at least three (3) separate other Medicare participating entities brings into question whether the methodology used in VUMC's FY 2012 cost report properly allocated costs to these other three units that were ***not*** part of the short-term acute care (*i.e.*, the hospital entity subject to IPPS). This is the very type of situation that a home office cost report is designed to address, as made clear by the following excerpt from PRM 15-1 § 2150:

> *A chain organization consists of a group of* ***two or more health care facilities*** *which are owned, leased, or through any other device, controlled by one organization*. Chain organizations include, but are not limited to, chains operated by proprietary organizations and chains operated by various religious, charitable, and governmental organizations. A chain organization may also include business organizations which are engaged in other activities not directly related to health care. (See §§l002.2 and l002.3 for definitions of common ownership and control.)
>
> *Home offices* of chain organizations ***vary greatly*** *in size, number of locations, staff, mode of operations, and services furnished to the facilities in the chain*. The home office of a chain is not a provider in itself; therefore, its costs may not be directly reimbursed by the program. The relationship of the home office to the Medicare program is that of a related organization to participating providers. Home offices usually furnish central management and administrative services such as centralized accounting, purchasing, personnel services, management direction and control, and other services. To the extent the home office furnishes services related to patient care to a provider, the reasonable costs of such services are includable in the provider's cost report and are reimbursable as part of the provider's costs. Where the home office of the chain provides no services related to patient care, neither the costs nor the equity capital of the home office may be recognized in determining the allowable costs of the providers in the chain.[147]

As there were 3 other health care facilities associated with VUMC, it is clear that, contrary to the testimony of the Providers' witness, Vanderbilt could have filed a home office cost report for FY 2012.

Further, it is important to note that PRM 15-1 includes instructions on the "Allocation of Home Office Costs to Components in Chain."[148] These instructions provide an order or hierarchy of methods by which home office costs are to be allocated:

[146] Tr. at 117.
[147] (Emphasis added.)
[148] *See* PRM 15-1, § 2150.3.

> [T]he ***initial*** step in the allocation process is the *direct* assignment of costs to the chain components.[149]
>
> * * * *
>
> The allowable home office costs that have not been directly assigned to specific chain components must be allocated among the providers (and any non-provider activities in which the home office may be engaged) on a basis designed to ***equitably*** *allocate* the costs over the chain components or activities receiving the benefits of the costs.[150]
>
> * * * *
>
> In each home office there will be a *residual* amount, or "pool" of costs incurred for general management or administrative services *which cannot be allocated on a* ***functional*** *basis*. . . .Where the home office cannot determine its costs by functions an allocate them on a functional basis, the home office must allocate its costs as one cost center of pooled costs.[151]

The home office cost report structure is developed to ensure the most accurate allocation of costs possible and the above PRM provision makes clear that there is a hierarchy of allocation methods.

1. Direct allocation
2. Functional allocation
3. Pooled allocation

Thus, if a cost ***can be*** *directly* assigned, then it must. Otherwise, it must be determined if a *functional* allocation is possible (again ***only*** if a direct allocation is not possible). And, finally, if neither direct nor functional allocation is possible, a pooled allocation is allowed.

Based on this hierarchy of allocation methods, the analysis of the various costs can then be separated by type and allocation method, through the specified home office cost report format. In the present case, VUMC's Representative, in her opening statement, argued that VUMC's "allocation methods are *comparable* to those used to allocate home office costs."[152] However, the presentation of the data at issue makes that contention very difficult to support, or to verify. Indeed, with a home office cost report, a Medicare contractor has the ability to review and approve statistical bases when a provider changes them, or to audit them when the home office cost report is filed. In this respect, PRM 15-1, § 2150.3(C) states:

> The functions, or cost centers, used to allocate home office costs, and the unit bases used to allocate the costs, including those for pooled costs described in Subsection D, *must be used* ***consistently*** from one home office accounting period to another.

[149] PRM 15-1 § 2150.3B.
[150] PRM 15-1 § 2150.3C.
[151] PRM 15-1 § 2150.3D.
[152] Tr. at 9 (emphasis added).

> However, *if the home office wishes to change its allocation bases* and believes the change will result in more appropriate and more accurate allocations, *the home office **must** make a written request*, with its justification, to the intermediary responsible for auditing the home office cost for approval of the change no later than 120 days after the beginning of the home office accounting period to which the change is to apply.

In this case, by opting not to file a home office cost report, VUMC denied the Medicare Contractor the opportunity to determine if the allocation statistics and methodologies were acceptable ***before*** using them (consistent with PRM 15-1 §§ 2307 and 2312). Conversely, it denied itself the opportunity to verify with the Medicare Contractor that its allocation methodologies were appropriate/approvable. Instead, it presented the Medicare Contractor with a *fait accompli*, or "done deal," and, in doing so, the Providers were unreasonably relying on the Medicare Contractor to do a very detailed review in a very short timeframe; the same time frame in which it must also review the wage index and wage-related costs of every other hospital under its supervision.

E. THE MEDICARE CONTRACTOR'S REVIEW WAS SUFFICIENT

The Providers argue that the Medicare Contractor should have done more work on VUMC's FY 2012 wage index audit. The Board questioned the Providers' witness on this position:

> [BOARD MEMBER]: Given the unusual accounting in this case, whose responsibility should it be to make sure that the MAC and then CMS understand that unusual accounting?
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> THE WITNESS: Well, . . . , had I been there, I would certainly have been . . . willing to roll up my sleeves and sit down and help anybody get through it. . . . but I don't think it's 100 percent the provider's responsibility. I think that the MAC is responsible to review the work papers, ask questions . . . .[153]

Following this questioning, the Providers' Representative, Ms. Webster, returned to this issue, as follows:

> MS WEBSTER: To your knowledge . . . did anybody from the MAC dig into the supporting documentation the way [the] Board Member [ ] did?
>
> THE WITNESS: Not with me and not to my knowledge.
>
> MS. WEBSTER: In your view, would – what kind of working through the issues here and the worksheets and the documentation would be helpful?

[153] Tr. at 187.

> THE WITNESS: I mean, I would be delighted to sit down and – you know – do sort of what we did, but maybe on a more – you know – smaller scale in terms of – you know – taking more time and ticking [and tying] things. I'd be happy to roll up my sleeves and sit down and go through it with anybody that wants to look at it. I'm sorry I wasn't here at the time to be able to do that . . . .[154]

While the Providers' witness focuses on what she thinks the Medicare Contractor should have done, there is no evidence that, *during the FY 2012 wage index review process,* anyone at VUMC, or their consultants, took the action to make the analysis of their voluminous documentation easier for the Medicare Contractor or CMS to understand and review. In contrast, the record is clear in that there is a 75-page string of 23 separate emails between: (1) the Medicare Contractors' witness (who was an auditor involved in the wage index audit at issue); (2) CMS; and (3) VUMC's consulting firm, Core Finance.[155] These emails cover a period from March, 2014 to July, 2014, coinciding with the end of the review of the FY 2012 data for the IPPS FY 2015 wage index process. Thus, it is apparent that there was significant involvement between all parties regarding the various issues of VUMC's wage index review.[156] At the very least, the amount of back and forth certainly substantiates a robust review of issues. Furthermore, Exhibit C-10 is a letter from the Deputy Director of CMS' Division of Acute Care to VUMC's Associate Vice Chancellor for Finance. This letter, dated July 8, 2014, is a response to VUMC's request for intervention. It addresses several issues, specifically: (1) Adjustment for Hours on several lines; (2) Adjustment for Physician Part A on Line 15; (3) Adjustment for MCA Benefits, Overhead Department Costs, and 3 areas of Contract Labor – Surgical Monitoring, Perfusionist, and MCA Contract Labor.[157] For each issue, CMS explains its handling and specifically grants or denies certain requests. This does not appear to be a situation where no review was done and then CMS "punted" back to Palmetto, as was suggested in the hearing.[158]

The following example of CMS' response to one of the issues highlights this point:

> You state that Cahaba GBA (Cahaba) removed $78 million (Adjustment 12). You request that we include the $78 million and corresponding hours in the wage index since these are salaries and hours related to the Medical Center Administration (MCA) which are costs applicable to the hospital. You also stated that if CMS denies the hospital's request to reinstate the $78 million that CMS should remove the corresponding hours as Cahaba failed to remove these hours when removing the $78 million. We reviewed this matter and Cahaba denied the hospital's request to include the $78 million in the wage index due to lack of adequate documentation. . . . Our Medicare

[154] Tr. at 222-23.
[155] *See* Ex. C-25.
[156] Ex. C-25 at C0300-22.
[157] Ex. C-10.
[158] Tr. at 188.

> contractors are in the best position to evaluate and determine matters regarding the adequacy of supporting documentation. Therefore, we are denying your request to include the $78 million in the wage index. However, we are granting your request to make an adjustment to remove the hours related to the $78 million.[159]

In this example, CMS had an option – it could allow the $78 million in cost and leave the related hours or it could disallow the $78 million and remove the hours. In either case, an adjustment to the wage index data was going to be made very late in the review process (the Final Rule was published in August 2014). CMS made a specific and definite choice, based on its discussions with Cahaba, and its review of the costs/allocations. And, as a result, CMS determined that the exclusion of the costs was its final decision. In the case of the Physician Part A amounts, CMS stated:

> [U]pon further review, Cahaba has concluded that there is adequate documentation for *some* of the Part A physician costs on line 15. . . .Therefore, we agree with the *part* of your request involving the adjustment for the Physician part A salaries and hours related to Vanderbilt University Hospital and are denying the remaining parts of your request.[160]

It is clear that this process included many discussions between VUMC, the Medicare Contractor and CMS before specific decisions were reached. Some corrections were made, some were not (indeed, as noted above, it appears as if VUMC's AHW went up $4.20 from $30.70 to $34.90[161]). Certainly, the record before the Board demonstrates that this wage index review involved a more detailed review and did result in significant changes.[162] Accordingly, the Board does not find that the alleged lack of detailed work/review is supported by the record at hand.

F. THE IMPACT OF THE ISSUE IS UNCLEAR

Finally, at the hearing, the Providers repeatedly asserted that the Medicare Contractor disallowed its costs or that "zero is not the answer."[163] The Board notes it is very important to make clear that the costs at issue were not "disallowed" in terms of Medicare reimbursable cost for cost report calculations, but rather they were excluded from the wage index review, for inclusion in the wage index and average hourly wage ("AHW") calculations.[164] Many large amounts have been addressed over the course of the hearing – "$41 million from Vanderbilt University. . .$98 million from the Medical University Administration, or MCA. The $41 million and the $98 million total

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[159] Ex. C-10 at C0128.
[160] Ex. C-10 at C0128-29.
[161] Ex. C-25 at C0334. *See also* C-7 (Medicare Contractor workpapers detailing VUMC wage data that was added to Worksheet S-2, Part II as a result of the Wage Index review and audit process for FY 2012).
[162] Tr. at 267-68.
[163] *See, e.g.*, Tr. at 218-19. (Witness states, "But, zero is not the answer. Again, I mean, nothing for overhead to the hospital can't possibly be the right answer. . . .I mean, throw me in that briar patch. That would be a better answer than getting zero for my wage index here.") *See also,* Tr. at 139-140. (Witness states, "you know, this is a hospital, and we're talking about – we got nothing. I mean, zero can't be the right answer.")
[164] Instead of being "disallowed," the costs were treated as allowable but were treated as "other" costs, not as "salary" or "wage-related costs."

the [$]139 million at issue."[165] It is important to be aware that this is not a situation in which VUMC was due $139 million Medicare reimbursement or expected a portion of that amount as a result of its Medicare utilization. The wage index review is an analysis of salaries, wage related costs, and their related hours. The purpose is to use this cost data to develop an Average Hourly Wage ("AHW") for the CBSA (of which VUMC is just one hospital) and then to compare the CBSA's AHW to that for the nation. How the CBSA's AHW "stacks up" across the nation results in a wage index multiplier for the valuation of a provider's standardized amount, which is then used as the basis of IPPS payment.

The Providers have argued that VUMC's wage-related costs were reduced to zero. This is also untrue. It is true that some costs were excluded from the wage index, but there were still remaining salary and wage-related costs included in the FY 2012 Wage Index for VUMC. Review of the as-filed Worksheet S-3 for FY 2011 (Exhibit P-18) and FY 2012 (Exhibit P-17) shows adjusted overhead cost of $197 million and Total Patient Care Related Salaries and wage-related costs of $765.2 million in 2012[166] vs. $173 million in overhead cost and $716.8 million in Salaries/wage-related costs in 2011.[167] Thus, overhead, as-filed, increased by $24 million or 13.87 percent while Salaries/wage-related costs increased by $48.4 million or only 6.75 percent between fiscal years. A review of the adjusted Worksheet S-3, as of March 27, 2014 (no later or final Worksheet S-3 is found in the record for the case, in either VUMC's or the Medicare Contractors' exhibits), shows $123.1 million in overhead cost and $656.3 million in Salaries/wage-related costs.[168] While this is not the final Worksheet S-3, and it is indisputable that costs have been reduced, VUMC is also not getting "zero," nor is "all" of their overhead being removed. Further, the fact that AHW is a measure of total wages and wage related costs *divided by hours* which results in an ***average*** means that just because an adjustment of costs is large, depending on the hours involved, it may increase or decrease the overall AHW or even have no material impact on VUMC's AHW.[169] This is the specific reason why the documentation is so critical in wage index reviews.

The Board is concerned by the fact that the Providers alleged that "the MAC is violating that rule [73 Fed. Reg. 48434, 48570 (Aug. 19, 2008)] by distorting the calculation of hourly wage average

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[165] For example, the Medicare Contractor's witness, who was involved in the wage index review for VUMC, was questioned about the level of interaction between VUMC and the Medicare Contractor and CMS, as follows:

> [BOARD MEMBER]: You discussed that the interaction with the provider and you *was above average in this wage index compared to others you have done*.
> THE WITNESS: In the back and forth?
> [BOARD MEMBER]: *Yes*.
> THE WITNESS: Correct.
> [BOARD MEMBER]: *Did CMS get involved with other reviews in that year to the level they did with this one?*
> THE WITNESS: As far as my workload that I was responsible for and would know, *no*.
> [BOARD MEMBER]: This was the only one where you had contact back and forth with CMS trying to explain the situation?
> THE WITNESS: That I worked on, yes.

Tr. at 11-12.

[166] Ex. P-17 at P1801.

[167] Ex. P-18 at P1826.

[168] Ex. P-7 at P1272.

[169] The impact of cost removed can only be ascertained by knowing the associated hours. Indeed, if the average hourly rate associated with the cost removed were the same as the AHW, then the removal would have no impact regardless of how large the removed costs were.

not only for the Providers in these appeals, but also for all other hospitals in the CBSA."[170] However, the Providers fail to discuss the actual AHWs in that same position paper, and, instead, focus on the gross numbers which would feed into that calculation while ignoring the associated hours that would give a true indication of the impact, if any, that the gross numbers could have on VUMC's AHW. Indeed, even the calculation of the Amounts in Controversy (Exhibit P-2) begin with the finalized wage index for the CBSA, identify a revised wage index (including appeal items) and calculate an estimation of changed rates accordingly.[171] The Providers have provided ***no*** evidence as to ***how*** their proposed revised wage index is developed. The record is simply insufficient to support these arguments. Without data to compare the original and final AHWs, the gross amounts allowed or removed have no value, and the Board is unable to determine if this is a material issue or a tempest in a teapot. Regardless, the argument that a full exclusion of costs is overly punitive is not new and has been rejected.[172] For example, the U.S. Court of Appeals for the Fourth Circuit recently addressed this issue in *Lancaster Hosp. Corp. v. Becerra.*

Finally, the Board is surprised that no "final" Worksheet S-3 is included in the Exhibits provided by either of the Parties. However, as noted by the Medicare Contractor, "the adjustments proposed as a result of the Medicare Contractor's review and the CMS Intervention Request have benefitted the Providers' Wage Index data."[173] Indeed, an increase of $4.20 in the AHW, *after VUMC made its Intervention Request*, confirms that the Medicare Contractor indeed did review its correction requests and did make the appropriate adjustments to improve its VUMC's wage index which brought it in line with other hospitals in the area.[174]

The Board finds that the Medicare Contractor properly excluded costs which had questionable allocation methodologies from the wage index calculation. On the other hand, the Board further notes that VUMC did receive benefits from these costs, as they were allowed to remain on the cost report and be used to develop cost-to-charge ratios used for future outlier calculations for VUMC

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[170] Providers' FPP at 27.
[171] Ex. P-2 at P0008.
[172] *See Lancaster Hosp. Corp. v. Becerra*, 58 F.4th 124 (4th Cir. 2023) (stating "Lancaster asserts that – even if some reduction were warranted – the Board erred by denying its entire 1997 reimbursement request. There appears no doubt Lancaster provided services to Medicare beneficiaries in 1997 and denying all reimbursement for that year may seem harsh. But the principle that people 'must turn square corners when they deal with the Government" "has its greatest force when a private party seeks to spend the Government's money." *Heckler v. Community Health Servs. of Crawford Cnty., Inc.* 467 U.S. 51, 63, 104 S. Ct 2218, 81 L.Ed.2d 42 (1934). "As a participant in the Medicare program," Lancaster "had a duty to familiarize itself with the legal requirements for cost reimbursement," *id.* at 64, 104 S. Ct. 2218, including the need to provide cost data in a form "capable of being audited," 42 C.F.R. § 413.24(c).[3] The Board's decision to deny reimbursement for fiscal year 1997 was neither arbitrary nor capricious and was supported by substantial evidence."); *also see, Springs Mem'l. Hosp. v. Palmetto GBA,* PRRB Dec. 2019-D24 (Apr. 30, 2019), *decl'd review* Adm. Ltr. (Jun. 27, 2019).
[173] Ex. C-25 at C0334. This exhibit includes a discussion between Cahaba staff and CMS staff regarding the Average Hourly Wage at different points in the process. In an email dated June 18, 2014 (at the end of the wage index process), Cahaba's In-Charge Auditor informs the CMS staff that the AHW "has increased from $33.91 on [VUMC's] As-Filed Cost Report…to $34.90 on the most-recently revised Medicare Cost Report." *Id.* He further went on to note that VUMC's "overall AHW at the beginning of the Appeal Review/end of the 2nd Round PUF was $30.70. So the adjustments proposed as a result of the Medicare Contractor's review and the CMS Intervention Request have benefitted the Providers' Wage Index data." *Id.* The Board notes that the $30.70 figure is also supported by VUMC's own CMS Intervention Request. Ex. P-6 at P0137. That request also cites that 2011's AHW was $35.12. *Id.* at P0138. Thus, the final 2012 wage index is comparable with the final 2011 wage index, at 99.37 percent of 2011's AHW.
[174] *See supra* note 173.

and to provide information for future DRG valuations in IPPS. Further, some of the overhead would be allocated to areas which may receive pass-through reimbursement. However, the lack of verifiability in terms of salaries, wage-related costs, and the related hours, plus uncertainty of proper reporting of costs "in the proper cost center"[175] resulted in the proper exclusion of these costs from the wage index calculation.

DECISION:

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board" or "PRRB") finds the Medicare Contractor and CMS properly disallowed certain wage data from VUMC when the wage index for FFY 2015 was calculated.

BOARD MEMBERS PARTICIPATING:

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Kevin D. Smith, CPA
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FOR THE BOARD:

9/24/2024

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

[175] PRM 15-2 § 4005.2.