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|  | Whether the Medicare Administrative Contractor (“MAC”) and the Centers for Medicare and Medicaid Services (“CMS”) improperly removed certain contracted physician part A costs claimed by Duke University Hospital (“University”) from the calculation of University’s average hourly (“AHW”) wage index calculation and from the federal fiscal year (“FFY”) 2023 wage index calculation for the Durham-Chapel Hill, NC core based statistical area (“CBSA”). |

1. **Facts**

The Social Security Amendments of 1983 created an Inpatient Prospective Payment System (IPPS) to reimburse hospitals for operating costs incurred in providing acute care inpatient services to Medicare patients. Under this system, hospitals are paid a fixed amount for each patient treated, depending upon the diagnosis related group (DRG) and the type of treatment provided. The Federal rate consists of two components: (a) the portion of costs that can be attributed to labor-related costs and (b) non-labor related costs. The prospective rates are set based on historical provider costs adjusted for various limits established by CMS.

Section 1886(d)(3)(E) of the Social Security Act, "Adjusting For Different Area Wage Levels," requires the Secretary to adjust the proportion of hospitals’ costs that are attributable to wages and wage-related costs for area differences in hospital wage levels. See also 42 C.F.R. § 412.64(h). This adjustment is made by a factor reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level. The function of the wage index is to measure relative hospital labor cost across different geographic areas. Accordingly, the Secretary establishes a wage index for each Core Based Statistical Area (CBSA) and for each statewide area that is not within a CBSA. The statute requires CMS to update the wage indices annually. CMS bases the annual update on information regarding wages and wage-related costs taken from cost reports filed by each hospital paid under the IPPS. Wage index data is reported on Worksheet (W/S) S-3, Parts II and III of the hospital cost report. Each year, CMS publishes a wage index timetable setting various tasks and due dates for all parties to adhere to. Reference the FFY 2023 timetable at **Exhibit P-7**.

This group consists of two providers, Duke University Hospital (34-0030) and Duke Regional Hospital (34-0155). Reference the Final Schedule of Providers at **Exhibit C-1**. The MAC performed a wage index audit on the Providers’ cost reporting period ending June 30, 2020. The data from these cost reports was used in establishing the FFY 2023 IPPS Wage Index for the Hospitals’ Durham-Chapel Hill, NC CBSA (CBSA 20500). For purposes of this appeal, only the documentation and related MAC adjustments for Duke University (34-0030) are in dispute.[[1]](#footnote-1)

In performing the MAC’s wage index review of Duke University’s (Duke) cost report, the MAC removed 100% of the contract labor costs reported on W/S S-3, Part II, Line 13: Physician Part A – Administrative. The salaries and hours reported on this line related solely to one vendor, Private Diagnostic Clinic, PLLC (PDC). PDC contracts with Duke to supply physicians to serve as medical directors and/or provide management services in various departments at Duke. PDC then separately contracts with each supplied physician to provide the services it contracted with Duke to provide (i.e., each physician’s contract is a contract within a contract). The MAC selected an invoice from three PDC contracts to review for propriety and determined that in all sampled cases, the invoiced salaries and hours did not trace to the associated physician contracts. Therefore, 100% of the claimed PDC contract labor was removed from the cost report and in turn, was not utilized in determining the FFY 2023 wage index. Reference the MAC’s Contract Labor Wage Index Workpaper and Duke’s supporting documents at **Exhibit C-2**.

Specifically, Sample 1 is a contract between PDC/Duke and [SL[[2]](#footnote-2)] for Infection Control and Epidemiology Medical Director Services. Effective December 1, 2018, the physician was initially contracted to provide 1,008 hours per year (or 84 hours/month) of medical director services at Duke at a rate of $125 per hour, annual compensation of $126,000 ($10,500/month). Effective March 1, 2020, PDC/Duke entered into a supplemental contract with the physician due to the COVID-19 Public Health Emergency (PHE) and increased the physician’s medical director hours to 220 hours per month (2,640 hours/year) at the same $125 rate per hour, maximum monthly compensation of $27,500 ($330,000/year). The MAC sampled the April 2020 invoice for the supplemental contract expense, totaling $17,000 and 76 hours, for an average hourly wage (AHW) of $223.68. Reference **Exhibit C-2**, Workpapers 800-7 I, 800-7 J and 800-7 L. The MAC determined that the AHW exceeded the contracted hourly rate. Therefore, the entire physician contract was disallowed.

Sample 2 is a contract between PDC/Duke and [IA] for Pediatric Infectious Disease Medical Director Services. Effective August 1, 2018, the physician was initially contracted to provide 702 hours per year (or 58.5 hours/month) of medical director services at Duke at a rate of $125 per hour for an annual compensation of $87,750 ($7,312.50/month). Effective March 1, 2020, PDC/Duke entered into a supplemental contract with the physician due to the COVID-19 PHE and increased the physician’s medical director hours to 300 hours per month (3,600 hours/year) at the same $125 rate per hour for a maximum monthly compensation of $37,500 ($450,000/year). The MAC sampled the April 2020 combined invoice expense, totaling $37,500 and 280 hours, for an average hourly wage (AHW) of $133.93. Reference **Exhibit C-2**, Workpapers 800-7 M, 800-7 N and 800-7 O. The MAC determined that the AHW exceeded the contracted hourly rate. Therefore, the entire physician contract was disallowed.

Sample 3 is a contract between PDC and Duke to provide multiple physicians for the co-management of the Provider’s Heart department. Effective August 1, 2018, in exchange for providing qualified physicians to manage or co-manage the Provider’s heart program, Duke will pay PDC (not any individual physician) a fixed amount of $112,069 per month, or $1,344,822 per year, based on total estimated annual hours of 4,860. In addition, Duke agrees to pay PDC up to $680,000/year of incentive compensation based on certain performance metrics. Per the contract, incentive compensation is paid out within 60 days after each 12-month contract period. Incentive compensation is paid to PDC, not to any individual physician. The MAC sampled the May 2020 invoice expense, totaling $153,750 and 458 hours, for an average hourly wage (AHW) of $335.70. Reference **Exhibit C-2**, Workpapers 800-7 P and 800-7 Q. The MAC determined that the amount actually paid exceeded the monthly contracted rate and no documentation was supplied to support the Provider’s claim that the variance was due to incentive pay. Therefore, the entire co-management contract was disallowed.

In accordance with the CMS FFY 2023 Wage Index Timetable, providers that were dissatisfied with the MAC’s wage index determinations were allowed to file an appeal, including all supporting documentation, directly to CMS, with a copy to the MAC, by the stated due date. In this case, Duke submitted its appeal to CMS properly and timely, i.e., by April 1, 2022. Reference **Exhibit P-13**. Duke requested reversal of the MAC’s Line 13 contract labor adjustments for the same reasons stated in its appeal request to the Board. CMS ultimately denied the Provider’s wage index appeal, noting that the MAC is in the best position to evaluate and determine matters regarding the adequacy of supporting documentation, and agreed with the MAC’s determination to exclude the PDC contract labor from the wage index calculations. Reference **Exhibit P-14**.

1. **Arguments**
2. **Background**
   1. **Reasonable Cost**

Section 1861(v)(1)(A) of the Medicare Act defines “reasonable cost” as “the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs…” The statute authorizes the Secretary to outline the regulations to create methods to determine reasonable costs and the items to be eligible for reimbursement services. The statute states: “[i]n prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers…”.

* 1. **Providers are Required to Produce Records to Support Claims for Reimbursement**

Section 1815(a) of the Social Security Act provides that, “no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period.”

Furthermore, the regulation at 42 C.F.R. § 413.20 (a) provides: “*General* - the principles of cost reimbursement will require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program… (d) Continuing provider recordkeeping requirements. (1) The Provider must furnish such information to the intermediary as may be necessary (i) to assure proper payment by the program…(ii) to receive program payments, and (iii) to satisfy program over payment determinations. (2) The provider must permit the intermediary to examine such records and documents as are necessary to ascertain information pertinent to the determination of the proper amount of program payment due…”. 42 C.F.R. § 413.24(a) defines the principle of adequate cost data and cost finding. It states, “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.” 42 C.F.R. § 413.24(c) further identifies the importance of supplying adequate cost information to obtain program reimbursement. It states, “adequate cost information must be obtained from the provider's records to support payments made for services rendered to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended. Adequate data capable of being audited is consistent with good business concepts and effective and efficient management of any organization, whether it is operated for profit or on a nonprofit basis. It is a reasonable expectation on the part of any agency paying for services on a cost-reimbursement basis.” Reference **Exhibit C-3**.

* 1. **Wage Index Contract Labor Instructions**

In accordance with the Provider Reimbursement Manual (PRM) 15-2, Section 4005.2, Hospital Wage Index Information, for Worksheet S-3, Part II,

General Instructions for Contract Labor:

Only contract labor costs reported on the provider’s trial balance and, therefore, on Worksheet A, column 2, 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. 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 nonlabor costs.** Hospitals must be able to provide such documentation when requested by the contractor. Report only personnel costs associated with the contract. DO NOT include cost for equipment, supplies, travel expenses, and other miscellaneous or overhead items (non-labor costs).

Line 13 – Enter from your records the amount paid under contract (in accordance with the general instructions for contract labor) for Part A physician services - administrative, excluding teaching physician services. DO NOT include contract I & R services (to be included on line 7). DO NOT include the costs for Part A physician services from the home office allocation and/or from related organizations (to be reported on line 15). Do not include wages or hours associated with Part B services. **As stated in the General Instructions for Contract Labor, “the minimum requirement for supporting documentation is the contract itself.** If the wage costs, hours, and nonlabor 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.” Refer to CMS Pub. 15-1, §§2313.2E and 2182.3.E, for instructions related to keeping time studies to track time spent in Part A versus Part B activities. **Adequate documentation must be maintained to support total hours in a manner that is verifiable. Total hours worked by the physicians cannot be imputed.** In the absence of a written allocation agreement, the contractor assumes that 100 percent of the physician compensation cost is allocated to Part B services. Services that are neither Part A nor Part B services (for example, research, non-allowable teaching of residents in non-approved programs, teaching and supervision of medical students, writing for medical journals, reasonable availability services in departments/cost centers other than emergency room, etc.) are not reported on line 13. Reasonable availability services for emergency rooms can be considered Part A in certain circumstances (see CMS Pub. 15-1, chapter 21, §2109.3.A. through C. for instances when emergency department physician availability services costs are allowable, and for the associated required documentation). **(Emphasis added.)**

Reference **Exhibit C-4**. See also 42 C.F.R. § 415.60, Allocation of physician compensation costs, which also requires physicians to maintain and produce auditable time records or other information needed to support total and allocated hours. In this case, 100% of the contracted services are Part A, as they are related to medical director duties. Therefore, an allocation agreement is not applicable. However, the Providers must still document the Part A hours worked and salary expense paid and those hours/salaries must be in compliance with or supported by the contract itself.

1. **The MAC’s Adjustment to Duke University’s Part A Contract Labor does not Violate the Wage Index Statutes and Regulations and is not Arbitrary and Capricious**

Duke first complains that the MAC’s total exclusion of University’s Physician Part A cost violates the plain meaning and purpose of the Medicare wage index statute and implementing regulations. The Provider contends that CMS must collect data and calculate the wage index “[u]niformly and nationwide”, applying rules “consistently and evenhandedly for all hospitals”. To do otherwise defeats the commands and purpose of § 1395ww(d)(3)(E).

The MAC contends that CMS did collect data and calculate the wage index uniformly and nationwide. CMS published its FFY 2023 wage index timetable to every hospital in the country and each hospital and all servicing MACs were strictly held to this timetable. Every hospital in the country was given the same instructions as it related to deadlines, documentation, changes to the Public Use File (PUF) throughout the process, the associated appeal process if providers remained dissatisfied, etc. Each MAC used the same statutory, regulatory and PRM guidance to apply to all reviews equally. The issue in this case is not that the MAC applied these published policies any differently to Duke University, but that Duke could not supply the complete documentation to support its contract labor salaries and hours for its sole vendor, PDC, and Duke believes that it should be exempt from the rules because of the complications created by the COVID-19 PHE and its subsequent failure to ensure that its physicians were maintaining appropriate time records in accordance with its own contracts.

Duke argues that the MAC’s sample size was not sufficient to represent its total population of invoices/contracts. CMS Pub. 100-6, Chapter 8, Section 60.6 allows the MAC to design such tests as are necessary to accomplish its audit objectives as long as the tests aid in reaching conclusions necessary to complete the audit. CMS allows the MACs to use sampling when it would be more efficient in testing the universe of transactions, entries, etc. within an area of consideration. CMS recognizes two general sampling approaches, nonstatistical and statistical, and that either approach, when properly applied, can provide sufficient evidential data related to the design and size of an audit sample, among other factors. The CMS instructions are also in compliance with the American Institute of Certified Public Accountants (AICPA) Statement of Auditing Standard (SAS) Number 39 at **Exhibit C-5**.

Duke has a master contract with PDC, which then encompasses 227 separate subcontracts, representing 294 individual physicians and 2,481 monthly payments/disbursements during its cost reporting period ending June 30, 2020. Reference **Exhibit P-13**. Duke contends that the MAC’s decision to only select three invoices from those 227 separate contracts is an unfair representation of the total population. The MAC contends that each subcontract is a separate “population” and that it would therefore be impossible to statistically sample a larger population of the 2,481 monthly payments/disbursements and project a proper error rate, as the terms of each physician contract are distinct. Furthermore, regardless of if the MAC has access to all 227 separate contracts, it is unrealistic for Duke to expect the MAC to review each one individually. The wage index review is a fast-paced audit in order to meet the due dates in the published timetable. Therefore, in accordance with CMS Pub. 100-6, Chapter 8, Section 60.6, the MAC is permitted to use smaller, non-statistical sampling in order to achieve its audit objectives. The MAC applied its sample selection process equitably to all hospitals subject to a wage index review. The MAC contends that it is not necessary or required by the regulations to expand the sample to encompass more contracts simply because the invoices already selected by the MAC for review all contained errors and the Provider is dissatisfied with the subsequent adjustments. As noted in the PRM General Contract Labor instruction, “the minimum requirement for supporting documentation is the contract itself”, “if hours cannot be accurately determined, the contract labor costs must not be included in the wage index” and “attestations or declarations from the vendor or hospital are not acceptable in lieu of supporting documentation for wages, hours, wage-related costs, and nonlabor costs”. As material errors were found in all sampled contracts, total exclusion of the PDC vendor is properly within the published regulations. The MAC used the best available data in its wage index determinations and any resulting reduced average hourly wage affecting the entire CBSA is a result of Duke not properly enforcing its contracts and/or not maintaining or submitting the associated documentation capable of verification by audit.

1. **Duke University did not Supply Sufficient Documentation to Support its Line 13 Contract Labor Expense**

In accordance with the above cited statutes and regulations, providers have a requirement to submit accurate cost reports and the associated supporting documentation. Regarding Samples 1 and 2, Duke entered into a Master Contract with PDC to provide medical director physicians in its facility. Reference **Exhibit C-2**, Workpapers 800-7 J and 800-7 M. As a part of that contract, Section 5(c) states,

In order for the Practice to receive such monthly compensation, each Physician must demonstrate fulfillment of such Physician's obligations hereunder. Each Physician shall maintain and within fifteen (15) days after the end of each month submit documentation satisfactory to the Hospital's chief executive officer or his or her designee, which evidences and describes the duties and tasks, and corresponding number of hours (the "Actual Monthly Hours") performed by the Physician pursuant to this Agreement and the relevant Addendum during the month for which compensation is to be paid. Such documentation shall be submitted electronically via email notification in substantially the form attached hereto as Exhibit B and incorporated herein by reference. DUHS shall compensate the PDC by the last Friday of the month upon receipt of such documentation by no later than the fifteenth (15th) day after the end of such month. The PDC is responsible for ensuring that Physicians complete the documentation of time and duties. In the event that a Physician does not perform the expected duties, tasks and hours in such month or does not submit timely and satisfactory documentation of such performance as required by the terms of this Agreement and the applicable Addendum, Hospital shall withhold monthly compensation for such Physician until such time as satisfactory documentation is submitted; (Emphasis added)

Section 9 goes on to state,

Record Keeping Requirements. Practice agrees that each Physician shall complete and provide DUHS with information and documentation that DUHS may require from time to time in order to secure reimbursement from federal or state agencies, intermediaries, carriers or other third party payors, or patients for any services provided pursuant to this Agreement. This information and documentation shall include, but not be limited to, the recording and maintenance by each Physician of time records required by Medicare or by any third party reimbursement entity of all services provided pursuant to this Agreement by Physician at the Hospital. Until the expiration of four (4) years following the furnishing of goods or services pursuant to this Agreement, Practice shall make available, upon written request, to the Secretary of the Department of Health and Human Services or, upon request, to the Comptroller General, or any of their duly authorized representatives, this Agreement, books, documents and records of the Practice that are necessary to certify the nature and extent of their costs under this Agreement.

For Samples 1 and 2, the COVID-19 PHE Contract Modification at **Exhibit C-2**, Workpapers 800-7 I and 800-7 N, re-iterates that,

Hours performed should be entered into the Physician Timesheet Management System, as under the Original Agreement. Payment will be made by DUHS to the PDC for the documented hours worked in accordance with the hourly rate and maximum hour figures set forth below, with such payment being made on the same timetable as under the Original Agreement.

To facilitate accurate timekeeping, Duke utilizes an electronic badging system that tracks physicians’ ins and outs. Accordingly, the MAC maintains that Duke not only knew about CMS’s cost reporting requirements and its obligation to maintain and supply the supporting documentation upon request, but that it also personally required the maintenance of said documentation in its own contracts. For Samples 1 and 2, in its wage index appeal to the MAC and CMS and as maintained in the Group’s preliminary position paper, Duke argued that the physicians average hourly wage was reasonable based on PRM 15-1, Section 2103’s Prudent Buyer principle. Further, it argued that the sampled invoices were at the height of the COVID-19 pandemic and that these physicians were risking their lives to develop a plan for caring for COVID patients, so these physicians should essentially be excused from maintaining proper time records. Duke argues that its Chief Financial Officer (CFO) and Chief Medical Officer (CMO) could attest that these physicians essentially lived at the hospital during the start of the PHE and that these physicians therefore worked well above their contracted hours. The MAC is sympathetic of Duke’s predicament, but it must still apply the CMS cost reporting and wage index regulations “uniformly and nationwide”, which includes auditing the sufficiency of the documentation supplied to support the cost report, not imputing hours worked and not relying on attestations of hospital upper management. Furthermore, both physician subcontracts, both original and the COVID supplement, specifically outline the expected “total number of hours per year” that Duke expected the sampled physicians to work. The PDC Master Contract may include an estimation adjustment clause that may apply to some of the subcontracted physicians or co-management agreements, but for the sampled physicians, the contract is clear about how much each physician will work for the stated pay and at what rate.

For Samples 1 and 2, the physicians failed to report their time in accordance with their individual contracts and PDC failed to ensure that its contracted physicians reported their time in accordance with those subcontracts and the master contract. Before paying PDC each month, Duke should have ensured that it had timesheets sufficient to support the amount it paid out to PDC in accordance with Section 5(c) of the master contract. The prudent buyer principle is not in dispute here. Whether the average hourly wage, as calculated using the documentation submitted, is reasonable is irrelevant because the physician contracts specifically outlined what the hourly rate was and the master contract, Section 5(d) states, “In no event shall DUHS compensate the PDC for additional hours, regardless of whether the Actual Quarterly Hours for such calendar quarter exceed one-fourth (1/4) of the Estimated Annual Hours”. Therefore, it does not matter if the physician’s worked over their estimated hours because they would be paid the capped salary amount based on the contractually agreed upon monthly maximum number of hours to be worked. The salary expense is only adjusted each quarter if the physicians do not work at least the estimated monthly hours. To further that, the amount that PDC would have to repay to Duke for physicians that did not work at least the minimum monthly hours is based on the contracted $125 hourly wage.

Finally, even if the MAC had expanded its sample for each physician to cover additional months of the contract (for example May and June 2020), the MAC notes that for Sample 1 [SL], the additional salary expense traces to the COVID addendum ($17,000), but the recorded hours come nowhere close (36 actual hours vs. 220 expected hours). When averaged for the quarter, the average hours worked (133.33) also do not trace to the expected hours (220) in the contract. In that instance, Duke should have adjusted the contract expense and/or taken remedial actions against the physician in accordance with Section 5(d) and 5(e) of the master contract. In addition, based on the physician’s yearly labor summary at **Exhibit C-2**, Workpaper 800-7 L, the physician was paid a total of $177,000 for the year and worked 1,298 hours, which results in an average hourly wage of $136.36. Again, this does not trace to the contracted rate and the prudent buyer principle is not the problem here. Therefore, even if the MAC had reviewed every single month of this physician’s invoices, the MAC’s findings would not have changed.[[3]](#footnote-3)

Regarding Sample 3, Section 4.2 of the heart co-management subcontract states that Duke is to pay PDC (not any individual physician) a fixed monthly amount of $112,069 for the physician co-management services agreed upon in the contract based on an estimated number of hours and that additional hours worked will not result in an increase in the fixed monthly payment, unless agreed upon through a written amendment. The hours must be supported through appropriate timesheets in compliance with Sections 5(c) and 9 of the master contract. The contract also allows up to $680,000 of incentive compensation if PDC meets certain performance metrics. At **Exhibit C-2**, Workpaper 800-7 Q, Duke submitted a summary listing of the PDC heart co-management contract labor expense for the year. The MAC sampled the May 2020 invoice and determined that the maximum payout for labor for the month was $112,069 in accordance with the contract, but the Provider’s labor summary totaled $153,750 and that because the amount paid exceeded the fixed contracted monthly rate, the contract was not allowable. See MAC’s findings at **Exhibit C-2**, Workpaper 800-7 A. Duke rebutted the MAC’s determination stating that the MAC was failing to consider incentive pay. However, Duke did not submit any documentation to show that the $41,666.67 monthly variance related to incentive pay. Section 4.2 of the contract states that the incentive payment is made within sixty days after each twelve-month period. There is nothing in the contract that indicates that the incentive payout would be allocated on a monthly basis nor is there anything on the labor summary to indicate that this amount is related to incentive pay or that it was paid to the physicians themselves. Incentives paid to PDC are not allowable bonus pay for the purposes of wage index if they were not paid to the actual physicians, as it would not relate to the “cost of labor”, which is the entire basis of the wage index adjustment. Duke had the opportunity to submit the performance metric and invoice documentation necessary to prove its contention that the additional pay related to incentives and that the alleged incentives were ultimately paid to the actual physicians prior to the end of the wage index period but chose not to. It was not the MAC’s responsibility to request additional documentation after the Provider’s rebuttal and in fact the CMS FFY 2023 wage index timetable specifically instructed providers to “submit requests (including supporting documentation)” for corrections to errors in the January PUFs and reiterated that “MACs must receive the request and supporting documentation by this date”. Emphasis added. Reference **Exhibit P-7** (February 15, 2022 due date) and **Exhibit P-11** (Duke’s February 14, 2022 response). Therefore, the MAC contends that Duke cannot now recover in this appeal. Finally, to address Duke’s prior point that the MAC’s sample size for this contract was also insufficient, the MAC contends that it would not have mattered if it had reviewed every month of this contract because the salary expense and supporting documentation were the same for each month and again, the MAC could not have projected an error rate across the entire contract labor population, as each contract has distinct terms. Accordingly, since three of the three contracts sampled for the same vendor were found to be materially deficient, total exclusion of the PDC vendor was proper and the MAC respectfully requests that the Board uphold is disallowance.

1. **Conclusion**

The MAC’s wage index adjustments were not made erroneously and were not arbitrary and capricious. The MAC contends that prudent buyer concept is not the issue here and that Duke failed to supply the necessary supporting documentation to overturn the MAC’s adjustments in accordance with the Social Security Act, Section 1815(a), 42 C.F.R. §§ 413.20, 413.24 and 415.60 and PRM 15-2, Section 4005.2. Duke violated the payment terms of its own contracts. Therefore, the MAC respectfully requests that the Board uphold its removal of Duke’s Worksheet S-3, Part II, Line 13 contract labor expense for vendor PDC and determine that no adjustment to the Durham-Chapel Hill CBSA is necessary.

IV. LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS

**Laws:**

Social Security Act, Section 1815(a);Social Security Act, Section 1861(v)(1)(A);Social Security Act, Section 1886(d)(3)(E)

**Regulations:**

42 C.F.R. § 412.64(h);42 C.F.R. § 413.20;42 C.F.R. § 413.24;42 C.F.R. § 415.60

**Program Instructions:**

PRM 15-1, Section 2103;PRM 15-2, Section 4005.2;CMS Pub. 100-6, Chapter 8, Section 60.6

**Other Sources:**

CMS FFY 2023 Wage Index Timetable;American Institute of Certified Public Accountants (AICPA) Statement of Auditing Standard (SAS) Number 39

V. EXHIBITS

C-1: Group’s Final Schedule of Providers

C-2: MAC’s Wage Index Contract Labor Workpaper & Provider Supporting Documentation

C-3: 42 C.F.R. § 413.20 – 413.24

C-4: PRM 15-2, Section 4005.2

C-5: AICPA Statement of Auditing Standard Number 39

1. Duke Regional (34-0155) is a participant in this group appeal because it is related by common ownership to Duke University Hospital (34-0030). Duke Regional (34-0155) is in the same CBSA as Duke University and Duke University’s wage index adjustments affect Duke Regional’s future IPPS claims payments. [↑](#footnote-ref-1)
2. The MAC has redacted all physician names from the workpapers and supporting documents. The MAC has assigned initials to each disputed physician for reference during this appeal. [↑](#footnote-ref-2)
3. Note: Physician was originally contracted to work 84 hours per month x 9 months, then entered into the COVID contract at 220 hours per month for 3 months. Accordingly, total expected hours would then be 1,416. Based on documentation provided, physician did not work this amount. Therefore, based on the terms of the contract, the physician should not have been compensated for the full salary amount. [↑](#footnote-ref-3)