# PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2023-D18

**PROVIDER –**
Sunnyside Community Hospital

**Provider No. –**
50-1330

**vs.**

**MEDICARE CONTRACTOR –**
WPS Government Health Administrators

**HEARING DATE –**
January 25, 2021

**Fiscal Years –**
2011, 2012, 2013

**Case Nos. –**
16-0304, 16-1222, 16-1429

**INDEX**

## ISSUE STATEMENT

Whether the Provider is entitled to certain emergency room availability costs including costs for mid-level providers ("MLPs") for the fiscal years ending December 31, 2011,[1] December 31, 2012,[2] and December 31, 2013[3] ("FYs 2011, 2012, and 2013").[4]

## DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor's disallowance of the Provider's emergency room availability costs for FYs 2011, 2013, and 2013 was proper and the Provider is not entitled to the emergency room availability costs at issue, including costs for MLPs, for those fiscal years.

## INTRODUCTION

Sunnyside Community Hospital ("Sunnyside" or "Provider") is a critical access hospital ("CAH") located in Sunnyside, Washington.[5] The hospital includes five rural health clinics.[6] Sunnyside's designated Medicare contractor[7] is WPS Government Health Administrators ("Medicare Contractor").

The Medicare Contractor disallowed a portion of Sunnyside's emergency room *physician availability* costs for FY 2011 due to a lack of certain documentation, including physician allocation agreements and time studies or other support for hours and compensation allocations. The Medicare Contractor based its disallowance on 42 C.F.R. §§ 413.24, 415.60, the Provider Reimbursement Manual, CMS Pub. No. 15-1 ("PRM 15-1"), §§ 2108, 2109, 2182.3, and PRM 15-2 § 4018,[8] and identified the missing documentation.

The Medicare Contractor disallowed the same costs for FY 2012 "based on the prior year audit findings, because the provider did not demonstrate, or submit support, that alternative methods for obtaining physician coverage in the ER were explored and found to be unfeasible; Physician contracts were requested but not submitted, Provider payroll register was requested but only 2 pages were submitted (and pertained to only 3 doctors)."[9] Similarly, on this same basis (*i.e.*,

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[1] Case No. 16-0304.
[2] Case No. 16-1222.
[3] Case No. 16-1429.
[4] The parties stipulated to the issue statement at the hearing. *See* Transcript ("Tr.") at 5-6. While there was a second issue in Case Nos. 16-1222 and 16-1429, the Provider withdrew that issue, as confirmed at the hearing. *Id.*
[5] Medicare Contractor's Final Position Paper (hereinafter, "Medicare Contractor's FPP") at 1; Initial Appeal Request at Tab 3 (Case No. 16-0304).
[6] Initial Appeal Request at Tab 3 (Case No. 16-0304).
[7] CMS' 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.
[8] Initial Appeal Request, Tabs 3-4 (Case No. 16-0304).
[9] *Id.* at Tab 4 (Case No. 16-1222).

based on findings noted in the penultimate year), the Medicare Contractor disallowed the same costs for FY 2013.[10]

Sunnyside timely appealed the Medicare Contractor's adjustments to the Board for all three fiscal years, and met the jurisdictional requirements for a hearing. The Board conducted a consolidated video hearing on January 25, 2021. Sunnyside was represented by Cory Talbot, Esq. and Lisa Carlson, Esq. of Holland & Hart LLP. The Medicare Contractor was represented by Joseph Bauers, Esq. and Charles Moreland, Esq. of Federal Specialized Services.

## STATEMENT OF FACTS AND RELEVANT LAW

The CAH designation was established by the Balanced Budget Act of 1997[11] in order to improve access to healthcare for rural and underserved areas.[12] To be eligible as a CAH, a facility must meet certain requirements, including certain status and location requirements, and also must make available emergency care services. In particular, 42 U.S.C. § 1395i-4(c)(2)(B) requires:

> **(B) Criteria for designation as critical access hospital**
>
> A State may designate a facility as a critical access hospital if the facility--
>
> (i) is a hospital that is located in a county (or equivalent unit of local government) in a rural area (as defined in section 1395ww(d)(2)(D) of this title) or is treated as being located in a rural area pursuant to section 1395ww(d)(8)(E) of this title, and that--
>
> (I) is located more than a 35-mile drive (or, in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive) from a hospital, or another facility described in this subsection; or
>
> (II) is certified before January 1, 2006, by the State as being a necessary provider of health care services to residents in the area;
>
> (ii) makes available 24-hour emergency care services that a State determines are necessary for ensuring access to emergency care services in each area served by a critical access hospital;
>
> (iii) provides not more than 25 acute care inpatient beds (meeting such standards as the Secretary may establish) for providing inpatient care for a period that does not exceed, as determined on an annual, average basis, 96 hours per patient;

[10] *Id.* at Tab 4 (Case No. 16-1429).
[11] Pub. L. No. 105-33, § 4201, 111 Stat. 251, 369 (1997).
[12] *See* 62 Fed. Reg. 45966, 46009 (Aug. 29, 1997).

> (iv) meets such staffing requirements as would apply under section 1395x(e) of this title to a hospital located in a rural area . . . ; and
>
> (v) meets the requirements of section 1395x(aa)(2)(I) of this title.

Because a CAH's emergency room volume may not generate sufficient physician revenue from direct patient care, the CAH "may have to offer physicians supplemental compensation or minimum compensation guarantees to secure coverage of emergency departments."[13] Given this set of circumstances, certain regulations and manual provisions allow for *different* types of contract arrangements to allow for CAHs to be sufficiently staffed. These cases focus on two types of contract arrangements:

1. On-call arrangements; and
2. Availability services (also known as standby services) arrangements.

In an on-call arrangement, the physician, or MLP, is not on the hospital premises but is able to be summoned to the hospital when needed. In contrast, an availability, or standby arrangement,[14] only applies to physicians that are be both onsite at the hospital *and* available to render services. Here, Sunnyside has represented that it entered into arrangements for "availability services" for physicians and MLPs and seeks to use the regulations and guidance governing on-call arrangements to support its position.

### *A. Emergency room availability services arrangements.*

PRM 15-1 § 2109 states CMS' longstanding policy regarding *availability* services provided for emergency rooms, and how they are reimbursed.[15] Significantly, in 2004, when CMS revised is policy for emergency room *on-call* provider arrangements (as discussed *infra*), it did not otherwise revise its policy regarding *availability* services.

PRM 15-1 § 2109 provides the following general overview of *availability* services:

> 2109. REIMBURSEMENT OF HOSPITAL EMERGENCY DEPARTMENT SERVICES WHEN PHYSICIANS RECEIVE COMPENSATION FOR ***AVAILABILITY*** *SERVICES*
>
> 2109.1 General.--Wide variations can occur in the utilization of hospital emergency department services and hospitals cannot always schedule physician staffing at a level commensurate with

[13] PRM 15-1 § 2109.1.
[14] "Standby" and "availability" are terms that are used interchangeably. *See, e.g.,* 66 Fed. Reg. at 39922 ("[c]onsistent with the general policies stated in section 2109 of the Medicare Provider Reimbursement Manual (PRM), Part I (HCFA Publication 15-1), the reasonable cost of CAH services to outpatients may include reasonable costs of compensating physicians who are on standby status in the emergency room (that is, physicians who are present and ready to treat patients if necessary).").
[15] PRM 15-1 § 2109 has been in effect since May 1985. *See* PRM 15-1 § 2109 posted on CMS' website at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929 (accessed June 9, 2023 showing that § 2109 was last revised by Transmittal No. 326, PRM 15-1 (May 1985)).

> the actual volume of services rendered. As a result, emergency department physicians may spend a portion of their time in an ***availability*** status awaiting the arrival of patients. Alternatively, hospitals may need to arrange for emergency department physician coverage for evenings, weekends or holidays, when staff or community physicians are not available. *Since these periods frequently generate inadequate physician revenue through charges for professional services due to lower utilization, hospitals may have to offer physicians supplemental compensation or minimum compensation guarantees to secure coverage of emergency departments*.
>
> When emergency department physicians are compensated on an hourly or salary basis or under a minimum guarantee arrangement (§ 2109.2E) providers may include a reasonable amount in allowable costs for emergency department physician availability services subject to limitation through the application of Reasonable Compensation Equivalents (RCEs). ***Availability*** *costs will be recognized only in the emergency department of a hospital, and only as described in this section*.[16]

The calculations in PRM 15-1 § 2109 use RCEs to determine the reasonable costs paid for *availability* services. However, the regulations, as noted previously, do not require CAHs to apply RCEs in reasonable cost calculations. As a result, in the case of a CAH, other means, outside of using RCEs, need to be applied to determine if the *availability* costs paid are reasonable.

### *B. Emergency room on-call arrangements*

One of the statutory requirements of a CAH is that it "*makes available* 24-hour emergency care services. . . ."[17] Prior to October 1, 2001, emergency rooms ("ERs") had to be staffed by a physician that was on-site 24 hours a day. However, after considering the low volumes and staffing difficulties of a CAH, regulations were promulgated, effective October 1, 2001, to allow for a CAH's ER to be staffed by an ***on-call*** physician.[18] These ***on call*** regulatory provisions were further revised, effective January 1, 2005, to expand its application to the following mid-level practitioners ("MLPs"): (a) physician assistants; (b) nurse practitioners; and (c) clinical nurse specialists.[19] As a result of these revisions, the regulation at 42 C.F.R. § 413.70(b)(4) (2011) provides:

> (4) *Costs of certain* ***emergency room on-call*** *providers.* (i) Effective for cost reporting periods beginning on or after October 1, 2001, the reasonable costs of outpatient CAH services under paragraph (b) of

[16] (Bold and italics emphasis added and underline emphasis in original.)
[17] 42 U.S.C. § 1395i-4(c)(2)(B)(ii) (emphasis added).
[18] 66 Fed. Reg. 39828, 39922-39923 (Aug. 1, 2001).
[19] 69 Fed. Reg. 49215, 49253 (Aug. 11, 2004) (discussing the adoption of the regulatory language in § 413.70(b)(4)).

> this section may include amounts for reasonable compensation and related **costs for an emergency room physician** who is **on call** but who is not present on the premises of the CAH involved, is **not otherwise furnishing physicians' services**, and is not on call at another other provider or facility. Effective for costs incurred for services furnished on or after January 1, 2005, the payment amount of 101 percent of the reasonable costs of outpatient CAH services may also include amounts for reasonable compensation and related costs for the following **emergency room providers** who are **on call** but who are not present on the premises of the CAH involved, are not otherwise furnishing physicians' services, and are not on call at another other provider or facility: **physician assistants, nurse practitioners, and clinical nurse specialists**.
>
> (ii) For purposes of this paragraph (b)(4)—
>
> (A) "Amounts for reasonable compensation and related costs" means all allowable costs of compensating **emergency room** physicians, physician assistants, nurse practitioners, and clinical nurse specialists who are **on call** to the extent that the costs are found to be reasonable under the rules specified in paragraph (b)(2) of this section and the applicable sections of Part 413. Costs of compensating these specified medical emergency room staff are allowable **only if** the costs are incurred under written contracts that require the physician, physician assistant, nurse practitioner, or clinical nurse specialist to come to the CAH when the physician's or other practitioner's presence is medically required.
>
> (B) Effective for costs incurred on or after January 1, 2005, an "emergency room physician, physician assistant, nurse practitioner, or clinical nurse specialist who is on call" means a doctor of medicine or osteopathy, a physician assistant, a nurse practitioner, or a clinical nurse specialist, with training or experience in emergency care who is immediately available by telephone or radio contact, and is available onsite within the timeframes specified in §485.618(d) of this chapter. [20]

### *C. Reasonable cost reimbursement for qualifying on-call and availability services arrangements*

As a CAH, Sunnyside is reimbursed for inpatient and outpatient services on a reasonable cost basis.[21] The Medicare statute 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[.]"[22] The intent of the reasonable cost statute, which has been in place since the beginning

[20] (Bold and underline emphasis added and italics emphasis in original.)
[21] *See* 42 U.S.C. §§ 1395f(l)(1), 1395m(g)(1); 42 C.F.R. §§ 413.70(a)(1), (b)(2)(i).
[22] 42 U.S.C. § 1395x(v)(1)(A).

of the Medicare program in 1965, is "to meet the actual costs" incurred in rendering necessary services, "including normal standby costs."[23] Under this fundamental precept, a provider's actual incurred costs may nonetheless be limited when "a particular institution's costs are found to be substantially out of line with those of institutions similar in size, scope of services, utilization, and other relevant factors."[24]

Consistent with the intent of the reasonable cost statute, the applicable regulation provides that "reasonable cost" includes "all necessary and proper costs incurred in furnishing the services[.]"[25] The regulation broadly defines the term "necessary and proper costs" to mean "costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities."[26] And, again consistent with the intent of the statute, the implementing regulations include "standby costs" and "administrative costs," including the certain costs of physician services provided to the hospital, rather than directly to an individual patient, within the definition of reasonable costs.[27]

While CAHs are subject to the regulatory reasonable cost calculation methodologies, these providers have been granted certain exceptions and exclusions from those calculations. For example, the reasonable compensation equivalent ("RCE") test for the reasonableness of physician service costs to providers does not apply to CAHs.[28] Similarly, the regulations expressly define reasonable costs in a CAH to "include amounts for reasonable compensation and related costs for an emergency room physician who is on call but who is not present on the premises of the CAH involved," so long as the emergency room physician "is not otherwise furnishing physicians' services, and is not on call at any other provider or facility."[29] Thus, reimbursement to CAHs for the services of emergency room physicians may include both on-call costs and standby costs, provided that these services are furnished consistent with regulatory requirements.

As explained above, the Medicare program allows for emergency room physician *availability* costs to be claimed on the Medicare cost report, however, they must be claimed in accordance with 42 C.F.R. § 415.60 and PRM 15-1 § 2109. According to PRM 15-1 § 2109.2(A), "[p]hysician availability services consist of the *physical* presence of a physician in a hospital under a formal arrangement with the hospital to render emergency treatment to individual patients as and when needed."[30] PRM 15-1 § 2109.3 confirms that emergency department physician availability services will be allowable ***only*** in certain "special circumstances":

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[23] S. Rep. No. 89-404, at 35-36 (1965) (*available at* https://www.finance.senate.gov/imo/media/doc/SRpt89-404.pdf).
[24] PRM 15-1 § 2102.1 ("It is the intent of the program that providers are reimbursed the actual costs of providing high quality care, regardless of how widely they may vary from provider to provider, except where a particular institution's costs are found to be substantially out of line with other institutions in the same area which are similar in size, scope of services, utilization, and other relevant factors.").
[25] 42 C.F.R. § 413.9(a).
[26] 42 C.F.R. § 413.9(b)(2).
[27] 42 C.F.R. § 413.9(c)(3). *See also* 42 C.F.R. § 413.5(a) (stating that payment on a reasonable cost basis is meant to include "[a]ll necessary and proper expenses of an institution in the production of services, including normal standby costs[.]"). 42 C.F.R. § 415.55(a) (Allowable costs).
[28] 42 C.F.R. §§ 413.70(a)(1)(iii), (b)(2)(i)(B).
[29] 42 C.F.R. § 413.70(b)(4)(i).
[30] (Emphasis added.)

2109.3 Allowability of Emergency Department Physician Availability Services Costs.--Emergency department physician availability services costs will be allowable ***only*** *in special circumstances*, as follows:

A. No Feasible Alternative Way to Obtain Physician Coverage is Available. - In order for physician availability services costs to be allowable, the provider ***must demonstrate*** *that it explored alternative methods* for obtaining physician coverage but was unable to do so....

B. Physicians Provide Immediate Response to Life-Threatening Emergencies. – The physician must be on the hospital premises in reasonable proximity to the emergency department. The physician cannot be "on call."

C. Documentation. – A claim for Part B hospital costs or Part A and Part B hospital costs must be supported by the following data maintained by the hospital:

1. A signed copy of the contract between the hospital and the physician(s).

2. A written copy of the allocation agreement and supporting data depicting the distribution of the physician's time between services to the provider, services to individual patients and services not reimbursable under Medicare.

3. A permanent record of payments made to the physician(s) under the agreement.

4. A record of the amount of time the physician was physically present on the hospital premises to attend to emergency patients.

5. *A permanent record of* ***all*** *patients* (Medicare and non-Medicare) *treated by the physician*, copies of all physician bills generated for such services and a record of imputed charges for services for which no billing was made by the hospital or physician.

6. A schedule of physician charges.

7. *Evidence that the provider explored* ***alternative methods for obtaining emergency physician coverage*** *before agreeing to physician compensation for availability services*.[31]

[31] *Id.* § 2109.3(A)-(C) (bold and italics emphasis added and underline emphasis in original).

Physician emergency room availability costs must be claimed in accordance with 42 C.F.R. § 415.60, which governs the allocation of physician compensation costs and states, in full, as follows:

> **§ 415.60 Allocation of physician compensation costs.**
>
> (a) *Definition.* For purposes of this subpart, *physician compensation costs* means monetary payments, fringe benefits, deferred compensation, and any other items of value (excluding office space or billing and collection services) that a provider or other organization furnishes a physician in return for the physician services. Other organizations are entities related to the provider within the meaning of § 413.17 of this chapter or entities that furnish services for the provider under arrangements within the meaning of the Act.
>
> (b) *General rule.* Except as provided in paragraph (d) of this section, each provider that incurs physician compensation costs must allocate those costs, in proportion to the percentage of total time that is spent in furnishing each category of services, among –
>
> (1) Physician services to the provider (as described in § 415.55);
>
> (2) Physician services to patients (as described in § 415.102); and
>
> (3) Activities of the physician, such as funded research, that are not paid under either Part A or Part B of Medicare.
>
> (c) *Allowable physician compensation costs.* Only costs allocated to payable physician services to the provider (as described in § 415.55) are allowable costs to the provider under this subpart.
>
> (d) *Allocation of all compensation to services to the provider.* Generally, the total physician compensation received by a physician is allocated among all services furnished by the physician, unless -
>
> (1) The provider **certifies** that **the compensation is attributable solely to the physician services furnished to the provider**; and
>
> (2) The physician bills all patients for the physician services he or she furnishes to them and personally receives the payment from or on behalf of the patients. If returned directly or indirectly to the provider or an organization related to the provider within the

meaning of § 413.17 of this chapter, these payments are not compensation for physician services furnished to the provider.

(e) *Assumed allocation of all compensation to beneficiary services.* If the provider and physician agree to accept the assumed allocation of all the physician services to direct services to beneficiaries as described under § 415.102(a), CMS does not require a written allocation agreement between the physician and the provider.

(f) *Determination and payment of allowable physician compensation costs.* (1) Except as provided under paragraph (e) of this section, the intermediary pays the provider for these costs only if -

(i) The provider submits to the intermediary a written allocation agreement between the provider and the physician that specifies the respective amounts of time the physician spends in furnishing physician services to the provider, physician services to patients, and services that are not payable under either Part A or Part B of Medicare; and

(ii) The compensation is reasonable in terms of the time devoted to these services.

(2) In the absence of a written allocation agreement, the intermediary assumes, for purposes of determining reasonable costs of the provider, that 100 percent of the physician compensation cost is allocated to services to beneficiaries as specified in paragraph (b)(2) of this section.

(g) *Recordkeeping requirements.* Except for services furnished in accordance with the assumed allocation under paragraph (e) of this section, each provider that claims payment for services of physicians under this subpart must meet all of the following requirements:

(1) Maintain the time records or other information it used to allocate physician compensation in a form that permits the information to be validated by the intermediary or the carrier.

(2) Report the information on which the physician compensation allocation is based to the intermediary or the carrier on an annual basis and promptly notify the intermediary or carrier of any revisions to the compensation allocation.

> (3) Retain each physician compensation allocation, and the information on which it is based, for at least 4 years after the end of each cost reporting period to which the allocation applies.

Most relevant here are paragraphs (b) and (d). Paragraph (b) sets forth the general rule that requires providers to *allocate* physician compensation costs between services rendered to the provider and services rendered to the patients. Paragraph (d) provides an exception to the general rule when "the compensation is attributable solely to the physician services furnished to the provider" and the physician bills and receives payment for all services rendered to patients.

### *D. Factual Background*

In the instant cases, Sunnyside entered into an Emergency Department Services Agreement ("Agreement") with EmCare of Washington, Inc. ("EmCare") effective June 1, 2003, which included payment for emergency room services, and continued to renew the Agreement through the periods at issue in this appeal.[32] The original Agreement specifies that EmCare shall provide certain "administrative services ***to*** [Sunnyside]" which include (but are not limited to):

A. "Emergency Department Coverage. EmCare shall arrange for qualified physicians ("Emergency Physicians") and mid-level providers ("MLPs") approved by the Hospital . . . to provide coverage in the Emergency Department and Level II Trauma Service twenty-four (24) hours per day, seven (7) days per week."[33]

B. "Medical Director. EmCare shall designated an Emergency Physician to be Medical Director of the Emergency Department and such Emergency Physician . . . . shall be responsible for managing Emergency Department issues on a day-to-day basis . . . ."[34]

C. "Quality Assurance and Risk Management. EmCare shall require that Emergency Providers participate in [Sunnyside's] Quality Assurance and Risk Management programs."

D. "Billing Coordinator. EmCare shall provide, either itself or by subcontract, a part-time person to assist EmCare in gathering the information it requires to bill patients for [EmCare's] services."[35]

Effective February 1, 2007, the Parties expanded EmCare's "Emergency Department Coverage" under the Agreement so that, in addition to 24-hour coverage 7 days per week, EmCare provided the following MLP coverage in the Emergency Department:

> EmCare shall arrange for qualified physicians . . . and mid-level providers ("MLPs") approved by Hospital . . . to provide *coverage* ***in the Emergency Department*** twenty-four (24) hours per day, seven (7) days per week. Specifically, [EmCare] shall arrange for

[32] Exhibit ("Ex.") P-6 (Case Nos. 16-0304, 16-1222, 16-1429).
[33] *Id.* at 21.
[34] *Id.*
[35] *Id.* at 22.

> Emergency Physician coverage twenty-four (24) hours per day and MLP coverage eight (8) hours per day Monday through Friday and twelve (12) hours of MLP coverage per day Saturday and Sunday.[36]

Thus, effective February 1, 2007, EmCare provided to Sunnyside the following Emergency Department coverage: (1) physician coverage for the Emergency Department twenty-four (24) hours per day, 7 days per week; and (2) MLP coverage for eight (8) hours per day Monday through Friday, and for twelve (12) hours per day Saturday and Sunday.[37] Effective January 1, 2008, Sunnyside agreed to modify these services by expanding the weekly MLP coverage from 8 hours per day Monday through Friday ***to*** *10 hours per day Monday through Friday*.[38]

Under the original June 2003 Agreement, Sunnyside agreed to pay an annualized Administrative Fee of **$192,707.04** (*i.e.*, $16,058.92 per month).[39] The original fee amount was set "[i]n recognition that the payments reasonable contemplated to be received by EmCare under Section 8(A) above [*i.e.*, payments received from payors for actual patient care] are insufficient to enable EMCare to assure the provision of twenty-four (24) hour coverage and other services sought by [Sunnyside] in the Emergency Department."[40] Significantly, the Agreement does ***not*** define what "Emergency Department coverage" entails (*e.g.*, physical presence at Sunnyside and/or on-call availability within a specified driving distance or time). However, Sunnyside has presented certain evidence suggesting that the physicians and MLPs provided coverage by being on site for the entirety of their shifts during FYs 2011-2013 (*i.e.*, furnished only availability services as opposed to on call services).[41]

Prior to the time period at issue (*i.e.*, FYs 2011-2013), EmCare's fees were increased 5 times with the last increase occurring as part of the 2008 Amendment. The following four (4) increases to the Administrative Fee occurred prior to the 2008 Amendment:

> *1st Increase* – In June 2004, Sunnyside agreed to amend the Agreement, **effective June 1, 2004**, to increase the annualized Administrative Fee to **$362,706.96** (*i.e.*, $30,225.58 per month).[42] The amendment states that the increase was made "due to a lower than forecasted CPV [*i.e.*, cost per patient visit] and a forecasted future drop of Five-dollars ($5.00) in CPV."[43]

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[36] *Id.* at 4-5 (emphasis added).
[37] *Id.*
[38] *Id.* at 2.
[39] *Id.* at 26-27.
[40] *Id.*
[41] *See, e.g.*, Provider's FPP at 4 (Case No. 16-1222); Tr. at 16, 54-57, 204-205; Ex. P-20 (Case No. 16-1222) (open letter dated Dec. 12, 2016 from Sunnyside's Medical Staff Services Director certifying for FYs 2012 and 2013 that "[p]er our policy and agreement with Emcare [*sic* EmCare], the Emergency physicians hired during those years stayed within the hospital for the entirety of their work shifts at Sunnyside"); Ex. P-25 (Case No. 16-1222 (emergency room log showing all FY 2012 patients by date with treating physician/MLP); Ex. P-20 (Case No. 16-1429 (emergency room log showing all FY 2013 patients by date with treating physician/MLP).
[42] Ex. P-6 at 12.
[43] *Id.*

*2nd Increase* – In February 2005, Sunnyside again agreed to amend the Agreement, **effective December 1, 2004**, to not only increase the Administrative Fee but also to allow the Fee to vary each month "depending upon the Emergency Department volume and resultant professional fee revenue received by EmCare."[44] The monthly fee is "based upon projected annualized Emergency Department Billable Volume . . . and the projected average revenue generated from each patient visit . . . for that month." Based on the initial projected volume, the amendment set the monthly administrative fee at **$46,893 per month** for the first 3 months (*i.e.*, December 2004 through February 2005).[45] Finally, the amendment states that the increase was made "after a review of the financial performance of the Agreement … in order to maintain EmCare's compensation at fair market value."[46]

*3rd Increase* –In March 2006, Sunnyside again agreed to an amendment to the Agreement, **effective February 1, 2006**, to increase the annualized Administrative Fee by $25,000 (*i.e.*, $6,250 per quarter) to an overall annualized Fee of **$587,716** in order "to assist [EmCare] with the extraordinary recruiting costs associated with the recruitment of Dr. Christensen."[47]

*4th Increase* – In February 2007, Sunnyside again agreed to amend the Agreement, **effective February 1, 2007**, to increase the annualized Administrative Fee to **$683,765** (*i.e.*, $56,980.42 per month).[48] *NOTE—this increase also coincides when EmCare's services were expanded to include MLP coverage for 10 hours per day Monday through Friday, and for 12 hours per day Saturday and Sunday*. However, the amendment only suggests that the increase was made "after a review of the financial performance of the Agreement … in order to maintain EmCare's compensation at fair market value."[49]

Finally, the 2008 Amendment *increased* the Administrative Fee payable to EmCare for the fifth time. Under this Amendment, Sunnyside agreed to pay EmCare an Administrative Fee in the amount of **$1 million** per year, *effective January 1, 2008*, and which remained in effect during the

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[44] *Id.* at 15.
[45] *Id.* at 15-16. The chart suggests that the initial monthly amount was set based on 17,000-17,499 expected annual patient billable visits (volume) for EmCare and $62.50 in "the projected average revenue generated from each patient visit." There was also a temporary increase in the monthly administrative fee by $5,000 for the first 7 months (*i.e.*, December 2004 through June 2005) "in order to assist Dr. Young in procuring [professional liability] tail insurance" for which the then-existing obligation was $65,456. *Id.* at 14-16.
[46] *Id.* at 14.
[47] *Id.* at 8.
[48] *Id.* at 5-6. The Amendment further states that: "The parties agree and acknowledge that as of the Administrative Fee Effective Date, [EmCare] does not have a sufficient number of MLP employees to provide all of the coverage set forth above. Accordingly, in the event that [EmCare] provides less than sixty-four (64) hours of MLP coverage each week, the Hospital and [EmCare] agree that the Administrative Fee shall be reduced by Fifty Dollars ($50) for each hour of MLP coverage below the target MLP coverage of sixty-four (64) hours per week."
[49] *Id.* at 4.

years at issue in this appeal.[50] This $1 million Administrative Fee was explained in the 2008 Amendment as follows:

> In recognition that the payments reasonably contemplated to be received by [EmCare] under [the section on compensation, EmCare's billing for services rendered by emergency providers – Section 8(A)] are insufficient to enable [EmCare] and Emergency Providers to assure the provision of twenty-four hour services of the quality and nature sought by [Sunnyside] in the Emergency Department, including the administrative services provided by [EmCare], and that the compensation necessary to provide such services will vary depending upon the Emergency Department volume and resultant professional fee revenue received for services provided by Emergency Providers.[51]

Sunnyside asserts that the Agreement, and its Amendments, "establish that Sunnyside's payment for services was exclusively for EmCare's provision of administrative services to Sunnyside, or Part A services."[52] For each of the three of the fiscal years at issue, Sunnyside claimed emergency room availability costs on its cost report in the amount of $1,028.710.[53] For each fiscal year, the Medicare Contractor disallowed the emergency room availability costs by reclassifying these costs from "physician component" (Part A – Administrative) to "professional component" (Part B – Professional) on the cost report Worksheet A-8-2.[54]

In the instant cases, Sunnyside asserts that the exception at 42 C.F.R. § 415.60(d) was met.[55] The Medicare Contractor counters that the exception, specifically at 42 C.F.R. § 415.60(d)(1), was ***not*** met because the Agreement between Sunnyside and EmCare documents that the lump-sum compensation to EmCare was ***not*** attributable *solely* to physician services, and instead includes MLP services. The Medicare Contractor's position is that the special payment of emergency room availability costs does *not* extend to MLPs, because the special payment only relates to *physician* services.[56] Further, the Medicare Contractor asserts that Sunnyside failed to meet several of the documentation requirements related to availability costs as required by PRM 15-1 § 2109.3(C).[57]

## DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

Sunnyside has asserted that it arranged for physician and MLP "availability services" to be furnished by EmCare for FYs 2011, 2012, and 2013; and that the fees it paid to EmCare for those "availability services" are allowable. For the reasons set forth below, the Board finds that Sunnyside did not properly claim "availability services" costs for emergency department

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[50] *Id.* at 2.
[51] *Id.*
[52] Provider's Final Position Paper ("Provider's FPP") at 4 (Jan. 12, 2021) (Case No. 16-1222).
[53] Ex. P-3 at 2 (Case Nos. 16-0304, 16-1222, 16-1429).
[54] *Id.*
[55] Provider's FPP at 5 (Case No. 16-0304).
[56] Medicare Contractor's Final Position Paper at 4 (Case No. 16-0304).
[57] *Id* at 5.

physicians in accordance with 42 C.F.R. § 415.60 and PRM 15-1, § 2109. Further, the Board finds that emergency room *physician* availability costs do ***not*** extend to MLPs, and that Sunnyside has not provided sufficient evidence to show or calculate the split between the allowable and non-allowable emergency room physician availability costs (*e.g.*, it has not removed, or provided sufficient information for the Board to remove, the costs attributable to the MLPs or the Medical Director provided by EmCare from the total amount of emergency room availability costs that it claimed during the FYs at issue[58]). Indeed, as discussed *infra*, there are also other costs outside of the MLP costs for which there also needs to be an accounting. Therefore, the Board is not able to determine the correct amounts of emergency room physician availability costs for the FYs at issue, and whether those amounts are reasonable costs.

Furthermore, Sunnyside failed to satisfy the "availability services" documentation requirements of PRM 15-1, § 2109.3. First, the documentation submitted was insufficient to show that alternative methods for obtaining emergency physician coverage were adequately explored before Sunnyside entered into the EmCare Agreement for the FYs at issue and agreed to physician compensation for availability services. Indeed, EmCare's fees increased five-fold between the initial 2003 contract year and 2011. The Board notes that the annual fee for 2003 was $192,707.04 and the fee for FY 2011 was $1,000,000.[59] However, there is no documentation of any review of the Agreement or any consideration of alternatives to the EmCare contracted services. The purpose of the "Administrative Fee" is similar between the first contract in 2003 and the most recent 2011 contract, in that the "Administrative Fee," is being paid "in recognition that the payments reasonably contemplated to be received by EmCare...are insufficient to enable EmCare to assure the provision of twenty-four (24) hour coverage and other services sought by [Sunnyside] in the Emergency Department."[60] Yet, this fee increased from less than $200,000 to over $1 million with no clear explanation of the increase in the contract addendums included at Exhibit P-6. Moreover, Sunnyside failed to show the schedule of physician charges. Accordingly, the Board finds that the Medicare Contractor's disallowances of Sunnyside's emergency room physician availability costs for FYs 2011, 2012, and 2013, were proper.

### *A. Allocation of Physician Compensation Costs, 42 C.F.R. § 415.60*

In their Appeal Request, Sunnyside gave the following explanation for its arrangement with EmCare for the FYs at issue:

> The Hospital uses EmCare Physician Services (EmCare) to staff its emergency room. EmCare bills for services provided to patients in the Hospital's emergency room. The Hospital only bills a technical (hospital) component for emergency room visits. EmCare considers the patient volume in the Hospital's emergency room insufficient for them to cover the emergency room without

[58] This is one example and not meant to be exhaustive, particularly since the Board has not seen any underlying detail (*e.g.*, time studies or other time records).
[59] Ex. P-6 (Annual amounts calculated as 12 months' worth of the monthly fee identified in the applicable contract or addendum included in the Exhibit.)
[60] *Id.* at 12.

> additional compensation. The Hospital paid EmCare $1,028,710 [in FYs 2011, 2012, and 2013] to be available to treat patients as they present to the emergency room. The only payment to EmCare for services to an individual emergency room patient is through EmCare individually billing that patient. There is no payment to the Hospital for emergency room physician services to individual patients.[61]

Sunnyside contends that it properly claimed the entire amount paid to EmCare (under the Administrative Fee section of the Agreement) as emergency room physician availability costs on the Medicare cost report because EmCare bills for all patient services. Per Sunnyside, "[t]he Hospital only pays for availability services. The amount of time spent with patients is paid through EmCare billing and collecting charges from patients and their insurance companies."[62]

Based on this contention, Sunnyside argues that it meets the exception under 42 C.F.R. § 415.60(d)(1)-(2).[63] Specifically, Sunnyside asserts that its Agreement with EmCare "states that EmCare bills for patient services provided by their physicians."[64] Sunnyside further asserts that, "[b]ecause the contract [with EmCare] delineates the requirements for 42 C.F.R. § 415.60(d), it is support for the allocation agreement,"[65] It is Sunnyside's contention that these two facts demonstrate that the Agreement (as amended) meets the regulatory exception at subsections (d)(1)-(2).[66] Therefore, Sunnyside argues for the reversal of the Medicare Contractor's adjustments because "the total amount paid to EmCare physicians for availability coverage of the Hospital's emergency room is an allowable cost."[67]

At the hearing, Sunnyside explained that it included MLPs in the emergency room physician availability costs, based on 42 C.F.R. § 413.70(b)(4)(i).[68] Specifically, the relevant portion of § 413.70(b)(4)(i) (2011) states: "the reasonable costs of outpatient CAH services may also include amounts for reasonable compensation and related costs for the following emergency room providers who are on call but who are not present on the premises of the [CAH] involved, are not otherwise furnishing physician services, and are not on call at any other provider or facility: physician assistants, nurse practitioners, and clinical nurse specialists" (which collectively are MLPs).[69]

While that regulation speaks to on call services, Sunnyside contends it is applicable when considered with the implementing regulations at 42 C.F.R. § 413.9(a) and (c)(3):

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[61] Initial Appeal Requests at Tab 3 (Case Nos. 16-0304, 16-1222, 16-1429).
[62] *Id.*
[63] *Id.*
[64] Ex. P-15 (Case No. 16-0304) (copy of Provider's letter to the Medicare Contractor, dated Oct. 17, 2016).
[65] *Id.*
[66] Initial Appeal Requests at Tab 3 (Case Nos. 16-0304, 16-1222, 16-1429).
[67] *Id.*
[68] Tr. at 12-13.
[69] *See also id.* at 12 (where the Provider in its opening statement essentially quotes this excerpt from 42 C.F.R. § 413.70(b)(4)(i)).

> [Sections 413.9(a) and (c)(3)] define[ ] reasonable cost to include all necessary and proper costs incurred in furnishing the services, including standby costs. And the Board has repeatedly noted that the term standby and availability costs are interchangeable. And so taken together, these regulations allow for the reimbursement of compensation for physician services furnished to the Provider. This includes mid-level providers providing physician services while on call, and as defined for these purposes, that includes standby or availability costs.[70]

Thus, Sunnyside's view is that "these regulations support that the special payment of [emergency room] availability costs does, in fact, exten[d] to [MLPs]."[71] Sunnyside uses MLPs "to provide *overflow* coverage for the emergency room . . . . seeing lesser acute patients, maybe the runny noses and headaches, ear infections. . . independently of the physician."[72]

At the hearing, the Medicare Contractor noted that the Agreement "calls for EmCare *to staff* the Provider's [emergency department] with physicians and [MLPs]."[73] The Medicare Contractor argues that the regulation at 42 C.F.R. § 415.60 and the PRM 15-1 § 2109 address availability costs for physicians only. While Sunnyside points to other regulations and PRM sections that allow MLP costs, the Medicare Contractor countered:

> [E]ach of those address specifically and ***only*** *on-call* services, not availability services, and therefore do not supersede the limitation of emergency department availability service costs to physicians. The fact that other regulations [and] PRM sections dealing with on-call services specifically include MLPs and [*sic*] the determination of lateral costs is even more evidence that MLPs are intentionally not included in the determination of allowed costs or availability services.[74]

The Medicare Contractor explains that "availability services require the physician to be physically present or on site at the hospital while under an on-call arrangement a physician is not on the hospital premises."[75] Further, PRM 15-1 § 2109.3 states that "emergency department physician availability service costs will be allowed *only in special circumstances*."[76]

The documentation and testimony furnished by Sunnyside suggests that EmCare furnished physician and MLP availability services for FYs 2011, 2012, and 2013. Following a review of the above authorities, the Board concludes that the plain language of the regulations and manual provisions applicable to the emergency room ***physician availability costs*** do not include MLPs, and ***are specific only to physicians***. Further, the argument that, because the provisions related to

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[70] *Id.* at 13.
[71] *Id.* at 14.
[72] *Id.* at 170 (emphasis added).
[73] *Id.* at 29 (emphasis added).
[74] *Id.*
[75] *Id.* at 22.
[76] *Id.* (citing to PRM 15-1) (emphasis added).

on-call services include MLPs, availability costs should also include MLPs, is not persuasive. The PRM's general overview of emergency room physician availability costs, explains that these costs address the following concern:

> Wide variations can occur in the utilization of hospital emergency department services and hospitals cannot always schedule physician staffing at a level commensurate with the actual volume of services rendered. As a result, emergency department physicians may spend a portion of their time in an availability status awaiting the arrival of patients.[77]

The PRM continues, stating that "[p]hysician availability services consist of the physical presence of a physician in a hospital under a formal arrangement with the hospital to render emergency treatment to individual patients as and when needed."[78] Thus, after comparing the authorities for on-call services to those for availability services, the Board concludes that MLPs and physicians can both be on call; but, when the MLPs and physicians are on the premises instead of on call, the fees attributable to MLPs (*i.e*., MLP "availability" costs) cannot be claimed. In making this finding, the Board rejects Sunnyside's suggestion that there is no difference between on-call arrangements and on-site availability arrangements. In contrast to availability services where the physician is paid to be present and immediately available, the on-call arrangements specifies that the physician/MLP must be available to come into the --hospital within a specified time frame (*e.g*., within 30 minutes) and, as such, has the ability to do other things while they are on call (*e.g*., work at their practice) as long as the physician/MLP can arrive at the hospital within the specified time frame.[79] For these reasons, the Board finds that the costs attributable to MLPs may ***not*** be included in the emergency room physician availability costs claimed on cost reports. Therefore, the regulatory exception at 42 C.F.R. § 415.60(d)(1) is not met because the availability costs certified by Sunnyside included costs attributable to MLPs.

To determine the allowable amount of emergency room physician availability costs in the instant cases, it is necessary to separate the costs attributable to MLPs from those attributable to physicians. Contrary to Sunnyside's assertion, it does not meet the regulatory exception at 42 C.F.R. § 415.60(d)(1) because this regulation only applies to *physicians* and the costs at issue include costs attributable to MLPs. As a result, a provider that incurs physician compensation costs, must allocate the physician costs in accordance with 42 C.F.R. § 415.60(b). That allocation must be in proportion to the percentage of total time that is spent in furnishing each category of services: (1) physician services to the provider; (2) physician services to patients;

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[77] PRM 15-1 § 2109.1.

[78] PRM 15-1 § 2109.2(A).

[79] *See*, *e.g.*, Tr. at 156 (Sunnyside witness stating: "So as you may be aware, I mean, these guys have to work at their own practice, guys and gals they have to work their own practice. They have to be able to make a living. And anytime you would give them a certain dollar amount per day to be on call, it means they had to get away from their office and maybe drive 10 to 15 minutes to the hospital to provide coverage for whatever presented itself. So the physicians at some point got tired of that as well as the hospital because the hospital wants an instant response but you don't have that so it's a phone call and you can call a physician *who's in the middle of a procedure*. Then *that physician would also have to finish his procedure and then come*, so it might be a 30-minute delay. And a 30-minute delay is really not acceptable in an emergency room. So again, when you look at this, I think the physicians were getting tired of being on call because it disrupted their lives and their practice . . . .").

and (3) activities of the physician, such as funded research, that are not paid under either Part A or Part B of Medicare.

Moreover, the Administrative Fee in the Agreement, which includes MLP and physician costs, is $1 million, and Sunnyside claimed $1,028,710 on its cost reports.[80] Therefore, even if the Board had sufficient information to allocate fees between the MLP and physicians, the Board would also need to determine for and to what the additional $28,710 amount should be attributed.

After review of the exhibits and testimony admitted in these cases, the Board finds that Sunnyside has not met its burden because it has not submitted sufficient information and documentation to establish the amount for the emergency room *physician* availability costs for the fiscal years at issue, and to determine whether these costs were reasonable. The record is unclear on the actual break down of the costs included in the Administrative Fee. The Agreement at Section 3 specifies that EmCare shall provide certain "administrative services ***to*** [Sunnyside]" as described in paragraphs A through I.[81] Paragraph A addresses the "emergency department coverage" and outlines the total number of hours per week that the physicians and MLPs will provide "emergency department coverage."[82] Paragraphs B through I address other administrative services covered by the $1 million administrative fee and include the provision of a medical director for the emergency department, certain quality assurance and risk management activities, *and* ***a billing coordinator*** *"to assist . . . in gathering the information it requires to bill patients for [EmCare's] services."*[83] However, for a proper cost allocation, there must be a breakdown of the split between the hours of the MLPs and physicians' services to Sunnyside and their hours of service to patients (as well as the time attributable to the *other* Administrative services furnished by EmCare to Sunnyside as noted above).[84] Additionally, the Board needs information on the cost of the part-time billing coordinator. The allowable costs attributable to Part A patient care furnished by the hospital do not include the cost of the billing coordinator because that cost is associated with Part B patient care furnished by the MLP/physician that EmCare bills and collects for itself.[85] Sunnyside submitted ER logs that include the name of the practitioner (MLP or physician) who furnished the service, the diagnosis that was treated, the date treated and the total time.[86] However, the ER logs are not sufficiently specific to determine how many hours each MLP/physician provided "availability services" to Sunnyside versus how many hours of services to the patient on a particular day or shift. Critically, the record does not identify which practitioners are MLPs and which are physicians, much less what shifts each had. The ***total*** time provided for each patient from registration, or time of entry into the emergency department, through the discharge date may include not only the patient's time in the emergency department, but also *additional* time the patient stayed in the hospital, including observation or if

[80] Ex. P-3 (Case Nos. 16-0304, 16-1222, 16-1429).
[81] Ex. P-6 at 21-22 (Case Nos. 16-0304, 16-1222, 16-1429).
[82] *Id.* at 21.
[83] *Id.* at 21-22 (emphasis added).
[84] The fact that the Administrative Fee in Section 8(C) of the Agreement at Exhibit 6 (Case Nos. 16-0304, 16-1222, 16-1429) states that the Fee will be reduced by $50 per hour in the event that EmCare provides less than sixty-four (64) hours of MLP coverage per week, does not mean that $50 per hour is the cost of the MLP per hour (*e.g.*, salary broken down to an hourly rate). The record does not contain any information on how the $50 per hour was determined or on what it is based.
[85] *See* Ex. P-6 at 22.
[86] *See, e.g.*, Ex. P-25 (Case No. 16-1222).

they had to be admitted, their admission time.[87] The ER logs do not capture the total time each patient was in the emergency room, or, more specifically, the time associated with direct patient care in the emergency room.[88] While Sunnyside furnished the average physician rate and how that rate was calculated, without determining the split between the hours of physician's services to Sunnyside and hours of physician's services to the patient, the availability costs cannot be determined (particularly since there were other Administrative Services provided that were included in the Administrative Fee, of which some appear nonallowable). For these reasons, Sunnyside did not meet the allocation cost requirements of 42 C.F.R. § 415.60. Consequently, the Board's analysis ends here *and* ***never reaches*** *whether the availability costs were* ***reasonable costs***.

### *B. Documentation Requirements for Availability Services*

The Medicare Contractor reclassified the emergency room availability services costs reported on Worksheet A-8-2 from the physician component to the professional component because it determined that Sunnyside also did not meet the documentation requirements contained in PRM 15-1 § 2109.3.[89] There are seven items for which there must be supporting documentation in order for emergency department physician availability services costs to be allowable under PRM 15-1 § 2109.3C. Those seven items are:

> 1. A signed copy of the contract between the hospital and the physician(s).
>
> 2. A written copy of the allocation agreement and supporting data depicting the distribution of the physician's time between services to the provider, services to individual patients and services not reimbursable under Medicare.
>
> 3. A permanent record of payments made to the physician(s) under the agreement.
>
> 4. A record of the amount of time the physician was physically present on the hospital premises to attend to emergency patients.
>
> 5. A permanent record of all patients (Medicare and non-Medicare) treated by the physician, copies of all physician bills generated for such services and a record of imputed charges for services for which no billing was made by the hospital or physician.
>
> 6. A schedule of physician charges.

[87] Provider's Post-Hearing Brief at 17-18 (June 3, 2022).
[88] When an EmCare physician or MLP treated a patient in the ER, that physician/MLP was no longer "available" and their time in that patient care would have been billed to the patient or patient's insurance as professional fees.
[89] Medicare Contractor's Post-Hearing Brief at 4 (June 3, 2022).

> 7. Evidence that the provider explored alternative methods for obtaining emergency physician coverage before agreeing to physician compensation for availability services.[90]

Items 1, 3 and 4 were submitted to the Medicare Contractor. Item 2 was found to be not applicable.[91] The Medicare Contractor deferred the submission of Item 5 until an audit of such billing (copies of all bills generated by EmCare for patient services) becomes necessary.[92] Finally, the Medicare Contractor found that the documentation submitted was insufficient to meet Items 6 (schedule of physician charges) and 7 (evidence that Sunnyside explored alternative methods for obtaining emergency room physician coverage).[93] Therefore, the Board will address Items 6 and 7 below.

*1. PRM 15-1 § 2109.3C, Item 6, Schedule of Physician Charges*

With regard to the documentation requirement for Item 6, Sunnyside explains that it does not generate any schedule of physician charges, as that information would only be able to come through EmCare. However, the Board notes that, per the Agreement at § 8(A), EmCare "agree[d] to provide [Sunnyside] with a schedule of its charges for professional services *and agrees to provide any changes to such charges at least thirty (30) days prior to implementation of such change*."[94] As a result, it is unclear why Sunnyside is unable to present the schedule of physician charges for FYs 2011 through 2013.

In the alternative, EmCare has provided a summary of its total patient collection amounts, which was submitted as Exhibit P-8.[95] That summary shows that the total collection amounts were $1,760,572 in FY 2011; $1,713,034 in FY 2012; and $1,797,430 in FY 2013. Sunnyside asserts that the information required for Item 6 "exists through the charge master and is already available to the Medicare Contractor."[96] Therefore, Sunnyside contends that it should not be required to provide information that is already available to the Medicare Contractor.

However, the PRM requires that providers maintain this documentation, as PRM 15-1 § 2109.3.C states: "[a] claim for Part B hospital costs or Part A and Part B hospital costs must be supported by the following data ***maintained by the hospital***."[97] The information provided by EmCare is the total patient collection amounts, which does not meet this requirement. Also, those total collection amounts include amounts collected for services provided by MLPs, despite the requirement that the "availability services" costs should be *only* costs related to ***physician***

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[90] *Id.* at 8-9.
[91] Item 2 was found not applicable at the time of the Medicare Contractor's review. However, now that it has been determined that the exception at 42 C.F.R. § 415.60(d) was not met, this documentation requirement is applicable and Sunnyside would need to show the general physician allocation cost requirements at 42 C.F.R. § 415.60(b) were met, as discussed, *supra,* in section A of this part of the decision.
[92] If Items 6 and 7 are met, the Medicare Contractor would then proceed with auditing Item 5. The documentation for Item 6 is "something that will be used in conjunction with number 5 if that were the sole Item remaining in dispute." Tr. at 115-116.
[93] Tr. at 113.
[94] Ex. P-6 at 26 (Case Nos. 16-0304, 16-1222, 16-1429).
[95] Tr. at 18. *See also* Exhibit P-8 (Case No. 16-1222).
[96] Provider's Post-Hearing Brief at 6.
[97] (Emphasis added.)

services. Further, Sunnyside's argument that the charge master contains this data is incorrect. Sunnyside's charge master would generally be expected to contain *only its charges* (*i.e.*, charges that Sunnyside bills), and would not be include EmCare's charges because Sunnyside does not bill for EmCare's professional services. Accordingly, Sunnyside has not met this documentation requirement even though, per the Agreement, Sunnyside was to receive this documentation from EmCare.

*2. PRM 15-1 § 2109.3C, Item 7, Evidence Provider Explored Alternative Methods*

PRM 15-1 § 2109.3(A) requires that a provider provide evidence that it explored alternative methods for obtaining emergency physician coverage but was unable to find a suitable alternative *before* agreeing to physician compensation for availability services. This "requirement is applicable prior to the renegotiation of expiring arrangements or the initiation of new arrangements for physician coverage of the emergency department."[98] Section 2109.3(C), Item 7, further requires that the provider maintain "evidence that the provider explored alternative methods for obtaining emergency physician coverage before agreeing to physician compensation for availability services."[99] This requirement is consistent with the general "prudent buyer" principle stated in PRM 15-1 § 2103.[100]

To demonstrate compliance with Item 7, Sunnyside submitted a newspaper article *from 2003* when Sunnyside first decided to enter a contract with EmCare. The article states that "[e]nsuring quality care and cost savings are two of the reasons Sunnyside Community Hospital has decided to contract with a Texas firm [EmCare Inc.] to provide emergency room management service."[101] The article explains that Sunnyside has "nearly 20,000 emergency room calls per year and a critical need for qualified physicians to work in the [emergency room]."[102] Moreover, the article indicates that the hospital has had "trouble recruiting a board certified director of emergency medicine"[103] and that small rural hospitals have difficulty recruiting qualified help. Sunnyside, which had "been searching for a director of the [emergency room] for the past year without success . . . started researching EmCare Inc. about six months ago."[104] EmCare "handles the recruiting and scheduling of emergency room physicians . . . the emergency room will be covered 24-7 . . . two of the hospital's current on-call emergency room physicians have already signed with EmCare and will continue to work at the Sunnyside facility in their current capacity."[105]

The second document that Sunnyside submitted, as support for compliance with Item 7, is a June 30, 2016 letter written by Cary Rowan, who was the Chief Financial Officer on that date.[106]

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[98] PRM 15-1 § 2109.3(A).
[99] PRM 15-1 § 2109.3(C)(7).
[100] *See* PRM 15-1 § 2103 (stating: "The prudent and cost conscious buyer not only refuses to pay more than the going price for an item or service, he/she also seeks to economize by minimizing cost. This is especially so when the buyer is an institution or organization which makes bulk purchases and can, therefore, often gain discounts because of the size of its purchases. In addition, bulk purchase of items or services often gives the buyer leverage in bargaining with suppliers for other items or services.").
[101] Ex. C-3 at 11 (Case No. 16-1222).
[102] *Id.* at 12.
[103] *Id.*
[104] *Id.*
[105] *Id.*
[106] Ex. P-12 (Case Nos. 16-0304, 16-1222, 16-1429).

While Mr. Rowan started employment at the hospital in June 2012, and the CEO at that time had started in May 2012, the letter indicates that "[p]er discussion with the previous administration, they indicated that they reviewed the contract with EmCare on an ongoing basis, and reviewed the fee structure and felt it was fair."[107] The letter explains that, in November 2013, the hospital sent notice to EmCare that Sunnyside would be terminating the Agreement, effective May 31, 2014, stating: "EmCare asked to increase the amount of fees received from the hospital, and the hospital solicited proposals from other emergency care groups. Another group was selected and the EmCare agreement was cancelled."[108]

These two documents do not demonstrate that Sunnyside explored alternative methods for emergency physician coverage *before* agreeing to physician compensation for availability services *for the three fiscal years at issue* (*i.e.*, prior to January 1, 2011). The newspaper article announces Sunnyside's ***initial*** *2003* decision to enter a contract with EmCare for emergency department services, and the reasons why it chose to do so. However, the article was written *well before the fiscal years at issue* ***and*** *well before the 2008 Amendment* and, thus, does not satisfy Item 7. This article's irrelevance is further demonstrated by the fact that, between 2005 and 2011, Sunnyside agreed to amend the Agreement 5 different times to increase the administrative fee paid to EmCare. Indeed, there was a fivefold increase from the initial $192,707.04 fee for 2003 to the $1 million fee for 2011. Moreover, the initial services changed from physician and MLP "availability services" for 24-hours per day, 7 days a week to physician services for 24-hours per day, 7 days a week plus a daily block of MLP availability services.[109] Based on these intervening material changes in circumstances, the Board finds the 2003 article has no relevance to the fiscal years at issue.

Further, the 2016 letter written by Cary Rowan does not demonstrate that alternative methods were explored near or during the fiscal years at issue (much less before the renewals during the relevant fiscal years).[110] It primarily explains that Sunnyside terminated its contract with EmCare in 2014, and chose a different emergency care group with which to enter a contract, when it learned of EmCare's decision to increase administrative fees ***for the sixth time*** since 2003. That letter pertains to Sunnyside's actions in 2014, *i.e.*, *after the fiscal years at issue in these appeals*.

While Sunnyside is not required to demonstrate *annually* that it explored alternative methods for obtaining emergency physician coverage, it is required to show that it explored alternative methods *prior to* the re-negotiation of expiring arrangements containing material amendments in the renewals. Mr. Rowan's letter states that the EmCare Agreement was renewed, ***effective***

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[107] *Id.*
[108] *Id.*
[109] This change occurred effective February 1, 2007 when MLP coverage was broken out and was to be provided "eight (8) hours per day Monday through Friday and twelve (12) hours . . . per day Saturday and Sunday." Ex. P-6 at 5. The 2008 Amendment then increased MLP availability services to 10 hours per day Monday through Friday and kept the 12 hours per day Saturday and Sunday. *Id*. at 2. Compare this to the original 2003 Agreement which calls for EmCare "arrange for qualified physicians . . . and [MLPs] . . . to provide coverage in the Emergency Department and Level II Trauma Service twenty-four (24) hours per day, seven (7) days per week." *Id.* at 21.
[110] The fact that a "review" *may* have occurred "on an ongoing basis" does not indicate how often it actually occurred or what the nature of that review was (*e.g.*, whether alternatives were explored/considered and how the fairness of the fee structure was assessed).

***January 2008***, for a three-year term (which would have ended in December 2010), and included subsequent one-year renewals, which included Agreement renewals for each of the FYs at issue (2011 through 2013). This requirement is particularly important to help determine if the contracted rates were reasonable rates under the circumstances of the instant cases given the series of material changes in the Administrative Fees that occurred following 2003.[111] For the reasons stated above, the two documents submitted do not support a finding that alternative methods for emergency physician coverage were explored prior to the annual renewals of the EmCare Agreement for each of FYs 2011, 2012 and 2013 (much less prior to the 2008 renewal).

Sunnyside asserts that guidance published on the website of another Medicare contractor, Noridian, is evidence that CMS has indicated that if the criterion in Item 7 "was the only requirement not met, the [Medicare] contractor should not disallow the availability cost."[112] However, the Medicare Contractor asserts that it is clear from the language on Noridian's website, that the majority of the text consists of Noridian's comments, as it states that this information is "to provide the auditors guidance in reviewing ER availability costs, the documentation requirements in PRM 15-1, Section 2109.3.C are listed below along with Noridian comments."[113] Further, on the website is a "Note" that specifically states that its guidelines "are not intended to create CMS policy. . . . [and] are intended to provide general guidance for Noridian auditors only. . . ." and that "CMS has indicated that they are reviewing this issue and may issue new PRM instructions in the future."[114]

PRM 15-1 § 2109.3 has remained unchanged and CMS has ***not*** issued any guidance or instructions adopting the Noridian statement as CMS policy. Further, Noridian is not Sunnyside's assigned Medicare contractor and, therefore, the Noridian statement is not applicable to the instant case, particularly when the Medicare Contractor (as Sunnyside's assigned Medicare contractor) has not issued the same or similar guidance.

At the hearing, Sunnyside's witness testified that she reached out via email to the rural coordinator at CMS' Regional Office in Seattle, and a copy of that email correspondence was submitted as evidence to show that the Noridian statement was in collaboration with CMS' central office.[115] That email states that Noridian gave an explanation on Item 7 "after consulting CMS CO [Central Office] back in 2010,"[116] and that CMS indicated "that if this criterion was the only requirement not met, the contractor should not disallow the availability cost."[117] However, the Board finds that this email is insufficient, by itself, to show that the Noridian statement was in collaboration with CMS' Central Office, or that the Noridian statement should apply to Sunnyside. If this statement was CMS ***policy***, the Board would expect CMS to have issued guidance *for the benefit of all providers nationwide* (as opposed to certain oral guidance that one

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[111] The Board notes that the amounts of the Administrative Fee paid by Sunnyside increased from $192,707 in 2003, the first year of the Agreement, to $683,765 in 2007, and then to $1 million in 2008, which is a period of only five years (and it remained at $1 million through the period at issue).
[112] Ex. P-13 (Case No. 16-1222) (Copy of Noridian's guidance titled "Noridian Audit Guidelines – Critical Access Hospital (CAH) ER Availability Cost").
[113] Medicare Contractor's Post-Hearing Brief at 11.
[114] *Id.* at 12.
[115] Tr. at 66-67.
[116] Ex. P-21 at 1 (Case No. 16-1222).
[117] *Id.*

Medicare contractor transposes and disseminates only to those providers in its service area).[118] It has been 13 years since this consultation occurred and, as of 2023, CMS has not issued guidance remotely resembling the Noridian statement. Accordingly, the Board concludes that the Noridian statement is not equivalent to CMS guidance or policy, that PRM 15-1 § 2109.3(C) remains CMS' guidance with respect to Item 7, and is applicable to Sunnyside.

In summary, the Board finds that the documentation submitted by Sunnyside is not enough to show that the requirement of Item 7 was met for the three FYs at issue. Moreover, as discussed in other sections of this Decision, this was not the sole basis for denying availability costs in these cases.

## DECISION

After considering the Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor's disallowance of Sunnyside's emergency room availability costs for FYs 2011, 2012, and 2013 was proper and Sunnyside is not entitled to the emergency room availability costs at issue, including costs for MLPs, for those fiscal years.

## BOARD MEMBERS:

Clayton J. Nix, Esq.
Robert A. Evarts, Esq.
Kevin D. Smith, C.P.A.

**FOR THE BOARD:**

6/29/2023

X Clayton J. Nix

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

[118] As it is unclear what guidance the CMS Regional Office *orally* gave to Noridian, it is unclear whether the Noridian statement reflects that guidance, in whole or in part.