PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2007-D55

PROVIDER -
Covenant Health Care
Saginaw, Michigan

Provider No.: 23-0070

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
United Government Services, LLC (n/k/a
National Government Services)

DATE OF HEARING -
March 21, 2006

Cost Reporting Periods Ended -
June 30, 1999; June 30, 2000 and
June 30, 2001

CASE NOs.: 02-1565; 03-0517;
and 04-0338

INDEX

ISSUES:

1. Whether the Intermediary properly determined the full-time equivalent (FTE) intern and resident count for purposes of computing the Provider's indirect medical education (IME) adjustment and the direct graduate medical education (DGME) payment for FYEs 6/30/99, 6/30/00 & 6/30/01.

2. Whether bank fees claimed by the Provider are allowable interest related costs. (FY 6/30/99)

3. Whether the hospital-based physician compensation should be reimbursed under Medicare Part A or Part B. (FY 6/30/99)

4. Whether the proper statistic to allocate housekeeping costs is hours worked or square footage. (FY 6/30/00)

5. Whether the Intermediary properly adjusted the hospital's cafeteria costs by removing all non-administrative Home Health Agency (HHA) FTEs from the Worksheet B-1 statistical base. (FY 6/30/00)

6. Whether the Intermediary properly disallowed the allocation of nursing administration costs to the HHA. (FY 6/30/00)

7. Whether the Intermediary properly weighted Worksheet B-1 statistics to account for the psychiatric unit being closed during the year. (FY 6/30/00)

8. Whether the Intermediary properly adjusted the rehabilitation unit hospital-based physician compensation from Medicare Part A to Part B. (FY 6/30/00)

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20(b) and 413.24(b).

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the portion of those

costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Covenant Health Care (Provider) is a multiple facility complex (hospital, rehabilitation unit, HHA, etc.), located in Saginaw, Michigan. The Provider and Intermediary (United Government Services, LLC) entered into Partial Administrative Resolutions (PARs) for the periods ended June 30, 1999, June 30, 2000 and June 30, 2001 for Issues 2-8. The only issue addressed by the Board at the hearing was Issue 1 involving reimbursement for medical education costs. Medicare reimburses teaching hospitals for their share of costs associated with direct graduate medical education (DGME) and indirect medical education (IME). The calculation for reimbursement requires a determination of the total number of full time equivalent (FTE) residents in the teaching program. This case arises from a dispute over the FTE count.

The parties jointly stipulated to the following facts:

The Provider's Ownership of Synergy

> The Provider and Saginaw Cooperative Hospitals, Inc., d/b/a Synergy Medical Education Alliance. ("Synergy") are related parties, as that term is defined by 42 C.F.R. §413.17, because the Provider and another Saginaw hospital, St. Mary's, are the sole owners of Synergy.

The Purpose of Synergy

- Since 1968, Synergy has conducted the accredited graduate medical education training programs in Saginaw, Michigan.
- Graduate medical education accreditations are issued to Synergy.
- Synergy operates clinical facilities (the "Synergy Clinic").
- Synergy employs and compensates all residents training at the Provider as well as at all other provider and non-provider sites, including the Synergy Clinic.

- Synergy compensates, either through an employment or a contractual arrangement, all physicians providing supervision and training at the Synergy Clinic.

Synergy Payment of Costs of Residents

- For FYE's 6/30/1999, 6/30/2000 and 6/30/2001, Synergy employed the residents and directly incurred the entire cost of compensation of residents, including without limitation salary, professional liability insurance and benefits (the "Residents Cost").

- For FYE's 6/30/1999, 6/30/2000 and 6/30/2001, Synergy employed or contracted with physicians (the "Synergy Physicians") who train and supervise residents at the Synergy Clinic and directly incurred the entire cost of compensation of such physicians, including without limitation salary, professional liability insurance and benefits (the "Synergy Physicians Costs").

Synergy Arrangements With Non-provider Settings

- Synergy confirmed by written correspondence with non-provider settings dated in 2002 that resident teaching services were performed relating to FYE's 6/30/1999, 6/30/2000 and 6/30/2001.

- The teaching and supervision services of the non-provider settings were on a voluntary basis.

The Provider's Funding of Synergy

- For FYE's 6/30/1999, 6/30/2000 and 6/30/2001, there was a budget for Synergy which reflects contributions of the Provider and another Saginaw hospital, St. Mary's. In fact, the Provider and St. Mary's made the contributions reflected in the budget.

- The Member Hospital contributions are substantially equal to the salary and fringe benefit expenses of Synergy.

- The budget for FYE's 6/30/1999, 6/30/2000 and 6/30/2001 reflected the respective contributions of the Provider and St. Mary's [and] was based on their agreement of the aggregate percentage of time that residents were assigned to the respective facilities of the Provider and St. Mary's.

- The Provider made the contributions to Synergy as prescribed by the budget.

The Intermediary issued NPRs for the periods ended June 30, 1999 (FY99), June 30, 2000 (FY 00) and June 30, 2001 (FY 01) disallowing time spent by residents in offsite

rotations because the Provider did not meet the written agreement requirements of 42 C.F.R. §413.86(f)(3). The Provider appealed the Intermediary's adjustments to the Board pursuant to 42 C.F.R. §§405.1835-405.1841 and met the jurisdictional requirements of those regulations.

The Provider was represented by Kenneth R. Marcus, Esquire, of Honigman, Miller, Swartz and Cohn, LLC. The Intermediary was represented by James R. Grimes, Esquire, of Blue Cross Blue Shield Association.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and program instructions, the parties' contentions and the evidence, the Board finds and concludes as follows:

With regard to Issues 2 through 8, the parties have stipulated to the treatment and disposition of these issues as follows:

1. The Provider and the Intermediary agree with the description of facts and the proposed adjustments as set forth in the Partial Administrative Resolutions achieved in each of the three captioned appeals, copies of which are attached hereto as Exhibits 1, 2 and 3, and which are incorporated herein by reference (the "Partial Administrative Resolutions").

2. The Provider and the Intermediary agree that the Board decision in the captioned appeals should include a determination affirming as appropriate the agreement of the Provider and the Intermediary regarding the description of facts and the proposed adjustments relating to the issues as set forth in the Partial Administrative Resolutions.

3. The Intermediary is in possession of all documentation and information with which to implement the Partial Administrative Resolutions, the Intermediary has obtained all requisite approvals, and the Intermediary has no questions regarding, and is otherwise aware of no impediments preventing implementation of, the Partial Administrative Resolutions.

4. The Intermediary agrees to implement the Partial Administrative Resolutions promptly following the decision of the Board in the captioned appeals. In the event the decision of the Board in the captioned appeals is reviewed by the Administrator of the Centers for Medicare and Medicaid Services (the "Administrator"), the Intermediary agrees to implement the Partial Administrative Resolutions promptly following the decision of the Administrator so long as the decision of the Administrator does not reverse the decision of the Board affirming as appropriate the agreement of the Provider and the Intermediary regarding the description of facts and the proposed adjustments relating to the issues as set forth in the Partial Administrative Resolutions.

5. Implementation of the Partial Administrative Resolutions shall consist of payment of the reimbursement to the Provider and issuances of amended notices of program reimbursement to the Provider reflecting the provisions of the Partial Administrative Resolutions.

Regarding Issue number 1 - - IME/DGME Intern and Resident Count - the Board majority finds that the Provider should include the residents employed by Synergy for services performed at the Synergy Clinics and at other non-provider settings outside of Synergy in its IME and DGME count. The treatment of this unique agreement between the Provider and Synergy is appropriate, reasonable and in accordance with appropriate Medicare regulations. The Board will address this issue from both the legal and factual aspects.

Regarding the legal arguments in issue number 1, both the Provider and Intermediary agree that the following regulation at 42 C.F.R. §413.86(f)(4) applies to this case:

> For portions of cost reporting periods occurring on or after January 1, 1999, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs may be included in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met -
>
> (i) The resident spends his or her time in patient care activities.
>
> (ii) The written agreement between the hospital and the nonhospital site must indicate that the hospital will incur the cost of the resident's salary and fringe benefits while the resident is training in the nonhospital site and the hospital is providing reasonable compensation to the nonhospital site for supervisory teaching activities. The agreement must indicate the compensation the hospital is providing to the nonhospital site for supervisory teaching activities.
>
> (iii) The hospital must incur all or substantially all of the costs for the training program in the nonhospital setting in accordance with the definition in paragraph (b) of this section.

The IME regulation adapts the GME provisions. See, 42 C.F.R. §412.105(f)(1))ii)(c).

Both parties also agree that the Provider and Synergy are related parties as defined by the Medicare regulations at 42 C.F.R. §413.17. The parties disagree however about the impact and interface of this regulation with 42 C.F.R. §413.86(f) above. The Provider argues that since these two parties are related under the above regulation, no written agreement is necessary. It argues that, for all intents and purposes, the Provider and

Synergy are one and the same organization, and to the extent that Synergy is fully in compliance with the regulatory requirements, the Provider indirectly is also in compliance with those requirements.

The Intermediary argues that there must be a written agreement between the Provider and non-provider entities, without regard to whether the outside entity are related organizations as defined under Medicare regulations at 42 C.F.R. §413.17. The Intermediary asserts that the purpose of the regulatory requirement is to ensure that providers receive full reimbursement when residents spend a portion of their training time in another setting. Further, it states that in order to fully reimburse a provider and still protect against the possibility of double payment, the hospital and the non-hospital site must enter into a written agreement covering the costs of training residents at offsite facilities. The Intermediary maintains that the written agreement should explain the nature of the relationship between the hospital that wants to claim the costs of the residents' time and the outside entity where the resident is spending time. It should also address the specific activity of an offsite residency training program, including the activities that will take place, where they will take place, and which party will incur the costs of the program. Therefore, the agreement should reflect that: (1) the residents will be engaged in patient care activities; (2) the hospital will be responsible for the salaries and benefits of the residents while they are at the non-hospital site; and (3) it should describe the compensation paid to the non-hospital provider for supervisory teaching services or state that no payment will be made for such services. The Intermediary contends that only with that level of specificity is it clear that the hospital is incurring substantially all of the costs of the residency training program and is, therefore, entitled to include the time spent off-site in the FTE resident count.[1]

The Board majority concurs that the parties are related under 42 C.F.R. §413.17; therefore, the Provider and Synergy are, for all intents and purposes, considered part of the same overall organization. The Provider argues that when this factual situation exists, no written agreement is required. The Intermediary argues that a written agreement is required in all cases, including those involving organizations that are defined in the Medicare regulations as related, and cites the Federal Register, Vol. 63, No. 147[2] dated July 31, 1998, which states in part:

> [w]ith regard to the costs of related parties under §413.17, our policy was not to include costs associated with training in nonhospital clinics in the per resident amount even though certain direct GME costs of related parties could have been allowable. We also do not believe that §413.17 has applicability to our proposed policy. We are requiring a written agreement between hospitals and nonhospital sites for purposes of this final rule, even where the hospital and nonhospital site are related organizations under §413.17. In practice, since we are requiring an agreement between hospitals and nonhospital sites that are under common ownership or control, the agreements should be a formality.

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[1] Intermediary's Post-Hearing Brief at p. 5.

[2] See, Intermediary Exhibit I-2, p. 11.

The Board majority concurs with the Provider that the above specific limiting regulation requirement should not overrule the general requirements for determining relatedness.

The Board majority finds the Provider's argument relevant and convincing. Synergy is the operating arm of the Provider for the Provider's medical education program. Synergy provided all functional activities to operate the graduate medical education training programs. It was funded and paid for by the Provider and another Saginaw hospital, St. Mary's to the extent that their respective residents participated in the Synergy programs. Thus, the Board majority concludes that all payments made by the Provider to Synergy for resident costs are allowable and that the resident count for the Synergy residents and related teaching physicians should be included in the direct GME and IME resident counts.

The remaining sub-issue is the inclusion of residents that performed services in non-provider, non-Synergy settings. 42 C.F.R. §413.86(f)(4) requirements must be met in order for residents performing activities in this setting to be included in the appropriate DGME/IME counts. The Intermediary argues that there were written agreements as required; however, the agreements were between Synergy and the non-provider of service and thus cannot be considered to be the Provider's agreement. As stated above, the Board majority considers the Provider and Synergy to be one and the same for Medicare reimbursement purposes. Thus, a contract between Synergy and another party is essentially a contract between the Provider and that party. Moreover, the agreements between Synergy and the non-provider settings were appropriate contracts for services under customary business practice. The Board requested and the Provider furnished various documents demonstrating actual services provided by residents in the non-provider settings. The documents, taken as a whole, provide a "written agreement" sufficient to support appropriate reimbursement payment. The Board majority agrees with the Provider's argument that the form and content of what constitutes a "written agreement" is not defined in 42 C.F.R. §413.86. Therefore, the documentation provided, of the Provider's normal business practices and agreements, furnished a reasonable explanation of services rendered and supports the thesis that the agreements meet the regulatory definition of a "written agreement" stated in 42 C.F.R. §413.86(f)(4).

The Provider also challenged the validity of the Medicare regulation, 42 C.F.R. §413.86, to the extent that it imposes a "written agreement" requirement so as to deprive the Provider of Medicare payment where the Provider has satisfied the statutory requirements that its residents be involved in patient care and that all or substantially all of the costs of the training program be incurred by the Provider. In light of the Board majority's determination, it is unnecessary to reach this question and it is beyond the Board's authority to declare a regulation invalid.

DECISION AND ORDER:

Issue No. 1 – DGME/IME Count

The Provider properly included residents that performed services at Synergy Clinics and other non-provider settings in its DGME/IME resident counts. The Intermediary's adjustments are reversed.

Issue Nos. 2-8

The determinations of payment as reflected in the Parties' Partial Administrative Resolutions are affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Elaine Crews Powell, C.P.A (Dissenting Opinion)
Anjali Mulchandani-West
Yvette C. Hayes

DATE: August 2, 2007

FOR THE BOARD:

Suzanne Cochran
Chairperson

Covenant HealthCare
Dissenting Opinion of Elaine Crews Powell

Issue No. 1 – GME/IME FTE Count

The majority concluded that because Covenant Healthcare (the Provider) and Synergy Medical Education Alliance (Synergy) are related parties, as defined by 42 C.F R. §413.17, there is no need for the written agreement required by 42 C.F R. §413.86(f)(4), finding that the Provider and Synergy "are, for all intents and purposes, considered part of the same overall organization"[3] and that the documents submitted by the Provider "taken as a whole, provide a 'written agreement' sufficient to support appropriate reimbursement payment."[4] I respectfully disagree.

It is undisputed that Covenant and St. Mary's were corporate members or co-sponsors of the non-profit corporation that operated as Synergy, and therefore, that the Provider was related to Synergy. The residents were employed by Synergy, and the Provider and St. Mary's shared in the training costs incurred through a contribution to Synergy's budget. Each facility then claimed FTEs for the residents being trained based on the share of Synergy's costs that each one bore. Synergy's residents rotated to both hospitals and to non-hospital sites such as Synergy's Clinics and doctors' offices.

I find nothing in the record to support a finding that the Provider and Synergy can be considered the same "overall organization." Doing so ignores St. Mary's interest in Synergy. Therefore, even though the Provider is related to Synergy, it is not the sole sponsor of that organization and it is certainly not the same organization. Furthermore, I find nothing in either the direct graduate medical education regulation at 42 C.F R. §413.86(f)(4)(ii) or the indirect medical education regulation at 42 C.F R. §412.105(f) that exempts from the written agreement requirement providers that are related to the non-hospital sites to which their residents rotate. On the contrary, in the preamble to the 1999 final rule covering the payment of medical education costs published at 63 Fed. Reg. 40954, 40996 (July 31, 1998)[5] CMS made it perfectly clear that even when a provider and a non-hospital site are related, a written agreement is still required. The relevant portions of the comment and CMS' response read as follows:

> *Comment:* One commenter stated that . . . the regulation should include specific language which states that costs incurred by an organization related to the hospital under § 413.17 will be recognized as if incurred by the hospital in applying the expanded definition of "all or substantially all" of the costs**.**

[3] Majority decision at pg. 7.
[4] Id. at 8.
[5] Exhibit I-2.

> *Response*: . . . [w]e also do not believe that § 413.17 has applicability to our proposed policy. We are requiring a written agreement between hospitals and nonhospital sites for purposes of this final rule, even where the hospital and nonhospital site are related organizations under § 413.17. In practice, since we are requiring an agreement between hospitals and nonhospital sites that are under common ownership or control, the agreements should be a formality.

Program Memorandum (PM) No. A-98-44[6] issued by CMS included a discussion of the requirement that hospitals seeking to include residents' time spent at a non-hospital site must incur substantially all of the costs of the training programs. To ensure that the hospital is incurring substantially all of the costs, the PM reiterates the requirement that a written agreement entered into between the hospital and the non-hospital site must indicate that the hospital is paying the costs of the residents' compensation as well as the costs of supervisory teaching activities. CMS made it clear that the written agreement between the hospital and the non-hospital site must simply reflect the facts of the arrangement and fully acknowledge what costs exist and who is responsible for them.

The Provider ignored the written agreement requirements of the GME and IME regulations as well as the PM and the comments in the *Federal Register* to its peril. Since there were no written agreements between the Provider and the non-hospital sites to which the residents rotated, the Provider is not entitled to claim the FTEs associated with those rotations.

Finally, the various accumulated documents that the Provider claims constitute the required written agreements simply do not meet the requirements of the regulations. The agreements are not between the required parties – the Provider, Covenant HealthCare, and the non-hospital sites, including, but not limited to, Synergy.

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Elaine Crews Powell, CPA

[6] Exhibit I-3.