CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Covenant Health Care **Provider** **vs.** **Blue Cross Blue Shield Association/ United Government Services, LLC** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 06/30/99; 06/30/00 and 06/30/01** **Review of: PRRB Dec. No. 2007-D55 Dated: August 2, 2007**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in §1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). The Intermediary commented, requesting review and reversal of Issue No. 1. The parties were notified of the Administrator's intention to review the Board's decision on Issue No. 1. Comments were received from CMS' Center for Medicare Management (CMM), requesting reversal of Issue No. 1. The Provider requested affirmation of Issue No. 1. Accordingly, this case is now before the Administrator for final agency review.

ISSUE(S) AND BOARD'S DECISION

Issue No. 1

Issue No. 1 is whether the Intermediary's determination of the Full-time Equivalent (FTE) intern and resident count for purposes of computing the Provider's Indirect Medical Education (IME) and direct Graduate Medical Education (GME) adjustments for FYEs June 30, 1999 through June 30, 2001 was proper.

The Majority of the Board, reversing the Intermediary's adjustment, held that the residents that performed services at Synergy Clinics and other non-provider settings are properly included in the Provider's GME/IME resident counts. The Majority found that the Provider and Synergy are related parties under 42 C.F.R. §413.17 and, thus, are considered part of the same overall organization. With respect to relatedness, the Majority found that Synergy equals the operating arm of the Provider for the Provider's medical education program and, provided all functional activities to operate the graduate medical education training programs. In addition, Synergy was funded and paid for by the Provider and another Saginaw hospital, St. Mary's Hospital, to the extent that their residents participated in the Synergy programs. Thus, the Majority determined 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.

Regarding the inclusion of residents that performed services in non-provider settings, the Majority noted that the criteria at 42 C.F.R. §413.86(f)(4), includes the need for written agreements, in order for these residents to be included in the appropriate GME/IME counts. The Majority found, however, that this regulation should not overrule the general requirements for determining relatedness. The Majority determined that the Provider and Synergy to be one and the same for Medicare reimbursement purposes and, therefore, a contract between Synergy and another party is essentially a contract between the Provider and that party. The agreements between Synergy and the non-provider settings were appropriate contracts for services under customary business practice. The Majority concluded that since the substance of what equals a written agreement is not set forth in the regulations, the documentation, taken as a whole, establishes written agreement in this case.

One Board member dissented. The dissenter noted that, 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. Nothing in the direct graduate medical education regulation at 42 C.F.R. §413.86(f)(4)(ii) and the indirect medical education regulation at 42 C.F.R. §412.105(f) exempts providers from the written agreement requirement when related parties are involved. The dissenter noted that in the preamble to the Federal Fiscal Year (FFY) 1999 final rule covering the payment of medical education costs published at 63 Fed. Reg. 40954, 40996 (July 31, 1998), CMS made it perfectly clear that, even when a provider and a non-hospital site are related, a written agreement is still required. The Program Memorandum (PM) Transmittal No. A-98-446 (December 1, 1998). 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. The dissenter concluded that, since there were no written agreements between the Provider and the non-provider sites, the Provider is not entitled to claim the FTEs associated with those rotations.

Issue Nos. 2 through 8

The Intermediary and Provider agreed to the following stipulations and disposition of the following issues subject to adoption of the Board and Administrator review.

Issue No. 2 is whether bank fees claimed by the Provider are allowable interest related costs. (Fiscal Year (FY) 6/30/99).

The Provider stated that bank fees are treated as a normal operating expense and included in the administrative and general cost center. The Provider submitted a breakdown of bank fees by month. After a review of the documentation, the Intermediary agreed that the bank fees were allowable. The Intermediary proposed to reclassify the bank fees from the old-capital building cost center to the administrative and general cost center and reverse the offset of the bank fees from the old-capital building cost center.

Issue No. 3 is whether the hospital-based physician compensation should be reimbursed under Medicare Part A or Part B. (FY 6/30/99)

The Intermediary had offset the Rehab Unit hospital-based physician (Part A) hours due to a lack of documentation. After reviewing further documentation, the Intermediary agreed to reclassify 100 percent of the professional service compensation from Part B to Part A and to file 2080 hours and RCE limits consistent with the FYE 1998 administrative resolution.

Issue No 4 is whether the proper statistic to allocate housekeeping costs is hours worked or square footage. (FY 6/30/00)

The Intermediary proposed to adjust the housekeeping statistical base to square footage and agreed not to allocate square feet to any areas that did not have cleaning hours originally assigned to them.

Issue No 5 is 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)

The Intermediary agreed to treat offsite clinic FTEs consistent with the treatment of offsite HHA employees that do not have access to hospital cafeteria.

Issue No. 6 is whether the Intermediary properly disallowed the allocation of nursing administration costs to the home health agency (HHA). (FY 6/30/00)

The Intermediary originally disallowed the allocation of nursing administration costs to the HHA, because there was an indication that this function did not service the HHA. The Intermediary since determined that there are some functions within nursing administration that do service the HHA. The parties agreed to the direct allocation of the proper expenses.

Issue No. 7 is whether the Intermediary properly weighted Worksheet B-1 statistics to account for the psychiatric unit being closed during the year. (FY 6/30/00)

The parties resolved the allocation of the building related space to the unit, as allowable, while the area is "temporarily idle."

Issue No. 8 is whether the Intermediary properly adjusted the rehabilitation unit hospital-based physician compensation from Medicare Part A to Part B. (FY 6/30/00)

After review of further documentation, the Intermediary agreed to reclassify 100 percent of the compensation to Part A and to use 2080 hours, consistent with the earlier cost years.

For Issue Nos. 2 through 8, the Board affirmed the determination of payment as reflected in the partial administrative resolutions.

SUMMARY OF COMMENTS

The Intermediary commented, requesting reversal of the Board's decision on Issue No. 1. The Intermediary argued that the Majority incorrectly found that the Provider could include all of the residents' off-site time in its FTE count. The Intermediary noted that, despite the Majority's finding, the Provider had no written agreements with either a non-provider setting, or the related organization, as required by the governing regulation.

CMM commented, requesting that the Board's decision be reversed on Issue No. 1. CMM noted that the statute permits a hospital to include resident time spent in non-provider settings in its FTE resident count if the residents are spending their time in patient care activities, and if the hospital incurs all or substantially all of the costs. The relevant regulation defines "all or substantially all of the costs" as the residents' salaries and fringe benefits including travel and lodging expenses and a portion of teaching physicians salaries and fringe benefits attributable to training residents at the site. In addition, at issue in this case, the regulations require that, for counting residents at non-provider settings, there must be a written agreement between the hospital and nonhospital site, in place prior to the time in which such residents commence training. The agreement must also state that the hospital will incur the costs of the resident's salaries and fringe benefits, while the resident is training in the non-provider site; the hospital is providing reasonable compensation to the non-provider site for supervisory teaching activities; and, the amount of compensation the hospital is providing for supervisory teach activities.

CMM noted that the purpose of a written agreement establishes: (1) who would be responsible for incurring "all or substantially all" of the costs of the training program and the nonhospital site; and (2) the specific costs of the program that must be incurred to ensure that the statutory conditions are met. Consequently, CMM argued that it is imperative for the hospital to have a written agreement with

each of the non-provider sites, especially, in this case where the Provider is a co-sponsor of Synergy that in turn owns Synergy Clinics. CMM, in agreeing with the dissenting opinion, maintained that while the Provider and Synergy are related parties, they are not the same organization and, indeed, Synergy is not a wholly-owned subsidiary of the Provider. All three parties together, (the Provider, St. Mary's Hospital and Synergy), do not constitute the same overall organization. CMM pointed out that the documentation submitted in lieu of a written agreement for training that occurred at Synergy's clinics is insufficient as it does not specify the costs of training at the clinics and how much the Provider is paying for the training program at such sites. Not only did the Provider fail to furnish valid written agreements for resident training at non-hospital sites, but it did not comply with the substance of the statutory requirement specifying that hospitals may include the time a resident spends in non-hospital settings in its FTE resident count if it meets the regulatory criteria. Without a written agreement that specifies which of the two hospitals is incurring all or substantially all of the costs, CMM must assume that both of the hospitals are contributing to the funding of Synergy and its clinics. Thus, CMM argued that the Provider has not met the statutory requirement, and may not include these FTe residents in the hospital count for GME and IME.

The Provider commented requesting that the Board's decision be affirmed on Issue No. 1. The Provider argued that the Majority properly applied the related party principle. The Provider pointed out that, as stipulated, in 1968 the provider and two other hospitals in Saginaw Michigan, St. Mary's Hospital and Saginaw General Hospital established and were the sole owners of Saginaw Cooperative Hospitals, Inc., d/b/a Synergy Medical Educational Alliance. As a result of a subsequent affiliation transaction, the Provider now operated Saginaw General and, thus, the Provider and St. Mary's Hospital were the sole owners of Synergy for the cost years under appeal.

Synergy operates a clinic that is not part of the Provider and, therefore, is a non-hospital setting. Synergy employs and compensates the graduates enrolled in the medical education programs. Synergy compensates physicians through either an employment or a contractual arrangement. The parties stipulated that the teaching and supervision activity at the nonprovider setting was voluntary. Thus, it was clear that Synergy was established to avoid duplication and to contain costs in the administration of the graduate medical education activities in Saginaw Michigan. The establishment of Synergy resulted in significant cost savings for the Medicare program.

The Provider stated that the Intermediary is relying on a technical argument that the Provider did not strictly comply with the written agreement requirements of 42 CFR 413.86, which were adopted thirty years after Synergy was established. The Board rejected and the Intermediary's argument, which would place form over substance and which has been successful in achieving significant Medicare savings for three decades. The Provider argued that the Administrator should find that the interests of upholding an inflexible and erroneous interpretation of the requirement for counting residents in nonprovider settings is clearly outweighed by the interest of encouraging providers to take cost containment strategies.

Further, the Provider argued that the Board properly found, based on the stipulation and uncontradicted evidence, that Synergy complied with the written agreement requirements of the regulation at 42 C.F.R. §413.86(f)(4) and 42 C.F.R. §412.105(f)(i)(2). Synergy employed and compensated the residents and employed and contracted with the teaching and supervising physicians. Longstanding Medicare principle holds the separate existence of two entities is ignored if they are related parties as the Provider and Synergy are in this case. The Board properly rejected the Intermediary's argument that the preamble superseded the related party regulation. Even if the 1998 Preamble statement is accorded the force of law, the context of comments and responses concerning related party principle do not contemplate the situation as exists between the Provider and Synergy in which it is clear that these two entities are alter egos. In addition, the documentation, when taken as a whole, meets the written agreement requirement, and, therefore, the analysis of the dissenting opinion should not be adopted.

The Provider also stated that the Intermediary had counted the FTEs residents at issue when it established the FTE cap. Historically, the Provider had testified that it prorated the non-provider FTEs based on its inpatient rotations. For example, if the Provider had 75 percent of the inpatient rotations, it would claim 75 percent of the clinic rotations and 75 of the nonprovider physician office FTEs. In addition, the Provider claimed that the Intermediary did not previously treat Synergy as a nonprovider setting. The Provider claimed that the Intermediary's workpapers do not show a lack of written agreements as the basis for the disallowance. Finally, the Provider alleged that CMS has been inconsistent in requiring written agreements. The Provider concluded that the Intermediary's argument was not supported by substantial evidence. The Provider also stated that the dissenting opinion was also not supported by the law or substantial evidence. Finally, the Provider stated that the Intermediary's and CMM's position was contrary to other statements made by CMS.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

Since the inception of Medicare in 1965, the program has shared in the costs of educational activities incurred by participating providers. The regulations at 42 CFR 413.85(b) define approved educational activities to mean formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of patient care in an institution. These activities include approved training programs for physicians, nurses, and certain allied health professionals. Medicare reimburses for both the direct and indirect costs of graduate medical education. Under section 1886(h) of the Act and the implementing regulation at 42 CFR 413.86, Medicare reimburses hospitals for the costs of direct graduate medical education. Under 1886(d)(5)(B) of the Act and the implementing regulation at 42 CFR 412.105, Medicare reimburses hospitals for the costs of IME.

FTE Count For GME Payment

Since July 1, 1987, the Social Security Act has permitted hospitals to count the time residents spend training in sites that are not part of the hospital, non-hospital sites, for purposes of graduate medical education (GME).[1] Section 1886(h)(4)(E) of the Act states that the Secretary's rules concerning computation of FTE residents for purposes of GME payments shall:

> [P]rovide that only time spent in activities relating to patient care shall be counted and that all the time so spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting. (Emphasis added.)

The regulation governing payment for GME at 42 CFR 413.86(b)(1999) states:

> For purposes of this section the following definitions apply:

[1] Omnibus Budget Reconciliation Act of 1986 (Pub. Law No. 99-509).

> ....
>
> *All or substantially all of the costs for the training program in the nonhosptials setting* means the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the costs of teaching physicians' salaries and fringe benefits attributable to direct graduate medical education.

Further, the regulation explains at 42 CFR 413.86(f)(3) that:

> On or after July 1, 1987, and for portions of cost reporting periods occurring before January 1, 1999, the time residents spend in nonprovider settings, such as freestanding clinics, nursing homes and physician offices in connection with approved programs is not excluded in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met:
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> (i) The resident spends his or her time in patient care activities.
> (ii) There is a written agreement between the hospital and the outside entity that states the resident's compensation for training time spent outside of the hospital setting is to be paid by the hospital.[2]

Further, in response to the payment of certain qualified nonhospital providers for GME, the regulation at 42 CFR 413.86(f)(4)(1999) was amended to specify that:

> For portions of cost reporting periods occurring on or after January 1, 1999, [and before October 1, 2004,][3] the time residents spend in non-

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[2] See also 62 Fed. Reg. 45966, 46007 (Aug. 29, 1997) (Section 413.86(f)(1) allows hospitals to include resident time in nonhospital sites when the hospital incurred all or substantially all of the costs. Under section 413.86(f)(1(iii)(B) we have defined "all or substantially all" to mean that the hospital has a written agreement with the nonhospital site that it will continue to pay the residents' salary for training in that setting.....)

[3] For periods after October 1, 2004, the regulation was amended to allow providers to count the FTE residents in the calculation without a written agreement if certain criteria were including that "all or substantially all" of the costs are paid by the hospital met. The regulation at 42 CFR 413.86(f) was redesignated to 42 CFR 42 CFR 413.78(d) (2007) and included at (d)(4) that the hospital is subject to the principles of community support and redistribution of costs as specified in section 413.81.

> provider setting the time residents spend in non-provider 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 costs 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 non-hospital site for supervisory teaching activities.
> (iii) The hospital must incur all or substantially all of the costs for the training program in the non-hospital setting in accordance with the definition in paragraph (b) of this section.

Notably, the definition of "all or substantially all" of the costs was clarified pursuant to the FFY 1999 IPPS final rule (July 31, 1998). The Secretary explained in the FFY 1999 IPPS final rule that:

> We proposed that, in order for a hospital to include residents' training time in a nonhospital setting, the hospital and the nonhospital site must have a written contract which indicates the hospital is assuming financial responsibility for, at a minimum, the cost of residents' salaries and fringe benefits (including travel and lodging expenses where applicable) and the costs for that portion of teaching physicians' salaries and fringe benefits related to the time spent in teaching and supervision of residents.
>
> The contract must indicate that the hospital is assuming financial responsibility for these costs directly or that the hospital agrees to reimburse the nonhospital site for such costs.

One commenter objected to the changes on the basis that some arrangements between hospitals and nonhospital settings for the training of residents predated the GME base year. However, the Secretary explained that:

> hospital and nonhospital sites will have 5 months following publication of this final rule to negotiate agreements that will allow

> hospitals to continue counting residents training in nonhospital sites for indirect and direct GME. These agreements are related solely to financial arrangements for training in nonhospital sites. We do not believe that the agreements regarding these financial transactions will necessitate changes in the placement and training of residents[4]

The Secretary also stated, in response to a commenter who suggested that CMS should encourage "affiliations," that the revised definition of "all or substantially all" of the costs provides incentives for hospitals and nonhospital sites to reach agreement with regard to financial arrangements for training in nonhospital sites to avoid the situation where neither entity receives payment for GME. The Secretary also addressed the effect of the related party rule on the written agreement requirement stating that:

> With regard to the costs of related parties under §413.17, our policy was not to include costs associated with training in non-hospital 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 non-hospital sites even where the hospital and the non-hospital site are related organizations under §413.17. In practice, since we are requiring an agreement between hospitals and nonhospitals sites that are under common ownership or control the agreements are a formality.[5]

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[4] 63 Fed Reg. 40986 40995(July 31, 1998) One commenter asked whether hospitals would be eligible to receive payments in situations where the teaching faculty volunteers their services and neither the hospital or' nonhospital entity incurs costs for supervisory teaching physicians, but the hospital incurs the costs of resident salaries and fringe benefits (including travel and lodging expenses where applicable). 63 Fed Reg. 40996. The Secretary found that, for purposes of satisfying the requirement of a written agreement, the written agreement between a hospital and a nonhospital site may specify that there is no payment to the clinic for supervisory activities because the clinic does not have these costs.

[5] 63 Fed. Reg. 40986, 40996 (July 31, 1998). *See also* Medicare Policy Clarifications on Graduate Medical Education Payments for Residents Training in Non-Hospital Settings (April 2005), "Question 8) Must the hospital incur the teaching physician costs and have a written agreement with the nonhospital site if a) the nonhospital site is owned by the hospital, or b) the nonhospital site is owned by the same organization that owns the hospital? Answer 8) In either scenario, the hospital must incur the teaching physician costs, and there must be a written agreement in place before the time the residents begin training in the nonhospital

Subsequent to the cost years in this case, in the FFY 2008 IPPS rule, the Secretary addressed the existing policy in discussing the further clarification to the definition of "all or substantially all" costs and stated that:

> Global agreements with lump sum payment amounts, either for teaching physician costs or for nonhospital training in general, have not been sufficient under existing policy and would not be sufficient under the finalized policy. Similarly, as under current policy, if two (or more) hospitals train residents in the same accredited program, and the residents rotate to the same nonhospital site(s), the hospitals cannot share the costs of that program at that nonhospital site (for example, by dividing the FTE residents they wish to count according to some predetermined methodology), as we do not believe this is consistent with the statutory requirement at section 1886(h)(4)(E) of the Act which states that the hospital incur "all, or substantially all, of the costs for the training program in that setting."[6] (Emphasis added.)

FTE Count for IME Payment

Prior to October 1, 1997, for IME payment purposes, hospitals were not permitted to count the time residents spent training in non-hospital settings. Section 4621(b)(2) of the Balanced Budget Act of 1997 revised §1886(d)(5)(B) of the Act to allow providers to count time residents spend training in non-hospital sites for IME purposes, effective for discharges occurring on or after October 1, 1997. Section 1886(d)(5)(B)(iv) of the Act was amended to provide that:

> [A]ll the time spent by an intern or resident in patient care activities under an approved medical residency program at an entity in a nonhospital setting shall be counted towards the determination of full-time equivalency if the hospital incurs *all or substantially all*, of the costs for the training program in that setting. (Emphasis added.)

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site ... The hospital would need to demonstrate, under either ownership scenario, that it is paying all or substantially all of the costs of the training program by actually paying the nonhospital site through the hospital's accounts payable system. (If the hospital and nonhospital site share a single accounting system, the hospital could demonstrate payment of the nonhospital site training program costs using journal entries that expense these costs in the hospital's GME cost center and credit the nonhospital site.)"

[6] 72 Fed. Reg. 26870, 26968 (May 11, 2007).

The regulation was amended to read at 42 CFR 412.105(f)(1)(ii)(C) (1999) that:

> Effective for discharges occurring on or after October 1, 1997, the time spent by a resident in a nonhospital setting in patient care activities under an approved medical residency program is counted towards the determination of full time equivalency if the criteria set forth at 413.86(f)(4)[7] are met. (Emphasis added.)

Findings of Facts and Conclusions of Law

The Provider and several other area hospitals entered into an agreement to create Saginaw Cooperative Hospitals, Inc., later renamed Synergy Medical Education alliance (Synergy). For the cost reporting periods at issue, the Provider and St. Mary's Hospital were the sole owners of Synergy. Synergy was accredited to conduct medical education programs. Synergy conducted its graduate medical education programs in conjunction with the hospitals, including the Provider, located in Saginaw, Michigan. Residents trained onsite at the hospitals (including the Provider and St. Mary's Hospital) located in Saginaw, Michigan, at clinical facilities of Synergy and at physicians' offices located in the community. Synergy employed and compensated all residents training at the Provider as well as at all other provider and nonprovider sites, including Synergy Clinic. Synergy also had employment, or contractual, arrangements for all physicians providing supervision and training at the Synergy Clinic. The record shows that Synergy residents rotated through the Provider, St. Mary's, the Synergy Clinic and physicians' offices. The Provider reported certain FTEs which it alleged was based on a percentage of the total FTEs that matched the percentage of the total costs of Synergy paid by the Provider. The total FTEs claimed on the Provider's cost report included time spent by the residents at the Provider, time spent at the Synergy clinics and time spent in outside physician offices. The only FTEs at issue in this case are the time spent by residents in nonhosptial settings.

The Provider argued that as Synergy and the Provider were related party, no written agreement was required under 42 CFR 413.86(f)(4) in order to claim the time spent by the FTEs in the nonprovider settings. The Board agreed that, as the parties were related under 42 CFR 413.17, the Provider and Synergy are, for all intents and purposes, considered part of the same overall organization. Thus, the Board concluded that "all payment made by the Provider to Synergy for residents costs

[7] Redesignated at 413.78(c) and 413.78(d).

are allowable and that the resident count for Synergy residents and related teaching physicians should be included in the direct GME and IME resident counts."

The Board further concluded that the written agreements between Synergy and the nonprovider settings were in essence agreements between the nonprovider settings and the Provider. The Board also found that the agreements were appropriate contracts for services under customary business practice. The Board found that the Provider also furnished various documents demonstrating that actual services provided by residents in nonprovider settings. The Board concluded that the written agreements as a whole were sufficient to support the thesis that the agreements met the regulatory definition of a written agreement stated in 42 CFR 413.86(f)(4).

Applying the Medicare law, regulations and instructions to the facts of this case, the Administrator initially finds that, for purposes of the IME and GME count of FTEs for residents performing work at nonhospital settings, there must be a written agreement, even if the hospital and the nonhospital setting are related. A rule of statutory construction equally applicable to regulatory interpretation is that the specific controls over the general. The specific regulation controlling the counting of FTEs in the nonhospital setting does not provide for an exception, pursuant to the related party regulation, to the written agreement requirement. Further, the Secretary specifically confirmed that a written agreement was required under these circumstances. The Administrator finds that the related party rule, under reasonable costs, is to prevent inflated costs from being borne by the Medicare program. In the GME and IME context, a purpose of the written agreement is to show that the provider is financially responsible for paying the costs of the residents and supervising physicians. The related party rule does not ensure that the provider is in fact financially responsible to pay "all or substantially all" of the costs and, therefore, that the provider meets the statutory requirement. Rather, the related party rule is to ensure the payment of only reasonable costs by Medicare. Consequently, where the nonhospital setting involves a related party, the hospital is still required to have in place a written agreement with the nonhospital setting that meets the criteria of 42 CFR 412.86.

The Administrator finds in this case there is no written agreement between the Provider and the nonprovider settings. Moreover, the documentation submitted by the Provider cannot act as a proxy, nor does it otherwise meet the written agreement requirements. For example, some of the documentation submitted includes, inter alia, agreements between Synergy and particular nonproviders; an agreement between Synergy and Provider with respect to the rotation of Synergy residents; Synergy W-2s for residents; letters indicating payment by Synergy for

contracted physicians (or the volunteering of physician time),[8] and documentation indicating a 75/25 split between the Provider and St Mary's for Synergy funding. Contrary to the Board's finding, these various documents do not provide "a written agreement" and do not support the inclusion of the FTEs in the Provider's GME and IME count. In particular, the regulation requires a written agreement between the hospital and the non-hospital site, which must indicate that the hospital will incur the costs of the resident's salary and fringe benefits while the resident is training in the non-hospital site and the hospital is providing reasonable compensation to the non-hospital site for supervisory teaching activities. The written agreement must indicate the compensation the hospital is providing to the non-hospital site for supervisory teaching activities. The documents offered in support of the Provider's claim do not meet the requirements of 42 CFR 413.86(f).

Finally, the Administrator finds that the Provider has not demonstrated that it incurred all or substantially all of the costs for the training program in the nonhospital setting.[9] In particular, the record shows that the Provider and St Mary's own Synergy and that Synergy operates Synergy Clinics. Synergy is responsible for the medical education program. As two providers are involved with funding Synergy, the record does not support a finding that the Provider incurred "all or substantially all of the costs" of the training of the resident and compensation of the supervising physicians.[10] Thus, the Provider also fails to meet the criteria of 42 CFR 413.86(b) and (f)(4)(iii).

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[8] Certain agreements Synergy had with physicians state that the time was volunteered, but do not state whether there were no costs.

[9] The Administrator notes that under the pre-January 1, 1999 definition, as the Provider did not have a written agreement, by definition, it was not incurring all or substantially all of the costs. See also 62 Fed. Reg. 45966, 46007 (Aug. 29, 1997).

[10] The Provider submitted a financial document of Synergy funding showing a 75/25 split of the contributions made by the Provider and St. Mary's which appears to be interval "lump sum payment amounts" as if a global agreement. Even assuming the reference contributions accurately reflects the costs of the residents and supervisory physicians in the nonhospital settings, this document, on it face, shows that the Provider did not incur "all or substantially all" of the costs.

DECISION

Issue No. 1

The Administrator reverses the Board's decision in accordance with the foregoing opinion. The Intermediary's determination of the Full-time Equivalent (FTE) intern and resident count for purposes of computing the Provider's Indirect Medical Education (IME) and direct Graduate Medical Education (GME) adjustments for FYEs June 30, 1999 through June 30, 2001 was proper.

Issue No. 2

The Administrator affirms the administrative resolution with respect to whether bank fees claimed by the Provider are allowable interest related costs. (FY 6/30/99)

Issue No. 3

The Administrator affirms the administrative resolution with respect to whether the hospital-based physician compensation should be reimbursed under Medicare Part A or Part B. (FY 6/30/99)

Issue No. 4

The Administrator affirms the administrative resolution with respect to whether the proper statistic to allocate housekeeping costs is hours worked or square footage. (FY 6/30/00)

Issue No. 5

The Administrator affirms the administrative resolution with respect to 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)

Issue No. 6

The Administrator affirms the administrative resolution with respect to whether the Intermediary properly disallowed the allocation of nursing administration costs to the HHA. (FY 6/30/00)

Issue No. 7

The Administrator affirms the administrative resolution with respect to whether the Intermediary properly weighted Worksheet B-1 statistics to account for the psychiatric unit being closed during the year. (FY 6/30/00)

Issue No. 8

The Administrator affirms the administrative resolution with respect to whether the Intermediary properly adjusted the rehabilitation unit hospital-based physician compensation from Medicare Part A to Part B. (FY 6/30/00)

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES.

Date: 10/3/07

/s/
Herb B. Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services