PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON THE RECORD
2000-D4

PROVIDER -
Good Samaritan Regional Medical Center
Phoenix, Arizona

Provider No. 03-0002

vs.

INTERMEDIARY - Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Arizona, Inc.

DATE OF HEARING-
September 15, 1999

Cost Reporting Periods Ended -
December 31, 1989 and 1990

CASE NOS. 94-0426 &
94-0429

INDEX

ISSUE:

Must the Provider have a written agreement with its related facilities in order to have the resident rotations included in its GME count?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:
Good Samaritan Regional Medical Center ("Provider") is a 679 bed, not for profit, acute care teaching hospital located in Phoenix, Arizona. The Provider is a member of the Samaritan Health System which also owns or operates White Mountain Community Hospital, Grand Canyon Clinic, Camelback Behavioral Hospital-East, and Camelback Behavioral Hospital-West.[1]

Blue Cross and Blue Shield of Arizona ("Intermediary") audited the Provider's cost and statistical records for the Medicare cost reporting periods ended December 31, 1989 and December 31, 1990. Based upon these examinations, the Intermediary adjusted the Provider's count of full-time equivalent ("FTE") residents used to determine program payments for the direct costs of graduate medical education ("GME"). In particular, the Intermediary excluded time spent by residents working at the above mentioned "related" facilities from the Provider's count.[2]

On July 29, 1993, the Intermediary issued a Notice of Program Reimbursement ("NPR") for the Provider's 1989 cost reporting period, which reflected the subject adjustment. On September 30, 1993, the Intermediary issued an NPR for the Provider's 1990 cost reporting period, which reflected the subject adjustment for that accounting period. On December 9, 1993, the Provider appealed the Intermediary's adjustments to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§405.1835-.1841, and met the jurisdictional requirements of those regulations. The amount of Medicare program funds in controversy is approximately $30,000 for the Provider's 1989 cost reporting period, and approximately $40,000 for 1990.[3]

To assist the Board's review of this case, the Provider and Intermediary stipulated that:[4]

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[1] Provider's Position Papers at "Introduction." Intermediary's Position Paper dated February 26, 1999 at 1.

[2] Intermediary's Position Paper dated May 1, 1997 at 4. Intermediary's Position Paper dated February 26, 1999 at 8.

[3] Provider's Position Papers at "Issues Presented and Reimbursement Controversy." Intermediary's Position Paper dated May 1, 1997 at 1 and 2.

[4] See Provider letter submitted by Julie Mathis Nelson on June 10, 1999.

1. The Board may issue one decision relevant to both cases.

2. The Board may limit its review to the Provider's arguments set forth in its Position Paper dated June 9, 1997, which is applicable to the 1990 cost reporting period, and to the arguments set forth in the Intermediary's position paper dated February 26, 1999, which is also applicable to 1990.[5]

3. The number of FTE residents at issue for 1989 is 1, and the number of FTE residents at issue for 1990 is approximately 1.5 (18 months and 11 days), as set forth in Exhibit P-4.

4. The only issue to be resolved in these cases, as captioned above, is whether the Provider must have a "written agreement" with its related facilities in order to have the resident rotations included in its GME count; the Provider meets all other program requirements necessary to include the resident time in the count, and there are no factual matters in dispute.

The pertinent Medicare regulation, 42 C.F.R. § 413.86(f)(1)(iii), states:

> [o]n or after July 1, 1987, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' 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:
>
> (A) The resident spends his or her time in patient care activities.
>
> (B) There is a written agreement between the hospital and the outside entity that states that the resident's compensation for training time spent outside of the hospital setting is to be paid by the hospital.

42 C.F.R. § 413.86(f)(1)(iii) (emphasis added).

The Provider was represented by Julie Mathis Nelson, Esquire, of Coppersmith Gordon Schermer Owens & Nelson PLC Attorneys and Counselors. The Intermediary was represented by Bernard M. Talbert, Esquire, Associate Counsel, Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's adjustments are improper. The Provider asserts that it is entitled to be reimbursed for the direct costs of its approved GME programs pursuant to 42 U.S.C. § 1395ww(h). In this regard, the Provider explains that it remained responsible for substantially all of the

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[5] Note: all further references to Provider/Intermediary position papers will pertain to those referenced in the parties' stipulation.

direct costs, e.g., salary and fringe benefits, of the subject residents while they rotated through its related facilities. None of the related facilities incurred nor claimed any reimbursement for these GME expenses. The Provider adds that the resident rotations were an integral part of its approved GME programs, and that all time spent by the residents at the related facilities was clinical in nature and directly related to patient care.[6]

The Provider also contends that the Intermediary's refusal to reimburse the GME costs of its rotating residents is arbitrary and capricious for several reasons.[7] First, the applicable statute clearly entitles a provider to these costs. Provisions at 42 U.S.C. § 1395ww(h)(2) state that the Secretary of Health and Human Services ("Secretary") "shall determine, for each hospital with an approved medical residency training program, an approved FTE resident amount. . . ." The statute defines an "approved medical residency training program" as "a residency or other postgraduate medical training program participation in which may be counted toward certification in a specialty or subspecialty. . . ." 42 U.S.C. § 1395ww(h)(5). At 42 U.S.C. § 1395ww(h)(4)(A) the statute further requires the Secretary to "establish rules consistent with this paragraph for the computation of the number of full-time equivalent residents in an approved medical residency training program."
Id. (emphasis added).

With respect to these statutory requirements, the Provider maintains that it has an approved medical residency training program. As part of its approved program, the Provider must allow its residents to rotate through its related facilities. The time these residents spend on these rotations counts towards the residents' certification in their specialty or subspecialty. While on these rotations, the residents are still participating in the Provider's approved program. Thus, the Provider asserts that the plain language of the statute directs the Intermediary to include all residents in its approved programs in its FTE count, including those residents rotating through its related facilities.

The Provider argues that 42 U.S.C. § 1395ww(h)(4)(E) further supports its position, by stating:

> [s]uch rules shall provide 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 of the training program in that setting.

Id. (Emphasis added).

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[6] Provider's Position Paper at 4 and 7.

[7] Provider's Position Paper at 8.

Respectively, the Provider asserts that this provision confirms that it should be reimbursed for the costs associated with residents rotating outside its facility, i.e., all of the residents' time was spent under the Provider's approved GME program, and the Provider incurred all, or substantially all, of the costs of the training program in those outside settings.

The Provider argues that any other conclusion would fail to adequately reimburse its GME costs since it was solely responsible for the residents' salaries and other direct costs when they rotated through the related facilities. This failure forces patients not covered by Medicare to bear program costs in violation of 42 U.S.C. § 1395x(v) and 42 C.F.R. § 413.9(b)(1).

The Provider notes that the title of 42 U.S.C. § 1395ww(h)(4)(E), quoted above, refers to "outpatient settings." However, the Provider also argues that this fact is not dispositive. The text of the statute does not limit its application to outpatient settings. Even if the statute's title did dictate its scope, Grand Canyon Clinic certainly qualifies as an "outpatient setting." With respect to the related hospitals, the statute simply did not contemplate a large health care system, such as the Provider's, with many related hospitals through which the residents must rotate as a prerequisite to approval of its GME program.

Next, the Provider asserts that the Intermediary's refusal to reimburse the GME costs of its rotating residents is arbitrary and capricious because the pertinent regulation requires the inclusion of the residents' time in a provider's FTE count.[8] As stipulated, the Intermediary's adjustments are based solely upon 42 C.F.R. § 413.86(f)(1)(iii)(B), which states:

> [t]here is a written agreement between the hospital and the outside entity that states that the resident's compensation for training time spent outside of the hospital setting is to be paid by the hospital.

Id. (emphasis added).

The Provider argues, that while it did not have a formal "written agreement" with its related facilities stating that it would pay the residents' compensation, none was needed. The Provider maintains that the regulation simply requires a written agreement with an outside entity. Since the White Mountain, Grand Canyon, and Camelback facilities are affiliated with the Provider, they are not outside entities, and the written agreement criterion does not apply. Regardless, the Provider asserts that the crucial issue is whether or not the residents spent their time in patient care activities, and whether the Provider incurred the costs of the residents' training during these rotations, which are not at issue.

Also, the Intermediary's refusal to interpret the regulation in this manner plainly violates the regulation's intent. That is, when the Health Care Financing Administration ("HCFA") implemented the per resident payment methodology, it explained the intent of the enabling statute and implementing regulation, as follows:

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[8] Provider's Position Paper at 11.

> [e]ssentially, section 1886(h)(4)(E) of the [Social Security] Act simply ensures that the FTE amount attributable to an individual resident is not reduced below 1.0 simply because he or she is assigned to a freestanding clinic for a portion of his or her residency program.

54 Fed. Reg. 40286 at 40304 (Sept. 29, 1989).

The Provider asserts that this language clearly explains that the regulation is designed to make sure providers receive full reimbursement for residents when they spend a portion of the provider's program in another setting. Here, the Intermediary has reduced the Provider's FTE amounts for its rotating residents below 1.0 simply because they spent a portion of their residency program assigned to a freestanding clinic (Grand Canyon Clinic) and related facilities. By doing so, the Intermediary has failed to properly reimburse the Provider for the full direct costs of its approved GME program as required by the statute and implementing regulation.

The Provider also notes that the implementing regulation must be read consistently with the statute, and this fact dictates that its position be upheld. Specifically, the statute makes clear that when rotations are required by a provider's approved GME program, and the provider is responsible for substantially all of the residents' costs, the residents must be included in the provider's GME count. Accordingly, the regulation implementing the statute must also command this result. To the extent that the regulation or interpretative guideline implementing the statute conflicts with this interpretation, it is arbitrary and capricious, and therefore invalid. As explained at 42 U.S.C. § 1395ww(h)(4)(A), the Secretary must establish rules for counting FTE residents "consistent with" the statute.

Finally, the Provider asserts that the Intermediary's adjustments are arbitrary and capricious because the Provider has furnished sufficient documentation to support its claim.[9] This information was furnished to the Intermediary when the Provider submitted its cost report and again when the Intermediary audited its cost report. Also, a portion of this information, Exhibit P-4, was furnished once again to the Intermediary when the Provider submitted its draft position paper. The Provider argues that it is clear that the Intermediary has sufficient information to determine when the residents rotated through its related facilities, and sufficient information to see that the residents were in the Provider's approved GME program, and that the Provider, and only the Provider, was responsible for their direct GME costs.

The specific information furnished to the Intermediary in compliance with 42 C.F.R. § 413.86(f)(2), includes:

> (i) The name and social security number of the resident.

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[9] Provider's Position Paper at 14.

(ii) The type of residency program in which the individual participates and the number of years the resident has completed in all types of residency programs.

(iii) The dates the resident is assigned to the hospital and any hospital-based providers.

(iv) The dates the resident is assigned to other hospitals, or other freestanding providers, and any nonprovider setting during the cost reporting period, if any.

(v) The name of the medical, osteopathic, dental, or pediatric school from which the resident graduated and the date of graduation.

(vi) If the resident is an FMG, documentation concerning whether the resident has satisfied the requirements of paragraph (h) of this section.

(vii) The name of the employer paying the resident's salary.

42 C.F.R. § 413.86(f)(2).

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its adjustments are proper. The time spent by residents rotating to facilities related to the Provider was excluded from the Provider's FTE count based upon 42 C.F.R. § 413.86(f). The Provider acknowledges that it does not have a formal "written agreement" with its related facilities stating that the residents' compensation for training time spent at their facilities was to be paid by the Provider, as required by 42 C.F.R. § 413.86(f)(1)(iii)(B).[10] Accordingly, the Provider did not fulfill the requirements set forth in the regulations pertaining to rotations outside of the Provider's facility and, therefore, the Intermediary's adjustments should be upheld.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - 42 U.S.C.:

§ 1395x(v)	-	Reasonable Cost
§ 1395ww(h) et seq.	-	Payments for Direct Graduate Medical Education Costs

[10] Intermediary's Position Paper at 9.

2. Regulations - 42 C.F.R.:

§§ 405.1835-.1841	-	Board Jurisdiction
§ 413.9 et seq.	-	Cost Related to Patient Care
§ 413.86(f) et seq.	-	Determining the Total Number of FTE Residents

3. Other:

Stipulations-Provider Letter Dated June 10, 1999.

54 Fed. Reg. 40286 at 40304 (Sept. 29, 1989).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, and evidence presented, finds and concludes that the Provider is not required to have a written agreement with its related facilities in order to have the subject resident rotations included in its GME count.

The Board finds that the Intermediary reviewed the Provider's count of FTE residents used to determine program payments for the direct costs of GME. Based upon these reviews, the Intermediary excluded from the count time spent by residents working at facilities other than the Provider's, although related through common ownership or control. The reason for the Intermediary's exclusions is the fact that the Provider did not have a written agreement with the other facilities in accordance with 42 C.F.R. § 413.86(f)(1)(iii), which states:

> [o]n or after July 1, 1987, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' 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:
>
> (A) The resident spends his or her time in patient care activities.
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> (B) There is a written agreement between the hospital and the outside entity that states that the resident's compensation for training time spent outside of the hospital setting is to be paid by the hospital.

42 C.F.R. § 413.86(f)(1)(iii) (emphasis added).

Significantly, the Board finds that the written agreement provision of 42 C.F.R. § 413.86(f)(1)(iii) does not apply to the instant case. As emphasized above, the regulation applies to nonprovider settings and outside entities. The resident rotations at issue, however, do not fall within the literal or connotative definitions of either of these designations. The subject rotations involve three hospitals which are clearly Medicare providers as opposed to nonprovider settings, and one clinic which also participates in the Medicare program and is related to the Provider; it is a related organization rather than an outside entity. [11]

The Board believes that the stated intent of 42 C.F.R. § 413.86(f)(1)(iii) supports its position. In 54 Fed. Reg. 40304 (Sept.29, 1989), HCFA requested comments on how it could ensure that the time spent by residents working in "nonhospital settings" was spent in patient care activities. In response to comments received, HCFA states:

> [e]ssentially, section 1886(h)(4)(E) of the Act simply ensures that the FTE amount attributable to an individual resident is not reduced below 1.0 simply because he or she is assigned to a freestanding clinic for a portion of his or her residency program. Therefore, we are not changing our original proposal that there be a written agreement between the hospital and nonhospital entity that the resident will spend substantially all of his or her time in patient care activities, and that the resident's compensation for the time spent in the outside entity is paid by the hospital.

54 Fed. Reg. 40304 (Sept.29, 1989) (emphasis added).

Clearly, 42 C.F.R. §413.86(f)(1)(iii) was promulgated to provide assurances that program requirements are being met in settings where HCFA has no authority to make its own such determinations. For example, where a health care facility is not participating in the Medicare program an intermediary would not have access to its books and records. With respect to the instant case, however, this condition does not exist. As discussed immediately above, the facilities involved in this case are Medicare participating hospitals and a related organization whose books and records are available to the Intermediary.

Related to HCFA's need to assure that program requirements are met, the Board finds that the subject rotations should be included in the Provider's FTE count based upon the requirements of the enabling statute. Provisions at 42 U.S.C. § 1395ww(h)(4)(E) state, in part:

> [s]uch rules shall provide 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

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[11] Provider's Position Paper at 6.

> which the activities are performed, if the hospital incurs all, or substantially all, of the costs of the training program in that setting.

Id. (emphasis added).

With respect to the instant case, the Board finds that the Provider and Intermediary stipulated to various different factors. In part, the parties agree that the subject rotations meet all of the program's requirements to be included in the Provider's FTE count with the exception of the written agreement provision of 42 C.F.R. § 413.86(f)(1)(iii). This means there is no dispute that the subject residents' time was spent in patient care activities under the Provider's approved program, and that the Provider paid for all or substantially all of the residents' costs. Under these circumstances, the Board concludes that failure to include the residents' time in the Provider's FTE count reduces each individual resident's time below 1.0 in direct opposition to the intent of the statute, and shifts Medicare costs to individuals not covered by the program in opposition to 42 U.S.C. § 1395x(v) and 42 C.F.R. § 413.9(b)(1).

DECISION AND ORDER:

The Provider is not required to have a written agreement with its related facilities in order to have the subject resident rotations included in its GME count. The Intermediary's exclusions of the residents' time are reversed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esq.
Martin W. Hoover, Jr., Esq.
Charles R. Barker

Date of Decision: October 19, 1999

FOR THE BOARD:

Irvin W. Kues
Chairman