PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2010-D45

PROVIDER –
University Medical Center
Tucson, Arizona

Provider No.: 03-0064

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Noridian Administrative Services
(formerly Blue Cross Blue Shield of
Arizona)

DATE OF HEARING -
January 21, 2009

Cost Reporting Periods Ended -
June 30, 2000; June 30, 2001
and June 30, 2002

CASE NOs.: 04-0380; 05-1209
and 06-0688

INDEX

ISSUES:

1. Whether the Intermediary properly excluded resident rotations for research and other scholarly activities when calculating the resident full time equivalent (FTE) count for indirect medical education (IME) adjustment purposes.

2. Whether the Intermediary's calculation of the new program add-on to the Provider FTE cap was improper by virtue of the fact that it omitted time spent by residents in research and scholarly activities.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper amount of Medicare reimbursement due to 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 to organizations known as fiscal intermediaries or Medicare Administrative Contractors (MAC). Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395(h), 42 C.F.R. §§413.20 and 413.24.

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 receipt of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835 (2008).

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the Prospective Payment System (PPS). The PPS statute contains a number of provisions that adjust reimbursement based upon hospital-specific factors. This case involves two of those provisions.

The provision at 42 U.S.C. §1395ww(h) prescribes the Medicare payment methodology for direct graduate medical education (DGME) costs. In brief, the direct GME payment is the product of a hospital's average per resident amount and the hospital's number of interns and residents in approved GME programs during the payment year apportioned to Medicare based upon a hospital's Medicare patient load. The Medicare patient load is a

fraction representing the percentage of a hospital's Medicare patient days (numerator) to total patient days (denominator).

In 1983, Congress recognized that teaching hospitals incur indirect operating costs that would not be reimbursed under the prospective payment system or by the direct graduate medical education (DGME) payment methodologies and authorized an additional payment known as the indirect medical education (IME) payment, to hospitals with GME programs. 42 U.S.C. §1395ww(d)(5)(B). Specifically, the IME payment compensates teaching hospitals for higher-than-average operating costs that are associated with the presence and intensity of residents training in an institution but which cannot be specifically attributed to, and do not include, the costs of residents' instruction. The IME adjustment compensates for those costs based on "the ratio of the hospital's full-time equivalent interns and residents to beds." Id. Thus, the IME payment amount is based, in part, upon the number of intern and resident FTEs participating in a provider's GME Program.

For fiscal years 2000 and thereafter, the regulations governing IME reimbursement were codified at 42 C.F.R. §412.105(f) (2000).[1] The regulations state in pertinent part:

> For cost reporting periods beginning on or after July 1, 1991, the count of fulltime equivalent residents for the purposes of determining the indirect medical education adjustment is determined as follows:
>
> (i) The resident must be enrolled in an approved teaching program…
> (ii) In order to be counted, the resident must be assigned to one of the following areas:
>
> (A) The portion of the hospital subject to the prospective payment system.
> (B) The outpatient department of the hospital.
> (C) Effective for discharges beginning or after October 1, 1997, the time spent by 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) are met.

In 2001, CMS adopted a rule change to the IME regulation that expressly excluded time that was spent by residents in research unrelated to the care of specific patients from the count of residents for IME. 42 C.F.R. §412.105(f)(1)(iii)(B). Effective with discharges on or after October 1, 2001, the revised language states:

> The time spent by a resident in research that is not associated with the treatment or diagnosis of a particular patient is not countable.

[1] This regulation was re-designated from 42 C.F.R §412.105(g) to §412.105(f). See 62 Fed.Reg. 45966, 46029 (Aug. 29, 1997).

The new rule did not address didactic activities and did not expressly exclude such activities from the count of FTE residents.

The issue in this case involves the interpretation of the regulation for the proper determination of FTEs in the IME calculation.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

University Medical Center (Provider or Hospital) is a voluntary nonprofit teaching hospital located in Tucson, Arizona that operates approximately 40 graduate medical education programs in affiliation with the University of Arizona Health Sciences Center.[2] Although some of the 40 specialty and subspecialty programs are not approved by the Accreditation Council for Graduate Medical Education (ACGME), there is no dispute that for purposes of this appeal, all of the residency programs at issue are ACGME approved programs.[3]

The ACGME is an accreditation organization that has been specifically recognized by CMS as an acceptable authority for determining whether a graduate medical education program is an "approved" program for purposes of the Medicare program and the applicable payments for DGME costs and IME costs.[4] The ACGME has established certain "common program requirements" in order for a graduate medical training program to be "approved." The ACGME requires that, in order for a given residency program to be "approved," the program must ensure that residents and faculty participate in "research and scholarly activity."[5]

Residents enrolled in the ACGME approved programs at the Hospital participated in certain research and other scholarly activities (e.g., journal/reading club) in connection with fulfilling their requirements for specialty or subspecialty certification. This research and scholarly activity time was recorded on "rotation schedules" maintained by the University of Arizona GME Office.[6] For purposes of claiming IME payments on its Medicare cost reports for FYs 2000, 2001, and 2002, the Provider counted the time spent by residents enrolled in ACGME-approved teaching programs who were assigned to the PPS portions of the Hospital.[7] Time relating to residents assigned to the Hospital who engaged in required research and other scholarly activities as part of approved residency programs was included in this count.[8]

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[2] *See* Provider Exhibit P-43 at ¶¶ 1, 3; January 21, 2008; Transcript ("Tr.") at 51.
[3] Provider Exhibit P-43 at ¶ 4; Tr. at 54-55, 206.
[4] 42 C.F.R. §415.152; Provider Exhibit P-43 at ¶4.
[5] January 21, 2008 Stipulation Agreement at ¶ 5 (Provider Appendix P-43); Provider Exhibit P-34 at pages 6-8; *see also* Provider Appendix B.
[6] Provider Exhibits P-5, P-34 through P-41; Tr. at 56-57.
[7] Provider Exhibit P-43 at ¶ 7.
[8] *Id.*

Blue Cross Blue Shield of Arizona (Intermediary)[9] adjusted the Provider's cost reports to remove time relating to residents engaged in research and other scholarly activities from the Provider's IME FTE count.[10] Specifically, the amount of time relating to research and other scholarly activities claimed by the Provider for the cost reporting period ending June 30, 2000 amounted to 6.02 FTE residents for IME purposes.[11] With respect to FY 2001, this number was 8.11 FTE residents, and for FY 2002, this number was 3.59 FTE residents.[12] The Intermediary made the adjustment on the theory that such time is unrelated to direct patient care and is properly disallowed under the rules adopted by CMS in 2001. At issue is whether the intermediary may properly disallow such time using the 2001 rules.

The Provider appealed the issue to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835- 405.1841. The Provider was represented by Gregory N. Etzel, Esquire and Krista Barnes, Esquire, of Baker & Hostetler, LLP. The Intermediary was represented by James R. Grimes, Esquire, Senior Medicare Counsel of the Blue Cross Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider notes that the Board has addressed this issue for this Provider in earlier years. The Provider appealed the Intermediary's exclusion of research time from the Provider's FTE resident count for IME purposes for FYs 1998 and 1999 and the Board held that residents' research time must be included in the IME FTE count.[13] The facts relating to the Provider's residency programs, its residents' training assignments, and the basis for the Intermediary's adjustments in FY 2000, FY 2001 and FY 2002 are identical to those in the Provider's FY 1998-1999 appeals.[14] The parties agree that the testimony presented during the hearing for the Provider's FY 1998 and 1999 appeals (PRRB Case Nos. 02-0216 and 02-0217) relating to the operation of the Provider's residency programs accurately reflects the operation of the Provider's residency programs during its FYs 2000, 2001, and 2002.[15] The relevant portions of the regulation at issue during the

[9] The Intermediary was Noridian Administration Services when this case was heard by the Board.
[10] *See, e.g.*, Provider Exhibit P-2; Tr. at 207.
[11] Provider Exhibit P-43 at ¶ 8.
[12] *Id.*
[13] *See University Medical Center (Tucson, AZ) v. Blue Cross Blue Shield Association/Blue Cross & Blue Shield of Arizona*, PRRB Dec. 2005-D36 (April 12, 2005) (hereinafter "PRRB Dec. 2005-D36") (Provider Exhibit P-26).
[14] *Id.*; Provider Exhibit P-43 at ¶ 10; Tr. at 83-85.
[15] Provider Exhibit P-43 at ¶ 10. The hearing transcript relating to that case is at Provider Exhibit P-32.

Provider's FYs 2000, 2001, and 2002 (prior to October 1, 2001) are also identical to those in place during the 1998 and 1999 appeals.[16]

In 2005, following the Board hearing on the Provider's FY 1998 and 1999 appeals, the parties recognized that the Resident Research Time issue was a recurring dispute for later fiscal years as well, and entered into a Partial Administrative Resolution relating to the Provider's FY 2000 appeal, which was then pending before the Board.[17] The parties agreed to the following:

> Issue 1: Whether the Intermediary properly excluded resident rotations for research and other scholarly activities when calculating the resident Full Time Equivalent Amount ("FTE") for Indirect Medical Education ("IME") adjustment determinations.
> …
> This issue has already been heard by the Provider Reimbursement Review Board for Case Nos. 02-0216 and 02-0217 for cost reporting periods ending 6/30/98 and 6/30/99. The Provider Reimbursement Review Board ruled on April 12, 2005 (PRRB Hearing Dec. No. 2005-D36) in the Provider's favor to include the Research rotations and time spent in other scholarly activities in the IME count. However, the Administrator has agreed to review this case. Both the Provider and the Intermediary anticipate that the Administrator will overturn the PRRB decision, and the Provider is discussing the option to appeal the issue in Federal Court. ***The Provider and the Intermediary agree that the disposition of this issue will be addressed consistently with the ultimate outcome (including the outcome of litigation in federal courts) of the same issue outlined in the FY 1998 and 1999 appeals.***[18] (emphasis added)

The Partial Administrative Resolution was executed in May, 2005 by representatives of the Provider and the Intermediary.[19] The FY 2001 and 2002 appeals were not included in the Administrative Resolution because they were at an earlier stage in the appeals process than the 2000 appeal.[20]

The CMS Administrator reversed the Board's decision in the Provider's FYs 1998 and 1999 appeals on June 7, 2005.[21] The Provider appealed this final agency decision to the federal district court for the District of Arizona, which reversed the CMS Administrator

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[16] *See* Provider Exhibit P-43 at ¶ 12; *see also* Provider Appendix C (42 C.F.R. §412.105(f) (1997, 1998, 1999)); *see also* Provider Appendix A (42 C.F.R. §412.105(f) (2000)).
[17] *See* Provider Exhibit P-24; Tr. at 85.
[18] Provider Exhibit P-24 (emphasis added).
[19] *Id.*
[20] Tr. at 88.
[21] *See University Medical Center vs. Blue Cross/Blue Shield Association and Blue Cross & Blue Shield of Arizona,* CMS Admin. Dec. (June 7, 2005) (Provider Exhibit P-27).

decision and held in favor of the Provider.[22] The Arizona District Court decision was the "ultimate outcome" of the FYs1998 and 1999 appeals.[23] The Intermediary issued payment to the Provider for FYs 1998 and 1999 in accordance with the Court's final decision.[24]

The Provider sought to enforce the terms of the Partial Administrative Resolution and receive the resultant increase in its IME FTE count for its FY 2000.[25] However, the Intermediary was unable to honor the Partial Administrative Resolution based on a CMS directive that the Intermediary was to continue excluding resident research time from the Provider's IME FTE count, in spite of the District Court's decision in the case.[26]

The Provider contends that it sought affirmation from CMS that the agency had indeed instructed the Intermediary to ignore its Administrative Resolution and the Arizona District Court precedent.[27] In its letter, the Provider noted that it had three pending appeals involving the resident research time issue (FYs 2000, 2001, and 2002), and that the *UMC v. Leavitt* District Court decision compelled the Intermediary to include resident research time in the Provider's IME FTE count for its FYs 2000, 2001, and the portion of FY 2002 occurring prior to CMS's change to the IME FTE regulation at 42 C.F.R. §412.105(f)(1) (which was effective October 1, 2001).[28] The Provider argues that it urged CMS to reconsider its position, noting that repetitious administrative litigation would not only be wasteful of time and money, but also prohibited by principles of collateral estoppel.[29] CMS did not change its position,[30] the Intermediary's representatives confirmed at the hearing that CMS had issued instructions not to honor the Administrative Resolution in this case.[31] The Provider contends that it was forced to continue with its appeal, although it has honored the terms of the Administrative Resolution with respect to the portion of the agreement addressing the resident vacation

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[22] *University Medical Center Corp. v. Leavitt*, 2007 WL 891195 (D. Ariz. 2007) ("*UMC v. Leavitt*") (holding that "[a]s the IME regulation is unambiguous, the Agency's interpretation in this instance is owed no deference…The resident research time should be included in Plaintiff's 1998 and 1999 IME FTE calculations.") (Provider Appendix D); *see also* Provider Exhibit P-43 at ¶ 11.

[23] Tr. at 165-66.

[24] Provider Exhibit P-43 at ¶ 11.

[25] Tr. at 88.

[26] Provider Exhibit P-43 at ¶ 13; Tr. at 89.

[27] *See* Provider Exhibit P-28 (November 13, 2007 letter to Miechal Lefkowitz); Tr. at 89.

[28] Provider Exhibit P-28.

[29] *Id.*

[30] *See* Provider Exhibit P-29; Tr. at 90.

[31] Tr. at 36. It is important to note that the CMS instructions to disregard the Board's decision and District Court of Arizona decisions with respect to the resident research time issue came ***before*** the First Circuit's decision in *Rhode Island Hospital v. Leavitt*, 548 F.3d 29 (1st Cir. 2008), which supported CMS interpretation of the applicable regulation, albeit in a Circuit with no relationship to the Provider.

time issue.[32]

As with the FY 1998 and 1999 appeals, the Provider contends that the Intermediary has miscounted its residents for IME purposes for FYs 2000, 2001, and 2002, and that resident research and scholarly activity time must be included when calculating the Provider's FTE resident count for purposes of the IME adjustment. This conclusion is mandated by the plain language of the IME statute, the plain language of the IME regulation (42 C.F.R. §412.105(f)(1)), relevant manual provisions, Congressional intent relating to the purpose of the IME adjustment, and prior PRRB and Federal district court decisions on this issue (and in fact, with respect to this *very same provider* for earlier fiscal years). The Provider contends that the Intermediary's refusal to include resident research time (albeit based on CMS's instruction) is arbitrary, capricious, an abuse of discretion, and contrary to law. Additionally, the Provider believes that the Intermediary's actions violate the Administrative Procedure Act ("APA") in two respects: (1) the Intermediary's application of a substantive rule to the Provider without notice and comment rulemaking violates the notice and comment rulemaking provisions of section 553 of the APA; and (2) to the extent the Intermediary is applying the October 1, 2001 rule change to the Provider's FYs 2000, 2001, and portion of FY 2002 occurring prior to that date, such retroactive application violates section 551 of the APA.[33]

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that time spent by residents performing research and scholarly activities that is not directly related to the care of patients is excluded from the resident count. In the instant case, only resident rotations specifically titled "research" were excluded from the Provider's IME FTE count, and the Provider submitted no documentation to show that the time was, in fact, patient-care related. The Intermediary cites section 2405.3.F.2 of the Provider Reimbursement Manual, which states that a resident must *not* be included in the IME FTE count if "[t]he individual is engaged exclusively in research," and the preamble language found in the August 1, 2001 Federal Register,[34] where CMS explains that "exclusively" means that the research is not associated with the treatment or diagnosis of a particular patient of the hospital. The Intermediary also cites 42 C.F.R. §412.105(f)(1)(iii)(B), amended through the August 1, 2001, Federal Register, which CMS notes as a clarification of long-standing policy. The

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[32] Tr. at 146-47. Like the resident research time issue, the parties agreed that "the disposition of [the resident vacation time] issue will be addressed consistently with the ultimate outcome (including the outcome of litigation in federal courts) of the same issue outlined in the FY 1998 and 1999 appeals." Provider Exhibit P-24. The final disposition of that issue was not in the Provider's favor. Consistent with that decision and the Administrative Resolution, Provider dropped the resident vacation time issue from its FY 2000, 2001, and 2002 appeals. Despite the Intermediary's and CMS's actions being contrary to the Administrative Resolution, the Provider does not seek to raise the resident vacation time issue anew in order to avoid duplicative litigation.

[33] *See* Provider Appendix E.

[34] *See* 66 Fed. Reg. 39896-99, August 1, 2001. Intermediary's Final Position Paper at 8-9.

section states "[t]he time spent by a resident in research that is not associated with the treatment or diagnosis of a particular patient is not countable."

In further support of its position, the Intermediary cites the decision in *Rhode Island Hospital vs. Leavitt*. 548 F.3d 29 (1st Cir. 2008).[35] The court reviewed the Secretary's interpretation of the regulatory requirement that to be included in the IME FTE count the resident must be assigned to the portion of the hospital subject to the PPS. The Secretary argued the regulatory section should be given a functional meaning; that to be assigned to a portion of the hospital subject to PPS means the resident must be integrated into a hospital unit dedicated to a form of patient care subject to PPS. The court found the Secretary's reading of the regulation to be permissible and did not violate the statutory provisions.

In light of the Secretary's interpretation and the courts affirmation, the Intermediary alleges that the Provider has not provided adequate documentation to show where the residents were physically located in the hospital when performing research.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of Medicare law and guidelines, the parties' contentions and stipulations, and the evidence contained in the record, finds and concludes that the Intermediary's calculation of the Provider's IME reimbursement was improper.

The principles of statutory construction compel the Board's conclusion that CMS and Congress did not intend to impose a patient care requirement for the counting of interns and residents engaged in research activities at a hospital. The statute clearly states that the IME adjustment must be calculated in the same manner as it was in the Secretary's regulations in effect on January 1, 1983.[36] The regulations in effect as of January 1, 1983 contain no mention of excluding *any* resident time for residents in approved programs, regardless of the activity in which they are involved.[37] The regulatory IME adjustment in

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[35] *See* Intermediary's Exhibit I-21.

[36] *See* Social Security Amendments of 1983 § 601(e), ("[T]he Secretary ***shall*** provide for an additional payment amount for . . . hospitals with indirect costs of medical education, in an amount computed ***in the same manner*** as the adjustment for such costs under regulations (in effect as of January 1, 1983) . . .") (emphasis added). (Provider Appendix I).

[37] 47 Fed. Reg. at 43,310. In 1986, Congress expressly rejected an attempt by the Secretary to exclude time spent by residents and interns furnishing services to outpatients of the hospital from the IME resident count because, according to the Secretary, "the outpatient services are not subject to the prospective payment system." *See* 50 Fed. Reg. 35,646, 35,678 (Sep. 3, 1985). In the Comprehensive Omnibus Budget Reconciliation Act of 1986, Congress amended the IME statute to adopt the specific payment formula that is utilized today, and in the legislative history reminded the Secretary that ***"[t]here is no discretion on the part of the Secretary***." H. R. Rep. No. 99-241(I), at 15 (1986), *reprinted in* 1986 U.S.C.C.A.N. 579, 593. Congress

place in 1983 contains *no limitation* on training activities involving research or other scholarly activities that were part of an approved teaching program. Rather, the 1983 adjustment considers only three key factors for counting purposes:

> (1) whether the resident is in an approved teaching program;[38]
> (2) whether the resident is employed by the hospital; and
> (3) whether or not the resident furnishes services (not "patient care services") at the hospital or at another site.

Moreover, in 1997, Congress added the following provision to the IME statute, expanding the resident count:

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> (iv) Effective for discharges occurring on or after October 1, 1997, all the time spent by an intern or resident in patient care activities under an approved medical residency training program at an entity in ***a non-hospital setting*** shall be counted towards the determination of full-time equivalency . . .[39]

Congress specified that patient care is required in order to count residents in *non-hospital settings*, yet did not include a patient care specification with respect to residents assigned to the *hospital*. The Board finds that an important distinction. Common tenets of statutory construction require that each word and clause in a statute or regulation should be given effect and none should be presumed to be superfluous.[40] The Board concludes, therefore, that Congress did not intend to apply a patient care requirement with respect to the count of residents training in a hospital setting, for if they had, it would have been

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required "that the Secretary ***continue to count***, for purposes of establishing the IRB (interns & residents to beds) ratio, those interns and residents who serve in the outpatient department of hospitals." *Id.* Congress noted that the Secretary's attempt to exclude such time was "***technically incorrect because the regression analysis used to compute the adjustment factor was based on counts that included the interns and residents in hospital based outpatient settings***." *Id.* (emphasis added). In other words, the Secretary had failed to follow the mandate of the plain language of the statute which required that the resident count be conducted in "the same manner" as it was done in 1982, and there were no conditions on the counting of a resident except that he or she be enrolled in an approved graduate medical education program and assigned to the hospital.

[38] As discussed above, ACGME requires a research component for all resident training programs. It must be assumed, therefore, that CMS was aware of this and could have limited the pre-PPS IME adjustment to exclude research time, but did not do so.

[39] 42 U.S.C. 1395ww(d)(5)(B)(iv) (emphasis added). (Provider Appendix F).

[40] *United States v. Menasche*, 348 U.S. 528, 538-39 (1955); *Harper v. United States Seafoods L.P.*, 278 F.3d 971, 975 (9th Cir. 2002).

superfluous to explicitly insert language with respect to the new provision governing the count of residents training in a non-hospital setting.[41]

The Board also finds that the IME regulation, 42 C.F.R. §412.105(f), does not exclude time spent by residents in research and scholarly activity from being counted. It states, in relevant part:

> (1) For cost reporting periods beginning on or after July 1, 1991, the count of full-time equivalent residents for the purpose of determining the indirect medical education adjustment is determined as follows:
>
> (i) The resident must be enrolled in an approved teaching program. . . .
>
> (ii) In order to be counted, the resident must be assigned to one of the following areas:
>
> (A) The portion of the hospital subject to the prospective payment system.
>
> (B) The outpatient department of the hospital.
>
> (C) Effective for discharges occurring on or after October 1, 1997, the time spent by a resident in a non-hospital setting in patient care activities.[42]

In addition, the regulation requires that "full time equivalent status is based on the total time necessary to fill a residency slot."[43] It is undisputed that ACGME accreditation requires that residents participate in research and scholarly activity.[44] The *Riverside Methodist* court addressed these circumstances stating that:

> [U]nder ACGME standards medical residents are *required* to spend a portion of their time attending seminars and engaging in the type of educational activities involved in this case . . . Thus, by requiring residents to be enrolled in an approved educational program . . . the regulation

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[41] *See Andreiu v. Ashcroft*, 253 F.3d 477, 479 (9th Cir. 2001) (where Congress includes particular language in one section of a statute but omits it from another section, it is generally presumed that Congress acts intentionally and purposefully in the disparate inclusion or exclusion).

[42] 42 C.F.R. § 412.105(f)(1)(i)-(ii). The Provider contends that no residents in non-hospital settings are at issue in this case because all of the residents in question are "assigned to UMC."

[43] 42 C.F.R. § 412.105(f)(1)(iii).

[44] Provider Exhibit P-43 at ¶ 5 (The Stipulation states that, "[t]he ACGME requires that, in order for a given residency program to be 'approved,' the program must ensure that residents and faculty participate in 'research and scholarly activity.'").

> implicitly recognizes that "full-time" residents will spend some of their time engaged in solely educational activities that are not directly related to providing hands-on patient care; yet nothing in the regulation indicates that time so spent should be deducted from the FTE resident count. Although the phrase "total time necessary to fill a residency slot" is not specifically defined in the regulation, it can only reasonably be read to include time spent by residents participating in *required* educational activities (which of course *include*, but certainly are not limited to, activities involving participation in the direct care and treatment of patients), because such activities would be "necessary to fill a residency slot.[45]

It is undisputed that the residents at issue in this case were enrolled in an approved GME programs. The Board finds that the plain language of the regulation requires that resident be "assigned to" the PPS portion or outpatient department of the hospital in order to be counted. The resident rotation schedules show that all the residents in question were assigned to the Provider. The Board acknowledges that the First Circuit has reviewed this issue and reached a contrary conclusion. However, the Board is persuaded by, and compelled to adhere to the decision of the Arizona District Court on this precise issue with respect to this Provider, as well as the Ninth Circuit's ruling in *Alhambra*[46] which held that a regulation discussing the areas of a hospital should be viewed in geographic terms.

The Board also finds that, other than the statutorily required limitation relating to non-hospital settings, there is no regulatory requirement that the residents' activities be specifically delineated as connected to the care of a particular patient. There is an implicit recognition that all the activities of a resident in sub-specialty training are related, in one way or another, to the ultimate care of a patient. As the court held in *University of Cincinnati v. Bowen*, to the extent that residents' research activities are a necessary and proper component of a residency training program, "they *ipso facto* contribute to the quality of care received by the Hospital's Medicare patients" and the costs associated with those activities would be considered an allowable patient care related cost.[47]

The cost report years at issue in this case were filed based on the rules and regulations in place prior to the 2001 amendment. The Intermediary argues that the IME regulation effective October 1, 2001 to add a new provision stating that "the time spent by a resident in research that is not associated with the treatment or diagnosis of a particular patient is not countable"[48] was to "clarify" that "the time that residents devote specifically to performing research that is not related to delivering patient care, whether it occurs in the

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[45] *Riverside Methodist Hospital v. Thompson*, 2003 WL 22658129 at 5, FN6 (S.D. Ohio 2003) (Provider Appendix J).
[46] *Alhambra Hospital v. Thompson*, 259 F.3d 1071, 1074 (9th Cir. 2001)
[47] *See University of Cincinnati v. Bowen*, 875 F.2d 1207, 1211 (6th Cir. 1989)
[48] 42 C.F.R. § 412.105(f)(1)(iii)(B) (effective October 1, 2001).

hospital complex or in non-hospital settings, may not be counted for IME purposes."[49] This rationale was rejected in *Riverside Methodist Hospital v. Thompson supra*:

> While it is true that the purpose of the IME adjustment is to reimburse teaching hospitals for the largely unmeasurable increased operating costs of a teaching hospital, there is nothing in the statute, or in the statutory formula for estimating those costs, to indicate that Congress considered only the costs attributable to residents providing direct care and treatment of the hospital's patients (only one of the activities involved in a required residency program) as causing the indirect increase in the hospital's operating costs.[50]

Likewise, the magistrate's opinion in *UMC v. Leavit, supra,* which examined the very same provider, facts, and regulation at issue in the present appeal, stated:

> The Magistrate Judge agrees with the reasoning and decision of the District Court in *Riverside Methodist.* The regulation is not ambiguous, and, when considered in context with the historical intent of both the regulation and its governing statute, it is evident that all time spent by residents in research and other scholarly activities while they are 'assigned to' the Hospital must be included when determining the Hospital's resident count for purposes of calculating the IME payment.[51]

Moreover, with respect to the Provider's FY 1998 and 1999 appeals, this Board found that the 2001 amendment to the IME rule excluding non-patient care research time from the resident count represented a change in policy that cannot be applied retroactively to the subject cost reporting periods and clearly ruled that "the regulation in effect during the subject cost reporting periods does not exclude research time from the IME resident count nor does it require resident time to be related to patient care."[52]

The Board concludes that the Intermediary's application of the October 1, 2001 provision that eliminates research time from the calculation is improper for the fiscal years under consideration.

DECISION AND ORDER

Issue No. 1—Resident Research Time Issue

The Intermediary's adjustments excluding research time from the FTE resident count used to calculate the Provider's adjustment for IME were improper. The Intermediary's adjustments are reversed for FYs 2000, 2001, and the portion of 2002 occurring prior to October 1, 2001.

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[49] 66 Fed. Reg. 39,827, 39,896 (Aug. 1, 2001).
[50] 2003 (S.D. Ohio) (July 31, 2003) ("*Riverside Methodist*") (Provider Appendix J).
[51] 2007 WL 891195 at *7, FN9. (Provider Appendix D)
[52] PRRB Dec. No. 2005-D36. (April 12, 2005)

Issue No. 2—FTE Cap Add-On Issue

The FTE cap must be adjusted to include the research time disallowed by the Intermediary. The Board remands the new program add-on to the IME FTE cap issue to the Intermediary to incorporate the Board's findings and include previously excluded resident research time. The Intermediary must revise all of the Provider's cost reports beginning with FY 2000, utilizing the correct IME cap add-on.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Yvette Hayes
Keith E. Braganza, CPA
John Gary Bowers, CPA

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: September 16, 2010