PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2016-D11

PROVIDER –
University of Louisville Hospital
Louisville, Kentucky

Provider No.: 18-0141

vs.

MEDICARE CONTRACTOR –
CGS Administrators, LLC

HEARING DATE –
October 15, 2014

Cost Reporting Periods Ended –
December 31, 2000, December 31, 2001
December 31, 2002, December 31, 2003,
December 31, 2004, December 31, 2005,
December 31, 2006

CASE NOS. –
06-0213, 05-2117, 06-0167, 07-0976,
08-0181, 08-1846, 08-2830

INDEX

ISSUES:

ISSUE 1: DIDACTIC TIME - Whether the Medicare Contractor's exclusion of didactic time from the FTE counts for indirect medical education ("IME") and direct graduate medical education ("DGME") for fiscal years ("FYs") 2000 to 2006 was appropriate.[1]

ISSUE 2: DENTAL FOREIGN MEDICAL GRADUATE RESIDENTS - Whether the Medicare Contractor's exclusion of foreign dental medical graduate residents for FYs 2000 to 2003 was appropriate.[2]

ISSUE 3: RESIDENT TO BED RATIO - Whether the Medicare Contractor properly calculated the prior year interns and resident to bed ratio used to determine IME payment on the cost reports for FYs 2000 to 2003 and 2005 to 2006.[3]

DECISION

After considering the Medicare law and regulations, the parties' contentions, and the evidence submitted, the Provider Reimbursement Review Board ("Board") finds and directs as follows:

ISSUE 1: DIDACTIC TIME - The Medicare Contractor *improperly* excluded didactic time from the Hospital's FTE counts for IME and DGME prior to October 1, 2006 as it relates to the cost reports for FYs 2000 to 2006. The Medicare Contractor *properly* excluded didactic time from the Hospital's FTE counts for IME and DGME beginning October 1, 2006 as it relates to the cost report for FY 2006. Accordingly, the Board directs the Medicare Contractor to update the current year IME and DGME counts and the current year resident to bed ratios in the cost reports for FYs 2000 to 2006 *as it relates to didactic time prior to October 1, 2006*.

ISSUE 2: DENTAL FOREIGN MEDICAL GRADUATE RESIDENTS - The Medicare Contractor *properly* excluded dental foreign medical graduate residents from the Hospital's DGME FTE counts for FYs 2000 to 2003.

ISSUE 3: RESIDENT TO BED RATIO - To the extent that the *current year* IME FTE counts are (or have been) adjusted for FYs 1999 to 2002 and 2004 to 2005 as a result of this appeal or another appeal (pending or closed), the Board directs the Medicare Contractor to update the relevant *prior year* resident to bed ratios in the cost reports for FYs 2000 to 2003 and 2005 to 2006 to reflect those adjustments.

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[1] This issue is included in Case Nos. 06-0213, 05-2117, 06-0167, 07-0976, 08-0181, 08-1846, and 08-2830. *See* Modifications to Stipulations of the Parties at ¶ 4.a.

[2] This issue is included in Case Nos. 06-0213, 05-2117, and 06-0167. *See* Modifications to Stipulations of the Parties at¶ 4.b. Note Case No. 07-0976 includes the impact of prior year FTEs (currently under appeal) on this appeal.

[3] This issue is included in Case Nos. 06-0213, 05-2117, 06-0167, 07-0976, 08-1846, and 08-2830. *See* Modifications to Stipulations of the Parties at ¶¶ 1, 4.c. Note that the Hospital dropped this issue for Case No. 08-0181 which pertains to FY 2004.

Accordingly, the Board remands the cost reports for FYs 2000 to 2006 to the Medicare Contractor to: (1) recalculate the FTEs for both IME and DGME based on the above findings and directives for Issues 1 and 3; and (2) make any resulting revisions to the Hospital's IME and DGME payments.

INTRODUCTION

This decision consolidates issues pertaining to seven individual appeals for FYs 2000 to 2006 involving the University Medical Center Inc., doing business as the University of Louisville Hospital ("Hospital" or "Provider"). The Hospital is related to the University of Louisville ("University") and includes both the University of Louisville Medical School ("Medical School") and the University of Louisville School of Dentistry ("Dental School"). The Hospital's assigned Medicare contractor is National Government Services ("Medicare Contractor").[4]

During the fiscal years at issue, the Medicare Contractor excluded certain dental residents from the calculation of the Hospital's IME and DGME payments. The Medicare Contractor also excluded medical residents' time spent in "didactic" activities, including conferences and seminars, from the number of the fulltime hours ("FTEs") used to calculate reimbursement to the Hospital. The Hospital timely appealed the Medicare Contractor's adjustments and satisfied the jurisdictional requirements for a hearing before the Board.

The Board conducted a hearing on the record. The Hospital was represented by Stephanie A. Webster, Esq. of Akin, Gump, Strauss, Hauer & Feld, LLP. The Medicare Contractor was represented by Brendan G. Stuhan, Esq. of the Blue Cross and Blue Shield Association.

STATEMENT OF FACTS

In 1996, the Hospital and the University signed an affiliation agreement under which the Hospital would serve as the principal teaching hospital for the University's Medical and Dental Schools. Pursuant to this affiliation agreement, the Hospital trains oral surgery and dental general practice residents in the Dental School's approved graduate medical education programs.

The Medicare program pays the Hospital for inpatient services provided to Medicare beneficiaries through the Inpatient Prospective Payment System ("IPPS"). A number of provisions in the Medicare statute, including two involving graduate medical education payments, increase the Hospital's IPPS payment based upon hospital specific factors.[5]

One of these provisions establishes the Medicare payment methodology for DGME costs.[6] In brief, the DGME payment is the product of a hospital's average per resident amount and the hospital's number of interns and residents in approved graduate medical education programs

[4] Mr. Stuhan represented CGS Administrators, LLC ("CGS") as CGS succeeded National Government Services as the designated Medicare Contractor for the Hospital.
[5] *See* 42 U.S.C. § 1395ww(d).
[6] *See* 42 U.S.C. § 1395ww(h).

during the payment year apportioned to Medicare on a *pro rata* basis according to the proportion of the hospital's Medicare inpatient days compared to its total inpatient days.

In 1983, Congress authorized an additional payment known as the "IME" payment to compensate teaching hospitals for additional indirect operating costs that would not be reimbursed by either the IPPS payment or the DGME payment.[7] The Medicare Contractor calculates the IME payment using "the ratio of the hospital's full-time equivalent interns and residents to beds" as a proxy for teaching intensity.[8] Thus, the IME payment amount is based, in part, upon the number of intern and residents participating in a provider's graduate medical education program and the number of hours (measured in "full-time equivalents" or "FTEs").

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

ISSUE 1: DIDACTIC TIME

A. Arguments Regarding Didactic Time

The Hospital seeks to include didactic time for purposes of determining the number of DGME and IME FTEs. The Medicare Contractor contends that the Hospital may only include this time if it constitutes time spent in "patient care activities."

The Hospital believes didactic time should be included in the IME and DGME FTE counts and supports its position by pointing to a letter signed by a senior CMS executive that confirms the inclusion of didactic time in these FTE counts.[9] The Medicare Contractor counters this argument by asserting this CMS letter should not be given authoritative deference because, in the preamble to the final rule published on August 18, 2006 ("2006 Final Rule"), CMS confirms that this letter conflicts with its policy and is not accurate.[10]

The Medicare Contractor further contends that, for the years at issue here, 42 C.F.R. § 413.86(f)(4) (as designated in 2004 as § 413.78(d)-(e))[11] explicitly limits IME and DGME nonhospital resident time, to time spent in "patient care activities."[12] In particular, the Medicare Contactor contends that the plain meaning of "patient care activities" does not encompass didactic time spent in nonhospital settings and that CMS confirmed this in the 2006 Final Rule by promulgating a definition for "patient care activities" that does not encompass didactic time.[13] Accordingly, the Medicare Contractor concludes that its adjustments to exclude didactic time were proper.[14]

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[7] *See* 42 U.S.C. § 1395 ww(d)(5)(B).
[8] *Id*.
[9] *See* Provider Exhibit P-25.
[10] *See* 71 Fed. Reg. 47870, 48081-48082 (Aug. 18, 2006).
[11] *See* 69 Fed. Reg. 48916, 49112, 49235 (Aug. 11, 2004).
[12] *See* Medicare Contractor's Consolidated Supplemental Final Position Paper at 5; 71 Fed. Reg. at 48080 (adopting the § 413.75(b) definition for "patient care activities").
[13] *See* 71 Fed. Reg. at 48080-48082, 48142.
[14] *See* Medicare Contractor's Consolidated Supplemental Final Position Paper at 7.

B. Board Findings with Respect to Didactic Time

With respect to the DGME FTE count, the Board relies on 42 C.F.R. § 413.86(f)(4) (2003) which states in pertinent part:

> For portions of cost reporting periods occurring on or after January 1, 1999, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs may be included in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met:
>
> (i) The resident spends his or her time in *patient care activities*[15]

This operative language did not change in 2004 when CMS designated § 413.86(f)(4) as § 413.78(d)-(e).[16]

Similarly, with respect to IME for FYs 2000 and thereafter, the Board relies on 42 C.F.R. § 412.105(f)(1) (2003) which states in pertinent part:[17]

> 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: . . . .
>
> (ii) In order to be counted, the resident must be assigned to one of the following areas: . . . .
>
> (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.[18]

When CMS designated § 413.86(f)(4) as § 413.78(d)-(e) in 2004, CMS only updated the cross-reference in § 412.105(f)(1)(ii)(C) and did not change this operative language.[19]

The Board recognizes that, as part of the 2006 Final Rule, the Secretary made regulatory changes that, for the first time, defined "patient care activities" for purposes of DGME and IME reimbursement. Specifically, CMS added regulations at 42 C.F.R. § 413.75(b) to define the term

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[15] (Emphasis added.)
[16] *See* 69 Fed. Reg. at 49112, 49177-49178, 49235.
[17] 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).
[18] (Emphasis added.)
[19] *See* 69 Fed. Reg. at 49244-49245.

"patient care activities" as "the care and treatment of particular patients, including services for which a physician or other practitioner may bill." The Secretary recognized that that term had not previously been defined and enumerated examples of where earlier policy statements required the time in non-hospital setting to be in "patient care activities" to be included in the DGME and IME FTE count.[20] The Secretary characterized the new definition both as a "clarification" of existing policy and the plain meaning of the term.[21]

The Board also reviewed the letter dated September 24, 1999 from the Director of the Division of Acute Care for the CMS Plan and Provider Purchasing Policy Group that the Hospital entered into evidence in support of its appeal. The CMS Director wrote this letter in response to an inquiry and purports to provide the agency's interpretation of "patient care activities" in relation to the time residents spend in nonhospital sites. In particular, the letter states:

> HCFA[22] interprets the phrase "patient care activities" broadly to include any patient care oriented activities that are part of the residency program. As you stated in your letter, this can include resident participation in "1) the direct delivery of patient care, such as clinical rounds, discussions, and conferences, and 2) scholarly activities, such as educational seminars, classroom lectures, research conferences, patient care related research as part of the residency program, and presentations of papers and research results to fellow residents, medical students, and faculty." Therefore, as long as the residents are primarily involved in patient care oriented activities and other program requirements are met, a hospital may include other educational activities as part of the entire time spent by residents in nonhospital settings and include this time in its FTE count and GME/IME payment calculations. [23]

The Board is unconvinced by the statements in the 2006 Final Rule that the September 24, 1999 letter did not accurately reflect CMS' then-current policy. Rather, the Board finds that the September 24, 1999 letter is compelling evidence of CMS' policy during the period prior to the 2006 Final Rule. This official correspondence clearly provided a policy interpretation of the phrase "patient care activities" used to determine the IME and DGME FTE count in a nonhospital setting during the relevant period on appeal. The Board finds that the guidance furnished in this letter was not limited to a specific person or provider, but rather was a general statement of CMS' then-current policy. Moreover, the Board gives great weight to this guidance because this guidance was issued by the CMS Director who had responsibility over GME/IME reimbursement policy. As a result, it is not surprising that this letter was distributed to many hospitals and universities and that the provider community, including the Hospital, relied on the guidance in that letter.[24]

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[20] *See id.*
[21] *See* 71 Fed. Reg. 48081 (Aug. 18, 2006).
[22] CMS was previously known as the Health Care Financing Administration ("HCFA").
[23] *See* Provider Exhibit P-25.
[24] *See* Provider's Consolidated Final Position Paper at 73 (discussing and citing to Provider Exhibit 89).

Finally, the Board notes that evidence in the record confirms that the September 24, 1999 letter provided a reasonable interpretation of the term "patient care activities." In this regard, the Board finds evidence in the record that didactic activities are included in ACGME (Accreditation Council for Graduate Medical Education) and CODA (Commission on Dental Accreditation) accredited residency programs as activities relating to patient care. In conferences and seminars, residents are encouraged to discuss how the material relates to patients whom they are treating. The journal clubs, literature reviews, case presentation, and laboratory techniques are related to patients who are being treated. Even seminars on communication skills are related to patient care, as communication with patients, family, and other professionals is discussed in the context of how to care for current patients.[25]

Further, the parties stipulated that, as part of the Hospital's medical residency program, residents both engage in the direct treatment of patients and participate in classroom discussions of patient-care related issues.[26] The parties also stipulated that the time disallowed by the Medicare Contractor in calculating the Hospital's IME and GME FTE counts was spent in these classroom discussions.[27]

Based on the foregoing analysis, the Board concludes that, prior to October 1, 2006,[28] there is no regulatory requirement that "patient care activities" be specifically delineated as connected to the *billable care* of a particular patient. On the contrary, there is compelling evidence that CMS interpreted the phrase "patient care activities" broadly to include any patient care oriented activity that is part of the residency program, including didactic activities and that this interpretation was widely distributed to the provider community.

Therefore, for the appeal periods prior to October 1, 2006, the Board finds resident time spent in didactic settings while the residents were training at nonhospital sites can be included in the calculation of the IME and DGME FTE counts. However, for the appeal periods starting on October 1, 2006 through December 31, 2006, the revised IME and DGME regulations no longer support such a finding since during this later period "patient care activities" were specifically and more narrowly defined as "the care and treatment of particular patients, including services for which a physician or other practitioner may bill."[29]

ISSUE 2: FOREIGN DENTAL GRADUATE RESIDENTS

A. Arguments Regarding Foreign Dental Graduate Residents

The Hospital contends that the Medicare Contractor improperly excluded time related to its foreign dental graduate residents from the DGME FTE count based on an absurd and punitive reading of the Medicare statute. The Medicare Contractor denied this time because it believes the statute requires foreign dental graduate residents to pass the United States Medical Licensing Examination ("USMLE"), in order to qualify for a DGME payment. However, the Hospital

[25] S*ee* Provider Exhibit P-89 at 5.
[26] *See* Stipulations of the Parties at ¶ 8. *See also* Provider Exhibit P-34.
[27] *See* Stipulations of the Parties at ¶ 9. *See also* Provider Exhibits P-26 – P-32.
[28] *See* 71 Fed. Reg. 48,870 (Aug. 18, 2006) for the October 1, 2006 effective date.
[29] 42 C.F.R. § 413.75(b) (2006). *See* 71 Fed. Reg. 48,870 (Aug. 18, 2006) for the October 1, 2006 effective date.

argues that the statute imposes a requirement impossible for the Hospital to meet, as the USMLE is only offered to foreign *medical* graduate residents, not to foreign *dental* graduate residents. The Hospital further argues that the Medicare statute should be read to comply with what it believes was Congress' intent in the Balanced Budget Act of 1997 ("BBA '97"), to include *all* dental residents within the scope of DGME reimbursement.[30]

The Hospital also believes that current state certification procedures serve the same purpose as the USMLE (and thus satisfy Congress' intent) in ensuring that foreign dental graduate residents meet a standard of clinical proficiency before entering the practice of dentistry. The Hospital states its dental residents have been certified by a regulatory body to be proficient because, consistent with Kentucky regulations, they obtained limited Kentucky dental licenses upon entering the residency program. Thus, the Hospital believes it should not be denied payment for its foreign dental residents' time spent in DGME settings.[31] The Hospital argues that the Medicare Contractor's adjustment should be reversed because it imposes an unjust and impossible statutory requirement.[32]

The Hospital also contends that the Medicare Contractor's reliance on the Board's prior decision in *Harborview Med. Ctr. v. Blue Cross and Blue Shield Ass'n,* PRRB Dec. 1998-D90 (Sept. 9, 1998), *affirmed in part and modified in part*, CMS Adm'r Dec. (Nov. 13, 1998) is improper. The Hospital explains that, in that case, the Board did not have the opportunity to consider Congress' intent. As part of this appeal, the Hospital points to 42 U.S.C. § 1395ww(d)(5)(B)(v), where the "limit on the total number of residents specifically includes only residents in a hospital's approved medical residency program in the fields of allopathic and osteopathic medicine" and to the legislative history of the Balanced Budget Act of 1997.[33] The Hospital contends that Congress' intent in this later statute is to exempt *all* dental residents from the FTE cap. The Hospital believes that the Medicare Contractor's decision to exclude the Hospital's foreign dental graduate residents is contrary to statute and the clear intent of Congress.[34]

B. Board Findings with Respect to Foreign Dental Graduates.

While the Board empathizes with the Provider's position, it is bound by the controlling regulation at 42 C.F.R. § 413.86(h)(6) (2003). This regulation specifies that only "foreign medical graduate" residents who have passed the USMLE may be included in the DGME FTE resident count on or after July 1, 1993. Further, the term "foreign medical graduate" is defined in 42 C.F.R. § 413.86(b) to include foreign dental graduates. Accordingly, the Board concludes that the literal reading and interpretation of that regulation provides no basis for an alternate finding.

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[30] *See* Provider's Final Position Paper at 91.
[31] *Id.*
[32] *See* Provider's Final Position Paper at 91-92 (citing to *Nat'l Treasury Employees Union v. Reagan,* 663 F.2d 239, 252 (D.C. Cir. 1981) (rejecting the government's construction of a statute that would make submitting certifications and reports impossible)).
[33] *See* H.R. Conf. Rep. No. 105-217, 105th Cong., 1st Sess., 176, 821 (1997) (emphasis added).
[34] Provider's Final Position Paper at 92.

In addition, although the Hospital espouses a theory of Congressional intent to include dental FMGs who have not passed the USMLE in the DGME FTE count, the Board finds the record contains no convincing evidence of Congressional intent specific to including those dental FMGs in the count of DGME FTEs. Regardless, pursuant to 42 C.F.R. § 405.1867, the Board is bound to comply with the controlling regulation.

ISSUE 3: RESIDENT TO BED RATIO

CMS regulations at 42 CFR § 412.105 require the use of the prior year cost report items when determining the current year's IME payment. Accordingly, to the extent that *current year* IME FTE counts are (or have been) adjusted for FYs 1999 to 2002 and 2004 to 2005 as a result of this appeal or another appeal (pending or closed), the Board directs the Medicare Contractor to update the relevant prior year resident to bed ratios in the cost reports for FYs 2000 to 2003 and 2005 to 2006 to reflect those adjustments.

DECISION:

After considering the Medicare law and regulations, the parties' contentions, and the evidence submitted, the Provider Reimbursement Review Board ("Board") finds and directs as follows:

> ISSUE 1: DIDACTIC TIME - The Medicare Contractor *improperly* excluded didactic time from the Hospital's FTE counts for IME and DGME prior to October 1, 2006 as it relates to the cost reports for FYs 2000 to 2006. The Medicare Contractor *properly* excluded didactic time from the Hospital's FTE counts for IME and DGME beginning October 1, 2006 as it relates to the cost report for FY 2006. Accordingly, the Board directs the Medicare Contractor to update the current year IME and DGME counts and the current year resident to bed ratios in the cost reports for FYs 2000 to 2006 *as it relates to didactic time prior to October 1, 2006*.
>
> ISSUE 2: DENTAL FOREIGN MEDICAL GRADUATE RESIDENTS - The Medicare Contractor *properly* excluded dental foreign medical graduate residents from the Hospital's DGME FTE counts for FYs 2000 to 2003.
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> ISSUE 3: RESIDENT TO BED RATIO - To the extent that the *current year* IME FTE counts are (or have been) adjusted for FYs 1999 to 2002 and 2004 to 2005 as a result of this appeal or another appeal (pending or closed), the Board directs the Medicare Contractor to update the relevant *prior year* resident to bed ratios in the cost reports for FYs 2000 to 2003 and 2005 to 2006 to reflect those adjustments.

Accordingly, the Board remands the cost reports for FYs 2000 to 2006 to the Medicare Contractor to: (1) recalculate the FTEs for both IME and DGME based on the above findings and directives for Issues 1 and 3; and (2) make any resulting revisions to the Hospital's IME and DGME payments.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
Clayton J. Nix, Esq.
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FOR THE BOARD:

/s/
Michael W. Harty
Chairman

DATE: May 31, 2016