Hospital Reimbursement – Medicare
Reimbursement Extended to Research Hospitals
Conducting Non-Patient Care Activities—Univ. of Chi. Med. Ctr. v. Sebelius, 618 F.3d 739 (7th Cir. 2010)

Robert Corbin*

Under federal law, most hospitals rendering care to Medicare beneficiaries are entitled to reimbursement under a Prospective Payment System (“PPS”).¹ By enacting the Patient Protection and Affordable Care Act (“PPACA”) in March 2010, Congress amended many of the existing health care laws, including Medicare’s hospital reimbursement scheme for institutional costs, to expand available health care and curb associated costs.² In Univ. of Chi. Med. Ctr. v. Sebelius,³ the United States Court of

* J.D. Candidate, Suffolk University Law School, 2011; B.S. Providence College, 2007. Mr. Corbin may be contacted at rw.corbin@yahoo.com.

¹ See generally Social Security Act, 42 U.S.C. § 1395ww(d) (2006), amended by Social Security Amendments Act of 2010, Pub. L. No. 111-309, 124 Stat. 3289 (2010) (describing the implementation and methodology of PPS for varying classifications of hospitals). The government replaced a “reasonable cost” system with the PPS system, deciding the “reasonable cost” system was too costly. See 42 U.S.C. § 1395x(v)(1)(A); see also 42 C.F.R. § 413.30 (2008). For the purposes of inpatient hospital service payments using the PPS, an eligible hospital is one located within the fifty states or the District of Columbia that is not a psychiatric hospital, rehabilitation hospital, children’s hospital, a hospital with an average inpatient length of stay greater than twenty-five days, a hospital recognized as a comprehensive cancer center, or a hospital located in a State operating a demonstration project under section 1814(b) as a hospital involved extensively in treatment for research on cancer. See 42 U.S.C. § 1395ww(d)(1)(B); 42 U.S.C. § 1395x(v)(1)(A); see also 42 C.F.R. § 413.30; Bellevue Hosp. Ctr. v. Leavitt, 443 F.3d 163, 168 (2d Cir. 2006) (explaining the history of the PPS system and its effect). The PPS is a system that reimburses hospitals for their expenses. See Bellevue Hosp. Ctr., 443 F.3d at 168. Rather than base the reimbursements on actual expenditures, the reimbursements are determined according to fixed rates dependent upon categories of treatment, known as diagnostic related groups (“DRGs”). Id. These rates can vary and are supposed to reflect the resources an efficiently run hospital would expend in treating a patient with the same diagnosis at the time of discharge. Id.

² See Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119,
Appeals for the Seventh Circuit became the first Court to consider, in light of the PPACA amendments, whether the University of Chicago Medical Center (“Hospital”), an academic medical center and teaching hospital, was entitled to Medicare reimbursements for indirect medical education expenses (“IME”). The court looked specifically at expenses unrelated to the care of Medicare patients, referred to as “pure research,” discussed whether such expenses were within the definition of IME, took into account the full-time equivalent (“FTE”) adjustment that more adequately compensates teaching hospitals for their extra expenses by accounting for residents, and determined whether the Hospital would be entitled to reimbursement for the pure research under the FTE IME reimbursement scheme. In light of PPACA’s amendments to Medicare, the court ruled in the Hospital’s favor, holding that the Hospital’s proper FTE IME adjustment encompassed reimbursements for “pure research.”


In 2008, the United States spent more than 17 percent of our gross domestic product (“GDP”) on health care – more than any other industrialized country in terms of total and per capita spending. By 2017, health expenditures are expected to consume almost 20 percent of GDP, or $4.3 trillion annually. While spending is high, our nation ranks low in many areas of quality. Various reports have concluded that our current health care system is not making progress toward improving quality or containing costs for patients or providers. This combination of high spending and lagging quality is unsustainable for patients, business and state and federal governments.

See STAFF OF S. COMM. ON FINANCE, 111TH CONG., supra.

3 618 F.3d 739 (7th Cir. 2010).

4 Id. at 740; see Univ. of Chi. Med. Ctr. v. Sebelius, 645 F. Supp. 2d 648, 650 (N.D. Ill. 2009) (explaining IME factors and their application to reimbursement scheme). IME payments are made to reimburse teaching hospitals that incur extra costs associated with medical education not directly tied to hands-on patient care. Univ. of Chi. Med. Ctr., 645 F. Supp. 2d. at 649-50. The IME teaching factor is purported to depict the level of teaching intensity at a hospital. Id.

5 Univ. of Chi. Med. Ctr., 618 F.3d at 740. The court defines “pure research” as educational research that is not related to the care of Medicare patients. Id. Another definition of “pure research” can also be gleaned from the original Medicare provisions in the Federal Registrar that states hospitals were not reimbursed for costs incurred for research that is above and beyond usual patient care unless it was directly in conjunction with that care. 20 C.F.R. § 405.422(a)-(b) (1967).

6 Univ. of Chi. Med. Ctr., 618 F.3d at 745-46. See infra notes 41-45 and accompanying text.
At the close of the 1996 fiscal year, the Hospital submitted a cost report to receive direct and indirect medical educational payments from Medicare.\(^7\) In determining the appropriate Medicare reimbursement amount, the United States Department of Health and Human Services Secretary Kathleen Sebelius (“Secretary”) excluded the Hospital’s educational research, performed by the Hospital’s residents and unrelated to the care of the Hospital’s Medicare patients, from its IME calculation.\(^8\) In fact, the Secretary’s fiscal intermediary specifically left out over fifty full-time equivalent residents from the calculations, which the Hospital claimed resulted in $2,607,048 of neglected payments.\(^9\) Accordingly, the Hospital brought its claim through the appropriate procedural steps, and after two conflicting decisions, appealed to the United States District Court of the Northern District of Illinois.\(^10\)

The district court granted the Hospital’s motion for summary judgment,

\(^7\) Univ. of Chi. Med. Ctr., 645 F. Supp. 2d at 651. The hospital specifically submitted the cost report to the Secretary’s fiscal intermediary. \(\text{Id.}\) Unlike indirect medical expenses, which are expenses not directly related to the care of a Medicare beneficiary, direct medical expenses are those inextricably tied to the care of patients, such as salaries, stipends, and classroom expenses. Un\(\text{v. of Chi. Med. Ctr.}, 618 F.3d at 741 n.1.\)

\(^8\) Univ. of Chi. Med. Ctr., 645 F. Supp. 2d at 651. To be considered a FTE for purposes of IME reimbursement, the residents must be enrolled in an approved teaching program. 42 C.F.R. § 412.105(g) (1996) (current version at 42 C.F.R. § 412.105(f) (2011)). According to the regulation, an approved teaching program includes one that is approved under 42 C.F.R. § 415.152 (2010); one that counts towards certification in a specialty or subspecialty listed by the American Medical Association; or one that one that qualifies as a fellowship by the Accreditation Council for Graduate Medical Education. \(\text{Id.}\) Additionally, the residents must be assigned to a portion of the hospital subject to the PPS; the outpatient department of the hospital; or any entity receiving a grant under section 330 of the Public Service Act. \(\text{Id.}\)

\(^9\) Univ. of Chi. Med. Ctr., 645 F. Supp. 2d at 651.

\(^10\) Univ. of Chi. Med. Ctr. v. Sebelius, 645 F. Supp. 2d 648, 651 (N.D. Ill. 2009). The appropriate procedure to contest an IME reimbursement calculation requires a qualifying hospital to pursue an administrative appeal to the Provider Reimbursement Review Board (“Review Board”). 42 U.S.C. § 1395oo(a) (2006). The Review Board reversed the fiscal intermediary’s decision and held that a resident’s research time should be included in the IME calculation. Univ. of Chi. Med. Ctr., 645 F. Supp. 2d at 651. The fiscal intermediary appealed the Review Board’s decision to the Administrator of the Centers for Medicare and Medicaid Services (“CMS”), who reversed the Review Board’s decision, thus allowing the Hospital to appeal to the district court. \(\text{Id; see 42 U.S.C. § 1395oo(f); see also 42 C.F.R. § 412.105(g)(1)(ii)(A) (current version at 42 C.F.R. § 412.105(f)(1)(ii)(A) (2010)). This regulation states that to be counted as a FTE, the resident must be assigned to “[t]he portion of the hospital subject to the prospective payment system.” Id. See generally David W. Thomas, Review of Medicare Reimbursement Disputes Under 42 U.S.C. § 1395oo: Delineating a Unified Theory of the Provider Reimbursement Review Board’s Jurisdiction and Scope of Review, 39 DUQ. L. REV. 287 (2001) (describing process for Medicare participating hospitals to bring claims against Medicare). \)
disagreeing with the Secretary’s proffered interpretation and stating that the term “portion of the hospital subject to the PPS,” under 42 C.F.R. section 412.105(g)(2), referred to a geographical location of the hospital and did not have a functional definition requiring the Hospital’s residents’ educational research to be associated with the care of a Medicare beneficiary. On appeal, the Seventh Circuit recognized the considerable conflict surrounding the adoption of the PPS teaching adjustment and turned to the recently passed PPACA for guidance. The court found that PPACA amended 42 U.S.C. section 1395ww(d)(5)(B), giving the court a clear statutory answer as to whether pure research can be included in the Medicare reimbursement scheme. In affirming the district court’s decision, the Court of Appeals for the Seventh Circuit held that the proper reading of 42 U.S.C. section 1395ww(d)(5)(B), in conjunction with the Patient Protection and Affordable Care Act of 2010 section 5505(b), allowed pure research to be included under “non-patient care activities” as part of the Hospital’s FTE IME adjustment.

11 Univ. of Chi. Med. Ctr., 645 F. Supp. 2d at 654-55. The district court relied on statutory construction principles, which provide that a word used in the same section of the same enactment must be given the same effect. Id. at 654. The court also refused to read language into the regulation that did not appear on the face of the regulation or in the manifest intentions of the Secretary at the time of its promulgation. Id. at 655; see also supra note 8, infra notes 38-40 and accompanying text (discussing specific statutory language regarding “portion,” the parties’ positions, and the court’s interpretation). 42 C.F.R. § 412.105(g)(1)(ii)(A) (current version at 42 C.F.R. § 412.105(f)(1)(ii)(A) (2010)).

12 Univ. of Chi. Med. Ctr., 618 F.3d at 744. The court mentioned in dicta that had PPACA not been passed and they were faced with an ambiguous regulation, the court would defer to the agency’s construction and the Secretary’s interpretation. Id. It is interesting to note that the court heard oral arguments before PPACA’s adoption. Id.; see also infra notes 18-21 and accompanying text (discussing the legislative difficulties associated with adopting reimbursement provisions for teaching hospitals).


14 Univ. of Chi. Med. Ctr., 618 F.3d at 745 (discussing the appellate court’s decision in light of PPACA). The court recognized their position was divergent from the First Circuit’s decision in R.I. Hosp. v. Leavitt; however, the court distinguished this case by stating that the First Circuit did not have the opportunity to consider the PPACA. Id. (citing R.I. Hosp. v. Leavitt, 548 F.3d 29 (1st Cir. 2008)). The term “non-patient care activities” is not mentioned anywhere else in the law; therefore, the court took it upon itself to determine the significance of this term. Id. at 744-45. The court held that “non-patient care activities” included research activities not associated with the treatment of a particular patient for the relevant time period. Id. at 745-46.
In 1966, Congress established the Medicare program in an effort to provide health insurance to the elderly and disabled.\(^{15}\) Generally, Medicare must reimburse hospital costs related to the care administered to eligible individuals.\(^{16}\) The original Medicare repayment scheme enabled hospitals to receive reimbursements for actual inpatient medical expenses incurred using a “reasonable cost” method.\(^{17}\) More specifically, this “reasonable cost” method expressly allowed reimbursement for actual services, but it excluded “any part of incurred cost found to be unnecessary in the efficient delivery of needed health services.”\(^{18}\) Nonetheless, under the “reasonable cost” method, Medicare also reimbursed teaching hospitals for certain IME costs related to their teaching programs.\(^{19}\)

The government’s responsibility to pay for every necessary service led to inflated costs; therefore, the Secretary amended Medicare’s reimbursement scheme by limiting hospital repayment to reflect what a provider should generally spend for the

\(^{15}\) See generally 42 U.S.C. §§ 1395-1395klik-1 (2006) (listing the compilation of statutory provisions regarding Medicare services for elderly and disabled persons). Medicare allows any eligible person to receive health care from qualified institutions, agencies, or persons as long as any qualified entity undertakes to provide them services. 42 U.S.C § 1395a; see also David M. Frankford, The Complexity of Medicare’s Hospital Reimbursement System: Paradoxes of Averaging, 78 IOWA L. REV. 517, 527-30 (1993) (describing the enactment of Medicare and its primary focus). The idea behind Medicare was to shelter the aged and disabled from “financial catastrophe,” and because hospital bills pose the largest fiscal threat to beneficiaries, the focus of the legislation was on federal hospital insurance. See Frankford, supra, at 527-30.

\(^{16}\) See 42 C.F.R. § 405.402(a) (1983) (establishing a return on capital only permitted on the portion of capital related to the patient care); see also Human Inc. v. Heckler, 758 F.2d 696, 697 (D.C. Cir. 1985) (describing direct and indirect costs of patient care). Eligible individuals are limited to persons who are sixty-five or older and those under sixty-five suffering from certain disabilities. 42 U.S.C. § 1395c (describing Medicare program and eligible individuals).

\(^{17}\) See 42 U.S.C. § 1395d(a)(1) (stating scope of benefits for Medicare beneficiaries to include inpatient hospital services for up to 150 days); 42 U.S.C. § 1395f (b)(1) (naming conditions of amount of provider payment to be lesser of reasonable costs or customary charges with respect to such services); see also 42 U.S.C. § 1395x(v)(1)(A) (defining reasonable costs generally as costs actually incurred excluding costs found to be expendable in the efficient delivery of health services); 42 C.F.R. § 413.30(e) (2010) (describing reasonable costs as those costs to the extent they are reasonable, attributable to the circumstances specified, separately identified by the Skilled Nursing Facility or Home Health Agency, and verified by the intermediary).

\(^{18}\) See 42 U.S.C. § 1395x(v)(1)(A) (defining “reasonable costs”).

\(^{19}\) See R.I. Hosp. v. Leavitt, 548 F.3d 29, 43 (1st Cir. 2008) (explaining the reasonable cost system as including related teaching costs); Prospective Payments for Medicare Inpatient Hospital Services, 48 Fed. Reg. 39752, 39754 (proposed Sept. 1, 1983) (codified in 42 C.F.R. pts. 405, 409, and 489) (stating reasonable cost payments include the indirect costs of medical education); 42 C.F.R. § 405.422 (a)-(b) (1967) (explaining research conducted as part of patient care allowable for reimbursement provided costs not met by research funds).
efficient delivery of needed health services.\textsuperscript{20} This amendment, however, failed to take into account the higher indirect costs teaching hospitals expend.\textsuperscript{21} To appropriately compensate teaching hospitals, the Secretary developed a teaching adjustment, which is within the IME reimbursement scheme and is based upon both the number of FTE residents employed at a teaching hospital and the number of available hospital beds on a specific date.\textsuperscript{22} In 1983, in another effort to limit costs, Congress created the PPS, thereby displacing the “reasonable cost” system.\textsuperscript{23} The PPS effectively limited compensation to an estimate of what Medicare deemed to be the efficient delivery of needed health services given the diagnosis at discharge, and the PPS granted teaching hospitals additional payments for IMEs.\textsuperscript{24} In 2001, the Secretary yet again amended the

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  \item See 42 U.S.C. § 1395x(v)(1)(A) (using definition of reasonable costs to demonstrate change from original reasonable cost model); St. Elizabeth's Med. Ctr. v. Thompson, 396 F.3d 1228 (D.C. Cir. 2005) (stating Medicare history and Congress’ early instruction to CMS to limit payments to programs at what Secretary determined to be reasonable cost limits); St. Elizabeth Hosp. v. United States, 558 F.2d 8, 12 (Ct. Cl. 1977) (noting amendment to reasonable costs scheme based on regulations put into effect in 1970); see also 42 C.F.R. § 413.30(a)(2) (stating “provider costs may not exceed the costs CMS estimates to be necessary for the efficient delivery of needed health care services”). The new regulation recognized Medicare’s increased expenses and determined limits on direct costs, indirect costs, as well as costs for specific services or groups of services. 42 C.F.R. § 413.30(a)(2). Medicare retained the right to calculate these costs on a “per admission, per discharge, per diem, per visit, or other basis” and has significant discretionary authority in determining limits. \textit{Id.}
  \item See Medicare Program; Schedule of Limits on Hospital Per Diem Inpatient General Routine Operating Costs, 46 Fed. Reg. 48010, 48011 (proposed Sept. 30, 1981) (setting limits, classified as section 223 limits, on the efficient delivery of services Medicare can reimburse); Notice Medicare Program; proposed Schedule of Limits on Hospital Inpatient General Routine Operating Costs, 45 Fed. Reg. 21582 (Apr. 1, 1980) (stating reasonable costs limits failed to properly compensate indirect costs of teaching hospitals).
  \item See \textit{infra} notes 8-10 and accompanying text (describing FTEs); Notice Medicare Program; proposed Schedule of Limits on Hospital Inpatient General Routine Operating Costs 45 Fed. Reg. at 21582 (stating reasonable cost system did not properly compensate indirect costs of teaching hospitals); Medicare Program; Schedule of Limits on Hospital Per Diem Inpatient General Routine Operating Costs, 46 Fed. Reg. at 48011 (limiting the reimbursements Medicare can offer for the efficient delivery of services). Provisions of the Federal Register addressed the disadvantage teaching hospitals faced by receiving equivalent reimbursements to non-teaching hospitals because of their increased number of diagnostic tests and procedures they must perform for their care of severely ill patients, as well as their higher number of staff due to their obligation to educate residents. 46 Fed. Reg. at 48012.
  \item See 42 U.S.C. § 1395ww(a)(4) (2006) (describing Medicare reimburses hospitals at a federal rate per service given, such as an average per admission or per discharge rate, determined by the Secretary). This section denotes a switch from the “reasonable cost” system. \textit{Id.}
  \item 42 U.S.C. § 1395ww(d) (describing payments for inpatient hospital services based on prospective rates including indirect medical expenses). \textit{But see} 42 U.S.C. § 1395ww(a)(4) (stating Medicare no longer reimburses teaching hospitals for costs associated with graduate education).}

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regulations to clarify the classification of FTEs, excluding from the FTE count research not associated with the treatment or diagnosis of a particular patient in accordance with a “longstanding policy” in the Centers for Medicare and Medicaid Services ("CMS") Reimbursement manual.²⁵

See also 42 U.S.C. § 1395ww(d)(5)(B)(i)-(ii) (authorizing IMEs by stating, “[t]he Secretary shall provide for an additional payment amount for subsection (d) hospitals with indirect costs of medical education, in an amount computed in the same manner as the adjustment costs under regulations (in effect as of January 1, 1983")”). The adjustment factor is derived by multiplying the PPS payment by the IME adjustment factor with a goal of reflecting the magnitude of teaching at a particular teaching hospital. Id. The formula for calculating the IME adjustment factor is \( [(1 + \frac{R}{B})^{n} - 1] \times C \). Id. \( R \) represents the number of FTEs, \( B \) represents the number of hospital beds, \( n \) equals .405 (a measurement factor of the teaching adjustment), and \( C \) represents the statutory adjustment factor. Id. At the time the new system was put into effect, the term FTE was not specifically defined in any regulation, but the Secretary issued notices in the Federal Register that eventually led to the definition of FTEs, codified at 42 C.F.R. section 412.105(g)(1)(ii) (1996) (current version at 42 C.F.R. § 412.105(f)(1)(ii) (2010)). Medicare Program; Schedule of Limits on Hospital Inpatient Operating Costs for Cost Reporting Periods Beginning on or After October 1, 1982, 47 Fed. Reg. 43296, 43310 (Sept. 30, 1982). The regulation determined that to count as a FTE, a resident must be assigned to one of the following areas: the portion of the hospital subject to the PPS, the outpatient department of the hospital, or any entity receiving a grant under section 330 of the Public Service Act. 42 C.F.R. § 412.105(f)(1)(ii). It should also be noted that some residents can also count as partial FTEs based on the amount of time spent in a qualifying area of the hospital. Id.; see also Henry Ford Health Sys. v. Sebelius, 680 F. Supp. 2d 799, 802 (E.D. Mich. 2009) (stating Congress switched to PPS method to promote efficient health care services); Riverside Methodist Hosp. v. Thompson, 2003 U.S. Dist. LEXIS, at *11-15 (S.D. Ohio 2003) (explaining economic incentive for Medicare to adopt PPS and resulting promotion of efficient health care services); 42 C.F.R. § 412.60 (establishing classifications of diagnosis-related groups of inpatient discharges to determine Medicare reimbursement amount); Frankford, supra note 15, at 608-12 (summarizing the diagnosis related groups used to determine rate of reimbursements at discharge); R. Brent Rawlings & Hugh E. Aaron, The Effect of Hospital Charges on Outlier Payments Under Medicare’s Inpatient Prospective Payment System: Prudent Financial Management or Illegal Conduct?, 14 ANNALS HEALTH L. 267, 269-71 (2005) (providing a general understanding of how Medicare pays hospitals for inpatient services).

²⁵ See Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2002 Rates, 66 Fed. Reg. 22646, 22699 (proposed May 4, 2001) (to be codified at 42 C.F.R. pts. 405, 412, 413, 485, and 486); Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Rates and Costs of Graduate Medical Education, 66 Fed. Reg. 39828, 39897-97 (proposed Aug. 1, 2001) (to be codified at CFR pts. 405, 410, 412, 413, 482, 485, and 486) (leaving out from the FTE count “time spent by a resident in research that is not associated with the treatment or diagnosis of a particular patient”); see also CMS, Provider Reimbursement Manual – Part 1 (PRM) §§ 504.1-504.3 (2005) (“PRM”) (explaining the policy prohibiting certain research from FTE IME count). The PRM states, and has since 1988, that intermediaries are not allowed to count time that an individual is engaged in exclusive research towards the FTE count for IME reimbursement. See CMS, PRM – Part 1, supra. Resident time
Despite the Secretary's amended regulations, every federal district court to address this issue found that within the term "portion," as used in 42 C.F.R. section 412.105(g)(2), there was no patient-care requirement to be eligible for a FTE IME reimbursement, so residents conducting pure research must be included in IME reimbursement calculations. For instance, in *Henry Ford Health Sys. v. Sebelius*, the United States District Court of the Eastern District of Michigan held that the Secretary could not exclude residents engaging in educational research from the hospitals IME resident count. In addition, in *Riverside Methodist Hosp. v. Thompson*, the United States spent "exclusively" in research is defined as research not associated with the treatment or diagnosis of a patient of the hospital. Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2002, 66 Fed. Reg. at 22699-22670.

26 See *Henry Ford Health Sys.*, 680 F. Supp. 2d at 809 (stating only proper definition of "portion of the hospital subject to the PPS," under 42 C.F.R. section 412.105(g)(1)(ii)(C) (1996) (current version at 42 C.F.R. § 412.105(g)(1)(ii)(C) (2010)) in light of three other categories, is geographic not functional); *Univ. Med. Ctr. Corp. v. Leavitt*, 2007 U.S. Dist. LEXIS 20556, *5-*6 (D. Ari. Mar. 21, 2007) (concluding "portion of the hospital subject to the PPS," by its plain meaning, denotes a geographical character and the statute is thus unambiguous affording the Secretary’s interpretation no deference). It should be noted that the *Univ. Med. Ctr. Corp.* court found persuasive the Ninth Circuit’s application of a similar regulation using the term "area," deemed to be unambiguously geographical in character. *Univ. Med. Ctr. Corp.*, 2007 U.S. Dist. LEXIS, at *5-*6 (citing Alhambra Hosp. v. Thompson, 259 F.3d 1071, 1071-73 (9th Cir. 2001); see also *Riverside Methodist Hosp.*, 2003 U.S. Dist. LEXIS 15163, at *18-*20 (holding application of functional definition for "portion" was against plain language of 42 C.F.R. section 412.105). Additionally, the *Riverside* court held that if "Congress had believed that the IME costs of a teaching hospital could be separately identified and quantified, then it could easily have qualified its reimbursement formula to restrict the number of FTE residents to a number based only on hours that residents spent providing 'patient care.'" *Id.* at *31; see also *R.I. Hosp. v. Leavitt*, 501 F. Supp. 2d 283, 287, 291 (D. R.I. 2007), rev’d, 548 F.3d 29 (deciding Secretary’s interpretation to assign functional definition to “portion” was not reasonable, ignoring fact that research was part of teaching process contributing to increased costs, and determining such definition was incompatible with FTE definition used in regulation). *But see R.I. Hosp. v. Leavitt*, 548 F.3d 29, 36 (1st Cir. 2008) (finding pertinent regulation ambiguous, thus deference should properly be given to Secretary unless clearly erroneous or inconsistent with language). The court in *R.I. Hosp. v. Leavitt*, determined the purpose of the FTE regulation was to exclude residents from the FTE count who did not contribute to added IME costs, and the legislative history supported this claim. *Id.* at 43-44.


28 See *id.* at 804 (providing holding of case). There, the Secretary argued that the terms "areas" and "portion," as used in 42 C.F.R. § 412.6(g)(1)(ii), are ambiguous, and the Secretary’s interpretation, that only certain “activities” residents conduct contribute to the FTE calculation, should be given deference in accordance with administrative law principles. *Id.* at 806. Despite the court agreeing with the Secretary that the word "areas" is ambiguous as used in the regulation, the court nevertheless held that at one time or another the term "areas" was not
District Court of the Southern District of Ohio similarly rejected the Secretary’s determination that resident hours could be counted for IME purposes only if they were related to “patient care;” held that the IME adjustment was based on other factors that did not necessary involve residents directly rendering care to the hospital’s patients; and noted, if Congress had believed that the IME costs of a teaching hospital could be separately identified and quantified, then they would have so provided. The Court of Appeals for the First Circuit, in R.I. Hosp. v. Leavitt, in contrast, employed administrative law principles and adopted the Secretary’s interpretation. The court, in finding the FTE regulation, 42 C.F.R. section 412.105(f)(1)(ii), ambiguous, deferred to the Secretary’s interpretation as it did not conflict with the FTE regulation’s underlying purpose, which was to exclude residents who did not contribute to the added costs from a hospital’s FTE count; whereas, the IME adjustment was intended to reimburse hospitals.

Thus, in an effort to dispel inconsistencies between the Secretary’s amended regulations and the district court holdings, as well as to reform the U.S. health care system as a whole, President Barack Obama signed the PPACA into law in March 2010. Specifically, within the new health care reform legislation, Congress amended simply construed as a functional requirement; rather, three other classifications of “area,” under 42 C.F.R. § 412(g)(1)(ii) “unequivocally refer to geographic areas, not functions, and therefore, the court refused to adopt the Secretary’s suggested functional definition. Id. at 806-09.

30 Id. at *29-*37 (refuting the Secretary’s argument). The court further noted that congressional purpose, that being to adequately compensate teaching hospitals, would be thwarted if the court adopted the Secretary’s argument that resident time not directly related to patient care should be excluded. Id. at *34-*35.
31 548 F.3d 29 (1st Cir. 2008).
32 See id. at 36. There, the court noted, that the court would give effect to an agency’s interpretation of its own ambiguous regulation so long as that interpretation was reasonable. Id. (citing Visiting Nurse Ass’n Gregoria Auffant, Inc. v. Thompson, 447 F.3d 68, 72-73 (1st Cir. 2006)). To that end, an agency’s reading of a regulatory provision is reasonable if it sensibly conforms to the regulation’s wording and purpose. Id. In this case, the court held the Secretary’s interpretation of the FTE regulation was not unnatural or strained. Id.
33 Id. The court held that the Secretary’s interpretation of the FTE regulation was not “completely beyond the pale.” R.I. Hosp., 548 F.3d at 36. As the FTE regulation’s language itself “admits of more than one reasonable interpretation,” the court effectuated the Secretary’s reasonable interpretation. Id. (citing Gen. Motors Corp. v. Darling’s, 444 F.3d 98, 108 (1st Cir. 2006)).
provisions of 42 U.S.C. section 1395ww(d)(5)(B) by adding criteria for the determination of FTE status, including non-patient care activities retroactively applied to reporting periods on or after January 1, 1983. PPACA’s text regarding the IME determination significantly provides that,

In determining the hospital’s number of full-time equivalent residents . . . all time spent by an intern or resident in an approved medical residency program in non-patient activities, such as . . . conferences and seminars . . . that occurs in the hospital shall be counted toward the determination of full-time equivalency.

In *Univ. of Chi. Med. Ctr. v. Sebelius*, the United States Court of Appeals for the Seventh Circuit considered whether the Hospital was entitled to Medicare reimbursements for IMEs, and in particular, expenses for “pure research” that were

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35 See id. § 5505(b) (to be codified as amended at 42 U.S.C. § 1395ww(d)(5)(B)(s)(II)). The application of this section of the health care reform law states the Secretary shall implement amendments in a manner so as to apply to cost reporting dates beginning on or after January 1, 1983. *Id.* § 5505(c)(1) (to be codified as amended at 42 U.S.C. § 1395ww). Furthermore, “subsection (b) shall apply to all cost reporting periods beginning on or after October 1, 2001 . . . and shall not give any inference as to how the law in effect prior to this date should be interpreted.” *Id.* § 5505(c)(3) (to be codified as amended at 42 U.S.C. § 1395ww) (emphasis added). It should also be noted that section 5505 addresses direct graduate medical expenses (“DGME”), explaining,

> All time spent by an intern or resident in an approved medical residency training program in a non-provider setting that is primarily engaged in furnishing patient care in non-patient care activities . . . but not including research not associated with the treatment or diagnosis of a particular patient, shall be counted toward the determination of full-time equivalency.

*Id.* § 5505(a)(1)(B) (to be codified as amended at 42 U.S.C. § 1395ww(h)).

36 *Id.* § 5505(b) (to be codified as amended at 42 U.S.C. § 1395ww(d)(5)(B)(s)(II)). However, another portion of section 5505(b) expressly states,

In determining the number of full-time equivalent residents . . . all time spent by an intern or resident in an approved medical residency program in research activities that are not associated with the treatment or diagnosis of a particular patient . . . shall not be counted toward the determination of full-time equivalency.

Patient Protection and Affordable Care Act of 2010 § 5505(b) (to be codified as amended at 42 U.S.C. § 1395ww(d)(5)(B)(s)(III)). Congress intended this provision, however, to not support any inferences as to how the law should be interpreted prior to the applicable reporting date of October 1, 2001. See *id.* § 5505(c)(to be codified as amended at 42 U.S.C. § 1395ww).
unrelated to the care of Medicare patients.\textsuperscript{37} In considering this issue, the court specifically looked to whether or not the Hospital’s residents were assigned to a “portion of the hospital subject to the prospective payment system” under 42 C.F.R. section 412.105(g)(1)(ii)(A).\textsuperscript{38} The Secretary argued the term “portion” should be read as having a functional meaning, explaining Medicare reimbursement should be conditioned upon the functions performed involving residents’ activities dealing with patient-care.\textsuperscript{39} Conversely, the Hospital claimed that the regulation is clear on its face, the term “portion” refers to a spatial or geographic term, and thus, there exists no patient-care requirement.\textsuperscript{40}

The court explained the application of the IME adjustment to “pure research” is less than clear because of the confusion surrounding the implementation of the teaching adjustments for the PPS.\textsuperscript{41} However, the court avoided the question of whether or not it should defer to the Secretary’s interpretation of the regulation, claiming that PPACA provided an explicit statutory answer to the issue at hand.\textsuperscript{42} Thus, applying the amended provisions put forth in PPACA, the court found research activities are undoubtedly a subset of the “non-patient care activities.”\textsuperscript{43} The court dismissed the prior legislative history of the relevant federal regulations, as well as

\textsuperscript{37} Univ. of Chi. Med. Ctr. v. Sebelius, 618 F.3d 739, 740 (7th Cir. 2010) (outlining the question at bar). The court defines “pure research” as educational research that is not related to the care of Medicare patients. \textit{Id.} Another definition of “pure research” can also be gleaned from the original Medicare provisions in the Federal Registrar, which states hospitals were not reimbursed for costs incurred for research that is above and beyond usual patient care unless it was directly in conjunction with that care. 42 C.F.R. § 405.422(a)-(b) (1967).

\textsuperscript{38} Univ. of Chi. Med. Ctr., 618 F.3d at 743-44 (describing the court’s issue and the parties’ positions). \textit{See also supra} note 26 and accompanying text (outlining previous court decisions regarding this issue); 42 C.F.R. § 412.105(g)(1)(ii)(A) (current version at 42 C.F.R. § 412.105(f)(1)(ii)(A) (2010)).

\textsuperscript{39} Univ. of Chi. Med. Ctr., 618 F.3d at 743. The Secretary further argued that when residents are performing pure research, they are not performing patient care and are not assigned to the part of the hospital subject to the PPS. \textit{Id.}

\textsuperscript{40} \textit{Id.} at 743-44.

\textsuperscript{41} \textit{See id.} at 744. The court further noted that if it is faced with an ambiguous regulatory provision, it must give deference to the Secretary’s construction. \textit{Id.} (citing Auer v. Robbins, 519 U.S. 452, 462 (1997); Thomas Jefferson Univ. v. Shalala, 512 U.S. 504, 512 (1994)).

\textsuperscript{42} \textit{See Univ. of Chi. Med. Ctr.}, 618 F.3d at 744 (stating PPACA controls the relevant issue).

\textsuperscript{43} \textit{See id.} at 745 (dissecting the PPACA language to apply to the case at bar). The court based its decision on the plain meaning of the amendments that are supported by the specific language of the DGME provision, stating that reimbursable non-patient care activities do not include research not associated with the treatment or diagnosis of a patient. \textit{Id.} Additionally, the court referenced the fact that there is no legislative history to turn to for guidance, thus resulting in the Secretary’s argument that Congress intended to let the courts resolve this issue. \textit{Id.} n.4.
PPACA’s “no inference” clause, which applies to the provision that interns and residents conducting “research activities . . . not associated with the treatment or diagnosis of a particular patient” shall not be included in the FTE count; further, the “no inference” clause states that the aforementioned section “shall not give rise to any inference as to how the law in effect prior to [October 1, 2001] should be interpreted.”  

The court concluded that Congress spoke clearly when enacting PPACA and retroactively allowed reimbursement for non-patient care activities, including pure research, starting in 1983.

Although the court outlined one possible interpretation of PPACA for IME reimbursement, its interpretation is contrary to the regulatory history of 42 U.S.C. section 1395ww(d)(5)(B). The Seventh Circuit was unwilling to engage in a discussion of the ambiguous regulations pertaining to teaching reimbursements and the subsequent potential deference to the agency’s construction because the court found the PPACA language clear enough on its face to supersede said regulations. By ignoring the regulatory history, though muddled, the court relied solely on statutory construction principles and may have dismissed pertinent, albeit somewhat ambiguous, evidence that dispels its holding.

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45 See Univ. of Chi. Med. Ctr., 618 F.3d at 745-46 (explaining logic of overruling prior precedent). The Secretary urged the court to place emphasis on the “no inferences” clause of PPACA section 5505(c)(3), which stated that no inference should be given to how prior law is applied. Id. at 745. The Secretary claimed interpretative principles that the “specific trumps the general.” Id. The court dismissed the Secretary’s argument that the “no inference” clause of PPACA sections 5505(b) and 5505(c)(3), rendered the “non-patient care activities” language superfluous and that statutory interpretative principles call for the specific to trump the general. Id. at 745.

46 See supra notes 21-25 and accompanying text (discussing the relevant regulatory history regarding the IME teaching adjustments).

47 See Univ. of Chi. Med. Ctr., 618 F.3d at 744 (addressing confusion surrounding adoption of teaching adjustment and the court’s acceptance of PPACA as controlling); see also supra notes 21-25 and accompanying text (discussing the legislative difficulties associated with including reimbursement provisions for teaching hospitals). The court stated that if it were faced with an ambiguous regulation, specifically one dealing with complex technical problems, deference must be given to the agency’s construction. Id. But see R.I. Hosp. v. Leavitt, 548 F.3d 29, 36 (1st Cir. 2008) (holding legislative history of regulations ambiguous thus giving deference to Secretary’s interpretation because it conformed to regulation’s wording and purpose). The court in R.I. Hosp. decided the Secretary’s construction was neither unnatural nor strained because hospitals regularly divided on functional lines such as “psychiatric ward” or “oncology ward.” Id. at 36.

48 See Univ. of Chi. Med. Ctr., 618 F.3d at 744 (explaining court’s reluctance to address ambiguous
In addition, although the court depended on the clear language of the PPACA amendment in conjunction with statutory interpretation principles, PPACA lends itself to the same ambiguities that plagued the regulatory history, with inconsistent language and no legislative history on the matter. The court relied on the plain language of the text in an effort to clarify the complicated history associated with teaching hospitals’ IME reimbursements. Such dependence, however, neglected relevant considerations such as whether or not IME was intended to compensate teaching hospitals for added costs of patient care unremunerated by the PPS. The court made a respectable attempt to eradicate the previous ambiguity in relevant regulations; however, despite this effort, a further explanation of the regulatory history in compliance with PPACA could prevent additional litigation in the future.

Moreover, this decision appears to run contrary to the intended purpose for which the PPS and PPACA, in general, were enacted. Both the PPS and PPACA were enacted to reduce costs to the health care system. Conversely, the inclusion of “pure research” to the FTE IME count actually increases government spending by allowing reimbursements for costs unrelated to Medicare beneficiary care, which seems inapposite to the “efficient delivery of needed health care services.” This matter was

regulations that lend itself to regulatory deference). The court recognized the vague language applied in the adoption of the PPS teaching adjustments, as well as the multiple interpretations of the text, and considered itself “lucky” that Congress adopted a clear statutory answer in the PPACA. Id.; see also supra notes 21-25 and accompanying text (discussing the relevant regulatory history regarding the IME teaching adjustments).

See supra note 25 and accompanying text (explaining the varying views of statutory interpretation and their application to PPACA).

See supra note 14 and accompanying text (discussing the Seventh Circuit’s holding in the case at bar).

See supra notes 22, 24 and accompanying text (discussing the purpose of the PPS system and case law interpreting IME reimbursements).


See supra notes 1, 2 and accompanying text (stating switch to PPS and enactment of PPACA legislation was to reduce costs).


See supra note 22 and accompanying text (describing teaching adjustments made to compensate teaching hospitals).
addressed in the First Circuit’s opinion in *R.I. Hosp. v. Leavitt*, which ruled the term “portion” to have a functional meaning within the hospital, citing Congress’ policies to curb costs and giving deference to the Secretary’s authority. The *R.I. Hosp.* court’s deference to the Secretary’s authority appears compelling enough that even if Congress had enacted PPACA prior to the First Circuit’s ruling, it nonetheless could have reached the same decision, thus leaving a schism among the First and Seventh circuits.

In *Univ. of Chi. Med. Ctr. v. Sebelius*, the Seventh Circuit considered whether teaching hospitals are entitled to reimbursement for “pure research” unrelated to patient care under the PPS repayment scheme. The court’s conclusion that PPACA controlled the issue at bar, and the court’s literal reading permitting “pure research” IME reimbursements, is seemingly reasonable given the plain language of the PPACA amendment. However, by relatively ignoring much of the preceding regulatory and legislative history in conjunction with the “no inferences” clause, the court neglected almost forty years of legislative and administrative enactments regarding teaching hospitals’ Medicare reimbursements. This case was one of first impression implementing PPACA, and because both the First and Seventh Circuit’s diverging opinions hinged upon statutory and legislative interpretation, increased litigation concerning post-January 1, 1983 IME reimbursement claims is likely to result.

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56 See *R.I. Hosp.*, 548 F.3d at 41-42 (citing Congress’ need to curb additional teaching hospital reimbursements due to increased costs by approving a Secretary created formula).

57 See *id.* at 41-43 (describing Secretary’s reading of regulations as not plainly erroneous or inconsistent with language, therefore appropriate).

58 See *supra* notes 4, 5 and accompanying text (citing and describing issue the court faced, i.e., defining IME payments and “pure research” for purposes of the court’s discussion).

59 See *supra* notes 13, 14, 42 and accompanying text (discussing the Seventh Circuit’s holding in light of PPACA amendments).

60 See *supra* notes 18-21, 44-45 and accompanying text (explaining vast legislative history and “no inferences” clause in PPACA).

61 See *supra* notes 14, 26, 47, 56-57 and accompanying text (comparing and contrasting findings of First and Seventh Circuits using statutory interpreting principles).