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Federal Court Strikes Down CMS Direct Graduate Medical Education Payment Regulation That Reduced Count of Certain Residents

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In a recent win for teaching hospitals, the U.S. District Court for the District of Columbia invalidated a CMS regulation implementing the direct graduate medical education (DGME) cap on full-time equivalent (FTE) residents. *Milton S. Hershey Med. Ctr. v. Becerra*, No. 19-2680 (May 17, 2021). The court ruled that the regulation's methodology for counting certain residents when a hospital exceeds its cap was contrary to the statute, and the court directed CMS to recalculate DGME reimbursement for the plaintiff hospitals that brought the challenge.

Background

Medicare reimburses teaching hospitals for certain costs related to training residents through a DGME payment. The DGME payment is calculated by multiplying a per-resident amount by the weighted average number of FTE residents employed by the hospital.Residents within their initial residency period (IRP) are weighted differently than residents or fellows who have exceeded that time period (collectively referred to as "fellows"). The applicable statute states that residents in their IRP are to be weighted at 1.00, while fellows that have exceeded that period are to be weighted at 0.50. 42 U.S.C. § 1395ww(h)(4)(C). Under the statute, the number of FTEs a hospital may claim is capped based on the number of FTEs it reported in its fiscal year ending in 1996 (subject to limited adjustments under other statutory provisions). The statute states that the FTEs are capped before application of weighting factors.

However, CMS's regulation implementing the 1996 cap calculates the ratio of a hospital's 1996 cap to its unweighted FTE count for the current year and then multiplies that ratio by the current year weighted FTE count. 42 C.F.R. § 413.79(c)(2)(iii). This reduces the number of weighted FTEs a hospital that exceeds its 1996 cap may claim by the proportion that the hospital's unweighted FTE count exceeds its 1996 cap.

The methodology applied under CMS's regulation can result in a significant reduction in reimbursement for hospitals that employ fellows and exceed their 1996 caps. Several teaching hospitals negatively impacted by the regulatory methodology challenged these reductions and the validity of the regulation, ultimately resulting in a consolidated case before the U.S. District Court for the District of Columbia.

Arguments and Ruling

The plaintiff hospitals challenged the regulation as both contrary to the statute and arbitrary and capricious. The plaintiffs argued that the regulation was not consistent with the Medicare statute because it alters the weights for residents and fellows set by the statute.

Applying the *Chevron* standard, the court sided with the plaintiffs, finding that the regulation was contrary to the unambiguously expressed intent of Congress. Using a hypothetical example, the court illustrated that where a hospital exceeds its cap and employs fellows, the weighted FTE calculated under the regulation is no longer consistent with the statutory weights for residents and fellows. Relying on the plain language of the statute, along with contextual cues within the statutory scheme, the court concluded that the statute required that residents be weighted at 1.0 FTE and fellows at 0.5 FTE. Based on this determination, the court ruled that the Secretary did not have authority to issue regulations that resulted in a change to those weights.

Although the Secretary argued that the plaintiffs' claims were waived because they did not raise their objections to the regulation during the notice and comment period, the court rejected this argument based on the direct application of the regulation to the calculations of the plaintiffs' reimbursement. The court also rejected the Secretary's arguments that the statute did not speak specifically to the methodology for calculating weighted FTE when a hospital exceeds its 1996 cap and that the statute incorporated discretion to adjust the weighting factors.

Because the court found the regulation to be invalid due to its impact on the weighting factors, it declined to address the broader question of whether the statute entitles a hospital to all FTEs that do not exceed its 1996 cap.

Conclusion

The court's ruling could impact DGME reimbursement for a large number of teaching hospitals that have appealed reductions in their reimbursement resulting from the invalidated regulation. However, it is not yet clear whether the Secretary will seek to appeal this ruling to the U.S. Court of Appeals for the District of Columbia. Teaching hospitals impacted by the application of this regulation should protest the issue on their cost reports and file related appeals at the Provider Reimbursement Review Board.

For more information or any questions regarding these issues, please contact Kathleen R. Salsbury or any member of Baker Donelson's Reimbursement team.