DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

JUL 12 2006

TO: Wynethea Walker
Director, Audit Liaison Staff
Centers for Medicare & Medicaid Services

FROM: Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Graduate Medical Education for Dental Residents Claimed by University of California at San Francisco Medical Center for Fiscal Years 2000 Through 2002 (A-04-04-06012)

Attached is an advance copy of our final report on Medicare graduate medical education (GME) payments for dental residents claimed by University of California at San Francisco Medical Center (the Hospital). We will issue this report to the Hospital within 5 business days.

Based on congressional interest, we reviewed 10 hospitals to determine the effect of the Balanced Budget Act of 1997 on direct and indirect GME payments for dental residents included in hospitals' counts of full-time equivalent (FTE) residents. That legislation permitted hospitals to count FTE residents who train in nonhospital settings in their calculations of indirect, in addition to direct, GME payments. This review focused on the Hospital's arrangements with the University of California at San Francisco School of Dentistry, which is a nonhospital setting.

Our objective was to determine whether the Hospital included the appropriate number of dental residents in its FTE counts when computing Medicare GME payments for fiscal years (FYs) 2000 through 2002.

The Hospital overstated its direct and indirect GME claims by a total of $3.9 million for FYs 2000 through 2002. The Hospital inappropriately included a total of 153.88 direct GME FTEs and 159.69 indirect GME FTEs in the counts for FYs 2000 through 2002 without incurring all of the costs of training dental residents in nonhospital sites for those years. Federal regulations stipulate that hospitals must incur all or substantially all of the training costs to include dental residents who train in nonhospital sites in the FTE counts for Medicare GME payments. The Hospital did not have written procedures to prevent the inclusion of FTEs for which it had not paid the training costs.

We recommend that the Hospital (1) file an amended cost report, which will result in a refund of $3,904,526 associated with FTEs for which the Hospital did not incur all or substantially all of the training costs; (2) establish and follow written procedures to

ensure that the FTE counts for residents in nonhospital settings include only those FTEs for which the Hospital has incurred all or substantially all of the training costs; and (3) determine whether errors similar to those identified in our review occurred in Medicare cost reports after FY 2002 and refund any overpayments.

In its written comments on the draft report, the Hospital generally disagreed with our findings and recommendations. In summary, the Hospital claimed that the $3,904,526 should be allowed because (1) we did not use the correct legal standard, (2) the Centers for Medicare & Medicaid Services (CMS) intended that hospitals should simply pay reasonable compensation for teaching activities to meet the Federal requirement of incurring all or substantially all of the training costs to claim GME payments, (3) the Hospital needed to compensate only for the estimated time that dental school faculty spent in nonbillable GME teaching/supervising activities, and (4) the Hospital made a good-faith estimate that 7.9 percent of total medical education time would be spent teaching and supervising residents in nonbillable activities.

We disagree with the Hospital's assertions and maintain that the findings and recommendations are valid. We correctly applied the criteria, appropriately considered CMS's guidance, accurately distinguished between all GME time and nonbillable GME supervision time, and properly determined that the Hospital's methodology for estimating the cost of GME supervision was inadequate.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or Lori S. Pilcher, Regional Inspector General for Audit Services, Region IV, at (404) 562-7750. Please refer to report number A-04-04-06012.

Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

JUL 13 2006

Report Number: A-04-04-06012

Mr. Mark Laret
Chief Executive Officer
UCSF Medical Center
500 Parnassus Avenue, Box 0296
San Francisco, California 94143-0296

Dear Mr. Laret:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Graduate Medical Education for Dental Residents Claimed by University of California at San Francisco Medical Center for Fiscal Years 2000 Through 2002." A copy of this report will be forwarded to the HHS action official named on the next page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. § 552, as amended by Public Law 104-231), OIG reports issued to the Department's grantees and contractors are made available to the public to the extent the information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

Please refer to report number A-04-04-06012 in all correspondence.

Sincerely,

Lori S. Pilcher
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

Jeff Flick
Regional Administrator
Centers for Medicare & Medicaid Services, Region IX
Department of Health and Human Services
75 Hawthorne Street, Fourth Floor
San Francisco, California 94105

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

GRADUATE MEDICAL EDUCATION FOR DENTAL RESIDENTS CLAIMED BY UNIVERSITY OF CALIFORNIA AT SAN FRANCISCO MEDICAL CENTER FOR FISCAL YEARS 2000 THROUGH 2002

Daniel R. Levinson
Inspector General

JULY 2006
A-04-04-06012

Office of Inspector General

http://oig.hhs.gov

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OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

The Medicare program makes two types of payments to teaching hospitals to support graduate medical education (GME) programs for physicians and other practitioners. Direct GME payments are Medicare's share of the direct costs of training residents, such as salaries and fringe benefits of residents and faculty and hospital overhead expenses. Indirect GME payments cover the additional operating costs that teaching hospitals incur in treating inpatients, such as the costs associated with using more intensive treatments, treating sicker patients, using a costlier staff mix, and ordering more tests. Payments for both direct and indirect GME are based, in part, on the number of full-time equivalent (FTE) residents trained by the hospital. The number of FTEs used for the current year's payments is the 3-year "rolling average" of the FTE count for the current year and the preceding 2 cost-reporting years.

Based on congressional interest, we undertook a review of 10 hospitals to determine the effect of the Balanced Budget Act of 1997 on direct and indirect GME payments for dental residents included in hospitals' counts of FTE residents. That legislation permitted hospitals to count FTE residents who train in nonhospital settings in their calculations of indirect, in addition to direct, GME payments.

This report focuses on the University of California at San Francisco Medical Center (the Hospital) and its arrangements with the University of California at San Francisco School of Dentistry (the Dental School). The Dental School is a nonhospital setting. In July 1999, the Hospital entered into an agreement with the Dental School to allow the Hospital to claim GME payments for dental residents in return for reimbursing the Dental School for residents' salaries and related teaching faculty costs. For all FTEs, including dental FTEs, the Hospital claimed more than $87 million in direct ($18 million) and indirect ($69.7 million) GME payments for the 3-year period that ended June 30, 2002. FTEs used to calculate reimbursable GME costs averaged 532 per year.

OBJECTIVE

Our objective was to determine whether the Hospital included the appropriate number of dental residents in its FTE counts when computing Medicare GME payments for fiscal years (FYs) 2000 through 2002.

SUMMARY OF FINDINGS

The Hospital inappropriately included a total of 153.88 direct GME FTEs and 159.69 indirect GME FTEs in the counts for FYs 2000 through 2002 without incurring all of the costs of training dental residents in nonhospital sites for those years. Federal regulations stipulate that hospitals must incur all or substantially all of the training costs to include dental residents who train in nonhospital sites in the FTE counts for Medicare GME payments. The Hospital did not have written procedures to prevent the inclusion of FTEs for which it had not paid the training costs.

As a result, the Hospital overstated its direct and indirect GME claims by a total of $3.9 million for FYs 2000 through 2002.

RECOMMENDATIONS

We recommend that the Hospital:

- file an amended cost report, which will result in a refund of $3,904,526 associated with FTEs for which the Hospital did not incur all or substantially all of the training costs;

- establish and follow written procedures to ensure that the FTE counts for residents in nonhospital settings include only those FTEs for which the Hospital has incurred all or substantially all of the training costs; and

- determine whether errors similar to those identified in our review occurred in Medicare cost reports after FY 2002 and refund any overpayments.

HOSPITAL COMMENTS

In its written comments on the draft report, the Hospital generally disagreed with our findings and recommendations. In summary, the Hospital claimed that the $3,904,526 should be allowed because (1) we did not use the correct legal standard, (2) the Centers for Medicare & Medicaid Services (CMS) intended that hospitals should simply pay reasonable compensation for teaching activities to meet the Federal requirement of incurring all or substantially all of the training costs to claim GME payments, (3) the Hospital needed to compensate only for the estimated time that Dental School faculty spent in nonbillable GME teaching/supervising activities, and (4) the Hospital made a good-faith estimate that 7.9 percent of total medical education time would be spent teaching and supervising residents in nonbillable activities.

The complete text of the Hospital's comments is included as Appendix B.

OFFICE OF INSPECTOR GENERAL RESPONSE

We correctly applied the criteria, appropriately considered CMS's guidance, accurately distinguished between all GME time and nonbillable GME supervision time, and properly determined that the Hospital's methodology for estimating the cost of GME supervision was inadequate. Therefore, we disagree with the Hospital's assertions and maintain that the findings and recommendations are valid.

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INTRODUCTION

BACKGROUND

Medicare Payments for Graduate Medical Education

Since its inception in 1965, the Medicare program has shared in the costs of educational activities incurred by participating providers. Medicare makes two types of payments to teaching hospitals to support graduate medical education (GME) programs for physicians and other practitioners. Direct GME payments are Medicare's share of the direct costs of training residents, such as salaries and fringe benefits of residents and faculty and hospital overhead expenses. Indirect GME payments cover the additional operating costs that teaching hospitals incur in treating inpatients, such as the costs associated with using more intensive treatments, treating sicker patients, using a costlier staff mix, and ordering more tests. Payments for both direct and indirect GME are based, in part, on the number of full-time equivalent (FTE) residents trained by the hospital. The number of FTEs used for the current year's payments is the 3-year "rolling average" of the FTE count for the current year and the preceding 2 cost-reporting years.

Balanced Budget Act of 1997

The Balanced Budget Act of 1997 placed some controls on the continuing growth of GME reimbursement by imposing caps on the number of residents that hospitals are allowed to count for the purpose of direct and indirect GME payments. Dental FTEs are not included in the caps. The legislation also created incentives for hospitals to train residents in freestanding nonhospital settings, such as clinics and ambulatory surgical centers, by permitting hospitals to count FTE residents who train in nonhospital settings in their calculations of indirect, in addition to direct, GME payments.

Based on congressional interest, we undertook a review of 10 hospitals to determine the effect of the Balanced Budget Act on direct and indirect GME payments for dental residents included in hospitals' counts of FTE residents.

University of California at San Francisco Medical Center

The University of California at San Francisco Medical Center (the Hospital) is an academic medical center. It comprises the 600-bed Medical Center at Parnassus, the 180-bed Children's Hospital, and the School of Dentistry (the Dental School). The Dental School is a nonhospital setting. In July 1999, the Hospital entered into an agreement with the Dental School to allow the Hospital to claim GME payments for dental residents in return for reimbursing the Dental School for residents' salaries.

For all FTEs, including dental FTEs, the Hospital claimed more than $87 million in direct ($18 million) and indirect ($70 million) GME payments for the 3-year period that ended June 30, 2002. FTEs used to calculate reimbursable GME costs averaged 532 per year.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the Hospital included the appropriate number of dental residents in its FTE counts when computing Medicare GME payments for fiscal years (FYs) 2000 through 2002.

Scope

Our review of the Hospital's internal control structure was limited to understanding those controls used to determine the number of residents counted for direct and indirect GME payments. We neither assessed the completeness of the Hospital's data files nor evaluated the adequacy of the input controls, except for limited testing of data from computer-based systems. The objective of our review did not require a complete understanding or assessment of the Hospital's internal control structure. We restricted our review to dental residents.

We performed the audit at both the Hospital and the Dental School in San Francisco, California. We obtained information documenting the dental FTEs reported on the Hospital's Medicare cost reports from the Hospital, the Dental School, and the fiscal intermediary.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal criteria, including section 1886 of the Social Security Act (the Act) and 42 CFR parts 412 and 413;
- gained an understanding of the Hospital's procedures for identifying, counting, and reporting dental resident FTEs on the Medicare cost reports;
- reconciled the dental resident FTEs reported on the Hospital's FYs 2000 through 2002 Medicare cost reports to supporting documentation;
- reviewed supporting documentation to determine whether the Hospital appropriately included dental residents in the FTE resident counts when computing direct and indirect GME payments on the Medicare cost reports;
- reviewed financial records at the Hospital and the Dental School to determine whether the Hospital incurred all of the costs of training dental residents in nonhospital settings; and
- summarized the audit results and provided them to the fiscal intermediary to recompute GME payments on the FYs 2000 through 2002 cost reports.

We conducted this audit in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

The Hospital inappropriately included dental residents who trained in nonhospital sites in the FTE counts for FYs 2000 through 2002 without incurring all of the residents' training costs for those years. Federal regulations stipulate that hospitals must incur all or substantially all of the training costs to include dental residents in the FTE counts for Medicare GME payments. The Hospital did not have written procedures to prevent the inclusion of FTEs for which it had not paid the training costs. As a result, the Hospital overstated its direct and indirect GME claims by a total of $3.9 million for FYs 2000 through 2002.

TRAINING COSTS INCURRED BY THE HOSPITAL

In computing FYs 2000 through 2002 GME payments, the Hospital did not comply with Federal regulations requiring that hospitals incur all or substantially all of the training costs for dental residents.

Sections 1886(h)(4)(E) and (d)(5)(B)(iv) of the Act state that in determining the FTEs for residents assigned to nonhospital settings, hospitals must incur all or substantially all of the costs for the training program. Federal regulations (42 CFR § 413.75(b)) define all or substantially all of the costs as "the residents' salaries and fringe benefits . . . and the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct graduate medical education."[1]

For dental residents training in nonhospital sites, the Hospital inappropriately included 51.16 direct GME FTEs and 49.38 indirect GME FTEs in the counts for FY 2000, 53.37 direct GME FTEs and 56.60 indirect GME FTEs in the counts for FY 2001, and 49.35 direct GME FTEs and 53.71 indirect GME FTEs in the counts for FY 2002. The Hospital should not have included these FTEs because it did not incur all of the training costs, as defined by regulations, for the dental residents. To include the dental FTEs, the Hospital should have paid all of the residents' salaries and fringe benefits in addition to the supervisory teaching physicians' costs attributable to GME. Instead, the Hospital paid the residents' salaries and fringe benefits and only 7.9 percent of the supervisory teaching physicians' salaries and fringe benefits attributable to GME. The Dental School, rather than the Hospital, paid the remaining supervisory teaching physicians' costs.

The Hospital did not have written procedures to ensure that it included in the calculation of GME payments only FTEs for which it paid the training costs. According to a Hospital official, the Hospital limited the amounts paid for faculty to 7.9 percent of the costs attributable to supervision of residents in nonhospital settings because of a State law concerning transactions between State-funded institutions. Although we requested the specific citation for this law from the Hospital, the Hospital did not provide the citation, and we were unable to locate it.

As a result, Medicare overpaid the Hospital $3.9 million in GME payments for FYs 2000 through 2002. The overpayments were $248,871, $1,657,527, and $1,998,128 for FYs 2000, 2001, and 2002, respectively. (See Appendix A for details.)

[1]During our audit period, these requirements were found in 42 CFR § 413.86.

RECOMMENDATIONS

We recommend that the Hospital:

- file an amended cost report, which will result in a refund of $3,904,526 associated with FTEs for which the Hospital did not incur all or substantially all of the training costs;

- establish and follow written procedures to ensure that the FTE counts for residents in nonhospital settings include only those FTEs for which the Hospital has incurred all or substantially all of the training costs; and

- determine whether errors similar to those identified in our review occurred in Medicare cost reports after FY 2002 and refund any overpayments.

HOSPITAL COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

The complete text of the Hospital's written comments on the draft report is included as Appendix B. In summary, the Hospital generally disagreed with our findings and recommendations and claimed that the $3,904,526 should be allowed because (1) we did not use the correct legal standard, (2) the Centers for Medicare & Medicaid Services (CMS) intended that hospitals should simply pay reasonable compensation for teaching activities to meet the Federal requirement of incurring all or substantially all of the training costs to claim GME payments, (3) the Hospital needed to compensate only for the estimated time that Dental School faculty spent in nonbillable GME teaching/supervising activities, and (4) the Hospital made a good-faith estimate that 7.9 percent of total medical education time would be spent teaching and supervising residents in nonbillable activities.

We disagree with the Hospital's assertions and maintain that the findings and recommendations are valid.

Using the Correct Legal Standard

Hospital Comments

The Hospital said that we did not set forth the correct legal standard related to the claiming of interns and residents on rotation at nonhospital settings. Specifically, the Hospital said that the draft report required hospitals to: (1) "incur all of the costs of training dental residents in nonhospital sites . . . ."; (2) "incur all of the residents' training costs . . . ."; and (3) "incur all of the training costs, as defined by regulations, for the dental residents." The Hospital believed the requirements should consistently include the phrase "all, or substantially all, of the costs of the training."

Office of Inspector General Response

We appropriately defined the correct legal standards in the draft report, stating: "the Hospital did not comply with Federal regulations requiring that hospitals incur all or substantially all of the

training costs for dental residents." We also correctly defined "substantially all" as "residents' salaries and fringe benefits . . . and the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct graduate medical education" (42 CFR 413.75(b)). Our reference to "all of the training costs" signifies all, or substantially all, of the costs of resident salaries and benefits in addition to the supervisory teaching physicians' costs attributable to GME.

Guidance on Teaching Cost

Hospital Comments

The Hospital stated that CMS's regulations for determining "the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct graduate medical education" were not clear. The Hospital further stated that CMS had allowed flexibility for hospitals and dental schools to determine reasonable compensation for supervisory activities and intended to allow the parties to the written agreement to reach an understanding on payment for the supervisory activities. Moreover, the Hospital said that nothing in the regulations suggested that the amounts paid for supervisory activities could be scrutinized after the fact to support the elimination of GME funding in a nonhospital setting.

Office of Inspector General Response

We acknowledge that CMS guidance provides that the determination of reasonable compensation is a matter of negotiation between the hospital and the nonhospital site. However, CMS was very clear that the amount negotiated must be set forth in a written agreement between the hospital and the nonhospital site (42 CFR § 413.78(d)(2)). Furthermore, CMS stated that the written agreement should reflect actual costs incurred for resident compensation and supervisory teaching activities (Program Memorandum A-98-44, dated December 1, 1998).

In regard to scrutinizing the amounts paid for supervisory activities, CMS stated that if there is evidence that the hospital is not incurring costs consistent with the written agreement, the residents should not be included in the FTE count (Program Memorandum A-98-44). For FY 2000, the amount for supervisory teaching costs shown in the written agreement between the Hospital and the Dental School was based on an unsupported estimate. The actual costs of training dental residents in nonhospital sites exceeded the estimated costs shown in the written agreement and paid by the Hospital. Moreover, the Hospital did not have written agreements in place for FY 2001 and 2002, as required by Federal regulations.

Teaching and Supervision Time

Hospital Comments

The Hospital stated that CMS had clarified that not all time spent by a teaching physician with residents in a nonhospital clinic is, in fact, teaching time that hospitals must compensate. Rather, CMS indicated that a hospital needs to compensate only for "activities related to non-billable GME activities at the nonhospital site."

Office of Inspector General Response

We agree with the Hospital's observation and note that our finding was not based on a requirement that the Hospital compensate all of the time that Dental School faculty were on the payroll. However, we question the Hospital's estimate of the cost needed to compensate the Dental School for supervisory activities related to nonbillable activities at the nonhospital site.

Amount Paid for Teaching and Supervision

Hospital Comments

The Hospital said that it made a good-faith estimate in determining that approximately 7.9 percent of Dental School faculty supervisory time was spent in teaching and supervisory activities that required the hospital to provide compensation. The Hospital stated that it reimbursed the Dental School for 7.9 percent of actual teaching and supervisory time and therefore paid 100 percent of the required supervisory costs. The Hospital said that our conclusion was inaccurate because we mistakenly believed that the Hospital paid 7.9 percent of total supervisory and teaching time. The Hospital stated that it conducted a 2-week time study between October and December 2005 to substantiate the 7.9 percent figure. This study indicated that 11.7 percent of the dental faculty time was spent in teaching and supervisory activities that required the hospital to provide compensation. According to the Hospital, if 11.7 percent was reflective of 2005 time, 7.9 percent was reasonable in 2000.

Office of Inspector General Response

The Hospital should have paid supervisory teaching physician costs attributable to nonbillable supervisory time. It estimated that 7.9 percent of total supervisory and teaching time was for nonbillable time; however, the Hospital did not substantiate this estimate. We do not believe that the 7.9 percent estimate was accurate and reflective of actual costs. The Hospital provided no documentation or satisfactory explanation to support the estimate, and the Hospital did not incur all or substantially all of the training costs for dental residents.

Moreover, the results of the Hospital's after-the-fact study provide further evidence that the 7.9 percent estimate was inaccurate. In fact, the Hospital's 2005 study showed that 11.7 percent of the dental faculty time was spent in teaching and supervisory activities that required the hospital to provide compensation. The Hospital implied that the percentage of time spent in supervisory activities increased over the 5 years between 2000 and 2005. However, this is an erroneous assumption because teaching and supervisory time is related to the GME program's specific requirements, which remain constant from year to year. Additionally, the number of dental students enrolled in the GME programs remained consistent over the period. Furthermore, as noted earlier, the hospital failed to produce written agreements for FYs 2001 and 2002.

APPENDIXES

CALCULATING GRADUATE MEDICAL EDUCATION PAYMENTS

DIRECT GRADUATE MEDICAL EDUCATION

Hospitals are paid for direct graduate medical education (GME) based on Medicare's share of a hospital-specific per resident amount multiplied by the number of full-time equivalent (FTE) residents and the percentage of Medicare inpatient days to total inpatient days. The payment methodology contained in 42 CFR § 413.76 is:[1]

> Medicare payment = (hospital's established per resident amount) x (number of FTE residents) x (number of Medicare inpatient days/number of total inpatient days)

The number of FTE residents used in the calculation is equal to the average of the FTE count for the current year and the preceding 2 cost-reporting years, or the 3-year rolling average. Table 1 illustrates the effect of the overstated fiscal year (FY) 2000 FTE count on the rolling average FTE count in FYs 2000 through 2002 at the University of California at San Francisco Medical Center (the Hospital). Because of the rolling average, the effect of the Office of Inspector General's (OIG's) adjustment to the FY 2000 FTE count is not fully recognized until FY 2002.

Table 1: Effect of Overstated FTE Count on Rolling Average

	FTE Count					
	1998	**1999**	**2000**	**2001**	**2002**	**3-Year Rolling Average**
2000 Cost Report						
Per Hospital	445.55	431.49	549.59			475.52
Per OIG	445.55	431.49	498.43			458.49
2001 Cost Report						
Per Hospital		431.49	549.59	474.93		485.33
Per OIG		431.49	498.43	421.56		450.49
2002 Cost Report						
Per Hospital			549.59	474.93	499.10	507.87
Per OIG			498.43	421.56	449.75	456.58

[1]During our audit period, these requirements were found in 42 CFR § 413.86.

INDIRECT GRADUATE MEDICAL EDUCATION

Medicare pays for indirect GME based on a formula that calculates an add-on to the Hospital's basic prospective payment. The add-on is determined by a multiplier (established by legislation) and the resident-to-bed ratio. The payment methodology contained in 42 CFR § 412.105 is:

$$\text{Medicare payment} = \text{multiplier} \times [(1 + \text{number of FTE residents/number of available beds})^{0.405} - 1]$$

The number of FTE residents used in the calculation is the 3-year rolling average. The resident-to-bed ratio is the lesser of the current or prior-year ratio. Table 2 illustrates the effect of OIG's reduction of the FYs 2000 through 2002 dental FTE counts on the resident-to-bed ratio.

Table 2: Effect of Overstated FTE Count on Resident-to-Bed Ratio

	Resident-to-Bed Ratio		
	Current Year	**Prior Year**	**Lesser of Current or Prior Year**
2000 Cost Report	2000	1999	
Per Hospital	1.195460	1.184800	1.184800
Per OIG	1.132998	1.184800	1.132998
2001 Cost Report	2001	2000	
Per Hospital	1.204638	1.195460	1.195460
Per OIG	1.102847	1.132998	1.102847
2002 Cost Report	2002	2001	
Per Hospital	1.120776	1.204638	1.120776
Per OIG	1.020855	1.102847	1.020855

SUMMARY OF AUDIT RESULTS

Table 3 summarizes the Hospital's overstated FTEs and the resultant overstated claims for direct and indirect GME reimbursement.

Table 3: Summary of Audit Results

Fiscal Year	Overstated FTEs		Overstated Claim for Reimbursement		
	Direct	Indirect	Direct	Indirect	Total
2000	51.16	49.38	$64,288	$184,583	$248,871
2001	53.37	56.60	250,326	1,407,201	1,657,527
2002	49.35	53.71	283,678	1,714,450	1,998,128
Total	**153.88**	**159.69**	**$598,292**	**$3,306,234**	**$3,904,526**

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February 17, 2006

Lori S. Pilcher
Regional Inspector General
For Audit Services, Region IV
Department of Health and Human Services
Office of Inspector General
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

Re: November 2005 OIG Draft Report Entitled "Graduate Medical Education for Dental Residents Claimed by the University of California at San Francisco Medical Center for Fiscal Years 2000 through 2002"

Dear Ms. Pilcher:

This office represents the University of California at San Francisco Medical Center ("UCSF"). By this letter, UCSF responds to the November 2005 Draft Report[1] of the Department of Health and Human Services' Office of Inspector General ("OIG") concerning "Graduate Medical Education for Dental Residents Claimed by [UCSF] for Fiscal Years 2000 through 2002." Significantly, UCSF respectfully requests that the OIG rescind its Draft Report or substantially modify it (see Conclusion below).

The OIG determined in its Draft Report that UCSF is entitled to no Medicare medical education reimbursement for any of the dental residents rotating at the University of California, San Francisco School of Dentistry's ("UCSF Dental School") clinics solely because of the OIG's unsupported opinion that UCSF, which is owned and operated by the Regents of the University of California ("Regents"), did not pay UCSF Dental School, which is also owned and operated by the Regents,[2] enough for teaching and supervision of those dental residents. As laid out in

[1] As you may know, the relevant persons at UCSF did not receive this Draft Report until January 3, 2006.

[2] For part of academic year ended 6/30/00, UCSF was joint ventured with Stanford Health Care and was known as UCSF Stanford Health Care. Still, UCSF Stanford Health Care (footnote continued)

this letter, the OIG's position is completely untenable and unsupported by any evidence or analysis.

In the OIG's Draft Report, the OIG erroneously (and vaguely) concludes that UCSF paid "7.9 percent of the supervisory teaching physicians' salaries and fringe benefits attributable to GME." Draft Report at page 3. Importantly, the OIG has not analyzed UCSF's facts under the correct legal standard, has not properly understood and characterized UCSF's facts, and has not properly implemented the stated policy of the Centers for Medicare and Medicaid Services ("CMS").

I. THE CORRECT LEGAL STANDARD

Medicare provides direct graduate medical education ("GME") payments to teaching hospitals, which are intended to reimburse a portion of the hospital's direct costs associated with training interns and residents. See, e.g., 42 U.S.C. § 1395ww(h). Medicare also provides indirect medical education ("IME") payments to teaching hospitals, which are intended to reimburse a portion of the hospital's additional indirect or overhead costs associated with training interns and residents. See, e.g., 42 U.S.C. § 1395ww(d)(4)(B).

For both IME and GME purposes, during the fiscal years at issue in the Draft Report, a hospital could properly claim on the Medicare cost report intern and resident full time equivalents ("FTEs") involved in nonhospital rotations so long as certain requirements were met. The requirements for claiming nonhospital rotation time were the same for GME and IME purposes. As discussed below, the OIG's Draft Report does not consistently and properly set forth the correct legal standard related to the claiming of interns and residents on rotation at nonhospital settings.

Specifically, the OIG's draft report erroneously refers to a requirement to: 1) "incur[] all of the costs of training dental residents in nonhospital sites. . . ."; 2) "incur[] all of the residents' training costs . . . ."; and 3) "incur all of the training costs, as defined by regulations, for the dental residents." Draft Report at pages i and 3. Given the OIG's erroneous statement of the legal standard at issue, UCSF will set forth, immediately below, the proper statutory and regulatory requirements, in pertinent part:

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and UCSF Dental School were related entities which were both operated by the Regents. Further, on March 31, 2000, the joint venture was disbanded and the Regents continued to be the sole legal entity that owned and operated both UCSF and UCSF Dental School. In other words, funds were simply being transferred internally within the Regents. Indeed, neither UCSF nor UCSF Dental School is a separate legal entity. Rather, only the Regents is a legally recognized entity.

GME STATUTE

> all the time . . . spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting.

42 U.S.C. § 1395ww(h)(4)(E).

IME STATUTE

> 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 nonhospital setting shall be counted towards the determination of full-time equivalency if the hospital incurs all, or substantially all, of the costs for the training program in that setting."

42 U.S.C. § 1395ww(d)(4)(B)(iv).

GME REGULATION

> For portions of cost reporting periods occurring on or after January 1, 1999, the time residents spend in nonprovider settings such as freestanding clinics . . . 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.
>
> (ii) The written agreement between the hospital and the nonhospital site must indicate that the hospital will incur the cost of the resident's salary and fringe benefits while the resident is training in the nonhospital site and the hospital is providing reasonable compensation to the nonhospital site for supervisory teaching activities. The agreement must indicate the compensation the hospital is providing to the nonhospital site for supervisory teaching activities.

> (iii) The hospital must incur all or substantially all of the costs for the training program in the nonhospital setting . . . .
>
> . . . .
>
> *All or substantially all of the costs for the training program in the nonhospital setting* means the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct graduate medical education.

42 C.F.R. § 413.86(b), (f)(4)(2001).

IME REGULATION

Effective for discharges occurring on or after October 1, 1997, the time spent by a resident in a nonhospital setting in patient care activities under an approved medical residency training program is counted towards the determination of full-time equivalency if the criteria set forth in § 413.86(f)(3) or § 413.86(f)(4) of this subchapter, as applicable, are met.

42 C.F.R. § 412.105(f)(1)(ii)(C)(2001).

II. CMS GUIDANCE ON THE TEACHING COST ISSUE

The Medicare statute does not require a hospital to incur "all" of the costs of training residents at a nonhospital site. Instead, Congress only requires a hospital to incur "substantially all" of those costs. CMS has interpreted that statutory provision to mean that the hospital must pay for resident salaries and fringe benefits (while training in the nonhospital setting) and just "the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct graduate medical education." 42 C.F.R. § 413.86(f)(4)(2001).

CMS's regulation on this issue is far from crystal clear. CMS also indicates that the hospital should simply pay "reasonable compensation" for "supervisory teaching activities." 42 C.F.R. § 413.86(f)(4). This statement suggests that there is flexibility for an estimated determination among the parties on what is considered "reasonable compensation." Indeed, CMS has expressly stated that it is up to the parties to the agreement to decide upon the compensation provided. See 63 Fed. Reg. 40954, 40993 (July 31, 1998). In that July 31, 1998 Federal Register, CMS stated that:

> These agreements and amounts paid by the hospital to the nonhospital site may be the product of negotiation between the hospital and nonhospital site. The hospital does not have to report the nonhospital site's GME costs. We anticipate that in the course of any negotiation between the hospital and nonhospital site, the

> nonhospital site may need to identify its training costs. However, this is a matter between the hospital and nonhospital site.

63 Fed. Reg. at 40993 (emphasis added). This CMS comment comes immediately after CMS indicated that the nonhospital resident counting policy will not establish a "burdensome regulatory structure with tremendous documentation requirements." Id. Further, later on that same page of the Federal Register, CMS clearly acknowledges that there "could be a variety of financial arrangements between hospitals and nonhospital sites with regard to training. The hospital and nonhospital site can take into account those types of arrangements in negotiating an agreement." Id. CMS went on to state that it is "not requiring hospitals to submit cost data to Medicare as precondition to counting the resident for indirect and direct GME." 63 Fed. Reg. at 40,994.

In a Program Memorandum to fiscal intermediaries, CMS was even more explicit about not second guessing the "reasonable compensation" agreed to by the parties. See Exhibit 1 (Excerpt of Program Memorandum A-98-44 dated December 1, 1998). In that Program Memorandum, CMS stated unequivocally that:

> The determination of what constitutes reasonable compensation is a matter between the hospital and nonhospital site. If there is a written agreement between the hospital and the nonhospital site as to the compensation which will be provided for supervisory teaching activities, the fiscal intermediary may include the resident training in the nonhospital site for indirect and direct graduate medical education. However, the written agreement should be reflective of the actual costs incurred for resident compensation and supervisory teaching activities. We do not expect fiscal intermediaries to do a detailed cost finding as to each party's respective costs. However, if there is evidence that a hospital is not incurring costs consistent with the written agreement, the fiscal intermediary should not allow the resident to be included in hospital FTE counts for indirect and direct graduate medical education.

See Exhibit 1.

Taken together (or individually), these Federal Register statements and the Program Memorandum indicate that CMS is most certainly not sanctioning the OIG's (or even a fiscal intermediary's) second guessing of what the parties to a written agreement have decided (or estimated) should be deemed reasonable compensation for teaching and supervisory activities in a nonhospital setting. CMS likely recognized that large teaching programs that use multiple nonhospital settings with various (and sometimes complex) cost structures will necessarily need

to make good faith estimates of the cost related solely to teaching and supervising the residents in a particular nonhospital setting. Nothing in the regulations or the regulatory history remotely suggests that the amount paid for teaching and supervision is going to be (or should be) scrutinized and second-guessed after the fact in order to somehow support the elimination of all GME and IME in a nonhospital setting. CMS absolutely intended to allow the parties to the written agreement to reach an understanding of what amounts would be paid for the teaching and supervision activities.

III. NOT ALL GME TIME IS TEACHING AND SUPERVISION TIME

CMS has clarified that not all time spent by a teaching physician with residents in a nonhospital clinic is, in fact, teaching time that hospitals must compensate. See http://new.cms.hhs.gov/AcuteInpatientPPS/Downloads/nonhospQA.pdf (attached as Exhibit 2). In this clarification, CMS indicates that a hospital only needs to compensate for "activities related to non-billable GME activities at the nonhospital site." Id. (emphasis added). CMS specifically noted that time spent by the teaching physician in billable patient care activities supervising the resident is not teaching and supervision time that requires compensation by the hospital. Instead, only more general teaching and supervising that is not related to a specific billable patient encounter is teaching and supervision time that requires compensation (e.g., general clinical didactic training or assessing the resident's performance). Id.

So, UCSF clearly was not required to compensate all of the time that the UCSF Dental School faculty were on the payroll of the Regents. Likewise, UCSF clearly was not required to compensate all of the time that the UCSF Dental School faculty were present in the nonhospital clinics at issue. Rather, UCSF only needed to compensate for the estimated time that UCSF Dental School faculty spent in teaching/supervision activities unrelated to billable patient care activities.

IV. UCSF PAID A SUFFICIENT AMOUNT FOR TEACHING AND SUPERVISION

UCSF and UCSF Dental School made a good faith estimate that about 7.9% of total medical education time would be spent teaching and supervising residents in the clinics at issue. See Exhibits 3 and 4 (excerpt of written agreement and chart demonstrating computation of the 7.9 percent). The OIG, however, has simply taken the chart in Exhibit 4[3] and assumed without any analysis that 7.9 percent is somehow not sufficient. Yet, the OIG has not even properly characterized what this 7.9 percent represents.

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[3] The names of faculty on the chart in Exhibit 4 have been redacted to protect their privacy and financial details.

The OIG mistakenly believes (as indicated on page 3 of the Draft Report) that UCSF paid 7.9 percent of actual supervisory and teaching time. That conclusion is completely inaccurate. Rather, UCSF and UCSF Dental School reached an agreement that approximately 7.9 percent of UCSF Dental School faculty time was spent in the type of teaching and supervision activities (at the nonhospital clinics) that required the hospital to provide compensation.[4] Indeed, the parties to the written agreement indicated that the amounts paid by UCSF to UCSF Dental School (about 7.9 percent of faculty time) was related to teaching and supervision in the nonhospital clinics and therefore represented "reasonable compensation for supervisory teaching activities. . . ." See Exhibit 3 (Section 3 of the Agreement between UCSF Stanford Healthcare and UCSF Dental School). The Agreement clearly intends to provide that UCSF's payments will cover only that part of the UCSF Dental Faculty time that is spent in teaching and supervisory activities at the two nonhospital clinics at issue. Exhibit 3. So, instead of paying for 7.9 percent of teaching time as the OIG suggests, UCSF paid 100 percent of the estimated teaching/supervision time in the nonhospital clinics.

As further support for the notion that UCSF incurred the necessary teaching cost, UCSF conducted a two-week time study of the UCSF Dental School faculty in October-December 2005. See Exhibit 5. That time study demonstrates that only two of ten GME type activities are properly considered the type of teaching and supervision activity requiring compensation by UCSF. Specifically, activity number 1 (developing dental resident schedules and/or evaluations) and activity number 7A (classroom/didactic activities within the nonhospital clinics) in the ten question survey are the only types of teaching and supervising activities requiring any hospital compensation. Eight other types of GME activities (e.g., administrative duties, teaching non-residents, research, patient care, etc.) not requiring hospital compensation make up the overwhelming majority of the dental faculty's time. Indeed, the 2005 time study shows that only 11.7 percent of the dental faculty time for those two weeks was related to activities 1 and 7A. This certainly supports the notion that paying 7.9 percent back in academic year 2000 was a reasonable estimate of teaching time. The 7.9 percent estimate is certainly closer to reasonable

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[4] The chart in Exhibit 4 has six columns and includes compensation data for academic year 6/30/00. The first column has the redacted names of the dental faculty at issue. The amounts in column 2 represent either full time faculty salaries or part time faculty salaries that were imputed to equate to a full time salary. The percentage factor applied in column 3 represents an estimate of the faculty member's time doing medical education type work for the dental residency programs at issue. That factor is applied to actual or imputed total compensation to yield compensation associated with GME-oriented work in column 4. Then, the approximate 7.9% teaching time factor is applied to the column 4 figure to result in the column 6 amount which is referenced in the written agreement (see Exhibit 3) and was paid by UCSF to UCSF Dental School.

and accurate than the apparent OIG suggestion that UCSF somehow needed to reimburse all of the UCSF Dental School's faculty compensation cost.

V. CONCLUSION

The OIG cannot reasonably assert that UCSF has not paid reasonable compensation for teaching and supervisory activities in the UCSF Dental School clinics. The OIG offered no studies or other data to somehow demonstrate that UCSF did not pay enough under the applicable regulations and CMS guidance. Indeed, there is simply no evidence that the amounts UCSF paid to UCSF Dental School were insufficient to cover the kinds of nonhospital teaching and supervision costs that CMS expects hospitals to pay. Instead, the OIG clearly misunderstood UCSF's payment methodology. As explained above, UCSF paid all of the estimated teaching and supervision time in the nonhospital clinics at issue. Pursuant to a written agreement, the parties estimated that about 7.9 percent of the relevant faculty's aggregate compensation related to said teaching and supervision time. Nothing more is required of UCSF under the pertinent CMS regulations, Federal Register commentary, and informal sub-regulatory guidance.

In light of the discussion in this letter, we respectfully urge the OIG to rescind its Draft Report and either: 1) issue a new report that expressly affirms UCSF's methodology, or 2) modify the current Draft Report so that it simply recommends that the intermediary and UCSF work together on whether UCSF's methodology was sufficient under CMS's stated policies.

If you have any questions, please call me.

Sincerely,

Jon P. Neustadter

JPN/jj

cc: Charles Bertolami, Dean, UCSF School of Dentistry
Charlotte Canari, Director of Reimbursement Services, UCSF Medical Center
Ken Jones, CFO, UCSF Medical Center
Mark Laret, CEO, UCSF Medical Center
Mary Ann Moreno, Audit Manager, DHHS OIG (via e-mail only)
Alexis Purcell, Senior Associate Dean Admin. & Finance, UCSF School of Dentistry

EXHIBIT 1

PROG-MEM, MED-GUIDE ¶150,171, FY 1999 PPS, TEFRA Hospital, and Other Bill Processing Changes, (Dec. 1, 1998)

FY 1999 PPS, TEFRA Hospital, and Other Bill Processing Changes

Program Memorandum (Intermediaries), HCFA Pub. 60A Transmittal No. A-98-44 Dec. 1, 1998

Medicare: Provider Reimbursement

Prospective payment systems --Development of hospital DRG rates --Bill processing. --

A *Final Rule* in the July 31, 1998, *Federal Register* outlined changes for inpatient hospital prospective payment system and Tax Equity and Fiscal Responsibility Act of 1982 (PubLNo 97-248) hospital bill processing for fiscal year 1999. Table 1A on FR page 41019 shows a large urban area nonlabor-related amount as $1,313.41, whereas the amount should be $1,131.38. Additionally, some ICD-9-CM changes, which are contained in the 1999 addendum to volumes 1, 2, and 3 of the ICD-9-CM, are effective Oct. 1, 1998. Providers should also note that changes have been made in electronic file record formats, with changes focusing on date fields for millennium compliance and on filler fields for inclusion of detailed information.

See ¶4200 et seq.

The *Final Rule* was reported at ¶46,370 for electronic subscribers and was sent to all subscribers in print as Part 2 of Report 1018.

[Text of Transmittal]

SUBJECT: FY 1999 Prospective Payment System (PPS), TEFRA Hospital and Other Bill Processing Changes -- ACTION

This Program Memorandum (PM) outlines changes for inpatient hospital PPS and TEFRA hospitals for FY 1999. The changes for FY 1999 were published in the *Federal Register* on July 31, 1998. There was an error in Table 1A on page 41019 of the *Federal Register.* The large urban area nonlabor-related amount shown as $1313.41 is incorrect. It should be $1131.38. All items covered in this PM are effective for hospital discharges occurring on or after October 1, 1998 unless otherwise noted. **Inform providers you service of these changes.**

I. *ICD-9-CM Changes*

● ICD-9-CM coding changes are effective October 1, 1998. These are contained in the FY 1999 addendum to volumes 1, 2, and 3 of the ICD-9-CM. The coding changes are available in Tables 6a and 6b in the addendum to the final rule for PPS changes for FY 1999. Invalid codes are contained in Table 6c and 6d, and revised diagnosis code titles are in Table 6e of the same final rule.

Grouper 16.0 assigns Diagnostic Related Groups (DRGs) based on the revised ICD-9-CM codes effective with discharges occurring on or after October 1, 1998. Medicare Code Editor (MCE) 15.0 and Outpatient Code Editor (OCE) 14.0 use the new ICD-9-CM codes to validate coding for discharges and outpatient services effective October 1, 1998.

II. *Furnished Software Changes*

The following software programs were issued for FY 1999:

● **PRICER 99.0** for discharges occurring on or after October 1, 1998. This processes bills with discharge dates on or after October 1, 1994.

(1)	Psychiatric:	$ 8,686	$ 6,214	$ 2,472
(2)	Rehabilitation:	$17,077	$12,219	$ 4,858
(3)	Long-term care:	$22,010	$15,749	$ 6,261

- Capital payments for excluded hospitals and units (§413.40(j))

Section 4412 of Public Law 105-33 amended §1886(g) of the Act to establish a 15 percent reduction on capital payments for certain hospitals and hospital distinct part units excluded from the prospective payment system for portions of cost reporting periods beginning on or after October 1, 1997 through September 30, 2002. The capital reduction applies to psychiatric hospitals and units, rehabilitation hospitals and units, and long-term care hospitals.

GRADUATE MEDICAL EDUCATION

- General Policy

For portions of cost reporting periods occurring on or after January 1, 1999, the time residents spend in nonprovider setting 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 for indirect and direct graduate medical education if the following conditions are met:

--the resident is providing patient care in those settings; and

--there is a written agreement between the hospital and the nonhospital site that indicates that the hospital will incur the costs of the resident's salary and fringe benefits while the resident is training in the nonhospital site and the hospital is providing reasonable compensation to the nonhospital site for supervisory teaching activities. The agreement must also indicate the compensation the hospital is providing to the nonhospital site for supervisory teaching activities.

The hospital may count residents training in any nonhospital site including a Federally Qualified Health Centers (FQHCs) or Rural Health Clinic (RHC). If the hospital has a written agreement with an FQHC or RHC that would allow the hospital to count the resident for indirect and direct GME, the written agreement must also:

--contain an acknowledgment on the part of the FQHC or RHC that the nonhospital site must report GME costs in a nonreimbursable GME costs center.

--indicate that portion of time the physician spends training residents in the FQHC or RHC.

- "Reasonable" Compensation

The statute requires that a hospital incur "all or substantially" all of the training costs while the resident is training in the nonhospital site for the hospital to be able to count the resident for indirect and direct graduate medical education. The regulation defines "all or substantially all" to mean that the hospital is incurring the cost of the resident compensation and providing reasonable compensation for supervisory teaching activities. The determination of what constitutes reasonable compensation is a matter between the hospital and nonhospital site. If there is a written agreement between the hospital and the nonhospital site as to the compensation which will be provided for supervisory teaching activities, the fiscal intermediary may include the resident training in the nonhospital site for indirect and direct graduate medical education. However, the written agreement should be reflective of the actual costs incurred for resident compensation and supervisory teaching activities. We do not expect fiscal intermediaries to do a detailed cost finding as to each party's respective costs. However, if there is evidence that a hospital is not incurring costs consistent with the written agreement, the fiscal intermediary should not allow the resident to be included in hospital FTE counts for indirect and direct graduate medical education.

- Situations Where the Nonhospital Site May Have No Supervisory Teaching Costs

The written agreement may indicate that the hospital is providing reasonable compensation for the cost incurred by the nonhospital site for supervisory teaching activities or that hospital itself is incurring these costs. There may be instances where the hospital is incurring the costs of supervisory teaching activities. For example, physicians supervising the residents in the nonhospital site may be employees on staff at the hospital or the hospital may contract with physicians for a variety of services including supervision of residents in nonhospital sites. In these instances, the written agreement between the hospital and the nonhospital site must indicate that the nonhospital site does not have any teaching physician costs because these costs are being incurred directly by the hospital.

The teaching physicians may also be on the staff of a medical school with a payment being made from the hospital to the medical school for supervisory teaching physician activities performed in both hospital and nonhospital sites. In this situation, there must be an acknowledgment on the part of the nonhospital provider, as part of the written agreement with the hospital, that it does not have supervisory teaching costs for the hospital to be able to count the resident for indirect and direct graduate medical education. This situation is distinguished from one in which the medical school is incurring the cost of the teaching physician salary in the nonhospital site and there is no payment from the hospital to the medical school for these costs. In the latter situation, the hospital is not incurring all or substantially all of the costs and cannot count the resident for indirect and direct graduate medical education.

As indicated above, resident training may take place in a variety of nonhospital settings including freestanding clinics, nursing homes and physician offices. There may be situations where the supervising physician and the nonhospital site are one and the same (e.g. a physician in private practice in an office practice). In this instance, the written agreement would be between the hospital and the private practice physician. In other situations, a private practice physician may be providing supervision to a resident in a distinct nonhospital site (e.g. a nursing home). The hospital may be providing compensation to the physician for supervisory activities and the nonhospital site does not have these costs. Again, this is a situation where there must be a written agreement between the hospital and the nonhospital site where the nonhospital site acknowledges that it does not have teaching physician costs.

- Travel and Lodging Expenses

There may also be situations where a hospital or, alternatively, the nonhospital site is directly incurring travel and lodging costs site associated with the resident's training outside of the hospital. In these situations, the travel and lodging costs constitute resident compensation. If resident compensation is being provided in the form of travel and lodging, the written agreement must indicate that the hospital itself is either incurring these costs or providing compensation to the nonhospital site.

- Compensation Amounts

The regulation also requires that the written agreement indicate the compensation that the hospital is providing to the nonhospital site for teaching activities. There may be situations where hospitals provide compensation to teaching physicians for supervising residents and there is no distinction between compensation for teaching in the hospital or nonhospital site. For instance, the teaching physicians may be part of a faculty practice plan and the hospital is providing compensation to the plan for teaching services provided in the hospital and a clinic. In this situation, the agreement must include an estimate of the amount of compensation provided to the supervising physicians attributable to training in the nonhospital site, based on the percentage of total time worked that the physicians spend supervising residents. The agreement may indicate that physician supervisory costs at the nonhospital site are reimbursed as part of the overall compensation the teaching physician receives from the hospital and that the compensation amount is an estimate derived based on the percentage of time the physician spends supervising residents in the nonhospital site applied to the physician's total compensation.

It is also possible that rather than providing direct financial compensation to the nonhospital site for supervisory teaching activities, the hospital is providing compensation through non-monetary, in-kind arrangements. In this situation, the written agreement needs to describe the arrangements which are involved but does not have to determine a monetary value for the in-kind service. For example, the hospital may provide continuing education

and other professional and educational support for supervising physicians in the nonhospital site in lieu of financial support. This type of support may be described in the written agreement in lieu of a monetary amount for the hospital, to allow the hospital to count the resident for indirect and direct graduate medical education.

- Volunteer Teaching Physicians

Several questions have also arisen as to whether the written agreement can specify that the hospital is providing no compensation for supervisory teaching physician activities because the supervising physician in the nonhospital site is a volunteer. The fiscal intermediary must distinguish situations where there is no explicit compensation for supervisory teaching physician activities, from those where there are truly no costs. For instance, a nonhospital site may provide compensation to a teaching physician for services provided to patients and for supervising residents in a clinic.

Although there be no explicit compensation for supervising residents in this situation, the portion of the teaching physician's compensation attributable to the time spent supervising and teaching residents remains a "cost" to the nonhospital clinic. The written agreement must specify and identify this cost for the hospital to meet the criterion of incurring all or substantially all of the costs.

We would distinguish this situation from those few unique situations where the nonhospital site has no supervisory costs and the physician is voluntarily participating in training. For instance, the resident may be training in a physician's private office. In this situation, the physician may receive all compensation through fee-for-service arrangements and may agree to engage in supervising residents without an expectation of additional compensation for teaching. If the physician agrees to participate in training without compensation, the written agreement must indicate that there is no payment made from the teaching hospital to the private physician because the physician agrees to participate voluntarily in teaching. Similarly, the private practice physician may be providing supervision to residents in a nonhospital site other than their private office, such as in a nursing home or skilled nursing facility without an expectation of compensation. In this situation, the physician would be voluntarily participating in teaching and the nonhospital site may have no costs associated with providing a training site to residents. The hospital may count the resident for indirect and direct medical education in this situation if the written agreement indicates that the physician is voluntarily supervising residents and the nonhospital site does not incur graduate medical education costs.

These instructions should be implemented within your current operating budget.

This Program Memorandum may be discarded after September 30, 1999.

Contact Person: Stuart Barranco --(410) 786-0187.

Attachment

PROVIDERS RECLASSIFIED FOR STANDARDIZED AMOUNT

ACTUAL NUMBER	PHYSICAL LOCATION CODE	PHYSICAL LOCATION NAME	SA CODE	STANDARDIZED AMOUNT LOCATION NAME
10005	1	Rural Alabama	3440	Huntsville, AL
10010	1	Rural Alabama	3440	Huntsville, AL

EXHIBIT 2

04/08/2005

MEDICARE POLICY CLARIFICATIONS ON GRADUATE MEDICALEDUCATION PAYMENTS FOR RESIDENTS TRAINING IN NON-HOSPITAL SETTINGS

Question 1) How does Medicare support Graduate Medical Education (GME) programs?

Answer 1) Medicare makes both direct GME and indirect GME (IME) payments to hospitals that train residents in approved medical residency training programs. The calculation of both direct GME and IME payments is affected by the number of full-time equivalent (FTE) residents that a hospital is allowed to count. Generally, the greater the number of FTE residents a hospital counts, the greater the amount of Medicare direct GME and IME payments the hospital will receive. The Medicare statute provides for direct GME payments to hospitals to cover Medicare's share of the **hospital's** direct costs of the residency training taking place at the hospital. The direct GME payment is based on a hospital-specific per resident payment amount that is based on the **hospital's** direct graduate medical education program costs (including teaching physician and resident salaries) incurred in a base year. IME payments to a hospital are paid under the Inpatient Prospective Payment System (IPPS) as a percentage add-on for each Medicare patient discharged from the hospital. IME payments are designed to cover Medicare's share of the higher indirect costs of providing patient care at teaching hospitals relative to non-teaching hospitals. The higher costs are primarily due to increased or inefficient testing of patients by residents and the relatively increased level of patient acuity at teaching hospitals.

Question 2) Does Medicare make both direct GME and IME payments to hospitals for training residents at nonhospital sites?

Answer 2) Prior to October 1, 1997, hospitals could receive only direct GME payments for the time that residents train in nonhospital settings. However, Congress recognized the importance of moving more resident training out of the hospital setting and into settings that more closely reflect the settings where most physicians will practice. Accordingly, beginning with discharges occurring on or after October 1, 1997, the Balanced Budget Act of 1997 (BBA), amended the Medicare statute to allow hospitals to count residents in nonhospital sites for IME payment purposes as well. In making this change Congress intended to encourage hospitals to rotate more residents to nonhospital sites. In implementing this provision, CMS acknowledges the value of training more residents in nonhospital sites and it is our intent to make sure our rules encourage and facilitate this kind of activity.

However, since the per resident direct GME payment is based on all of the costs incurred by the hospital in training residents during a base year (including teaching physician costs), we believe Congress intended to permit hospitals to count time spent by residents training in nonhospital sites for purposes of IME and direct GME payments only if the hospital is actually incurring "all or substantially all the costs" of the residents training at

the nonhospital site. For this reason, our current regulations require a hospital to incur the residents' salaries and fringe benefits, travel and lodging costs where applicable and the cost of teaching physicians' salaries and fringe benefits attributable to supervision of resident training in the nonhospital setting.

Question 3) Are there situations where it's ok for a physician to volunteer his/her time to supervise residents in a nonhospital site?

Answer 3) Under section 1886(d)(5)(B)(iv) of the Social Security Act for IME, and section 1886(h)(4)(E) for direct GME, the time residents spend training in nonhospital settings in connection with approved programs may be included in determining the hospital's number of full time equivalent (FTE) residents, if, in addition to other requirements, the hospital incurs "all or substantially all" of the costs for the training program in the nonhospital setting. Accordingly, the relevant question is *not* whether volunteerism is permissible, but whether *there is a cost* to the nonhospital site for supervising the resident training. If there is a cost, the hospital must reimburse the nonhospital site for those costs. If there are no costs, then no payment for supervisory physician time is required. Typically, there is a cost for teaching physician time if, for example, the physician receives a predetermined compensation amount for his/her time at the nonhospital site that does not vary with the number of patients he/she treats. In contrast, there is typically no cost for teaching physician time if the physician's compensation at the nonhospital site is based solely and directly on the number of patients treated and for which he/she bills. The most obvious example of this situation would be a solo practitioner that serves as a nonhospital training site. With respect to compensation for teaching physicians, the hospital is required to compensate the nonhospital site for the costs of the teaching physician's activities provided in connection with an approved residency program <u>other</u> than the supervision of residents while furnishing billable patient care services. That is, only the costs associated with teaching time spent on activities within the scope of the GME program, but <u>not</u> in billable patient care activities, would be considered direct GME costs that would need to be incurred by the hospital.

Question 4) In the context of GME training in nonhospital sites, what is the difference between a "solo practitioner" and a "member of a group practice"?

Answer 4) A solo practitioner works in his/her own private office and a member of a group practice is typically one of several physicians employed at a particular nonhospital site. The solo practitioner's compensation is based solely and directly on number of patients treated and for which he/she bills. When the solo practitioner is not treating patients, he/she is not receiving payment for any other duties at the nonhospital site. In this instance, there is <u>no</u> cost to the nonhospital site for the teaching physician's time. In the case of the group practice or clinic setting, however, the physician often receives a predetermined payment amount, such as a salary, for his/her work at the nonhospital site. This predetermined payment amount reflects *all* of his/her responsibilities at the nonhospital site, including treating patients, training residents, and other administrative activities (as applicable), and he receives that predetermined payment from the nonhospital site regardless of how many patients he/she actually treats. The

predetermined amount implicitly compensates the physician for supervising residents. A portion of this implicit compensation is the *cost* attributable to teaching activities, and the hospital must pay the nonhospital site this amount.

Question 5) How do we determine the amount of teaching physician costs that the hospital must pay the nonhospital site?

Answer 5) Determination of the teaching physician costs to the nonhospital site is dependent upon the teaching physician's salary and the percentage of time he/she devotes to activities related to non-billable GME activities at the nonhospital site. Assume, for example, that a resident spends 30 hours per week training at the nonhospital site and the teaching physician works 40 hours per week at the nonhospital site. Also assume that 20 out of the resident's 30 hours are spent in billable patient care activities supervised by the teaching physician, leaving 10 hours of the time the teaching physician spends with the resident in non-billable GME teaching activities, such as general clinical didactic training or assessing the resident's performance. Accordingly, 25 percent (10/40) of the teaching physician's time is spent with the resident in non-billable GME activities. Additionally, the teaching physician may take some time beyond the 30 hours spent with the resident to perform some administrative tasks related to the program, such as completing resident evaluation forms. Again, for illustrative purposes, assume the teaching physician spends one hour out of the 40-hour workweek, or 2.5 percent of his/her time, completing evaluation forms. Therefore, in this example, the teaching physician spends 27.5 percent (25 percent plus 2.5 percent) of his/her time in non-billable GME activities. If the teaching physician receives a salary of $100,000 per year, then 27.5 percent, or $27,500 is the direct GME cost of the physician's teaching activities in the nonhospital site for a whole year. In this example, the hospital would need to pay $27,500 to the nonhospital site in order to count the FTE resident time spent in the nonhospital site for direct GME and IME payment purposes. (If residents are not trained at the nonhospital site throughout the whole year, then $27,500 would be prorated based on the number of weeks that residents train at the nonhospital site).

Question 6) Should the written agreement be with the teaching physician or with the nonhospital site where the physician works?

Answer 6) If the physician is self-employed (e.g., a solo practitioner in his/her own private office), then the physician and nonhospital site are one and the same, and the agreement would be with the physician. However, if the physician is an employee, or must report to another official(s) at the nonhospital site, then the written agreement must be between the hospital and an authorized representative of the nonhospital site.

Question 7) What if the physicians supervising the resident training at the nonhospital sites are employees of the hospital?

Answer 7) If the teaching physicians are employees of the hospital, and the physicians do not receive any additional compensation from the nonhospital site, no additional payment from the hospital is needed since the salaries paid by the hospital to the physicians cover

teaching costs inside and outside of the hospital. In such a case, the written agreements should indicate that the teaching physicians are on staff at the hospital, and the hospital is already incurring the teaching physician costs for training time in nonhospital settings (unless, after October 1, 2004, the hospital opts to forego a written agreement and, instead, documents that it pays the nonhospital site for the teaching physician costs concurrently with the training at that site in accordance with 42 CFR §413.78(e)).

Question 8) Must the hospital incur the teaching physician costs and have a written agreement with the nonhospital site if a) the nonhospital site is owned by the hospital, or b) the nonhospital site is owned by the same organization that owns the hospital?

Answer 8) In either scenario, the hospital must incur the teaching physician costs, and there must be a written agreement in place before the time the residents begin training in the nonhospital site (unless 42 CFR §413.78(e) applies, in which case a written agreement is not required). The hospital would need to demonstrate, under either ownership scenario, that it is paying all or substantially all of the costs of the training program by actually paying the nonhospital site through the hospital's accounts payable system. (If the hospital and nonhospital site share a single accounting system, the hospital could demonstrate payment of the nonhospital site training program costs using journal entries that expense these costs in the hospital's GME cost center and credit the nonhospital site.)

Question 9) What if the teaching physician is on the staff of a medical school and supervises residents in the hospital and in clinics owned by the medical school?

Answer 9) In this case, (unless the hospital opts to pay for the training program costs concurrently under 42 CFR §413.78(e)), rather than having a written agreement with each clinic, it would be appropriate for the hospital to have a written agreement with the medical school, since the medical school owns the clinics. If the residents are training in various medical school clinics, the hospital must have written agreement(s) reflecting the compensation arrangements for each clinic.

Following are examples of situations where there is no teaching physician cost associated with resident training in nonhospital sites, and, therefore, the hospital would not be required to pay the nonhospital site for teaching physician time in order to count the residents for direct GME and IME purposes:

a) A physician trains residents in his private practice. He is a solo practitioner; he does not share the office with other physicians. His compensation is based solely and directly on the number of patients treated and for which he bills.
b) A physician that supervises residents in her private practice shares office space with two other physicians. The three physicians share overhead expenses, such as electricity and rent, but otherwise, there is no sharing of revenues from patient care activities, and the physicians are not compensated according to some predetermined arrangement. Despite sharing office space, the physician that supervises the residents essentially operates as an independent practitioner,

receiving her compensation solely and directly from the number of patients she treats and for which she bills.

c) A resident goes along with a *solo practitioner* to see the physician's patients in a freestanding nursing home (not a Medicare-certified skilled nursing facility). The physician does not receive any payment from the nursing home, and bills independently for the patient care services he provides.

Following are examples of situations where there could be a teaching physician cost associated with resident training in nonhospital sites since, in each instance, the physician receives a predetermined compensation amount regardless of the number of patients he/she treats. In these instances, the hospital is required to identify and pay for the costs of supervising resident training at the nonhospital sites in order to count the residents for direct GME and IME purposes:

a) A physician receives a predetermined salary as compensation for working at a nonhospital site.
b) The compensation of a member of a group practice consists of a base salary, plus a percentage of revenues based on productivity (i.e., the number of patients he treats relative to other physicians in the practice), or seniority.
c) A physician that supervises residents is a member of a group practice. His compensation at the practice is based on the number of patients that he sees and for which he bills, plus additional compensation for other duties that he performs at the practice.
d) A physician is employed and paid by the State (or some other third party) to provide services in various state-owned nonhospital settings. The physician does not receive any predetermined compensation from the nonhospital settings themselves, and bills independently for the patients that she treats in these settings. At the request of Hospital A, the physician has agreed to teach several residents when she is working in some of these nonhospital settings. Hospital A would be required to pay the State (i.e., the employer of the physician) for the portion of the physician's salary attributable to GME activities at the applicable nonhospital sites. The written agreement(s) between the hospital and the State would list each clinic and would specify the amount of compensation attributable to each clinic (unless 42 CFR § 413.78(e) is applicable).

EXHIBIT 3

MEDICARE NON-PROVIDER AFFILIATION AGREEMENT

This Medicare Non-Provider Affiliation Agreement ("Agreement") is entered into effective as of July 1, 1999, by and between the University of California, San Francisco School of Dentistry ("School"), which is owned and operated by The Regents of the University of California (the "Regents"), and UCSF Stanford Health Care ("UCHC"), a California nonprofit public benefit corporation, on behalf of the Medical Center at the University of California, San Francisco ("UCSF").

WHEREAS the School trains dentistry residents in a variety of specialties, including Advanced Education in General Dentistry ("AEGD"), Orthodontics, Pediatric Dentistry, Graduate Prosthodontics and Periodontics (collectively "Programs"), all of which are accredited by the Commission on Dental Accreditation;

WHEREAS in order to complete their dental residency, the dentistry residents in these Programs must provide patient care activities;

WHEREAS, certain residents in the Programs provide patient care services at UCSF as part of their residency training;

WHEREAS [certain] residents in the AEGD program provide patient care services at the clinic located at 100 Buchanan Street, San Francisco ("Buchanan Clinic") which is owned by the Regents and operated by the School;

WHEREAS [certain] residents in the Orthodontics, Pediatric Dentistry, Graduate Prosthodontics and Periodontics programs provide patient care services at the clinic located at 707 Parnassus Avenue ("Parnassus Clinic"), which is owned by the Regents and operated by the School;

WHEREAS, consistent with the Affiliation Agreement of November 1, 1997, between the School and USHC, and in furtherance of its mission, USHC desires to play a role in the training of dentistry residents in specialties by accepting responsibility for the cost of training such residents at the Buchanan Clinic and the Parnassus Clinic;

NOW THEREFORE, and pursuant to 42 C.F.R. §§ 413.86(f)(4) and 412.105(f)(1)(ii)(C), the parties agree to the following:

1. The term of this Agreement shall be July 1, 1999 through June 30, 2000.

2. [redacted]

[redacted]

a. [redacted]

b. [redacted]

c. [redacted]

d. [redacted]

e. [redacted]

3. During the term of this Agreement, USHC will provide $99,957 in compensation to the School, which represents reasonable compensation for supervisory teaching activities at the Buchanan Clinic and the Parnassus Clinic. Specifically, this amount is calculated as follows:

a. $31,277 toward the AEGD Program Director's and AEGD Faculty's salary and fringe benefits, which is based on the time the AEGD Program Director and AEGD Faculty spend in teaching and supervisory activities at the Buchanan Clinic compared to the total time spent on activities compensated by the School.

b. $16,255 toward the Orthodontic Program Director's and Orthodontic Program Faculty's salary and fringe benefits, which is based on the time the Orthodontic Program Director and Orthodontic Program Faculty spend in teaching and supervisory activities at the Parnassus Clinic compared to the total time spent on activities compensated by the School.

c. $21,009 toward the Pediatric Dentistry Program Director's and Pediatric Dentistry Program Faculty's salary and fringe benefits, which is based on the time the Pediatric Dentistry Program Director and Pediatric Dentistry Program Faculty spend in teaching and supervisory activities at the Parnassus Clinic compared to the total time spent on activities compensated by the School.

d. $11,957 toward the Graduate Prosthodontics Program Director's and Graduate Prosthodontics Program Faculty's salary and fringe benefits, which is based on the time the Graduate Prosthodontics Program Director and Graduate Prosthodontics Program Faculty spend in teaching and supervisory activities at the Parnassus Clinic compared to the total time spent on activities compensated by the School.

e. $19,458 toward the Periodontics Program Director's and Periodontics Program Faculty's salary and fringe benefits, which is based on the time the Periodontics Program Director and Periodontics Program Faculty spend in teaching and supervisory activities at the Parnassus Clinic compared to the total time spent on activities compensated by the School.

4. [redacted]

5. [redacted]

6. [redacted]

7. [redacted]

8. [redacted]

9. [redacted]

10. [redacted]

DATE: 12/22/,1999

UCSF Stanford Health Care

By: John B Stone

Title: Interim COO

DATE: 12/22, 1999

UCSF School of Dentistry

By: Charles H. Tebolami

Title: Dean

EXHIBIT 4

AEGD					
[redacted]	$106,200	0.80	$84,960		
	$88,889	0.55	$48,889		
	$67,808	0.80	$54,246		
	$62,400	0.80	$49,920		
	$75,569	0.50	$37,785		
	$67,482	0.30	$20,245		
	$55,700	0.50	$27,850		
	$48,700	0.40	$19,480		
	$71,230	0.20	$14,246		
	$110,685	0.10	$11,069		
	$55,700	0.10	$5,570		
	$48,690	0.05	$2,435		
	$96,000	0.10	$9,600		
	$96,230	0.10	$9,623		
			$395,916	**$31,291**	**$31,277**
Ortho					
[redacted]	$101,330	0.50	$50,665		
	$102,400	0.20	$20,480		
	$168,048	0.30	$50,414		
	$50,000	0.10	$5,000		
	$79,200	0.10	$7,920		
	$69,400	0.10	$6,940		
	$52,800	0.20	$10,560		
	$85,800	0.50	$42,900		
	$50,000	0.10	$5,000		
	$58,800	0.10	$5,880		
			$205,759	**$16,262**	**$16,255**
Pedo					
[redacted]	$62,200	0.05	$3,110		
	$131,400	0.68	$89,352		
	$62,200	0.10	$6,220		
	$86,600	0.10	$8,660		
	$114,500	0.50	$57,250		
	$55,700	0.20	$11,140		
	$90,200	1.00	$90,200		
			$265,932	**$21,018**	**$21,009**
Grad Perio					
[redacted]	$130,000	0.90	$117,000		
	$149,530	0.15	$22,430		
	$125,652	0.45	$56,543		
	$121,700	0.10	$12,170		
	$80,900	0.25	$20,225		
	$52,800	0.20	$10,560		
	$73,800	0.10	$7,380		
			$246,308	**$19,467**	**$19,458**
Grad Pros					
[redacted]	$147,000	0.40	$58,800		
	$73,800	0.20	$14,760		
	$135,000	0.30	$40,500		
	$110,000	0.20	$22,000		
	$79,200	0.10	$7,920		
	$73,800	0.10	$7,380		
			$151,360	**$11,963**	**$11,957**
Totals			**$1,265,276**		**$99,957**

EXHIBIT 5

UCSF School of Dentistry Time Study
Conducted Oct-Dec 2005
Teaching Physician Supervisory Time in Nonprovider Setting

Summary: Activity		Total Hours
1)	Developing dental resident schedules and/or resident evaluations	126
2)	Care of individual patients while supervising dental residents resulting in billable services	765
3)	Care of individual patients resulting in billable services	299
4)	Education of other health professionals (medical/nursing/other students)	82
5)	Administrative/supervisory services unrelated to approved educational activities (operational activities)	204
6)	Research education activities	253
7A)	Classroom/Didactic activities within the nonhospital clinics	136
7B)	Classroom/Didactic activities outside of the nonhospital clinics	67
8)	Medical/Dental School activities (Activities that include ACGME, ADA or other resident agencies)	30
9)	Education of undergraduate medical activities	138
10)	Committees, Boards or Administrative Meetings	137
TOTAL Reported Hours for Two Week Period		2,237

Questions 1 & 7A as % of total reported hours	11.7%