PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

On the Record
2019-D38

PROVIDER-
Northeast Regional Medical Center

Provider No.: 26-0022

vs.

MEDICARE CONTRACTOR –
WPS Government Health Administrators

RECORD HEARING DATE –
February 28, 2019

Cost Reporting Period Ended –
May 31, 2011

CASE NO. – 15-0887

INDEX

ISSUE

Whether Northeast Regional Medical Center ("Northeast" or "Provider"), as a Sole Community Hospital ("SCH"), was properly reimbursed for indirect medical education costs for services provided to Medicare Advantage patients[1] for the fiscal year ending May 31, 2011.[2] In particular, whether the Cost Report Worksheet E Part A properly calculates the indirect medical education ("IME" or "indirect GME") settlement on Medicare Managed Care claims, for a SCH whose hospital specific rate ("HSR") exceeds the hospital's inpatient prospective payment system ("IPPS") federal rate.[3]

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("PRRB" or the "Board") concludes that WPS Government Administrators (the "Medicare Contractor"[4]), failed to properly pay the Provider a medical education payment for its discharges related to Medicare Part C managed care enrollees for its cost reporting period ending May 31, 2011 ("FY 2011"). The Board remands this cost report back to the Medicare Contractor to pay Northeast a medical education payment for its discharges related to Medicare Part C managed care enrollees, in addition to the payment determined by the HSR rate calculation.

INTRODUCTION

Northeast is located in Kirksville, Missouri and is one of a small number of hospitals that is both an SCH and a teaching hospital.[5] As an SCH, Northeast was entitled to be paid by the Medicare program for inpatient services provided to its Medicare **Part *A*** patients, the higher of the amount calculated based on its HSR, or the amount calculated based on the IPPS.[6] When the Medicare Contractor issued Northeast's Notice of Program Reimbursement ("NPR") for FY 2011, it paid Northeast based on its HSR,[7] removing a certain medical education add-on payment relating to Medicare **Part *C*** managed care enrollees.[8]

Northeast timely appealed the Medicare Contractor's determination to the Board and met the jurisdictional requirements of 42 C.F.R. §§ 405.1835 - 405.1840. Pursuant to Northeast's request for a hearing on the record, the Board conducted a record hearing based on the position papers, supplements, and evidentiary materials submitted.[9] Northeast was represented by

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[1] Prior to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 201, 117 Stat. 2066, 2176 (2003), Medicare Advantage was called "Medicare+Choice." This program is located in Part C of Title XVIII of the Social Security Act and are also referred to as Part C plans/patients. *See* 42 U.S.C. § 1395w-21.

[2] Provider's Final Position Paper at 2-3; Proposed Parties' Stipulation of Undisputed Facts and Principles of Law ("Stip.") at ¶ 1.8.

[3] *See* Provider's Final Position Paper, Exhibit P-2 at 10 of 19.

[4] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate.

[5] Stip. at ¶¶ 1.4 and 1.5.

[6] 42 U.S.C. § 1395ww(d)(5)(D)(i); 42 C.F.R. §§ 412.92(d), 412.73.

[7] Stip. at ¶ 2.3; Exhibit P-2 at 13 of 19.

[8] *See* Stip. at ¶ 2.4; *see also* Exhibit P-2 at 13 of 19.

[9] Provider's Request for Hearing on Record (Dec. 28, 2017).

Daniel J. Hettich, Esq. of King & Spalding LLP. The Medicare Contractor was represented by Jerrod Olszewski, Esq. of Federal Specialized Services.

STATEMENT OF FACTS

The Medicare statute at 42 U.S.C. § 1395ww(d)(1)(B) specifies that SCHs are "subsection (d) hospital[s]"[10] and are reimbursed by Medicare for **Part *A*** services based on the greater of the IPPS Federal amount or the HSR.[11] For FY 2011, the Medicare program paid Northeast based on its HSR because it was greater than the IPPS Federal amount. This case focuses on whether an SCH can receive an adjustment or additional payment for certain graduate medical education costs associated with Medicare Advantage patients enrolled under Medicare **Part *C*** regardless of whether the SCH is receiving reimbursement under the IPPS or HSR payment methodologies.

The IPPS Federal Rate is a fixed amount per diagnosis-related group, subject to certain regional and other adjustments for purposes of payment for "operating costs of inpatient hospital services" as defined in 42 U.S.C. § 1395ww(a)(4). An example of what the Board is referring to as "an adjustment" to the IPPS Federal rate is a payment for IME where: (1) "operating costs of inpatient hospital services" includes IME; and (2) the IPPS Federal Rate is adjusted to ensure it encompasses that cost but only for the subset of hospitals that incur IME costs.[12] There are also certain payments that the Board will refer to as "add-on" payments that are for payment of certain costs that are not encompassed by the definition of "operating costs of inpatient hospital services." An example of an add-on cost is direct GME where Congress excluded such costs from "operating costs of inpatient hospital services" but makes a separate payment as an add-on to the adjusted IPPS Federal Rate to the subset of hospitals that incur direct GME costs.[13]

In contrast, the HSR is based on the hospital's own operating costs for Medicare Part A patients, calculated with reference to a base year trended forward to account for inflation.[14] An additional or add-on payment is made for certain direct costs of graduate medical education as those costs are excluded from the definition of "operating costs of inpatient hospital services" in 42 U.S.C. § 1395ww(a)(4).[15]

Historically, the Medicare program has reimbursed hospitals for direct and indirect GME costs *only* in connection with Medicare patients enrolled in Medicare **Part *A***. Any direct or indirect GME costs associated the Medicare patients enrolled in Medicare **Part *C*** HMOs or managed care organizations ("MCOs") were reimbursed by those Part C HMOs/MCOs because "Medicare

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[10] 42 U.S.C § 1395ww(d)(1)(B). *See also*, 73 Fed. Reg. 48434, 48630 (Aug. 19, 2008) ("Although SCHs and MDHs are paid under special payment methodologies, they are hospitals that are paid under section 1886(d) of the Act.").

[11] 42 U.S.C. § 1395ww(d)(5)(D); 42 C.F.R. § 412.92(d). The Board notes that § 1395ww(d)(5)(D) relates to payment under § 1395ww(d)(1)(A) which pertains to "the amount of payment with respect to the inpatient operating costs of inpatient hospital services) (as defined in subsection (a)(4)) of a subsection (d) hospital . . . ." Further, § 1395ww(b)(1) makes it clear that the term "inpatient operating costs" as it is used in the HSR context pertains only to costs associated with Medicare **Part *A*** patients.

[12] *See* 42 U.S.C. §§ 1395ww(a)(4), 1395ww(d)(1)(A), 1395ww(d)(2)(C), 1395ww(d)(3), and 1395ww(d)(5); 42 C.F.R. § 412.2(f).

[13] *See* 42 U.S.C. §§ 1395ww(a)(4), 1395ww(d)(1)(A), and 1395ww(h); 42 C.F.R. § 412.2(f). Direct GME is excluded from the definition of "operating costs of inpatient hospital services" and the method used to pay for direct GME is applied to teaching hospitals regardless of whether they were subject to the HSR or IPPS payment method.

[14] 42 U.S.C. § 1395ww(b)(3)(C)(i)(l) ("[i]n the case of a hospital that is a sole community hospital . . . the term 'target amount' means . . . the allowable operating costs of inpatient hospital services . . . .").

[15] *See also* 42 C.F.R. §§ 413.75 – 413.83. *See supra* note 13.

payments to risk-contract HMOs include[d] amounts that reflect[ed] Medicare's fee-for-service payments to hospitals in an area for indirect and direct graduate medical education costs."[16] In §§ 4622 and 4624 of the Balanced Budget Act of 1997 ("BBA"), Congress changed this payment scheme by amending the Medicare statutory provisions governing payments for subsection (d) hospitals to have the Medicare program pay hospitals directly for both indirect and direct GME costs associated with Medicare patients enrolled in Medicare **Part *C***. In particular, with respect to indirect GME costs, BBA § 4622 added 42 U.S.C. § 1395ww(d)(11) to provide to subsection (d) teaching hospitals an "additional payment" for each applicable discharge of an individual who is enrolled under Medicare Part C.[17] In particular, § 1395ww(d)(11) states:

> (11) ***ADDITIONAL PAYMENTS*** FOR MANAGED CARE ENROLLEES.
>
> (A) IN GENERAL.—For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an ***additional payment*** amount for each applicable discharge of any subsection (d) hospital that has an approved medical residency training program.
>
> (B) APPLICABLE DISCHARGE.—For purposes of this paragraph, the term "applicable discharge" means the discharge of any individual who is enrolled under a risk–sharing contract with an eligible organization under section 1876 and who is entitled to benefits under part A or *any individual who is enrolled with a Medicare+Choice organization under* ***part C***.
>
> (C) DETERMINATION OF AMOUNT.—The amount of the payment under this paragraph with respect to any applicable discharge shall be equal to the applicable percentage (as defined in subsection (h)(3)(D)(ii)) of the estimated average per discharge amount that would otherwise have been paid under paragraph (5)(B) if the individuals had not been enrolled as described in subparagraph (B).[18]

Significantly, while the title of § 4622 refers to this additional payment as "payment . . . of indirect medical education costs" (*i.e.*, a payment for IME), *the actual statutory language* added to the Medicare statute does not refer to or characterize the "additional payment" as relating to "indirect medical education" but rather simply refers to it as an "additional payment" to an otherwise "approved medical residency training program." Indeed, the actual statutory language does *not* describe the costs that the "additional payments for managed care enrollees" covers.

As part of the final rule published on August 29, 1997, CMS implemented § 1395ww(d)(11) by modifying its regulations related to IME payments located at 42 C.F.R. § 412.105.[19] Specifically, CMS added a new paragraph (g) to 42 C.F. R. § 412.105 stating:

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[16] H.R. Rep. No. 105-217, at 658, 818 (1997), *reprinted in* 1997 U.S.C.C.A.N. 176, 279, 439 (Conf. Rep. for BBA).
[17] Pub. L. No. 105-33, § 4622, 111 Stat. 251, 477 (1997).
[18] (Emphasis added.)
[19] 62 Fed. Reg. 45966, 46003 (Aug. 29, 1997).

> (g) *Indirect medical education payment for managed care enrollees*. For portions of cost reporting periods occurring on or after January 1, 1998, a payment is made to hospital for indirect medical education costs, as determined under paragraph (e) of this section, for discharges associated with individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1876 of the Act or with a Medicare+Choice organization under title XVIII, **Part C** of the Act during the period, according to the applicable payment percentages described in §§ 413.76(c)(1) through (c)(5) of this subchapter.[20]

Medicare regulations related to the payment of SCHs are located at 42 C.F.R. § 412.92(d). These regulations provide the following instruction on payment of SCHs based on either the HSR rate or the IPPS Federal rate:

> (1) General rule. For cost reporting periods beginning on or after April 1, 1990, a sole community hospital is paid based on whichever of the following amounts yields the greatest aggregate payment for the cost reporting period:
>
> (i) The Federal payment rate applicable to the hospitals as determined under subpart D of this part.
>
> (ii) The hospital-specific rate as determined under § 412.73.
>
> (iii) The hospital-specific rate as determined under § 412.75.
>
> (iv) For cost reporting periods beginning on or after October 1, 2000, the hospital-specific rate as determined under § 412.77 (calculated under the transition schedule set forth in paragraph (d)(2) of this section).
>
> (v) For cost reporting periods beginning on or after January 1, 2009, the hospital-specific rate as determined under § 412.78.

With respect to the HSR, 42 C.F.R. §§ 412.75. 412.77 and 412.78 state that the HSR is based on "the hospital's Medicare **Part *A*** allowable inpatient operating costs, as described in § 412.2(c)"[21] which is entitled "inpatient operating costs." Similarly, 42 C.F.R. § 412.73 applies to the **Part *A*** costs on a per discharge basis.[22] None of these regulations *specifically* address a medical education payment (whether for indirect or direct costs) for managed care enrollees under Medicare **Part *C***. Additionally, the cost report instructions for the years under appeal do

[20] (Bold and underline emphasis added and italics emphasis in original.)
[21] 42 C.F.R. §§ 412.75(a), 412.77(b), and 412.78(b).
[22] Specifically, per § 412.73(a), the costs are "the hospital's estimated adjusted base-year operating cost" and the base year operating cost is defined in § 412.71(a) as "the hospital's Medicare **Part *A*** allowable inpatient operating costs, as described in § 412.2(c), for the 12-month or longer cost reporting period ending on or after September 30, 1982 and before September 30, 1983." (Emphasis added.)

not specifically include the payment for medical education for managed care enrollees under Medicare **Part *C*** when the provider's HSR exceeds the federal payment rate.[23]

As part of the FY 2015 IPPS Final Rule published on August 22, 2014, CMS revised its policy and the related cost report instructions for cost reporting periods beginning on or after October 1, 2014.[24] The revised policy and cost report instructions include payment pursuant to 42 U.S.C. § 1395ww(d)(11) to SCHs for medical education for managed care enrollees under Medicare Part C when the SCH is paid on the basis of its HSR.[25] CMS gave the following explanation for making this change:

> After further consideration of the language at section 1886(d)(11) of the Act, we believe that the statute would allow an SCH that is paid based on its hospital-specific rate to receive IME add-on payments for its Medicare Part C patient discharges. Section 1886(d)(11)(A) of the Act provides for an additional payment amount for each applicable discharge of a Medicare Part C patient of a subsection (d) hospital that has an approved medical residency training program. Section 1886(d)(11)(C) of the Act sets forth the amount of this additional payment, by reference to the amount that would otherwise have been paid under section 1886(d)(5)(B) of the Act. We believe that section 1886(d)(11)(C) of the Act can be interpreted as simply establishing the methodology for calculating the amount of the add-on payment, without limiting the applicability of the add-on payment to those SCHs that are paid based on the Federal rate.[26]

In furtherance of this rulemaking, CMS enacted the following procedures for calculating the indirect GME payment for Part C patients *on a prospective basis*:

> In summary, effective with discharges occurring in cost reporting periods beginning on or after October 1, 2014, our final policies are: (1) To provide all SCHs that are subsection (d) teaching hospitals IME add-on payments for Medicare Part C patient discharges in accordance with [42 U.S.C. § 1395ww(d)(11)]; and (2) for purposes of the comparison of payments based on the Federal rate and the hospital-specific rate for SCHs under [42 U.S.C. § 1395ww(d)(5)(D)], IME add-on payments under [42 U.S.C. § 1395ww(d)(11)] for Medicare Part C patient discharges will no longer be included in the aggregate payment based on the Federal rate.[27]

This case focuses on whether or not Northeast, as an SCH and as a subsection (d) teaching hospital, is entitled under 42 U.S.C. § 1395ww(d)(11) to receive an additional medical education payment for its managed care enrollees under Medicare **Part *C*** for FY 2011 cost report

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[23] Provider's Final Position Paper at 3 (citing Provider Reimbursement Manual, CMS Pub. 15-2 ("PRM 15-2"), § 3630.1 (instructions as amended January 2010 for Form CMS-2552-96) (copy included at Exhibit P-5)).
[24] 79 Fed. Reg. 49853, 50002 (Aug. 22, 2014). *See also* Provider's Final Position Paper at 6.
[25] *See* 79 Fed. Reg. 27978, 28092-28093 (May 15, 2014); 79 Fed. Reg. 49853, 50002-50004 (Aug. 22, 2014).
[26] 79 Fed. Reg. at 50002.
[27] *Id*. at 50004.

notwithstanding the fact that it was paid for services rendered to Medicare **Part *A*** patients based on its HSR rather than the IPPS Federal rate.[28]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The Medicare Contractor argues that it properly relied on cost report instructions that were in effect for FY 2011 to determine Northeast's reimbursement.[29] Based on Worksheet E Part A of the Medicare cost report, the Medicare Contractor submits that it was otherwise *required* to use the higher of either the IPPS Federal rate (which includes the additional payment medical education for managed care enrollees) or the HSR rate (which does not include the additional payment for medical education for managed care enrollees) when determining Northeast's Medicare payments for FY 2011.[30] As Northeast was paid based on its HSR rate, it did not receive the additional payment for medical education for its managed care patients when its FY 2011 cost report was settled.[31] The Medicare Contractor maintains that this is correct because 42 C.F.R. § 412.92(d) provides the instructions on how to determine the prospective payment for SCHs and it does not mention an additional payment for medical education for managed care enrollees.[32]

In addition, the Medicare Contractor relies on certain *post-hoc* rulemaking statements in the preamble to the August 22, 2014 Final Rule that assert that CMS has previously been clear that the HSR calculation does not include add-on payments (*i.e.*, IME and DSH), and that a new policy to pay for medical education associated with Medicare Part C patients was to only apply for cost reports beginning on or after October 1, 2014.[33] Additionally, the Medicare Contractor points to the Administrator's decision in *Mary Imogene Basset Hosp. v. National Gov. Servs.* ("*Mary Imogene*") where the Administrator addressed the same legal issue that is before the Board in this case. The Medicare Contractor notes that the Administrator overturned the Board's decision in *Mary Imogene* stating: "while [§ 1395ww(d)(11)] is instructive as to the payment under [1395ww(d)] Federal rate payment determination, it is silent as to including a IME payment for a SCH HSR paid under section [1395ww(b)] methodology."[34]

Northeast argues that 42 U.S.C. § 1395ww(d)(11) is clear, and requires that ***any*** subsection (d) hospital (which includes an SCH) be paid an "additional payment" for medical education for managed care enrollees.[35] Northeast recognizes the Medicare Contractor's position that Northeast cannot receive this payment for FY 2011 because, prior to October 1, 2014, there was no mechanism for SCHs to receive it whenever an SCH was paid based on the HSR rate.[36] However, Northeast maintains that the Medicare Contractor's position represents a failure on the part of CMS to comply with the statute and the regulations.[37]

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[28] *See* Stip. at ¶ 1.10.
[29] MAC Final Position Paper at 6; Stip. at ¶¶ 2.1 - 2.4. *See also* PRM 15-2, § 3630.1 and § 4030.1.
[30] Stip. at ¶¶ 2.1 - 2.4.
[31] *Id.* at ¶ 2.4
[32] MAC Final Position Paper at 7.
[33] *Id.* at 7-8 (citing 79 Fed. Reg. 49853, 50002 (Aug. 22, 2014)).
[34] MAC Supplemental Final Position Paper at 2-4 (referencing *Mary Imogene Bassett Hosp. v National Gov. Servs., Inc.*, Adm'r Dec. at 12 (Apr. 26, 2018), *rev'g*, PRRB Dec. No. 2018-D25 (Feb. 27, 2018) (copy at Exhibit I-4) (hereinafter "Adm'r's Decision")).
[35] Provider's Final Position Paper at 9.
[36] *Id.* at 12-13.
[37] *Id.* at 13.

At the outset, it is important to recognize the context in which Congress made BBA § 4622. As previously noted, any direct or indirect GME costs associated with patients enrolled in Medicare **Part *C*** HMOs or MCOs historically were reimbursed indirectly by those Part C HMOs/MCOs because "Medicare payments to risk-contract HMOs include[d] amounts that reflect[ed] Medicare's fee-for-service payments to hospitals in an area for indirect and direct graduate medical education costs."[38] However, in 1997, Congress opted to have the Medicare program begin paying hospitals directly for *both* direct *and* indirect GME costs associated with Medicare **Part *C*** patients and, accordingly, enacted BBA §§ 4622 and 4624.

Consistent with BBA § 4624 addressing direct GME costs, the record confirms that the Medicare Contractor ***did*** allow reimbursement for Northeast's ***direct*** GME costs, presumably including any costs associated with Medicare **Part *C*** patients.[39] However, notwithstanding BBA § 4622, the Medicare Contractor denied reimbursement for Northeast's ***indirect*** GME costs associated with Medicare **Part *C*** patients. As the HSR reimbursement methodology only pays for the inpatient operating costs associated with Medicare **Part *A*** patients, it is clear that Northeast did not receive any reimbursement for the indirect GME costs associated with Medicare **Part *C*** patients. Accordingly, at first blush, there is a fundamental fairness concern in this case because Northeast has not been made whole for all of the GME costs (both direct *and* indirect) associated with its Medicare **Part *C*** patients for FY 2011.

With this understanding, the Board reviewed 42 U.S.C. § 1395ww(d)(11) and the implementing regulations at 42 C.F.R. § 105(g). The Board points out that Congress established the "additional payment" for medical education payment for managed care enrollees by adding a new § 1395(d)(11). Notably, Congress did not establish this new "additional payment" by modifying the existing statutory provisions addressing indirect GME located at 42 U.S.C. § 1395ww(d)(5)(B). Moreover, the actual statutory language of § 1395(d)(11) does not either use or refer to the terms "indirect medical education" or "IME." The Board finds these facts significant because Congress never established this payment under § 1395(d)(11) as an "IME" adjustment to the IPPS Federal Rate.

The Board recognizes that CMS implemented § 1395ww(d)(11) by revising its IME regulations.[40] However, in doing so, CMS was clear that this payment was for discharges associated with individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1876 of the Act (*i.e.*, 42 U.S.C. § 1395mm) or with a Medicare Advantage (previously known as a Medicare+Choice) organization under title XVIII, Part C of the Act, and *not for discharges of Medicare **Part A** patients*. As both § 1395ww(d)(11) and associated CMS regulations are clear that this payment is not for ***Part A*** discharges, the Board finds this payment to be a general "add-on" payment, not an adjustment to the subsection (d) hospital's ***Part A*** IPPS payment rate because 42 U.S.C. §§ 1395ww(d)(2) and 1395(d)(3) make clear that the adjusted per discharge IPPS rates are for discharges of Medicare **Part *A*** patients.

As such, the Board agrees with Northeast that for cost reporting periods occurring on or after January 1, 1998, Congress explicitly provided a general "add-on" payment for Medicare Part C patients to "***any*" subsection (d) hospital** with an approved medical residency training program.[41] The Board finds that Congress's specific command to CMS is to provide the

[38] H.R. Rep. No. 105-217, at 658, 818 (1997), *reprinted in* 1997 U.S.C.C.A.N. 176, 279, 439 (Conf. Rep. for BBA).
[39] *See* Exhibit P-2 at 13, Line 52. *See also* Exhibit P-2 at 15 (copy of the PS&R showing Part C days claimed).
[40] 42 C.F.R. § 412.105.
[41] 42 U.S.C § 1395ww(d)(11).

"add-on" payments to any subsection (d) hospital with an approved medical residency training program, and that this must be given context and effect.[42] Importantly, neither the statute, nor the CMS regulations at 42 C.F.R. § 412.105(g), carve out SCHs paid under the HSR, for differential treatment regarding the Part C medical education add-on payment. Indeed, as HSR payment methodology is, by definition, for inpatient operating costs associated with Medicare **Part *A*** patients, it inherently does not (and cannot) include any payment associated with graduate medical education costs (whether direct or indirect) associated with Medicare **Part *C*** patients. This is why Congress structured payment for the indirect GME costs associated with Medicare **Part *C*** patients as an "additional payments for managed care enrollees" and did not label or define it as an actual "IME" payment as that term is used elsewhere in the Medicare statutory provisions for payment of such costs associated with Medicare **Part *A*** patients.[43]

In *Mary Imogene Bassett*,[44] the Administrator reversed the Board's decision and found the Medicare Contractor was correct in not allowing the medical education payment described in 1886(d)(11) because the SCH was paid its HSR. The Administrator gave four different reasons for overturning the Board's decision:

1. "[W]hile [§ 1395ww(d)(11)] is instructive as to the payment under the [§ 1395ww (d)] Federal rate payment determination, it is silent as to including a IME payment for SCH HSR paid under the [§ 1395ww(b)] methodology. The silence is relevant when viewed in the context of Congresses' [*sic*] specific statutory direction and instruction as to method of paying sole community hospitals under [§ 1395ww(d)(5)(i)], which incorporated the [§ 1395(b)(3)(C)] non-IPPS HSR methodology and also the [§ 1395ww(b)(3)(I)] non-IPPS HSR methodology."

2. "CMS has repeatedly stated in notice and comment rulemaking that no IPPS add-ons were included in the HSR calculations throughout the time period prior to the 2015 effective change in methodology."

3. "It is reasonable to conclude that Congress was aware of CMS' pre-2015 stated policy when it repeatedly revisited the HSR methodology at [§ 1395ww(b)] after the addition of [§ 1395ww(d)(11)] and continued to remain silent as to the addition of the IME related managed care add-on under the HSR methodology."

4. "Thus, the Secretary reasonably concluded that the language at [§ 1395ww(d)(11)] did not directly address the matter, but also did not prohibit going forward with the policy[45] of allowing the inclusion of this payment in the HSRs for SCHs prospectively."[46]

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[42] *Jarecki v. G.D. Searle & Co.*, 367 U.S. 303, 307-08 (1961).
[43] Similarly, in connection with direct GME, the Board notes that 42 U.S.C. § 1395ww(a)(4) defines "operating costs of inpatient hospital services" in a manner that excludes "costs of approved educational activities" and, accordingly, SCHs are paid for their direct GME costs associated with *both* Medicare Parts A *and* C patients.
[44] *Mary Imogene Bassett vs. National Government Services, Inc.* PRRB Dec. No. 2018-D25.
[45] *Mary Imogene Bassett*, Adm'r's Decision at 10 ("The Administrator finds that the FY 2015 IPPS proposed and final rule stated explicitly that the Secretary was implementing a prospective change in policy . . . .").
[46] *Id.* at 11-12.

At the outset, the Board notes that it is not bound by the Administrator's decision in *Mary Imogene Bassett* because, during the time period at issue, the Administrator's policy as stated therein had not been codified in regulation, statute, or ruling. In this regard, PRM Pub. 15-1 § 2927.C.6 states:

> (e) Nonprecedential Nature of the Administrator's Review Decision.—Decisions by the Administrator are not precedents for application to other cases. A decision by the Administrator may, however, be examined and an administrative judgment made as to whether it should be given application beyond the individual case in which it was rendered. If it has application beyond the particular provider, the substance of the decision will, as appropriate, be published as a regulation, HCFA Ruling, manual instruction, or any combination thereof so that the policy (or clarification of policy having a basis in law and regulations may be generally known and applied by providers, intermediaries, and other interested parties.

Although the Board is not bound by the Administrator's decision in *Mary Imogene Bassett*, it still reviewed the rationale in the decision to determine its relevance to the Northeast appeal. Based on its review the Board disagrees with the Administrator's interpretation of Congressional actions (or inactions) regarding the "additional payment" for medical education payments to SCHs. The Board finds Congress was clear – not silent - that "any" subsection (d) hospital is to be paid "additional payments" for **managed care enrollees**. In establishing "additional payments" for medical education for managed care enrollees, Congress did not modify the statutory provisions governing payment of IME for Medicare Part A patients[47] or the IPPS payment rate for Part A inpatient discharges. Rather, Congress implemented a new § 1395ww(d)(11) requiring an additional payment to "***any***" subsection (d) hospitals with an approved medical residency training program, for managed care discharges. Since Congress based this payment on the hospital's discharges of individuals who were enrolled ***under Part C***, not discharges paid under Part A, the Board finds there was no need for Congress to change either §§ 1395ww(d)(5)(D)(i) or 1395ww(b)(3) as argued by the Administrator since these statutory provisions pertain to Medicare **Part *A***.

The Administrator also argued that CMS has repeatedly stated in *post-hoc* notice and comment rulemaking that no IPPS adjustments were included in the HSR calculations prior to the 2015 methodology change. In making these *post-hoc* statements, the Administrator referenced the following statement in the preamble to the August 29, 1997 final rule:

> Because hospitals receiving their hospital-specific rate do not receive outliers, IME, or DSH, they are unaffected by the policy changes related to these additional payments.[48]

Additionally, the Administrator pointed out that 42 C.F.R. §§ 412.73, 412.75, 412.77 and 412.78 do not provide for an "IME" payment with respect to the HSR methodology consistent with the general principal that the "IME" adjustment is an IPPS adjustment payment.[49]

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[47] 42 U.S.C. § 1395ww(d)(5)(B).
[48] Administrator's Decision at n.7 (quoting 62 Fed. Reg. 45966, 46122 (Aug. 29, 1997)).
[49] *Id.* at 8.

The Board agrees with the Administrator that IME, DSH and outliers are adjustments to the IPPS payment (*i.e.*, encompassed by the definition of "operating costs of inpatient hospital services" for **Part *A*** discharges) and, as such, should not be included in a SCH's HSR payment. However, as discussed previously, Congress did not make the medical education payment for managed care enrollees an "IME" payment and did not base that payment on the number of ***Part A*** discharges.[50] Rather, that payment is based on the number of **Part *C*** discharges. As such the Board finds that CMS' prior statements related to "IME" and the HSR rate do not apply to payments under § 1395ww(d)(11). The Board concludes that the "additional payment" for medical education for managed care enrollees is not an "IME" adjustment (as that term is used in § 1395ww(d)) to the IPPS rate and, therefore, an SCH that is also a teaching hospital must be paid a medical education payment for its managed care enrollees regardless of whether the SCHs payments are determined based on the IPPS Federal rate or the HSR rate.

Finally, the Board understands that the Medicare Contractor followed the cost report instructions for cost reporting periods prior to October 1, 2014, and that these instructions did not *specifically* provide for the "additional payment" of medical education for managed care enrollees when an SCH hospital is paid based on its HSR rate. However, based on 42 C.F.R. § 405.1867, the Board must comply with all provisions of the statute and regulations issued thereunder and must only afford great weight to the agency policies/manuals such as the cost report instructions in PRM 15-2. The Board finds the language in § 1395ww(d)(11) and the regulations at 42 C.F.R. § 412.105(g) unambiguously mandate that "***any***" subsection (d) hospitals with approved medical residency training programs are entitled to an "additional payment" for medical education for their managed care enrollees. Therefore, the Board concludes that Northeast is entitled to an "additional payment" for medical education for its managed care enrollees for its FY 2011 cost reporting period, notwithstanding the fact that the cost reporting instructions in effect for this period did not specifically provide for this payment when the SCH was paid based on its HSR rate. The Board remands Northeast's FY 2011 cost report back to the Medicare Contractor to pay Northeast the "additional payment" for medical education for its managed care enrollees that it is entitled to under 42 U.S.C. § 1395ww(d)(11).

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board concludes that the Medicare Contractor failed to properly pay Northeast a medical education payment for its discharges related to Medicare Part C managed care enrollees for its cost reporting period ending May 31, 2011. The Board remands this cost report back to the Medicare Contractor to pay Northeast a medical education payment for its discharges related to Medicare Part C managed care enrollees, in addition to the payment determined by the HSR rate calculation.

[50] Not only does the actual text for § 1395ww(d)(11) *not* identify the "additional payments" as being related to IME, it does not specifically identify or define any "costs" the "additional payment" for managed care enrollees is covering. Rather, it is simply describes the "additional payments for managed care enrollees" as "an additional payment amount for each applicable discharge of any subsection (d) hospital that has an approved medical residency program."

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For the Board:

8/30/2019

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A