PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2011-D34

PROVIDER -
Sutter 98-99 Managed Care (CIRP) Group

Provider Nos.: See Attachment

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
First Coast Service Options, Inc

DATE OF HEARING -
September 21, 2010

Cost Reporting Periods Ended -
December 31, 1998; December 31, 1999

CASE NO.: 05-1740G

INDEX

ISSUE:

Whether the Intermediary improperly disallowed direct graduate medical education (DGME) and indirect medical education (IME) payments related to managed care days, discharges, and simulated payments solely on the grounds the provider failed to submit UB 92 claim forms for Medicare managed care.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§ 1395 *et seq*. The Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries (FI) and Medicare Administrative Contractors (MAC). FIs and MACs determine payment amounts due the providers under Medicare law, regulation and interpretative guidelines published by CMS. 42 U.S.C. § 1395h, 42 C.F.R. §§ 413.20 and 413.24.[1]

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. § 413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. § 405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. § 1395oo(a); 42 C.F.R. §§405.1835 – 405.1837.

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the Prospective Payment System (PPS). The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors. See, 42 U.S.C. § 1395ww(d). This case involves two of those provisions.

The provision at 42 U.S.C. § 1395ww(h) prescribes the Medicare payment method for direct graduate medical education (GME) costs. In brief, the direct GME payment is the product of a hospital's average per resident costs, derived and updated from a 1984 base period, multiplied by the hospital's number of interns and residents in approved GME programs during the payment year, multiplied by the hospital's Medicare patient load. The Medicare patient load is a

[1] Both FI and MAC hereinafter referred to as intermediary.

fraction representing the percentage of a hospital's total patient days (denominator) attributable to Medicare patients (numerator).

The provision at 42 U.S.C. § 1395ww(d)(5)(B) provides that teaching hospitals that have residents in approved GME programs receive an additional payment for each Medicare discharge to reflect the higher indirect patient care costs of teaching hospitals relative to non-teaching hospitals. Regulations at 42 C.F.R. § 412.105 establish how the additional payment is calculated. The additional payment, known as the IME adjustment, is based on the indirect teaching adjustment factor, calculated using the hospital's ratio of full-time equivalent (FTE) residents to beds.

DGME and IME payments for Medicare+Choice[2] beneficiaries

Prior to the enactment of the Balanced Budget Act of 1997 (BBA '97), the numerator of the Medicare patient load fraction included only the number of patient days attributable to the Medicare beneficiaries who were entitled to have payment made under the Medicare Part A fee-for-service program. CMS did not include inpatient days attributable to enrollees in Medicare risk plans (i.e., Medicare Health Maintenance Organizations (HMOs) or Competitive Medical Plans (CMPs) with risk sharing contracts under section 1876 of the Act). In 1989, when CMS promulgated the regulations implementing the prospective payment method for GME, the agency determined that these Medicare managed care plan days would not be counted as Medicare days in the Medicare patient load used to calculate Medicare payment for GME.[3]

Section 4624 of BBA '97 amended the DGME statute by adding a new provision in section 1395ww(h)(3)(D) for an additional GME payment with respect to patient days attributable to services furnished to Medicare beneficiaries enrolled in a Medicare+Choice plan. The regulations implementing this provision were codified at 42 C.F.R. § 413.86. Similarly, BBA '97 amended the IME statute by adding a new provision in 42 U.S.C. § 1395ww(d)(5)(B). The regulations implementing this provision are set forth in 42 C.F.R. § 412.105(g).

In addition, CMS issued Program Memorandum Transmittal No. A-98-21 which implemented the provision and mandated the same claims filing practices as used for all other claims. Accordingly, a hospital is to submit a "no-pay" claim for each managed care enrollee in UB-92 format with appropriate condition codes.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Sutter Medical Center Sacramento (SMCS) and Sutter Merced Medical Center (Sutter Merced) (Providers) are teaching hospitals located in northern California.

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[2] The term Medicare+Choice will be used to represent "Medicare+Choice plan or any other Medicare managed care plan with a risk sharing contract under section 1876 of the Act."

[3] 54 Fed. Reg. 40286, 40294-95 (Sept. 29, 1989).

The cost reporting periods at issue in this appeal are the periods ended December 31, 1998 for SMCS, and December 31, 1999 for Sutter Merced. United Government Services, LLC[4] (Intermediary) audited both of the cost reports and made final determinations relating to the IME and DGME payments with respect to Medicare+Choice beneficiaries.

The Providers have supplied the Intermediary with the patient information regarding the Medicare managed care reimbursement at issue. However, both parties request that the legal question in this appeal be answered prior to having the Intermediary review the information supplied.

The Providers appealed the disallowances to the Board and met the jurisdictional requirements of 42 C.F.R. §§ 405.1835 - 405.1841. The Providers were represented by John P. Wagner, Esq., of Nossaman, LLP. The Intermediary was represented by James R. Grimes, Esq., of Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Providers argue that the Intermediary's requirement of a UB-92 claim form submission for Medicare managed care payments is not found in law or regulations. The Providers assert that changes enacted in BBA '97 allowed the Providers to receive additional DGME and IME payments based on costs attributable to Medicare managed care enrollees. The Providers note nothing in the Conference Report[5] or the text of the statute states the Medicare program may deny the additional managed care reimbursement Congress specifically enacted solely for a provider's failure to file Medicare claim forms. Similarly, the Providers argue the regulation at 42 C.F.R. § 412.105(e)-(g) does not require submission of claim forms as a prerequisite to Medicare managed care reimbursement. The Providers list numerous federal registers discussing rule changes to this regulation.[6] The Providers find it significant that the Secretary did not promulgate any amendment to the regulations stating Medicare managed care reimbursement would be contingent upon a provider submitting claim forms.

The Providers do not believe Program Memorandum (PM) A-97-13, PM A-98-21 or Provider Reimbursement Manual, Part 2 §36-136 condition reimbursement for Medicare managed care IME/DGME reimbursement upon submission of claim forms. The Providers argue in the alternative that if PM A-98-21were to be interpreted to require submission of claim forms as a prerequisite to Medicare managed care reimbursement they would still prevail for three reasons. First, the PM does not rise to the authoritative level of the Provider Reimbursement Manual. Second, the PM cannot create an additional requirement not contained in

[4] Subsequently the Intermediary changed to National Government Services, LLC and then First Coast Service Options, Inc. All of these organizations are affiliated with the BlueCross BlueShield Association.
[5] See Provider Exhibit P-8.
[6] See Providers' Final CIRP Group Position Paper to the Board, pg 4.

the applicable statute or regulation. Third, if CMS wanted to impose the claims form prerequisite it was obligated to do so by notice-and-comment rulemaking pursuant to the Administrative Procedure Act (APA), 5 U.S.C. § 553.

The Intermediary notes the Providers failed to submit UB-92 claims for Medicare managed care and therefore, those claims were not summarized on the Provider Statistical & Reimbursement Report (PS&R). Since the Medicare Cost Report instructions at Provider Reimbursement Manual, Part 2 § 3630 require the Intermediary to use the PS&R data to support Medicare managed care days the Intermediary believes their adjustments should stand. The Intermediary then references several Administrator Decisions to support its position.[7]

The Providers respond to the Intermediary's reliance on the Administrator's Decisions in their brief entitled, "Providers' Response to Intermediary's Revised Position Paper." They believe the Administrator relied on the following three pronouncements to support his/her position: (1) Response to Comments: one sentence in the preamble to the Final PPS Rule for FY 1998; (2) CMS PM A-98-21; and (3) Medicare Bulletin 416, July 13, 1998. The Providers assert the preamble to the Final PPS Rule for FY 1998 relied on by the Administrator only "anticipates" a continuing "process" and does not rise to the status of a substantive rule. The Providers then cite subsequent federal registers that indicate UB-92 claim forms were not required to be submitted by providers.[8] The Providers assert none of the pronouncements the Administrator relied upon have the force of law. The Providers also point out the Board has found the Medicare Bulletin 416, July 13, 1998 to be "confusing" and "simply states that you 'may' bill," which supports the Providers' position. Finally, the Providers refer to Cottage Health System v. Sibelius, 631 F.Supp.2d 80 D.D.C. 2009, (July 07, 2009) (Cottage Health)[9] for the finding that the claims filing requirement would violate the Paperwork Reduction Act (PRA), 44 U.S.C. § 3501 *et seq.*

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and program instructions, the evidence presented and the parties' contentions, the Board finds and concludes as follows:

BBA '97 provided IME and DGME payments for services provided under risk HMO contracts that, prior to the BBA, had not been available. The Secretary was given broad authority to provide for or devise a way to pay hospitals supplemental payments for DGME and IME. 42 U.S.C. § 1395ww(h)(3)(D) entitled "Payment for managed care enrollees" states:

> (i) *In general*. For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall

[7] See Intermediary's Final (Revised) Position Paper, pg 7.
[8] See Providers' Response to Intermediary's Revised Position Paper, pgs 5-8.
[9] Id, Exhibit P-21.

> provide for an additional payment amount under this subsection for services furnished to individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1395mm of this title and who are entitled to part A of this subchapter or with a Medicare + Choice organization under part C of this subchapter.

42 U.S.C. § 1395ww(d)(11) entitled "Additional payments for managed care enrollees" states:

> (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) of this section hospital that has an approved medical residency training program.

The question before the Board is what conditions precedent must be satisfied to entitle a hospital to payment for the new additional benefit.

The Board finds that this dispute is governed by the regulations, 42 C.F.R. § 424.30 et seq. Prior to the BBA '97, whether a "claim" (described elsewhere as a form UB-92) filed for each patient stay was required was governed by 42 C.F.R. § 424.30 which states:

> This subpart sets forth the requirements, procedures, and time limits for claiming Medicare payments. Claims must be filed in all cases except when services are furnished on a prepaid capitation basis by [HMOs].

42 C.F.R. § 424.32 et. seq. furnishes more detail regarding the "basic requirements" for filing all claims including the requirement that the claim be filed with the hospital's intermediary and within the time limits specified in 42 C.F.R. § 424.44.

Therefore, prior to BBA '97, in order to receive payment for the services furnished to Medicare beneficiaries, the hospital filed its claim for payment directly with its Medicare intermediary. However, if the beneficiary was a member of a risk HMO which had been prepaid by Medicare, the hospital filed its claim for payment for services furnished with the HMO, not the intermediary. The claims in question paid for by Medicare+Choice organizations or other Medicare risk plans, are specifically exempt from the requirements, procedures and time limits under this section. The information that would be needed by intermediaries to process these claims may not be available from the data submitted to the Medicare HMO plans because the data submitted in each case is used for entirely different purposes.

In addition, prior to the BBA '97, despite the process for filing claims for payment for *services furnished*, hospitals were nevertheless required by the hospital manual to file 'no pay' bills for tracking or utilization purposes only, for example, to set capitated rates. These were referred to as 'no-pay' bills and the data assembled was referred to as 'encounter data.'

> A. No-Payment Situations Where Bills Must be Submitted.-- Situations for which bills are required include the following. If part of the admission will be paid and part not, prepare one bill covering the entire stay. . . .
>
> * * * *
>
> For services provided to an HMO enrollee for which an HMO has jurisdiction for payment. Since CMS is instructing you to provide this information, negotiate an agreement with the HMO for submitting to it bills it pays. Include in your agreement with HMOs a clear statement of the data elements required for proper identification of Medicare HMO/CMP enrollees and accurate submission to the intermediary.
>
> Where the HMO does not have jurisdiction, prepare a payment bill.

CMS Program Manuals - Hospital (Pub. 10), Chapter IV - Billing Procedures 411. Submitting Inpatient Bills In No-Payment Situations.

The BBA '97 and the Secretary's implementing regulations clearly shifted the burden for filing encounter data squarely to the risk HMOs.

> In order to carry out this paragraph, the Secretary shall require Medicare+Choice organizations (and eligible organizations with risk-sharing contracts under section 1395mm of this title) to submit data regarding inpatient hospital services for periods beginning on or after July 1, 1997, and data regarding other services and other information as the Secretary deems necessary for periods beginning on or after July 1, 1998. The Secretary may not require an organization to submit such data before January 1, 1998.

42 U.S.C. § 1395w-23(a)(3)(B).

> *Data collection: Basic rule.* Each M+C organization must submit to CMS (in accordance with CMS instructions) all

> data necessary to characterize the context and purposes of each encounter between a Medicare enrollee and a provider, supplier, physician, or other practitioner.

42 C.F.R. § 422.257(a)

No changes were made to 42 C.F.R. § 424.30. Moreover, neither the regulatory changes implementing the new IME/DGME payment nor any other regulation gave notice that hospitals would be required to file a separate IME/DGME claim with the intermediary that was virtually identical to the claim filed with the HMO to recover payment for inpatient services.

When 42 C.F.R. § 424.30 governing claims filing was implemented, there was no contemplation of or any need for a "claim for payment" other than the claim to obtain payment for the inpatient *services furnished* to the beneficiary. When the additional payment for IME/DGME was authorized by the BBA' 97, it did not change the nature of the payment for "services furnished." Rather, the IME/DGME payment arises from "services . . . furnished on a . . . capitation basis . . ." for which filing a claim *with the intermediary* is excepted under 42 C.F.R. § 424.30.

The Board finds that the IME and DGME payments at issue here were "additional payment amounts" provided for in the BBA '97, effective beginning with 1998, the first period at issue in this appeal. 42 U.S.C. §§ 1395ww(d)(11)(A)-(B), 1395ww(h)(3)(D)(i). The Board further finds that these additional payment amounts are not for hospital costs associated with being a teaching hospital. Rather, the statute provides that both of these additional payment amounts are "for" the services furnished to Medicare HMO enrollees. The 1997 amendments to the IME statute provide that "the Secretary *shall provide* for an additional [IME] payment amount *for each applicable discharge . . . of any individual who is enrolled*" with a M+C organization. 42 U.S.C. § 1395ww(d)(11)(A)-(B) (emphasis added). Similarly, the 1997 amendments provide that "the Secretary shall provide for an additional [GME] payment amount under this subsection *for services furnished to individuals who are enrolled*" with a M+C organization. 42 U.S.C. § 1395ww(h)(3)(D)(i) (emphasis added).

The Secretary has been given broad authority to implement procedures for payment. However, once the system was established by regulation linking the obligation to file an intermediary claim with the method of payment, CMS' effort to impose a contrary claims filing requirement via informal guidance (program memoranda) is insufficient to deprive a provider of its statutory right to payment.

The lack of formal notice is evident in the instant case. Nowhere does the Board find a directive to the Providers that states in order to receive IME and DGME supplemental payments, the Providers ***must*** bill the Intermediary within the timeframe specified in the regulations at 42 C.F.R. § 424.44. Likewise, the

Intermediary has not identified any instance (other than the 2003 Program Memorandum directed to non-PPS hospitals) where CMS ever said that teaching hospitals had to submit separate bills for payment for M+C enrollees in order to receive the DGME supplemental payments. The Board agrees with the Providers' argument that the preamble to the Final PPS Rule for FY 1998 relied on by the Administrator only "anticipates" a continuing "process" and does not impose a regulatory command.[10]

Despite the fact that CMS had a very short timeframe to implement the provisions of BBA '97 specifically for the issue in question by the effective date of January 1, 1998, CMS should have followed the Administrative Procedure Act's (APA) prescribed "informal rulemaking" process and made provisions to handle the period from January 1, 1998 until the finalization of the rule. If the regulatory obligation to file a "claim" is to be bifurcated so that a provider has an obligation to file its claim for payment of services provided to the beneficiary with the HMO and to also file a virtually identical claim to its intermediary, then the Board believes that a regulatory notice is required.

The Board is aware that the D.C. District Court (Court) in Cottage Health has come to the opposite conclusion as to whether the Secretary gave proper notice regarding submission of claims. In that case the Court concluded "the Administrator's decision that plaintiff had notice that claims were to be submitted to the fiscal intermediary, and that notice and comment rulemaking was unnecessary for this kind of interpretive rule, was supported by substantial evidence and was not arbitrary or capricious."[11] The Court based its decision on proper notice on four documents. The Court believed "the May 12, 1998 rule stating the Secretary's 'anticipation' that 'teaching hospitals will need to submit claims associated with [Medicare HMO] discharges to the fiscal intermediaries for purposes of receiving [IME] and [GME] payments,"[12] combined with the PM, the Medicare Bulletin, and an August 20 letter sufficient for notice. The Board respectfully disagrees because this was a clear policy change. Again, the Board finds 42 C.F.R. § 424.30 specifically exempts providers from billing both before and after BBA '97. The Board finds that providers were required to bill only the Medicare HMOs to receive negotiated DGME and IME payment prior to the BBA '97 and that changing this policy would require a final rule change. The Board does not believe the anticipated policy in the Final PPS Rule for FY 1998, even if supported by the PM, the Medicare Bulletin and the August 20 letter would override a clear directive in 42 C.F.R. § 424.30. Since the Board is bound by this regulation it cannot adopt the Administrator's or Court's position.

The Board considered the Providers' assertion that the public protection provision of the Paperwork Reduction Act (PRA), 44 U.S.C. § 3501 et seq., precludes the Intermediary from denying the Providers the benefit of additional IME/DGME

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[10] See Providers' Response to Intermediary's Revised Position Paper, pg 4.
[11] See Provider Exhibit P-21 pg. 14.
[12] Id. pg. 10.

payments on the basis that duplicate claims were not submitted. The Board also noted that the Providers' assertion remained uncontroverted by the Intermediary. Nevertheless, the Board reached its conclusion on the merits of the case independently of PRA considerations and, accordingly, reaches no conclusion on the Providers' PRA assertions. The Board notes the D.C. Court remanded the PRA issue back to the Secretary for resolution in Cottage Health. Neither party has submitted the resolution from that remand.

DECISION AND ORDER:

The Intermediary improperly disallowed DGME and IME payments with respect to discharges of Medicare beneficiaries who were enrolled in the Medicare+Choice or other Medicare risk plans in fiscal years ended December 31, 1998, and 1999. This case is remanded to the Intermediary to calculate the IME and DGME payments due with respect to the patient days and stays at issue based upon the patient listing already supplied to the Intermediary.

BOARD MEMBERS PARTICIPATING:

Yvette C. Hayes
Keith E. Braganza, CPA
John Gary Bowers, CPA

FOR THE BOARD:

Yvette C. Hayes
Acting Chairperson

DATE: June 16, 2011

Sutter Health
1998-99 Managed Care Days CIRP Group
Case Number: 05-1740G

Schedule of Providers

Provider Number	Facility	Fiscal Year
05-0108	Sutter Medical Center (Sacramento, Sacramento County, CA)	12/31/98
05-0444 05-7000 05-3975	Sutter Medical Center (Merced, Merced County, CA)	12/31/99