CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Santa Barbara Cottage Hospital **Provider** **vs.** **Blue Cross Blue Shield Association/ National Government Services, LLC-CA** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Periods Ending: 12/31/1998; 12/31/1999; 12/31/2000; 12/31/2001** **Review of:** **PRRB Dec. No. 2007-D78** **Dated: September 28, 2007**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in Section 1878(f)(1) of the Social Security Act (Act), as amended (42 USC 1395oo(f)). Comments were received from the Intermediary requesting review of Issue No. 1. The parties were subsequently notified of the Administrator's intention to review the Board's decision on Issue No. 1. The Provider submitted comments requesting affirmation of the Board's decision on Issue No. 1. Accordingly, this case is now before the Administrator for final administrative review on Issue No. 1.[1]

ISSUE AND BOARD DECISION

Issue No. 1 concerns whether the Intermediary's adjustment to the Provider's direct graduate medical education (DGME) and indirect medical education (IME) payments with respect to discharges of Medicare beneficiaries enrolled in Medicare

[1] Issue No. 2 involved whether the Intermediary properly disallowed residents' time spent in non-provider settings from the Provider's full-time equivalent (FTE) resident counts for DGME and IME adjustment purposes. The Administrator summarily affirms the Board's decision on Issue No. 2.

+ Choice[2] or other Medicare risk plans in fiscal years ending December 31, 1998, 1999, 2000, and 2001, were proper. The Board noted that, the Balanced Budget Act of 1997 (BBA '97)[3] provided for IME and DGME payments for services provided under risk HMO contracts, that had not been available prior to the BBA. The Secretary was given broad authority to provide for, or devise a way, to pay hospitals a supplemental payment for DGME and IME services. The statute at section 1886(h)(3)(D) of the Act provides payment for managed care enrollees, and section 1886(d)(11) provides payments for managed care enrollees.

The Board Majority found that this dispute was governed by the regulations at 42 CFR 424.30, *et seq.* The Board noted that, prior to BBA '97, in order to receive payment for the services furnished to Medicare beneficiaries, a hospital filed a 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, rather than the intermediary. The claims in question, for services furnished by and paid for by Medicare + Choice organizations or other Medicare risk plans, are specifically exempt from the requirements, procedures and time limits under this section.

In addition, prior to the BBA '97, the Board Majority noted that, 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.[4] However, the Board explained that the BBA '97 and the Secretary's implementing regulations shifted the burden for filing encounter data to the HMOs.

The Board Majority recognized that no changes were made to 42 CFR §424.30. However, the Board relied on the fact that, 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 and DGME claim with the intermediary that was virtually identical to the claim filed with the HMO to recover payment for inpatient services.

The Board Majority further explained that, when the regulation which governs claims filing was implemented at 42 CFR § 424.30, 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. The Board noted that, when the

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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] See Pub. L. No. 105-33.

[4] CMS Program Manuals – Hospital (PUB. 10), Chapter IV – Billing Procedures 411. Submitting Inpatient Bills in No-Payment Situations.

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 and DGME payment arises from "services… furnished on a… capitation basis…" for which filing a claim with the intermediary is excepted under 42 CFR § 424.30.

The Board Majority recognized that the Secretary has been given broad authority to implement procedures for payment. However, the Board found that, 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 guidance in an Administrative Bulletin is insufficient notice to deprive a provider of its statutory right to payment.

The Board Majority noted that the lack of formal notice was evident in the instant case by the Provider's direct inquiry to its Intermediary in the letter dated July 17, 1998.[5] The letter was offered by the Provider as its formal written request "to receive Medicare reimbursement for its [direct] GME and IME managed care enrollees" and sought out further details on how and when this payment would be implemented. The Intermediary responded in a letter dated August 20, 1998, referencing the Medicare Bulletin No. 416 dated July 13, 1998.[6] Specifically, the Board stated that the Bulletin provides that "teaching hospitals may submit bills of inpatient stays by managed care enrollees for payment of IME." This Bulletin addressed only "IME cost" payments and did not specify a definite date when this billing should begin or make any reference to CMS Program Memorandum (PM) A-98-21 for further guidance. In addition, the guidance spoke to a need to bill for IME to receive interim payments, but that no such "interim" relief was available for DGME because of system limitations related to the accumulation of the inpatient days.

The Board Majority did not find persuasive a directive to the Provider that states that in order to receive IME and DGME supplemental payments, a Provider must bill the Intermediary. The Board found that the Medicare Bulletin states that you "may" bill and the August 20, 1998 letter states "how" to bill. The Board argued that CMS should have followed the Administrative Procedures 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 the 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 the intermediary, then the Board majority believed that a regulatory notice is required.

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[5] See Provider Position Paper, Exhibit P-15.
[6] See Provider Position Paper, Exhibits P-16 and P-17.

The Board Majority found that the Provider complied with the requirements for timely filing its claims for payment for inpatient services with the HMO, and sought to rely on those records as proof of entitlement and for calculation of its IME and DGME additional payment claimed via its cost report. The Board noted that the expense of graduate medical education that the hospital incurred in providing services furnished on a capitation basis was only one element of many costs properly reported and claimed on the cost report. Thus, the Board found that the data contained in those claims to the HMOs along with the remittance advices reflecting payment was proper evidence, and must be considered by the Intermediary to determine the IME/DGME payments due to the Provider.

Furthermore, from the period between January 1, 1998, until the date of constructive or actual notice, the option to bill and receive an interim payment was not available, and the use of an alternate method was necessary to allow providers to make a request for these payments. Consequently, the Board majority found that the Intermediary's disallowance of the subject days, based on the fact that the Provider did not bill and the data was not captured on the Provider Statistical & Reimbursement (PS&R), is without merit. The Board noted that the Provider furnished to the Intermediary a detailed log of the Medicare Managed Care enrollees it serviced during the periods at issue from its records for verification and inclusion in the Medicare cost report. The Majority found that the Intermediary's refusal to audit the data made available to support the Provider's claim was a misuse of discretion and the case must be remanded to the Intermediary to complete the audit.

Thus, the Board Majority found 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 ending December 31, 1998, 1999, 2000 and 2001. The Intermediary's adjustment for fiscal year (FY) 1998 is reversed and FYs 1999, 2000 and 2001 cost reports were remanded to the Intermediary to include the days applicable to the Medicare + Choice enrollees.

Two Board members dissented. The Dissent found that CMS notified intermediaries and the public regarding the added payments for Medicare managed care enrollees when it formally modified the IME and GME regulations on August 29, 1997 (62 Fed. Reg. 45,965). CMS' publication of Program Memorandum (PM) A-98-21 instructed intermediaries to notify their hospitals of the right to request the additional payments and the methodology that was required to secure them. The Dissenters found that there was no need for CMS to publish a new regulation with the required notice and comment period.

The Dissenters also noted that the Provider did not submit the specially coded UB-92s required by PM A-98-21, and that these claims were required to be submitted

within the time limitations set forth at 42 CFR §424.44. The additional reimbursement was made available to teaching hospitals by the BBA '97, and the Providers could elect to follow the methodology CMS prescribed for claiming the reimbursement, or ignore the instructions and forgo the additional reimbursement, as the Provider did in this case.

The Dissent also contended that PM A-98-21 was an appropriate means to implement program payments pursuant to the applicable IME and GME statutes and regulations. Moreover, the Dissenters noted that the requisite claims were not exempt from submission to the Intermediary, pursuant to 42 CFR §424.30, which applies to claims for services furnished on a prepaid capitation basis by a HMO, a competitive medical plan, or a health care prepayment plan. Thus, the Dissenters concluded that the Intermediary's refusal to accept the UB-92s after the filing deadline prescribed by 42 CFR §424.44 was proper.

SUMMARY OF COMMENTS

The Intermediary commented, requesting review of Issue No. 1, concerning whether the Intermediary properly disallowed the DGME and IME payments with respect to discharges of Medicare beneficiaries enrolled in Medicare + Choice or other Medicare risk plans. The Intermediary argued that to claim IME and GME payments for services to beneficiaries enrolled in risked-based managed care contracts, the hospital was directed by PM A-98-21 to file a claim using the UB-92 format. The Intermediary claimed that the Board incorrectly concluded that the requirements of PM A-98-21 imposed claims filing requirement contrary to the regulation. The Intermediary agreed with the dissenting opinion describing the filing procedures and concluding that the requirements of PM A-98-21 are a reasonable means of implementing the statutory provisions.

The Provider commented on Issue No. 1. The Provider maintained that the Board Majority correctly found that the Intermediary improperly disallowed DGME and IME payments with respect to Medicare beneficiaries enrolled in Medicare managed care plans.[7]

DISCUSSION

The entire record furnished by the Board has been examined, including all correspondence, position papers, exhibits, and subsequent submissions. Comments timely submitted have been included in the record and have been considered.

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[7] The Provider also commented that the Board incorrectly found that the Intermediary properly disallowed residents' time spent training in non-provider settings. .

Until 1983, Medicare paid for covered hospital inpatient services on the basis of "reasonable cost." Section 1861(v)(1)(A) of the Act defines "reasonable cost" as "the cost actually incurred," less any costs "unnecessary in the efficient delivery of needed health services." While §1861(v)(1)(A) does not prescribe specific procedures for calculating reasonable cost, it authorizes the Secretary to promulgate regulations setting forth the methods to determine reasonable cost and the items to be included in reimbursable services.

In addition, Medicare historically has paid a share of the net costs of "approved medical education activities" under the reasonable cost provisions.[8] The Secretary's regulations define approved educational activities as formally organized or planned programs of study, usually engaged in by providers to enhance the quality of care in an institution.[9] The activities include approved training programs for physicians, nurses and certain paramedical health professionals. Under the reasonable cost system, the allowable costs of the activities included: the direct costs of salaries and fringe benefits of interns and residents, the salaries attributable to teaching physicians' supervisory time, other teachers' salaries; and indirect or institutional overhead costs, including employee health and welfare benefits, that were appropriately allocated to the proper cost center on a provider's Medicare cost report.[10]

In 1982, Congress modified the Medicare program to provide hospitals with better incentives to render services more efficiently. Pursuant to the Tax Equity and Fiscal Responsibility Act (TEFRA),[11] Congress amended the Act by imposing a ceiling on the rate-of-increase of inpatient operating costs recoverable by a hospital. However, under § 1886(a)(4), GME costs were excluded from the definition of inpatient operating costs for purposes of the TEFRA base year and, thus, were not included in the hospital's TEFRA base year costs for purposes of determining the hospital's target amount.

In 1983, § 1886(d) was added to the statute to establish an inpatient prospective payment system (IPPS) for reimbursement of inpatient hospital services furnished to Medicare beneficiaries.[12] Under IPPS, providers are reimbursed their inpatient operating costs based on prospectively determined national and regional rates for each patient discharge, rather than on the basis of reasonableness. Graduate medical education costs continued to be paid on a reasonable cost "pass-through."

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[8] 20 CFR §405.421 (1966); 42 CFR §405.421 (1977); 42 CFR §413.85 (1986).
[9] 42 CFR §413.85(b).
[10] 54 Fed. Reg. 40,286 (Sept. 27, 1989).
[11] Pub. L. No. 97-248.
[12] Section 601(e) of the Social Security Amendments of 1983. Pub. L. No. 98-21 (1983).

However, applicable for all periods beginning on, or after, July 1, 1985, pursuant to §1886(h) of the Act,[13] Congress established a new payment policy for DGME costs.[14] Generally, the DGME payment is a combination of a hospital's per resident amount and the hospital's Medicare patient load. The Medicare patient load means with respect to a hospital's cost reporting period, the total number of hospital inpatient days during the cost reporting period that are attributable to patients for whom payment is made under Medicare Part A divided by total hospital inpatient days. To implement the new payment policy, the Secretary promulgated regulations at 42 CFR §413.86, et seq.

Section 1886(d)(5)(B) of the Social Security Act also 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. The regulations at 42 CFR §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 FTE residents to bed. Each hospital's indirect medical education payment under the prospective payment system for inpatient operating costs is determined by multiplying the total DRG revenue for inpatient operating costs by the applicable education adjustment factor.

Prior to the enactment of the BBA '97, for purposes of the DGME payments, 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 (Medicare Health Maintenance Organizations or Competitive Medical Plans with risk sharing contracts under section 1876 of the Act) in the Medicare patient load used to calculate Medicare payment for DGME. However, Section 4624 of BBA '97 amended the Social Security Act by adding a new provision for GME payments with respect to patient days attributable to services furnished to Medicare beneficiaries enrolled in a Medicare + Choice plan or any other Medicare managed care plan with

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[13] Section 9202 of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended.

[14] 54 Fed. Reg. 40,297 (September 27, 1989). (Revised payment method applies to all hospitals regardless of status under PPS.) See 50 Fed. Reg. 27,722 (July 1985)(Final rule that hospitals would be reimbursed lesser of allowable costs for current year or hospitals' approved GME costs incurred during 1984 FY; nullified by Section 1861(v)(1)(Q) pursuant to Section 9202 of COBRA 1985). Section 9314 of Omnibus Budget Reconciliation Act of 1986 (Pub. L. No. 99-509) added Section 1886(h)(4)(E).

a risk sharing contract under section 1876 of the Act. Section 1886(h)(3) of the Act states that:

> (D) Payment for Managed Care Enrollees.
> (i) For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall 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 1876 and who are entitled to part A or with a Medicare + Choice under part C. The amount of such a payment shall equal the applicable percentage of the product of –
> (I) the aggregate approved amount (as defined in subparagraph (B)) for that period; and
> (II) the fraction of the total number of inpatient-bed days (as established by the Secretary) during the period which are attributable to such enrolled individuals.
> (ii) Applicable Percentage – For purposes of clause (i), the applicable percentage is -
> (I) 20 percent in 1998,
> (II) 40 percent in 1999,
> (III) 60 percent in 2000,
> (IV) 80 percent in 2001… [Emphasis added.]

Similarly, the BBA ’97 amended the Social Security Act by adding a new provision at Section 1886(d)(11), addressing the IME payment, which states that:

> (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 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 been enrolled as described n subparagraph (B).[15] [Emphasis added.]

Thus, for discharges on, or after, January 1, 1998, the provisions of the BBA '97 required the recognition of the Medicare managed care enrollees in the IME and DGME payment.

These statutory changes were promulgated in the regulation for the DGME payment at 42 CFR 413.86 and since recodified at 42 CFR 413.76 (2004). The regulation at 42 CFR 413.76 states:

> A hospital's Medicare payment for the costs of an approved residency program is calculated as follows:
> (a) Step one. The hospital's updated per resident amount (as determined under Sec. 413.77) is multiplied by the actual number of FTE residents (as determined under Sec. 413.79). This result is the aggregate approved amount for the cost reporting period.
> (b) Step two. The product derived in step one is multiplied by the hospital's Medicare patient load.
> (c) Step three. For portions of cost reporting periods occurring on or after January 1, 1998, the product derived in step one is multiplied by the proportion of the hospital's inpatient days attributable to individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1876 of the Act and who are entitled to Medicare Part A or with a Medicare+Choice organization under Title XVIII, Part C of the Act. This amount is multiplied by an applicable payment percentage…….[16]

Likewise, for the IME payment, 42 CFR 412.105(g) was amended to state that:

> (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 a hospital for indirect medical education

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[15] The regulations implementing this provision were codified at 42 CFR §412.105(g).

[16] The regulation at 42 CFR 413.75(b) defines the Medicare patient load as: *Medicare patient load* means, with respect to a hospital's cost reporting period, the total number of hospital inpatient days during the cost reporting period that are attributable to patients for whom payment is made under Medicare Part A divided by total hospital inpatient days. In calculating inpatient days, inpatient days in any distinct part of the hospital furnishing a hospital level of care are included and nursery days are excluded. [Emphasis added.]

> 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. Sec. 413.76(c)(1) through (c)(5) of this subchapter. [Emphasis added.}

The regulation at 42 CFR 412.105(e) explains:

> (1) *Determination of payment amount*. Each hospital's indirect medical education payment under the prospective payment system for inpatient operating costs is determined by multiplying the total DRG revenue for inpatient operating costs, as determined under paragraph (a)(2) of this section, by the applicable education adjustment factor derived in paragraph (d) of this section.[Emphasis added.]

The IME/DGME payment for Medicare managed care enrollees was specifically addressed in the May 12, 1998 Federal Register[17] which promulgated the IPPS FFY 1998 rule and BBA changes. In response to comments regarding the claims process to be implemented for the DGME and IME payments, the Secretary stated that:

> Under section 4622 and 4624 of the BBA, teaching hospitals may receive indirect and direct GME payments associated with Medicare + Choice discharges. Since publication of the final rule with comment on August 29, 1997, we have consulted with hospitals, managed care plans, and fiscal intermediaries for purposes of developing a process to implement these provisions.
>
> We anticipate teaching hospitals will need to submit claims associated with Medicare + Choice discharges to the fiscal intermediaries for purposes of receiving indirect and direct medical education payments. When the claims are processed, the fiscal intermediaries will make the IME payment associated with a Medicare + Choice discharge directly to the teaching hospital. Teaching hospitals will also be required to submit bills associated with Medicare + Choice organizations to the manage care plans. The inpatient encounter data from these bills will be submitted by the managed care plans to HCFA for purposes of implementing the risk adjustment methodology. The fiscal intermediary's would revise interim payments to reflect the Medicare direct GME payment associated with Medicare + Choice discharges.

[17] 63 Fed. Reg. 26,318 (May 12, 1998).

> However, until the fiscal intermediaries have more experience with paying hospitals for direct GME associated with Medicare + Choice discharges, we believe the fiscal intermediaries will have limited data upon which to base interim payment. We are making adjustments to the Medicare cost report to allow for settlement of the cost report reflective of direct GME payment associated with Medicare + Choice discharges. [Emphasis added]

On July 1, 1998, the CMS Program Memorandum (PM) A-98-21[18] was issued consistent with the claims process set forth in the rule. The PM stated that:

> This Program Memorandum outlines intermediary and standard system changes needed to process requests for IME and DGME supplemental payments for Medicare managed care enrollees. Sections 4622 and 4624 of the Balanced Budget Act of 1997 state that hospitals may now request a supplemental payment for operating IME for Medicare managed care enrollees. During the period January 1, 1998 through December 31, 1998, providers will receive 20 percent of the fee for service DGME and operating IME payment. This amount will increase 20 percent each consecutive year until it reaches 100 percent.

Moreover, PM A-98-21 further explained that:

> PPS hospitals must submit a claim to the hospitals' regular intermediary in UB-92 format, which condition codes 04 and 69 present on record type 41, fields 4-13, (form locator 24-30). Condition code 69 is a new code recently approved by the National Uniform Billing Committee to indicate that the claim is being submitted for operating IME payment only. [Emphasis added]

The submission of claims to intermediaries for, inter alia, Part A payment, is controlled by the regulation at 42 CFR §424.30. The regulation explains the scope of claims for payment and 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 a health maintenance organization, (HMO), a competitive medical plan (CMP), or a health care prepayment plan (HCPP).

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[18] See Intermediary's Position Paper, Exhibit I-1.

Therefore, while claims for, inter alia, Part C managed care services are not controlled by this section, a hospital must submit claims in conformity with 42 CFR 424.30, et seq., to be able to include managed care enrollees for the Part A IME and DGME payments from its intermediary. The timeframe for filing claims is set forth at 42 CFR §424.44, which states that:

> (a) *Basic limits*. Except as provided in paragraph (b) of this section, the claim must be mailed or delivered to the intermediary or carrier, as appropriate –
> (1) On or before December 31 of the following year for services that were furnished during the first 9 months of a calendar year; and
> (2) On or before December 31 of the second following year for services that were furnished during the last 3 months of the calendar year.
> (b) Extension of filing time because of error or misrepresentation.
> (1) The time for filing a claim will be extended if failure to meet the deadline in paragraph (a) of this section was caused by error or misrepresentation of an employee, intermediary, carrier, or agent of the Department that was performing Medicare functions and acting within the scope of its authority.
> (s) The time will be extended through the last days of the 6th calendar month following the month in which the error or misrepresentation is corrected.

As the PM explained, filing a claim with the intermediary using the UB-92 form is required in order to generate data that may be used for payment. The procedures set forth in the PM are consistent with the Medicare Financial Management Manual (Pub. 100-6) which explains the role of the UB-92 form and claims processing in the settlement process. The claims system makes the required determination on eligibility rules and benefits available for Medicare, in contrast to the cost report settlement process. CMS provides each intermediary a standard Provider Statistical and Reimbursement System or the "PS&R" to interface with billing form CMS 1450 (UB-92 form). This system provides reports to be used in developing and auditing provider cost reports and related data accumulation operations. Providers also must use the reports in preparing cost reports and must be able to explain any variances between the PS&R report and the cost report. The intermediary uses information on such items as Medicare patient days (relevant for GME), discharges and DRGs. The statistical reports produced are the Payment Reconciliation Report; Provider Summary Report and DRG Summary Report. Thus, when a provider bills in accordance with the instructions for payment of the DGME and IME for Medicare managed care enrollees, the claims system would compute a simulated DRG payment and charges for patient days and issue a payment, all of which would be summarized on the PS&R. The CMS PM-A-98-21 explained that:

> The intermediary will submit the claim to the Common Working File (CWF). CWF will determine if the beneficiary is a managed care enrollee and what their plan number and effective dates are. Upon verification from the CWF that the beneficiary is a managed care enrollee, the intermediary will add the HMO Pay code of 0 to the claim and make an operating IME only payment with the proper annotation of the remittance advice.…
> The DGME payments are to be made using the same interim payment calculation you currently employ. Specifically you must calculate the additional DGME payments using the inpatient days attributable to Medicare managed care enrollees. As with DGME payments under fee-for-service, the sum of these interim payment amounts are subject to adjustment upon settlement of the cost report.

Claiming costs on the costs report alone is not sufficient to make a DGME and IME payment for managed care enrollees. If no claim is filed, no IME payment will be made and no data relating to days will be generated on the PS&R that can be reconciled with the claimed cost report amounts.

In this case, the Provider, a teaching hospital, argued that the Intermediary improperly adjusted the settlement data used to determine IME and DGME payments with respect to Medicare + Choice beneficiaries in its cost reports. The Provider claimed and the Board Majority agreed, that nothing in the statute required the Provider to submit data directly to the Intermediary and within a specified time. The Board majority also accepted the Provider's position that there was much confusion surrounding this issue and it was not made aware that it must bill its fiscal Intermediary directly.

However, the Administrator finds that, while the statute did not set forth in detail that the Provider was to submit data directly to the Intermediary, the provision for this payment for managed care enrollees is within framework of a pre-existing methodology for IME/DGME payments. That pre-existing methodology requires that claims be made to the intermediary in order to generate a payment and for the related data to be captured on the PS&R. The May 1998 preamble language published in the Federal Register anticipated this requirement. In addition, the PM A-98-21 explicitly stated that a "hospital must submit a claim to the hospital's regular intermediary." Moreover, the July 13, 1998 Bulletin stated that: "Teaching hospitals may submit bills for inpatient stays by managed care enrollees for payment of IME. Since hospitals are already submitting bills for payment (for services and IME) for members of cost HMOs, separate bills for IMEs are only to be submitted for members of risk HMOs….Risk Members: teaching hospitals to submit bills to regular intermediary for IME payment…." [Emphasis added.]

Finally, the letter from the Intermediary to the Provider, dated August 20, 1998,[19] stated that "to bill for the IME supplemental payment, PPS hospitals must submit a claim to the hospital's regular intermediary in UB-92 format."

The Bulletin, the Federal Register preamble language and the PM A-98-21 plainly instructed a hospital to bill its intermediary so that the claims could be processed. In fact, the Administrator finds that providers were informed of the billing policy as early as the May 1998 Federal Register publication that hospitals would be required to file claims for payment with their intermediary. The Provider was also given actual notice in the letter from the Intermediary, well prior to the date any claims were required to be filed. The Administrator finds that the Provider's failure to comply with the instructions was an error on its part.

The Administrator also finds that the APA does not require CMS to publish a new regulation under these circumstances. CMS is allowed to promulgate interpretive rules and guidance. In addition, contrary to the Board Majority's finding, this process did not implement a new payment methodology. Rather, the payment of IME/DGME was an already established payment methodology for teaching hospitals that was already linked to the claims processing system. In addition, consistent with the APA, the proposed claims processing methodology was published in the May 1998 Federal Register subject to notice and comment. Finally, the Intermediary gave actual notice to the Provider discussing the right to payments for both IME and DGME payments and how the claims were to be billed. The claims processing instructions implementing the IME/DGME payment did not violate the requirements of the APA. The Provider received adequate notice of its right to claim the reimbursement, but did not follow the procedures for doing so.

The IME and DGME payment for Medicare managed care discharges was effective for portion of cost reporting periods beginning on, or after, January 1, 1998. The PM A-98-21 was issued by CMS on July 1, 1998. Pursuant to 42 CFR §424.44, the earliest claims were due on or before December 31 of the following year for services that were furnished during the first 9 months of a calendar year. The Provider had adequate time to comply with CMS' instruction requiring the submission of the specially coded UB-92 billing forms. Thus, the Provider had approximately 15 months after actual notice of the change in policy that allows a hospital to submit claims for IME/DGME payment for Medicare managed care enrollees.

Moreover, the requisite claims were reasonably required to be submitted to the Intermediary pursuant to 42 CFR §424.30. The only exception to the claims processing requirements at 42 CFR §424.30 is for services furnished on a prepaid capitation basis to the beneficiary by a managed care plan, which is not at issue here.

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[19] See Intermediary's Position Paper, Exhibit I-2.

The claims in the instant case were claims for an established reimbursement methodology for hospitals' costs associated with being a teaching hospital and not for the services furnished to a managed care enrollees.

Requiring a standard claim format, which determines whether the claim belongs in the calculations, is also a reasonable method of implementing the requirements of the BBA'97 for submitting information. The Administrator finds that the PM A-98-21 was an appropriate means to implement program payments pursuant to the applicable IME and DGME statutes and regulations. The Secretary has the responsibility of ensuring proper program payments to providers of services, and utilizes various processes such as the issuance of regulations and manual instructions, as well as program memorandums. CMS notified its intermediaries and the public regarding the claims processing instructions for the Medicare managed care enrollees IME and DGME payments.[20] The standard claim format is reasonably required as the claims must be reflected in the PS&R as the PS&R is the necessary mechanism for the intermediaries and providers to reconcile the cost report settlement.[21]

Accordingly, the Administrator finds that the Intermediary properly disallowed DGME and IME payments with respect to discharges of Medicare beneficiaries who were enrolled in the Medicare + Choice or other Medicare risk plans. Thus, the Administrator reverses the Board's decision as to Issue No. 1.

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[20] See 62 Fed. Reg. 45, 965 (August 29, 1997).

[21] The Provider asserted that the Medicare risk plans (not providers) submitted UB-92 data relating to Medicare risk plan discharges to the Intermediary before the audits of each of the fiscal years at issue were completed and the Intermediary did not include that data in the settled cost reports, which the Board Majority accepted as relevant. However, the "encounter data" required by the BBA to be submitted to CMS is related to the risk adjustment methodology and not to a claims determination process required of the IME/DGME payment methodology.

DECISION

Issue No. 1

The Administrator reverses the decision of the Board in Issue No. 1.

Issue No. 2

The Administrator summarily affirms the decision of the Board in Issue No. 2.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 11/16/07 /s/

Herb B. Kuhn
Deputy Administrator
Centers for Medicare & Medicaid Services