CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Sparrow Health 98-99 IME Managed Care Group, **Provider** **vs.** **Blue Cross Blue Shield Association/ United Government Services,** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Periods Ending: 12/31/98–12/31/99** **Review of:** **PRRB Dec. No. 2008-D17** **Dated: February 12, 2008**

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 U.S.C. 1395oo(f)). Comments were received from the Center of Medicare Management (CMM) requesting reversal of the Board's decision. The parties were subsequently notified of the Administrator's intention to review the Board's decision. The Providers submitted comments requesting affirmation of the Board's decision. Accordingly, this case is now before the Administrator for final administrative review.

ISSUE AND BOARD DECISION

The issue concerns whether the Providers are entitled to receive additional indirect medical education (IME) and direct graduate medical education (DGME) payments for Medicare managed care enrollees.

The Board found that St. Lawrence Mercy had not claimed any Medicare managed care discharges/patient days in its 1998 cost report, nor did it claim additional reimbursement for IME and DGME pursuant to the Balance Budget Act of 1997 (BBA '97).[1] The Board concluded that it did not have jurisdiction over St.

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

Lawrence Mercy Hospital's challenge and dismissed it from the case. With respect to E.W. Sparrow, the Board Majority found that the final determinations with respect to Medicare managed care days and discharges were rendered by the Intermediary, thereby, meeting the jurisdictional requirements of the regulations.

The Board noted that, the BBA '97 provided for IME and DGME payments for services provided under risk Health Maintenance Organization (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 under Sections 1886(h)(3)(D) and 1886(d)(11) of the Act.

The Board Majority found that this dispute was governed by the regulations at 42 C.F.R. §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 involve services furnished and paid for by Medicare + Choice organizations or other Medicare risk plans and, thus, are specifically exempt from the requirements, procedures and time limits under this section.

While prior to the BBA '97, hospitals were required by the Hospital Manual to file 'no pay' [encounter data] bills for tracking or utilization purposes only,[2] 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 C.F.R. §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 additional payment for IME/DGME was authorized by the BBA '97, it did not

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

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 expected under 42 C.F.R. § 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 pursuant to guidance in an Administrative Bulletin is insufficient notice to deprive a provider of its statutory right to payment.

The Board Majority noted that the Administrative Bulletin issued by the Intermediary stated that "teaching hospitals may submit bills for 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.

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. The Board argued that 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 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.

The Board Majority found that the Intermediary's disallowance of the subject Medicare managed care discharges/patient days, based on the fact that the Provider did not bill and the data was not captured on the Provider Statistical & Reimbursement (PS&R) report, is without basis. The Board was unpersuaded by the Intermediary's argument that a claim filed in the UB-92 format is essential to determine a proper payment amount. The Board reasoned that, for the period from January 1, 1998, up until the date of 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. The Board Majority noted that the Provider has the information necessary for the Intermediary to pay the Provider the IME and DGME amounts to which it is entitled.[3]

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[3] See Provider's Position Paper at 3; Provider's Supplemental Position Paper at 6; and Transcript of Oral Hearing (Tr.) at 33-35.

Thus, the Board Majority found that the Provider is entitled to receive additional IME and DGME payments for Medicare managed care enrollees for its fiscal years ending December 31, 1998 and 1999, and remanded the case to the Intermediary to include the days applicable to the Medicare + Choice enrollees.

One Board member dissented. The Dissent disagreed with the Board Majority's finding of jurisdiction over the Medicare + Choice discharges/days claimed by E.W. Sparrow Hospital. The Dissenter found that the Provider failed to claim on its as-filed cost reports, the discharges/days at issue.

Despite the jurisdictional finding, the Dissent commented on the substantive nature of the Board's Majority decision. The Dissent argued that Transmittal No. A-98-21 was an appropriate means by which to implement program payments provided for in the applicable IME and DGME statutes and regulations. The Dissent also reasoned that the requisite claims for the additional reimbursement were not exempt from submission to the Intermediary pursuant to 42 C.F.R §424.30 and that these claims were not claims for services "furnished on a prepaid capitation basis by a health maintenance organization…" as envisioned by the section. 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. 45565, 45968-45969). CMS' publication of 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 Dissenter found that there was no need for CMS to publish a new regulation with the required notice and comment period.

The Dissent noted, that although the Provider maintained that it did not receive timely notice of the requirement to file the UB-92 claim forms, there is un-controverted evidence in the record demonstrating that the Provider had notice as early as March 11, 1999.[4] The Dissent noted that there was convincing evidence presented by the Intermediary witness' testimony that the Provider had notice of the requirement before this date. The testimony showed she discussed the billing requirement with the Provider's staff prior to the March 1999 Medicare Memo.[5]

The Dissent argued that, to the extent that the Provider ignored the Program's claims filing requirement, it did so to its detriment. The Provider was responsible for claiming all the reimbursement to which it was entitled and it received timely notification of the manner in which that reimbursement could be secured. The Dissent concluded that the Intermediary's refusal to compute the additional IME and

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[4] See, Intermediary Position Paper, Exhibit I-2.

[5] See, Tr. at 58-59, 90.

GME reimbursement through the cost report, using the Provider's internal logs as well as the rejection of the untimely filed Medicare + Choice claims, was proper.

SUMMARY OF COMMENTS

CMM commented, noting that it agreed with the Board's decision to dismiss St. Lawrence Mercy Hospital from the case on jurisdictional grounds, but disagreed with the Board's findings as to E.W. Sparrow Hospital. CMM stated that there was substantial evidence that the Provider was aware of the requirement to submit the Medicare managed care claims to the Intermediary in UB-92 format, but that it chose not to do so. As evidence of this, CMM cited testimony by the Intermediary's witness, who said she discussed the need for the Provider to submit the UB-92 claims when she noticed during the audit process that the hospital still had time to submit them for the FYE December 31, 1999 cost report. Additionally, CMM noted that the Provider did submit some of the UB-92 claims in both the FYE December 31, 1998 and December 31, 1999 cost reporting periods, which CMM claimed was further evidence of its knowledge of the requirement in question.

CMM noted that the Secretary was given broad authority in implementing the BBA provisions to provide hospitals with supplemental IME and DGME payments for Medicare managed care days. CMS implemented provisions, first through a final rule published in the Federal Register on August 29, 2007, and then through a final rule published on May 12, 1998. The preamble to this later final rule provided explicit notice to hospitals that they would be expected to submit Medicare managed care claims to the Intermediary for IME and DGME payment purposes under part A, in addition to the bills submitted to managed care plans for payment under part C. CMS' Program Memorandum, issued in July 1998, explained that hospitals must submit Medicare managed care claims to the Intermediary in UB-92 format. This was made explicit to the Provider in a monthly Medicare Administrative bulletin that was sent by the Intermediary.

The Board cited the Bulletin as proof that there was no directive that a Provider must bill the Intermediary. CMM pointed out that, while the Intermediary's Medicare Administrative bulletin stated that "teaching hospitals may submit bills for inpatient stays by managed care enrollees for payment of IME," it also specifically said "PPS hospitals must submit a claim to their intermediary in UB-92 format…." CMM argued that this constituted a directive to the Provider that it must bill the Intermediary. Furthermore, CMM argued, while the regulations at 42 CFR 413.76 and 412.105(g) do not include the filing instructions that CMS issued in the Program Memorandum, CMS has historically relied on the issuance of Program Memoranda to implement payment procedures and processes on a subregulatory basis subject to the applicable IME and DGME statutes and regulations.

Finally, CMM pointed out that, in a prior decision, the CMS Administrator's decision noted that there was a distinction between claims for services "furnished on a prepaid capitation basis by a health maintenance organization…" (that is, claims associated with Part C) which are exempt from the timely requirements and claims for payments (the supplemental IME and DGME payments for Medicare managed care enrollees under Part A) which are indeed subject to the timely requirements specified in the regulations. Thus, CMM argued, subject to 42 C.F.R. §424.44, the Provider must submit timely UB-92 claims to the Intermediary based on services provided to Medicare managed care patients in order to receive supplemental IME and DGME payments for Medicare managed care enrollees.

The Provider's assertion that the Intermediary can and should use the UB-92 claims submitted late to the Intermediary in order to manually calculate IME and DGME payments for the Medicare managed care enrollees was unreasonable. The UB-92 claims by themselves do not contain all the information necessary to determine accurate payment. Moreover, CMM noted, the use of the Provider's unsubstantiated internal logs does not meet the payment standards in place for Intermediaries. Compelling the Intermediary to manually compute the IME and DGME payments would not be appropriate and would not result in accurate payments. It would also entail a substantial effort on the Intermediary's part to resolve the situation that was precipitated by the Provider when it failed to heed CMS' requirement to submit the Medicare managed care UB-92 claims in a timely manner.

The Provider commented, noting that it did not contest the jurisdictional decision of the Board regarding St. Lawrence Hospital and, thus, the comments were being set forth on behalf of E.W. Sparrow Hospital. The Provider requested that the Administrator affirm the Board's decision based on the arguments made before the Board.

The Provider took issue with CMM's comment that there was substantial evidence to support that the Provider was aware of the requirement for hospitals to submit the Medicare managed care claims to the intermediary in the required UB-92 format. The Provider pointed out that the un-contradicted testimony of a Provider's witness supported its position that the Intermediary had failed to notify the Provider. Further, the Intermediary's witness testified that she did not personally notify the Provider of the requirement, and it was not within her job description to do so. The witness also acknowledged that there was no evidence of her alleged discussion with a former employee of the Provider and that, even if such discussions occurred, they would not have satisfied the Intermediary's notice requirement. She was also unaware of any Intermediary notification process or any indirect evidence that the notice requirement had been satisfied.

The Provider also challenged CMM's assertion that the Intermediary made the required notification "on the monthly Medicare administrative bulletin that it regularly sends to all of its providers." The Provider noted that, the Intermediary never made this assertion to the Board, and that there is no evidence in the proceedings conducted by the Board regarding this assertion. Finally, the Provider argued against CMM's assertion that the UB-92 cannot be simulated, noting that the testimony of the Provider's witness supports the Provider's position that it would be possible to simulate the claims. The Intermediary's witness agreed that this would be possible.

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.

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.[6] 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.[7] 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.[8]

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

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[6] 20 C.F.R. §405.421 (1966); 42 C.F.R. §405.421 (1977); 42 C.F.R. §413.85 (1986).
[7] 42 C.F.R. §413.85(b).
[8] 54 Fed. Reg. 40,286 (Sept. 27, 1989).

Responsibility Act (TEFRA),[9] 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) of the Act, 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.[10] 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."

However, applicable for all periods beginning on, or after, July 1, 1985, pursuant to §1886(h) of the Act,[11] Congress established a new payment policy for DGME costs.[12] 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 C.F.R. §413.86, et seq.

With respect to the indirect costs of teaching programs, section 1886(d)(5)(B) of the 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 C.F.R. §412.105 establish how the additional payment is calculated. The additional payment, known as the indirect medical

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[9] Pub. L. No. 97-248.

[10] Section 601(e) of the Social Security Amendments of 1983. Pub. L. No. 98-21 (1983).

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

[12] 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).

education or IME adjustment, is based on the indirect teaching adjustment factor, calculated using the hospital's ratio of FTE residents to beds. Each hospital's IME payment under the prospective payment system for inpatient operating costs is determined by multiplying the total Diagnosis-Related Group (DRG) revenue for inpatient operating costs by the applicable IME 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 DGME 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 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 –
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> (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.
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> (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, section 4622 of the BBA '97 amended the Social Security Act by adding a new provision at section 1886(d)(11) addressing the IME payment. This paragraph 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 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).[13] [Emphasis added.]

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

These statutory changes were promulgated in the regulation for the DGME payment at 42 C.F.R. §413.86 and since recodified at 42 C.F.R. §413.76 (2004). The regulation at 42 C.F.R. §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

[13] The regulations implementing this provision were codified at 42 C.F.R. §412.105(g).

> 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…….[14] [Emphasis added.]

Likewise, for the IME payment, 42 C.F.R. §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 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 C.F.R. §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,[15] 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

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[14] The regulation at 42 C.F.R. §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.]

[15] 63 Fed. Reg. 26,318 (May 12, 1998).

> 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.
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> 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 managed 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 intermediaries would revise interim payments to reflect the Medicare direct GME payment associated with Medicare + Choice discharges. 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.][16]

On July 1, 1998, CMS issued the CMS Program Memorandum (PM) A-98-21[17] was issued, consistent with the claims process that was 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:

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[16] 63 Fed. Reg. 26,342

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

> 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 C.F.R. §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).

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 C.F.R. §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 C.F.R. §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.
> (2) 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 with 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.…
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> 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.

Reporting costs on the cost report alone is not sufficient to seek 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 reported cost report amounts for purposes of the GME.

In this case, the Provider argued that the Intermediary failed to notify them of the reporting requirements contained in PM A-98-21. The Provider contended that due to this failure, it did not submit the requisite UB-92 forms and the PS&R did not reflect data for all of the Medicare managed care enrollees. The Provider also argued

that the UB-92 filing requirement is not supported by the enabling statutes, nor regulation.

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 the framework of a pre-existing methodology for Medicare Part A IME/DGME payments. The fiscal intermediaries are responsible for determining payments under Medicare Part A pursuant to Section 1816 of the Act. The pre-existing IME/DGME 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." The record shows that the Intermediary issued a Medicare Memo (Memo), dated March 11, 1999. This Memo stated that in order to bill for IME supplemental payment, "PPS hospitals must submit a claim to their intermediary in UB-92 format..."[18]

The Federal Register preamble language, the PM A-98-21, and the Memo plainly instructed providers to bill their intermediary so that the claims could be processed for the additional IME and DGME payments. 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 record supports that the Provider was also given actual notice in the memorandum from the Intermediary, well prior to the date any claims were required to be filed.[19]

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

[19] The Provider challenged the testimony of an Intermediary representative stating that she did not personally notify the Provider of the new reporting policy, nor did the Intermediary have documentation to show that the Provider did receive the Memo. However, the record shows that the Intermediary's Memo was sent out generally to all providers, to educate them about the Program Memorandum as a standard business practice. The witness explained that they do not send certified mail for this type of general documentation. (See Tr. at 81). The witness further explained that she had spoken with a Provider's staff member, expressing her concern of the low billing days in comparison to other institutions. She testified that the Provider's staff member responded that they were aware they needed to bill, but because the hospital was in the midst of a merger they did not have time as they were busy with other priorities. (See Tr. at 90). Consequently, the Administrator finds substantial evidence in the record to support a finding that the Provider had actual notice of the processing procedures.

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. 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 record supports a finding that 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.[20] The claims processing instructions implementing the IME/DGME payment was not contrary to the requirements of the APA.

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 C.F.R. §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 notice of the change in policy that allows a hospital to submit claims for IME/DGME payment for Medicare managed care enrollees.

Furthermore, the Provider claimed that it could not comply with the requirement to submit the UB-92 forms because it was not aware of the requirement. However, the record shows that the Provider did in fact submit some UB-92 forms to the Intermediary in the fiscal years ending December 31, 1998 and December 31, 1999. The Provider's PS&R showed that Medicare managed care claims had been submitted, totaling 17 days for FY 1998 and 967 days for FY 1999.[21] The record shows that the Intermediary adjusted the Provider's cost reports for FY 1998 and FY 1999 to reimburse the Provider for supplemental GME and IME payments for Medicare managed care discharges or patient days as provided for in the BBA. The Administrator finds that the Provider's claim to ignorance of the billing requirement is contradicted by the evidence on its PS&R reports, showing that managed care claims had been submitted.

Moreover, the requisite claims were reasonably required to be submitted to the Intermediary pursuant to 42 C.F.R. §424.30. The only exception to the claims processing requirements at 42 C.F.R. §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. The claims in the instant case were claims for an established reimbursement

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[20] See, n. 19.

[21] See, Provider's Position Paper, Exhibits P-1, P-2, P-8, P-9.

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 statutory provisions 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. The standard claim format is reasonably required as the claims must be reflected in the PS&R. The PS&R is the benchmark against which intermediaries and providers reconcile cost reports in the settlement process.[22]

Accordingly, the Administrator finds that the Intermediary properly determined 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.

[22] 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

The decision of the Board is reversed in accordance with the foregoing opinion.

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

Date: **4/14/08** **/s/**

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