CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Loma Linda University Medical Center, **Provider** **vs.** **Blue Cross Blue Shield Association/ United Government Services,** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Periods Ending: 12/31/98–12/31/00** **Review of:** **PRRB Dec. No. 2008-D26** **Dated: May 9, 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 CMS' Center for Medicare Management (CMM) requesting a reversal of the Board's decision. Comments were also received by the Provider requesting that the Board's decision be affirmed. Accordingly, this case is now before the Administrator for final administrative review.

ISSUE AND BOARD DECISION

The issue concerns whether the payments for indirect medical education (IME) and direct graduate medical education (DGME) was understated as a significant number of managed care days and discharges for inpatient services for Medicare beneficiaries were not included in the calculation.

The Board stated that it addressed this issue in two recent decisions.[1] The Board reasoned that the same rationale is applicable in this case. The Intermediary must review the alternative documentation that the Provider presented and, if verified, use

[1] *See* Santa Barbara Cottage Hospital, PRRB Dec. No. 2007-D78, and Bayfront Medical Center, PRRB Dec. No. 2008-D3.

it as a basis to approve payment for DGME services. In addition, the Board Majority found that, even if CMS had properly implemented the claims mechanism for the DGME payment for HMO enrollees, problems with the implementation constituted good cause to grant the provider an exception for late filing of claims. The Board Majority noted that, prior to the Balanced Budget Act of 1997 (BBA 1997)[2], IME and DGME payments for services provided under risk HMO contracts were not available. These payments were added by the BBA 1997 for cost reporting periods occurring on, or after January 1, 1998. Specifically, § 1886(d)(11) of the Social Security Act (the Act) mandates that the Secretary provide additional IME payments for each applicable discharge of any subsection (d) hospital that has an approved medical residency training program. Section 1886(h)(3)(D) provides that the Secretary make additional DGME payments for services furnished to individuals who are enrolled under a risk-sharing contract with an eligible organization under § 1876 and who are entitled to Medicare Part A, or with a Medicare + Choice organization under part C.

The Board Majority then examined the conditions which must be met to entitle a hospital to payment for this benefit. The Board Majority found that the regulations at 42 CFR § 424.30, *et seq.*, governed this issue. This section requires that claims for payment must be filed in all cases except when furnished on a prepaid capitation basis. The Board Majority noted that, prior to the BBA 1997, hospitals filed claims directly with Medicare intermediaries. However, if the hospital was a member of a risk HMO which had been prepaid by Medicare, it filed its claim with the HMO, not the Intermediary. Thus, the Board Majority concluded, the claims at issue in this case are "specifically exempt from the requirements, procedures, and time limits" noted in 42 CFR § 424.30, *et seq.* Additionally, the Majority noted, any information that would be needed by an Intermediary to process such a claim would be contingent upon the Medicare HMO plans' payment processing methods, which is separate from the fee-for-service plan.

The Board Majority also noted that, prior to the BBA 1997, hospitals were required to file "no pay" bills for tracking or utilization purposes, despite the process for filing claims for payment for services furnished. The data from these "no pay" bills was referred to as "encounter data". The BBA 1997 shifted the burden for filing this encounter data to the risk HMOs. Additionally, the interim final rule published in June 1998 at 42 CFR § 422.257(a) stated that each Medicare + Choice organization must submit to CMS all data necessary to characterize the context and purpose of each encounter between a Medicare enrollee and a provider, supplier, physician, or other practitioner.

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[2] *See* Pub. L. No. 105-33.

The Board Majority asserted that, despite these changes, no changes were made to 42 CFR § 424.30, nor to the regulations implementing the new IME or DGME payment. No other regulation gave notice that hospitals would now be required to file separate IME and DGME claims with the intermediary, even though the claim was virtually identical to the one filed with the HMO to recover for inpatient services. The Board stated that the IME and DGME payments arise 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 found that the Secretary has been given broad authority to implement procedures for payment. However, once a system was established by regulation linking the obligation to file an intermediary claim with the method of payment, CMS' effort to impose a contrary claim filing requirement via guidance in an Administrative Bulletin is insufficient to deprive a provider of its statutory right to payment. The Board Majority stated that, 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 to the beneficiary with the HMO and to also file a virtually identical claim to the Intermediary, then regulatory notice is required.

The Board Majority noted that, even if CMS could implement the claims requirement without a regulatory change, the Board Majority reasoned that the Provider would be entitled to an exception to the deadlines for filing claims. The Board Majority explained that, despite the short timeframe that CMS had to implement the provisions of the BBA 1997, CMS should have followed the Administrative Procedure Act (APA) prescribed "informal rulemaking" process and made provisions to handle the period from January 1, 1998 until the finalization of the rule. The Board Majority stated that the instructions were confusing as to whether the Provider could submit claims before June 30, 1998, and noted that the Administrative Bulletin issued by the Intermediary on July 13, 1998 stated that "teaching hospitals may submit bills for inpatient stays by managed care enrollees for payment of IME." The Board noted that the Bulletin only addressed IME cost payments and failed to mention DGME. Furthermore, the Bulletin did not specify a definite date when this billing should begin, or make any reference to, Program Memorandum (PM) A-98-21 for further guidance.[3] The Board Majority reasoned that there was no CMS directive that stated the Provider must bill the Intermediary in order to receive IME and DGME supplemental payments.

Finally, the Board Majority stated that the process established by CMS was flawed in that providers were required to submit a Medicare Health Insurance Claim (HIC) number to claim reimbursement, but that no effective mechanism, or methodology,

[3] *See* Provider's Position Paper, Exhibit P-158.

was established to allow providers to obtain HIC numbers. The Board Majority found that the Provider should be allowed to resubmit its claims for all three fiscal years in question once a mechanism is established by which it can obtain patient HIC numbers. The Provider furnished 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. Thus, the Board Majority concluded that the Intermediary's refusal to audit the data made available to support the Provider's claims was improper and remanded the case to the Intermediary to complete the audit and allow additional payment.

One member of the Board dissented. The Dissent stated that CMS has broad authority to carry out its responsibility for ensuring proper program payments to providers, and that this broad authority includes issuance of regulations, manual instructions, program memorandums, and transmittals. CMS notified intermediaries and the public regarding the added payments for Medicare managed care enrollees when it formally modified the IME and DGME regulations in 62 Fed. Reg. 45,965, 45968-45969 (August 29, 1997). The publication of PM A-98-21 instructed intermediaries to notify their hospitals of the right to request the additional payments and the means by which the payments could be secured.

The Dissent noted that the additional IME and GME payment for Medicare managed care days/discharges was effective for portions of cost reporting periods beginning on, or after, January 1, 1998, and PM A-98-21 was issued by CMS on July 1, 1998. Therefore, the Dissent reasoned, teaching hospitals had adequate time to comply with CMS' instructions regarding the submission of the specially coded UB-92 claim forms.[4] The Dissent noted that the subject claims were not exempt under 42 CFR § 424.30 because they were not claims for services "furnished on a prepaid capitation basis by a health maintenance organization." Instead, the claims at issue were "claims for payment" of additional teaching costs and, thus, were subject to the timely filing requirements of 42 CFR § 424.44. The Dissent argued that there was no need for CMS to publish a new regulation with the required notice and comment period, as the use of the Transmittal was a well-established and efficient way of informing the teaching hospitals of the additional reimbursement.

The Dissent noted that, unlike similar cases where providers alleged lack of notice of the billing requirement, it is undisputed in this case that Loma Linda was aware of this requirement. During the three years at issue, the Provider filed tens of thousands of the required UB-92s to claim the additional IME and DGME reimbursement, and it received payment for those claims. The Dissent reasoned that the Provider's argument, that the Transmittal's instructions were defective and

[4] *See* 42 CFR §424.44.

confusing, is unsupported given the Provider's ability to successfully bill and receive payment for so many of the required claims.

Moreover, the Dissent noted the Provider's argument that, through no fault of its own, the Provider failed to bill for 13,077 Medicare managed care days for 1998, 9,467 for 1999, and 6,615 for 2000. According to the record, however, these additional days were identified in late 2002 when the Provider hired a consultant, which identified a large discrepancy between the Provider's record of managed care volume and the number of days that appeared on the PS&R.[5] The Provider inquired about whether the unbilled claims could be reimbursed. However, CMS and the Intermediary responded that the claims needed to be billed and the timeliness standard applied.

The Dissent noted the Provider's argument that one of the reasons it could not bill some of its claims was that the HIC number for Medicare managed care enrollees was not readily available. However, the record shows that the Provider failed to file claims for which it had the patient's HIC number.[6] The Dissent concluded that the Provider failed to establish an internal process that ensured that all of the specially coded UB-92s were filed in accordance with CMS' instructions.

The Dissent finally determined that the data used to calculate the IME and DGME payments for regular Medicare patients is processed by the claims payment system and captured on the PS&R. The Dissent reasoned that it was reasonable to include the additional claims data for the Medicare managed care patients in the same claims processing system to ensure proper processing of the claims and accurate payment of the additional reimbursement due.

COMMENTS

CMM commented that the evidence did not support the Provider's argument that CMS' instructions regarding the billing requirement (that is, the filing of UB-92 "no-pay" bills) to receive IME and DGME payments for Medicare managed care days was confusing. The record shows that the Provider successfully filed 35,535 UB-92s during the fiscal years 1998, 1999 and 2000 and received IME and DGME payments for those claims. It was not until late 2002 that the Provider's consultant discovered additional Medicare managed care days that had been overlooked by the Provider. At that time, the Provider sought to receive payment for the additional 13,077 unbilled Medicare managed care days by contending that: the instructions in

[5] *See* Transcript of Oral Hearing (Tr.), p. 109.
[6] *See* Tr. p. 134.

PM A-98-21 were confusing; that the UB-92 filing requirement was not supported by the enabling statutes or regulations; that the UB-92 claims should be exempt from the timely filing deadlines under 42 CFR §424.44; and that even if the Intermediary's claims processing system could not accept the UB-92 claims that were beyond the timeliness requirements, the Intermediary could simulate the payments.

CMM stated that the Secretary was given broad authority in implementing the BBA 1997 provisions to provide hospitals with supplemental IME and DGME payments for Medicare managed care discharges/patient days. CMS implemented the provisions first through a final rule published in the *Federal Register* on August 29, 1997. The policy was subsequently refined through the final rule published on May 12, 1998. CMM noted that, despite the Board's findings, the preamble of the May 12, 1998 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. Additionally, CMM noted, CMS also issued a Program Memorandum in July 1998, which explained that hospitals needed to submit Medicare managed care claims to the Intermediary in UB-92 format in order for the standard system to process the claims so that hospitals could be paid the supplemental IME and DGME payments for Medicare managed care enrollees. CMM commented that CMS has historically relied on the issuance of Program Memoranda to implement payment procedures and processes on a sub-regulatory basis subject to the applicable IME and DGME statutes and regulations.

CMM also noted that the Administrator's decision in PRRB Decision No. 2007-D78 included an in-depth analysis regarding a claim that UB-92 claims should be exempt from the timely filing deadlines under 42 CFR §424.44. In that case, the Administrator distinguished 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 subject to the timely requirements specified in the regulations. Therefore, CMM stated, 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. Regarding the Provider's contention that it could not submit timely UB-92s for some of the claims, because the HIC number for Medicare managed care enrollees was not easily obtainable, CMM noted that the Provider could not explain why in a number of instances, where HIC numbers were readily available, the Provider also did not submit UB-92s for those claims.

Finally, CMM addressed the Provider's contention that the Intermediary could manually calculate the IME and DGME payments for the Medicare managed care enrollees. CMM stated that this request was unreasonable, as the UB-92 claims by themselves do not contain all the information necessary to determine an accurate payment. CMM further argued that it would require a substantial effort on the part of the Intermediary that would be expended simply because the Provider failed to establish a working internal process, and failed to include a number of Medicare managed care days when it submitted timely UB-92s for other Medicare managed care claims in fiscal years 1998, 1999 and 2000.

The Provider submitted comments, requesting that the Administrator affirm the PRRB decision. The Provider argued that the Secretary never issued a rule establishing a timeframe in which a teaching hospital had to submit bills to its intermediary in order to obtain IME and/or DGME payment for Medicare managed care enrollees. The Provider noted that past Administrator decisions regarding this same issue have focused on three primary documents to support the conclusion that providers had adequate notice needed to bill the intermediary to obtain the IME and DGME payments for Medicare+Choice beneficiaries: (1) the May 12, 1998 *Federal Register*, (2) the July 1, 1998 CMS PM A-98-21, and (3) the July 13, 1998 Bulletin 416. The Provider claimed that the May 1998 *Federal Register* merely anticipated that teaching hospitals will need to submit claims associated with Medicare+Choice discharges to the fiscal intermediaries, and did not establish a process or an obligation to follow a process. The Provider argued that the July 1, 1998 Memorandum identified a billing process and the July 13, 1998 Bulletin identified a billing process of sorts. Neither the *Federal Register*, the PM, nor the Bulletin, identified any billing process that existed under current regulations, or asserted that any existing regulations were applicable to the process they identified. Moreover, none of the documents identify a time limit in which the bills had to be submitted to the Intermediary.

Further, the Provider argued that, even if the Secretary had issued an "interpretation" that Part 42 of the CFR applied to Part C services, it would have been legally invalid. The Provider argued that Part 42 does not apply to payments for Part C services, and stated that the Secretary has attempted to avoid the limited scope of Part 42 by confusing the concept of a "Part A payment" with a "payment for Part A services". The Provider noted that the history of the IME and DGME payments, the creation of Part C, and Congress' transfer of the recipients of IME/DGME payments for Part C services from plans to teaching hospitals makes clear that the IME and DGME payments for Medicare managed care enrollees are all for Part C services.

The Provider also contended that the Secretary's position, that teaching hospitals must bill intermediaries within time limits incorporated from other statutory

schemes, is invalid under the APA. The Provider noted that the billing rules in Part 42 of the CFR were promulgated as regulations through notice and comment rulemaking, thus showing the Secretary's recognition that they are substantive rules which impose obligations, including who to bill and what the time limits for billing are. The billing "rules" and alleged time limits for IME and DGME payments for Medicare managed care enrollees only exist, if at all, in the July 1, 1998 CMS Program Memorandum No. A-98-21, and the July 13, 1998 Bulletin 416. These rules are invalid under the APA, because they impose obligations before payment can be made, and were not adopted under notice and comment rulemaking.

The Provider further argued that the Secretary's billing "rule" is arbitrary, capricious, an abuse of discretion, and not in accordance with the law, because it adversely places a burden on the teaching hospital to bill its intermediary when the Part C enrollee failed to present their HIC number. The Provider pointed out that the Secretary was aware of the concern about identifying and verifying managed care patient days and discharges, based on the Chairman of ProPAC's March 11, 1997 testimony before the Subcommittee on Health of the House Committee on Ways and Means. The Provider noted that, in designing the IME/DGME billing process, there is no requirement for the managed care enrollee to present their Medicare card at admission. In support of its argument, the Provider noted that the managed care enrollees admitted to the Provider during 1998 through 2000 presented only their insurance card issued by their Medicare managed care plans, and did not present their Medicare cards with the HIC number. Further, the Provider claimed that they were unable to access the HIC numbers for a large subset of managed care enrollees, despite their best efforts to do so. Many enrollees refused to give their HIC number, and some told the Provider that their Medicare managed care plan had instructed them not to present their Medicare card and not to disclose their HIC number to the hospital because all that was needed for the hospital to be paid was the Medicare plan card.

The Provider noted that, in its efforts to obtain HIC numbers for managed care enrollees, the Provider developed and sent a form letter asking enrollees to furnish their HIC number,[7] and used Common Working File. However, these methods were not often successful. Medicare managed care enrollees HIC numbers could not be obtained, because many of the beneficiaries during this period, particularly many of the women, had never worked and, thus, had not paid into the Social Security Program.

Moreover, the Provider claimed that its hospital data is sufficient for the Intermediary to calculate IME and DGME payments, but that the Intermediary will

[7] *See* Provider's Position Paper, Exhibit P-172.

not accept this data. The Providers noted alternative data has been accepted in other contexts, pointing to the Intermediary's instructions advising that it could supplement the PS&R with the hospital's own data.[8]

Finally, the Provider argued that, even if the regulations imposed the alleged time limits for the Provider to submit IME and DGME bills, the regulations do not bar submission of DGME data or late IME/DGME bills. The Provider noted that the regulation and CMS instructions provide for an exception to the time for filing if there is an "administrative error." Thus, the Intermediary could treat the Provider's January 13, 2006 letter and accompanying data as a request for waiver of the time period in which to submit the claims, or as a request for acceptance of the same information in the alternative format. Accordingly, there is no time bar preventing the correction of the error in payment for IME/DGME for Medicare managed care enrollees.

DISCUSSION

The entire record furnished by the Board has been examined, including all correspondence, position papers, exhibits, and subsequent submissions.

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.[9] 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.[10] 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

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[8] *See* Provider's Position Paper, Exhibit P-102 and P-138.
[9] 20 CFR §405.421 (1966); 42 CFR §405.421 (1977); 42 CFR §413.85 (1986).
[10] 42 CFR §413.85(b).

appropriately allocated to the proper cost center on a provider's Medicare cost report.[11]

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),[12] 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), graduate medical education 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.[13] 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, Congress established a new payment policy for DGME costs. 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 Act also provides that teaching hospitals that have residents in approved graduate medical education 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.[14] The regulations at 42 CFR §412.105 establish how the additional payment is calculated. The additional

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[11] 54 Fed. Reg. 40,286 (Sept. 27, 1989).

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

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

[14] Prior to the enactment of IPPS, the Medicare program had provided for adjustments for medical education under the routine cost limits of Section 1886(a)(2) of the Act.

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. Each hospital's indirect medical education payment under the prospective payment system for inpatient operating costs is determined by multiplying the total diagnosis related groups (DRG) revenue for inpatient operating costs by the applicable indirect medical education adjustment factor.

Prior to the enactment of the BBA 1997, 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. The statute did not provide for inclusion of inpatient days attributable to enrollees in Medicare risk plans (e.g. Medicare Health Maintenance Organizations or Competitive Medical Plans with risk sharing contracts under § 1876 of the Act or Medicare + Choice plans) in the Medicare patient load used to calculate Medicare payment for DGME. However, § 4624 of the BBA 1997 amended the 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 § 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 -
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> (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 1997 amended the Social Security Act by adding a new provision at § 1886(d), addressing the IME payment, which states that:

> (11) Additional Payments for Managed Care Enrollees. –
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> (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.
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> (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.
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> (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). [Emphasis added.]

Thus, for discharges on, or after, January 1, 1998, the provisions of the BBA 1997 allow for 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:
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> (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…….[15]

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 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.[16] [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.]

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[15] 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].

[16] *See* 62 Fed. Reg. 45966, 46003, 46029(Aug 29, 1997)(Final rule with commenting period for provisions resulting from the BBA 1997); 63 Fed. Reg. 26318 (May 12, 1998)(Final rule responding to comments received on those portions of the published August 29, 1997 final rule with comment period that revised IPPS to implement changes made as a result of BBA 1997).

The IME and DGME payment for Medicare managed care enrollees was specifically addressed in the May 12, 1998 *Federal Register*[17] which promulgated the final rule published August 29, 1997 implementing the BBA 1997 changes. In response to comments regarding the claims process to be implemented for the DGME and IME payments, the Secretary stated that:

> Under §§ 4622 and 4624 of the BBA 1997, 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 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 intermediary's 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]

On July 1, 1998, CMS issued the CMS Program Memorandum (PM) A-98-21, setting forth a process 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.

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

> 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 in the UB-92 format, 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).

Therefore, while claims for, *inter alia*, Part C and § 1876 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.
> (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 a standard Provider Statistical & Reimbursement (PS&R) system 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. The statistical reports produced are the Payment Reconciliation Report; Provider Summary Report and DRG Summary Report. The two primary reports produced by the PS&R system are the Provider Summary Report and Payment Reconciliation Report. The Provider Summary Report contains a summary of Medicare Part A charges, Medicare patient days, deductibles, coinsurance, payments, etc. for each provider for a specified period of time. The Provider Summary Reports are used by providers when preparing their Medicare Cost Reports. The Payment Reconciliation Report provides detailed claim data that supports the Provider Summary Report.

Providers 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. 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.[18]

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[18] For example, the 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

Consequently, if no claim is filed, no IME/DGME payment will be made and no data relating to payments or days will be generated on the PS&R that can be reconciled with that claimed on the cost report or through alternative data.

During the fiscal years ending December 1998, 1999, and 2000, the Provider submitted certain timely claims representing 10,032, 11,506 and 13,997 managed care days, respectively, and received IME/DGME payments for managed care enrollees. An internal review of the Provider's records in late 2002 and 2003 apparently showed a large number of Medicare managed care claims that had never been billed for IME/DGME payment. For FYs 1998, 1999 and 2000, the Provider requested payment for these additional claims that it stated represented 13,077, 9,467, and 6,615 days, respectively.[19]

The Provider directed a request to both the Intermediary and CMS asking that a waiver of the time limits for submission of claims be granted for the fiscal years in question.[20] The Provider also proposed, as an alternative, that the Intermediary verify a detailed list of managed care enrollees for use in the Provider's IME and DGME payments, rather than having the Provider submitting late claims.[21] The Intermediary did not accept the alternative data submitted by the Provider asserting that the proper mechanism to submit the information was to file a timely claim.[22] Neither CMS, nor the Intermediary, granted the Provider's request for a waiver. [23]

The Administrator finds that, the statute did not set forth in detail the process by which a Provider was to receive payment for manage care enrollees. However, the provision for this payment for managed care enrollees is within the framework of a pre-existing methodology for IME and 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 provider community was given notice of this procedure through several means. The May 1998 preamble language published in the *Federal Register* set forth that this would be an anticipated requirement. In addition, CMS issued PM A-98-21, dated July 1,

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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 [is] subject to adjustment upon settlement of the cost report."

[19] *See,* e.g., Provider Exhibits P-154-155.

[20] *See,* e.g., Provider Exhibit P-153.

[21] *See,* e.g., Provider Exhibit P-160.

[22] *See,* e.g., Intermediary's Position Paper at 5; Provider Exhibit P-161.

[23] *See,* e.g., Provider Exhibit P-162.

1998, and explicitly stated that hospitals "must submit a claim to the hospitals' regular intermediary in UB-92 format." The Intermediary in this case also issued a Medicare Part A Bulletin on July 13, 1998,[24] which detailed the filing requirements for payment to hospitals for DGME and IME payments for Medicare managed care enrollees.[25]

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 for that purpose. CMS notified its intermediaries and the public regarding the claims processing instructions for the Medicare managed care enrollees IME and DGME payments.[26] The *Federal Register* preamble language, the PM A-98-21, and the Bulletin, instructed a hospital to bill its intermediary so that the DGME and IME claims could be processed. The Administrator finds that PM A-98-21 was an appropriate means to implement program payments pursuant to the applicable IME and DGME statutory provisions and regulations. In addition, the standard claim format is reasonably required as a simulated payment must be made and the claims must be reflected in the PS&R, as the PS&R, *inter alia*, is also the necessary mechanism for the intermediaries and providers to reconcile the cost report settlement.

The Administrator finds that requiring a standard claim format and processing, which determines whether the claim meets the threshold requirement for inclusion in the calculations and performs the necessary simulated payment, is a reasonable method of implementing the requirements of the BBA 1997. Because a claim was

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[24] *See* Provider's Position Paper, Exhibit P-158. In the body of the Medicare administrative bulletin where the requirements are described in substantive detail, it is specified that: "Section 4622 and 4624 of the Balanced Budget Act of 1997 state that hospital may request a supplemental payment for operating IME for Medicare managed care enrollees… PPS hospitals must submit a claim to their intermediary in UB-92 format with conditionals codes 04 and 69 present on record type 41, fields 4-13 (form locator 24-30)." The Bulletin also 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 IME are only be to be submitted for members of risk HMOs. Currently, hospitals submit (risk) HMO paid bills for these individuals for utilization purposes only."

[25] The need for encounter data for managed care rate setting purposes is separate and distinct from the claims processing required for the IME and DGME payments under §§ 1886(d) and 1886(h).

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

required to be filed, the regulatory requirement of 42 CFR §424.30 were controlling. 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. The claims in the instant case were claims that were required to be process under the claims processing system in order for payment to be made 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.[27]

The Administrator also finds that the APA does not require CMS to publish a new regulation under these circumstances. As noted earlier, the Secretary may promulgate interpretive rules, guidance and procedures.[28] The payment of IME and DGME claims was an already established payment methodology for teaching hospitals that was already linked to the claims processing system and did not require the promulgation through notice and comment of specific instructions. In addition, the Provider received actual notice of its right to claim the reimbursement and the process for doing so. The record supports a finding that the Provider's failure to file timely claims was not because of confusion or the lack of notice. The Provider had adequate time to comply with the instructions requiring the submission of the

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[27] The regulation at 42 CFR 424.44(b)(1) states that: "the time for filing a claim will be extended if failure to meet the deadline… 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." CMS Pub 100-4, Section 70.7 provides for an exception if there is an "administrative error." CMS Pub 100-4, Section 70.7.1, then provides several exceptions, including failure that resulted from excessive delay by Medicare, the Intermediary, or the carrier in furnishing information necessary for the filing of the claim. If a provider files what is called a "statement of intent" before the end of the timely filing period there could be an extension of 6 months. However, even with a statement of intent, the provider must have notified the Intermediary before the end of the timely filing period that they would be submitting claims and provided the "placeholder for filing a timely and proper claim," in writing which would include beneficiary names, with dates of services. The record in this case does not support that there was error in not accepting the late claims. The Provider was not able to demonstrate that its failure to file timely was due to the conduct set out in 42 CFR 424.44(b)(1). In addition, among other things, the Provider also failed to take certain actions (such as filing an statement of intent) which would be expected if the failure submit claims timely was due to delays in locating HIC numbers.

[28] The Secretary in fact did publish pursuant to notice and comment that a Provider would be required to submit a bill to receive IME/DGME payments in the May 12, 1998 *Federal Register*.

specially coded UB-92 forms, for the years in contention and in fact did comply and receive payment for a significant number of claims during this period.

The Provider also argued that it could not bill some of its claims due to the fact that the HIC number for Medicare managed care enrollees was not readily available. However, the record indicates that the Provider also failed to file many claims for which it had the HIC number. At the oral hearing, the Provider's witness was asked why those individuals where they did have HIC numbers were not billed in a timely fashion, and the Provider's witness was unable to explain why this occurred.[29] The Provider also made no attempt to file a statement of intent for those claims while it was attempting to resolve any HIC number issues. Therefore, the record is not substantially supportive of the Provider's argument that the failure to file claims was due to the lack of HIC numbers, but rather, the record indicates this failure was more likely due to flaws in the Provider's internal process to ensure timely billing.[30]

Finally, the Provider's suggestion that, in the alternative, the Intermediary manually calculate IME and DGME payments for the Medicare managed care enrollees is not reasonable. The Administrator finds that the use of the Provider's internal logs does not meet the payment standards in place for intermediaries and cannot accurately duplicate the role of the claim processing system. A manual computation of the IME and DGME payments would result in inaccurate payments and would entail substantial burden.

Accordingly, the Administrator finds that the Intermediary properly disallowed the Provider's request for supplemental IME and DGME payments for Medicare managed care enrollees in the fiscal years 1998, 1999, and 2000 cost reporting periods. Thus, the Administrator reverses the Board's decision.

[29] *See*, e.g., Tr. p. 134.
[30] *See*, e.g., Tr. p. 109.

DECISION

The Administrator reverses the decision of the Board in accordance with the foregoing opinion.

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

Date: **7/7/08** **/s/**

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