CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Yale New Haven Health Services Group Appeals, **Provider** **vs.** **Blue Cross Blue Shield Association/ National Government Services,** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Periods Ending: 09/30/98–09/30/01** **Review of:** **PRRB Dec. No. 2009-D16** **Dated: April 2, 2009**

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) and the Intermediary requesting a reversal of the Board's decision. Comments were also received by the Providers[1] 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 Intermediary properly disallowed payments for indirect medical education (IME) and direct graduate medical education (DGME) with respect to discharges of Medicare beneficiaries who were enrolled in the Medicare + Choice or other Medicare risk plans for the fiscal years in contention.

[1] The Yale-New Haven Health Services Group includes Bridgeport Hospital, Yale-New Haven Hospital, and Greenwich Hospital, referred to as the Providers.

The Board stated that it addressed this issue in recent decisions,[2] and reasoned that the same rationale is applicable in this case. The Intermediary must review the alternative documentation that the Providers presented and, if verified, use it as a basis to approve payment for DGME services. In addition, the Board 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 Providers an exception for late filing of claims. The Board noted that, prior to the Balanced Budget Act of 1997 (BBA 1997)[3], 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 then examined the conditions which must be met to entitle a hospital to payment for this benefit. The Board 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 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 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 Board 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 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 were 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

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[2] *See* Santa Barbara Cottage Hospital, PRRB Dec. No. 2007-D78, Bayfront Medical Center, PRRB Dec. No. 2008-D3, Sparrow Health 98-99 IME Managed Care Group, PRRB Dec. No. 2008-D17, and Loma Linda University Medical Center, PRRB Dec. No. 2008-D26.

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

June 1998 for 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.

The Board 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 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 a Program Memorandum is insufficient to deprive a provider of its statutory right to payment. The Board found that no directive to the Provider was issued, stating that in order to receive IME and DGME supplemental payments the Provider must bill.

The Board noted that, even if CMS could implement the claims requirement without a regulatory change, the Provider would be entitled to an exception to the deadlines for filing claims. The Board 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 implementation of the final rule. The Board stated that, even 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 to the HMO and also file a virtually identical claim to its intermediary, then regulatory notice is required.

The Board reasoned that the Intermediary did not dispute that the hospital complied with requirements for timely filing its claims for payment for inpatient services with the HMO. In fact, the Board noted that the hospital seeks to rely on those records as proof of entitlement and for calculation of its IME/DGME additional payment to be claimed pursuant to its cost report. The Board contended that the data found in those claims to the HMOs, along with the remittance advices reflecting payment, is proper evidence and must be considered by the Intermediary to determine the IME/DGME payments due.

Finally, the Board noted that, for the period from January 1, 1998 through June 30, 1998, 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. For this reason, the Board found that the Intermediary's disallowance of the subject days based on the fact that the Providers did not bill and the data was not captured on the PS&R, is without basis. The Providers submitted to the Intermediary a detailed log of the Medicare managed care enrollees it serviced during the periods at issue. The Board found that the Intermediary's refusal to audit the data made available to support the Providers' claims was a misuse of its discretion and the case should be remanded to the Intermediary to complete the audit. The Board further found that, even if CMS had properly implemented the claims mechanism for the DGME payment for HMO enrollees, problems with the implementation constitutes good cause to grant providers an exception for late filing of claims.

COMMENTS

CMM commented 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 noted that the statements in the Program Memorandum issued by CMS, constitute a directive to the providers that in order to receive IME and DGME supplemental payments the providers must bill. The Program Memorandum also noted that the Intermediary would calculate the additional DGME payment using the inpatient days attributable to Medicare managed care enrollees, which would match the Medicare managed care patient days accumulated on the PS&R, as a result of the UB-92 claims submitted for the supplemental operating IME payment. 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 decisions in PRRB Decision Nos. 2007-D78 and 2008-D17 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 those cases, 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 that the Providers 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.

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 the use of the Provider's unsubstantiated internal logs does not meet the payment standards in place for Intermediaries.

The Intermediary commented, requesting that the Administrator reverse the Board's decision. The Intermediary argued that in order to claim IME and DGME payments for services to beneficiaries enrolled in risked based managed care contracts, the Providers were directed by CMS Program Memorandum A-98-21 to file a claim in the UB-92 format. The Intermediary further contended that the filing requirement of A-98-21 are a reasonable method of ensuring the data, needed to calculate the IME and DGME payments, would be captured in the system.

The Providers submitted comments, requesting that the Administrator affirm the PRRB decision. The Providers argued that the Board's decision in this case must be affirmed because the Providers were not put on notice of PM A-98-21 or its requirements. The Providers claimed that this fact distinguished this case from the other cases reviewed and reversed by the Administrator, concerning this issue. The Providers alleged that it did not receive any instruction from their Intermediary, whether in the form of a bulletin, news flash, or other form, that submitting a "no pay bill" to their intermediary by the claims filing deadline was a requirement to receive the IME and DGME reimbursement. The Providers argued that, in each of the cases previously reversed by the Administrator, there was actual notice to the provider, whether in the form of a letter or bulletin. The Providers contended that in this case, it is not necessary to construe PM A-98-21 because the Providers were never notified of the Program Memorandum or its contents until years later, after the filing deadline.

Further, the Providers argued that, in the four PRRB decisions reversed by the Administrator, the Administrator found that CMS was not required to promulgate a regulation, after notice and public comment, to implement the requirement that a hospital must submit a "no pay" bill. The Providers argued that, even if the Administrator is correct and formal rulemaking was not necessary, basic elements of fairness and due process mandate that a provider receive some form of notice of the new requirement. However, the Providers argued that in each case, the Administrator erroneously contends that teaching hospitals received notice by relying on an excerpt from the May 12, 1998 preamble in the Federal Register, together with notice of the contents of PM A-98-21. The Providers noted that such notice was not present in this case. The Providers also argued that the Administrator's reliance on an excerpt from the May 12, 1998 preamble in the Federal Register is misplaced, as it merely anticipated what the process will be for paying the teaching hospitals. The Providers argued that in no way can it be deemed to be notice to providers of a requirement to submit such claims to fiscal intermediaries to receive congressionally mandated payments.

The Providers also contended that CMM made the same mistake as the Intermediary by suggesting the PM A-98-21 directly imposed requirements on a provider. The Providers claimed that the Program Memorandum was directed solely to intermediaries and, by its express terms, required intermediaries to inform providers of its contents. The Providers argued that they were not apprised of the contents of the Program Memorandum or its requirements, and the Intermediary offered no testimony establishing that it transmitted the contents of the Program Memorandum to the Providers.

The Providers further argued that, even if the Providers had been put on notice of the contents of the Program Memorandum in a timely manner, the Board's decision should be upheld because under the controlling Federal regulations, the Providers were entitled to IME and DGME payments associated with Medicare managed care enrollees. The Providers also argued the language of the Program Memorandum itself is permissive, and not mandatory. The word "may" is utilized at a number of places in the document, and it was not until 2003 that the mandatory language was utilized by CMS, in PM A-02-007.

The Providers noted that, it fully complied with substantive and timing requirements for submitting claims to managed care organizations with respect to beneficiaries enrolled in managed care plans. The Providers argued that its documentation qualified the claims for reimbursement recognition. Moreover, the Providers contended that the black letter law provides that a program memorandum may not violate a controlling statute or regulations. Rather, it constitutes a limited vehicle whereby the Secretary may provide interpretations of controlling law that may

contain an ambiguity warranting clarification. Further, the Providers argued that the assertion that timeframes applicable to UB-92 claims submitted to intermediaries apply to this case, cannot be sustained because the assertion contradicts the express language of 42 C.F.R. §424.30 excepting managed care claims from the UB-92 deadline. The Providers noted that they correctly followed the established procedure by submitting claims for managed care enrollees directly to the managed care plan. The Providers argued that, under the BBA, managed care plans were charged in turn with submitting encounter data to CMS, and even if the submission of no-pay bills was required, the Intermediary should have accepted the Providers' offers to submit the claims. Finally, the Providers argued that, their position in this case gives full force and effect to applicable statutory and regulatory provisions. Thus, the Providers submit that the Administrator should affirm the decision of the Board.

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.[4] 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.[5] 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.[6]

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[4] 20 CFR §405.421 (1966); 42 CFR §405.421 (1977); 42 CFR §413.85 (1986).
[5] 42 CFR §413.85(b).
[6] 54 Fed. Reg. 40,286 (Sept. 27, 1989).

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),[7] 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.[8] 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.* (1998).

With respect to the indirect costs of teaching programs, §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.[9] The regulations at 42 CFR §412.105 (1998) establish the method for calculating the additional payment. The additional payment, known as the IME adjustment, is based on the indirect teaching adjustment factor, calculated using the hospital's ratio of full-time equivalent (FTE) residents to beds. Each hospital's indirect medical education payment under the prospective

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

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

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

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) <u>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.</u>
>
> (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. –

> (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). [Emphasis added.]

Thus, for cost reporting periods occurring, 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 payments.

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

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

> under Title XVIII, Part C of the Act. This amount is multiplied by an applicable payment percentage…….[10]

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.[11] [Emphasis added.]

The regulation at 42 CFR § 412.105(e) explains:

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

The IME and DGME payments for Medicare managed care enrollees were specifically addressed in the May 12, 1998 Federal Register[12] which promulgated the final rule published August 29, 1997 implementing the BBA 1997 changes. In

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[10] 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].

[11] *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).

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

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. 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.[13] Consequently, if no

[13] 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 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."

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 September 1998, 1999, 2000, and 2001, the Providers allege they included on their cost reports discharges for Medicare beneficiaries who were enrolled in Medicare risk plans. The Intermediary adjusted the cost report to match the statistics reflected on the PS&R reports. The Providers argued that the Intermediary improperly refused the Providers offer to submit bills or to consider alternative documentation submitted in support of their claims to receive IME and DGME payments for beneficiaries enrolled in the Medicare managed care plans after the filing deadline. However, the Intermediary contended that it is the Providers' responsibility to submit a timely UB-92 claim form to its Intermediary to be processed through the claims system in order to obtain payment. The Intermediary argued that the PM A-98-21 issued by CMS made clear that the Providers were required to bill their Intermediary if they wanted to receive the IME and DGME payments for Medicare managed care enrollees.

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, 1998, and explicitly stated that hospitals "must submit a claim to the hospitals' regular intermediary in UB-92 format."

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.[14] The Federal Register preamble language and the PM A-98-21 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

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

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 required to be filed, the regulatory requirements 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.[15]

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.[16] The payment of IME and DGME claims was an already established payment methodology for teaching

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[15] 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).

[16] 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.

hospitals that was already linked to the claims processing system and did not require the promulgation through notice and comment of specific instructions. A provider was required to submit a regular claim to its Medicare Managed Care entity to be paid for services rendered to the Medicare beneficiary, and also had to submit an additional claim to its intermediary. The additional claim was a "no-pay bill" that required no payment for services rendered, but provided the necessary data in the required format and timeframe for the Medicare program to pay IME and DGME adjustments for the services provided by the hospital to the Medicare Managed Care patients.

The Providers' argued that they did not receive actual notice from the Intermediary explaining the contents of PM-A-28-91, in the form of a letter or Bulletin, thus distinguishing this case from all previous cases. However, the record shows that the Providers did, in fact, comply and receive IME/DGME payment for claims submitted for services provided from January 1, 1998 to June 30, 1998. For those claims relating to inpatient services provided to Medicare Managed Care beneficiaries, during this six month time period, the Providers submitted "no-pay bills" to the Intermediary using the UB-92 forms, which allowed the Providers to receive additional DGME and IME payments.[17] For the remaining periods at issue, the inpatient services provided to Medicare Managed Care beneficiaries from July 1, 1998 through September 30, 2001, the Providers did not submit the "no-pay bills" to the Intermediary using the UB-92 forms. Thus, the record indicates that the Providers were on notice of the billing procedures and actually used them to receive payment, but failed to submit claims after that period, in a timely manner. The Providers had adequate time to comply with the instructions requiring the submission of the specially coded UB-92 forms, for the fiscal years in contention.

The Providers argued that their inability to properly bill for the claims was due to a number of factors, including: hospitals changing intermediaries, delays in Medicare issuing the PS&Rs, changes in hospital billing systems, difficulties in processing second claims for the IME payment, and dealing with Y2K issues.[18] At the oral hearing, the Providers' witness explained that during the period between January 1, 1998 and June 30, 1998, the Providers started a process where they submitted a bill directly to the managed care company and also manually submitted a bill to Medicare for the IME.[19] The Providers' witness testified that their system was only able to bill a single primary payer, and that with the new application requirement, they had to manually submit a second bill to Medicare.[20] The record also indicates

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[17] *See* Stipulations of Facts at 3, and Transcript of Oral Hearing (Tr.) p. 33.
[18] *See* Intermediary's Position Paper at 4, and Tr. pp. 54-55.
[19] *See* Tr. p. 39.
[20] *See* Tr. p. 40.

that the Providers made no attempt to bill using this manual process after this period.[21] Therefore, the record is not supportive of the Providers' arguments that the failure to file claims was due to lack of notice, but rather, the record indicates this failure was more likely due to flaws in the Provider's internal process and controls to ensure timely billing.[22]

Finally, the regulatory time limits require that claims must be filed on or before December 31 of the calendar year following the year in which the services are furnished, or the second year after the year in which services were furnished, for services furnished in the last quarter of the calendar year.[23] The record indicates that for the periods at issue, the claims for IME/DGME were not filed. The Providers' argued that they provided a log of the Medicare managed care patients furnished services as part of a reopening request made for each hospital and fiscal year in question. As a result, the Providers claim that the Intermediary must accept and review their data that demonstrates entitlement to payments for FYs 1998 through 2001.[24] The Administrator finds that the use of the Providers' internal logs does not meet the payment standards in place for intermediaries and cannot accurately duplicate the role of the claims processing system. A manual computation of the IME and DGME payments would result in inaccurate payments and would entail substantial unnecessary burden on the Medicare program.

Accordingly, the Administrator finds that the Intermediary properly determined the supplemental IME and DGME payments for Medicare managed care enrollees in the fiscal years 1998, 1999, 2000, and 2001 cost reporting periods. Thus, the Administrator reverses the Board's decision.

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[21] *See* Tr. p. 51.
[22] *See* Tr. p. 47.
[23] *See*, 42 C.F.R. §424.44.
[24] *See* Tr. p. 43.

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: **5/20/2009** **/s/**

Michelle Snyder
Acting Deputy Administrator
Centers for Medicare & Medicaid Services