CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Research Medical Center **Provider** **vs.** **Wisconsin Physicians Service** **Intermediary**	**Provider Reimbursement Determination for Cost Reporting Period Ending: 12/31/01** **Review of:** **PRRB Dec. No. 2012-D12** **Dated: March 9, 2012**

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)). The Intermediary submitted comments requesting that the Administrator review and reverse the Board's decision. Accordingly, the parties were notified of the Administrator's intention to review the Board's decision. Comments were also received from the Providers' requesting that the Administrator affirm the Board's decision. The Provider also submitted comments requesting that the Administrator affirm the Board's decision. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD DECISION

The issue concerns whether the Intermediary's determination of additional amounts paid to the Provider for nursing and allied health (N&AH) education associated with Medicare + Choice (M+C) enrollees was proper.

The Board held that the Intermediary improperly disallowed the N&AH payments in the Provider's FY 2001 with respect to the discharges of M+C beneficiaries for the period ending December 31, 1998. The Board remanded the case to the Intermediary to include the

FY 1998 paid M+C days as reported by the managed care organizations (MCOs) in recalculating the Provider's allowable N&AH payments for FY 2001.

In reaching this determination, the Board concluded that the Provider was not on notice in 1998 of a need to submit "no-pay" claims for M+C enrollees in 1998 in order to receive N&AH education payments. The Board found that the only requirement that there be "nopay" claims for N&AH payments in 2001 was not promulgated until May 2003, well past the dates the Provider could have submitted the "no-pay" claims under CMS timeline interpretation. Rather, the Board concluded that the regulations at the time simply informed providers that if they wished to receive additional direct graduate medical education (DGME) and indirect medical education (IME) for M+C enrollees they would have to submit "no-pay" claims to their intermediary which the Provider did. Furthermore, nothing in the statue or the implementing regulations required N&AH education payments for M+C enrollees to be supported by "no-pay" claims. The BBRA and BIPA amendments to the Medicare statute mandated only that the Secretary "shall" provide for additional N&AH payments for providers' M+C patients for cost reporting periods ending on or after January 1, 2000, without specifying the source of documentation.

The Board disagreed with the Intermediary's contention that CMS required it to only use the PS&R reports, to determine the number of days for purposes of M+C N&AH calculation. The Board found that under §2242 of the MIM, in place at the time these costs were incurred, while intermediaries were permitted to rely on the PS&R report in settling a provider's cost report, intermediaries were not prohibited from using other data if the Provider could demonstrate that more accurate and reliable data was available.

The Board also rejected the Intermediary's contention that, in order to claim additional N&AH payments associated with M+C enrollees the Provider had to submitted claims related to M+C enrollees directly to the Intermediary no later than December 31, 2000, well before reimbursement by Medicare for N&AH education payments was even authorized. In rejecting the Intermediary's position, the Board found that the services provided were all provided on a pre-paid capitation basis through Medicare MCOs. The Board then found that the applicable regulations exempted the timely filing requirements when services were furnished on a prepaid capitation bases. Thus, the Board concluded that, the claims at issue in this case were specifically exempt from the requirements, procedures, and time limits" noted in 42 C.F.R §§424.30, and 424.44.

In sum, the Board held that there was no statutory or regulatory requirement that providers submit "no-pay" claims in 1998 to receive reimbursement for services furnished to M+C enrollees or that intermediaries require "no-pay" claims to calculate that reimbursement for N&AH education payments in 2001. Moreover, although providers co u Id submit claims directly to intermediaries if they wished to receive reimbursement for additional DGME and IME payments associated with those M+C enrollees in 1998, nothing required that they do

so. Finally, the 2003 transmittal contradicts these pre-existing authorities and therefore, constitutes a new set of condition for reimbursement.

COMMENTS

The Intermediary submitted comments requesting that the Administrator review and reverse the Board's determination. The Intermediary argued that the Board's remand instructions for the Intermediary to include the FY 1998 paid M+C days as reported by the MCOs violates the regulation at 42 C.F.R. 413.87(e). The Intermediary stated that 42 C.F.R. §413.87(e), requires that "payments received for provider's N&AH programs are to be calculated based on data from settled cost reports for period(s) ending in the fiscal year that is 2 years prior to the current calendar year." Furthermore, despite the above, there are also legitimate concerns in allowing the Provider to submit stale data that was not submitted during its 1998 cost report year. Since these particular claims were not submitted, they should not be allowed to appeal these claims now for the first time for the purpose of reimbursement in its 2001 cost report. Moreover, the Provider cannot have it both ways. The Provider cannot be both satisfied with the finalized figures of its 1998 cost report for DGME purposes and now be dissatisfied with the exact same figures because the figures are used to calculate N&AH reimbursement. Finally, even if the data is accepted it is not clear if the claims could meet the intermediary's payment standards. The Intermediary contended that the data cannot accurately duplicate the role of the claims processing process that would have taken place in 1998.

The Provider submitted comments requesting that the Administrator affirm the Board's decision. The Provider contended that nothing in the statute or the regulations required that the Provider support its M+C days solely through "no-pay" bills submitted to the Intermediary. The Provider acknowledged that, while PM A-03-043, informed providers that intermediaries were to rely on the PS&R, in calculating M+C days for purposes of hospitals' N&AH payment for 2001, the PM also allowed intermediaries to accept other days' data to supplement the PS&R, if the provider established that inaccuracies existed and more accurate data was available. In this case, the Provider attempted to submit more accurate data to the Intermediary, but the Intermediary refused to accept it.

The Provider also argued that PM A-03-043 should not apply because it was not issued until May 23, 2003. The Provider maintained that if PM A-03-043 is applied it would be impermissibly retroactive because it would impose a requirement before the BIPA provision governing this case was even effective and long before CMS notified providers in 2003 of the need to submit "no-pay" claims for N&AH purposes. Moreover, the established law would not permit such a result. Unlike the cases involving DGME and IME payments for M+C days, the applicable notice in this case, was not given until 2003, long after the timely

filing period of 42 C.F.R. §424.44 had passed. In Loma Linda Univ. Med. Ctr. v. Sebelius,[1] the United States Court of Appeals for the District of Columbia Circuit ruled that providers must "receive notice 'with ascertainable certainty' … of the billing deadline for seeking payment for medical education costs associated with Medicare+ Choice (Part C) inpatients days." Furthermore, the filing requirements as it related to the 1998 DGME and IME days has been ruled invalid. In *Hospital of the University of Pennsylvania v. Sebelius*, the United States District Court for the District of Columbia, ruled that the application of 42 C.F.R. §424.44 filing limits were invalid absence of the hospitals' receiving legal notice of such a requirement. Thus, in 1998, the Provider was under no obligation to submit "no-pay bills to its Intermediary for M+C patients in order to preserve its entitlement to reimbursement for N&AH payments.

The Provider also disagreed with the Intermediary's contention that 42 C.F.R. 413.87(e), required that "payments received for provider's N&AH programs … be calculated based on data from settled cost reports for period(s) ending in the fiscal year that is 2 years prior to the current calendar year." The Provider maintained that while subsection (e)(1)(i) talked about data being obtained from "settled cost reports", neither subsection (e)(1)(ii) nor subsection (iii) contained such a limitation, and nowhere did those subsections state that the source of the data for M+C days or inpatient days must come from a "settled cost report." Furthermore, the Provider maintained that the Intermediary's position leads to an absurd result.

Finally, the Provider disagreed with the Intermediary's position that the Provider's failure to submit "no-pay" claims for the hospital's M+C patients in 1998 to preserve its right to payment for GME days and that its failure to do so should be construed as prejudicing the Provider's entitlement to N&AH payments.

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.

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[1] 408 Fed. Appx. 383 (D.C. Cir. 2010), reprinted in 2010 WL 4903887 (D.C. Cir. Dec. 2, 2010)

In addition, Medicare historically has paid a share of the net costs of "approved medical education activities" under the reasonable cost provisions.[2] 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.[3] 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.[4]

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),[5] 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.[6] 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," i.e., paid on a reasonable cost basis. Rather, for cost years subject to PPS, these costs were considered to be part of normal operating costs covered by the per case payments made under the PPS for hospitals paid under that system. This approach was similar to the treatment that these costs had received since 1979 for purposes of the cost limits.

The regulation implementing inpatient hospital PPS at 42 C.F.R. §412.113(b) provided that the costs of "approved education activities," including training programs for nurses and paramedical (allied health) professionals, will be paid on a reasonable cost basis, as defined in 42 C.F.R. §413.85. The regulations at 42 C.F.R. §413.85 set forth the applicable principles for reimbursing the reasonable cost of educational activities under the Medicare program, and explicitly defined the types of approved educational activities which are within

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[2] 20 C.F.R. §405.421 (1966); 42 CFR §405.421 (1977); 42 C.F.R. §413.85 (1986).
[3] 42 C.F.R. §413.85(b).
[4] 54 *Fed. Reg.* 40,286 (Sept. 27, 1989).
[5] Pub. L. No. 97-248.
[6] Section 601(e) of the Social Security Amendments of 1983. Pub. L. No. 98-21 (1983).

the scope of these reimbursement principles under PPS and those activities which are outside the scope of these reimbursement principles under PPS.

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 C.F.R. §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.[7] The regulations at 42 C.F.R. §412.105 establish how the additional payment is calculated. The additional payment, known as the IME adjustment, is based on the indirect teaching adjustment factor, calculated using the hospital's ratio of full-time equivalent (FTE) residents to beds. 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 §1886(h)(3) of 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. Similarly, the BBA 1997 amended the Act by adding a new provision at §1886(d), addressing the additional IME payment. These statutory changes were promulgated in the regulation for the DGME payment at 42 C.F.R. §413.86 and since recodified at 42 C.F.R. §413.76 (2004).

[7] 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.

The IME and DGME payment for Medicare managed care enrollees was specifically addressed in the May 12, 1998 *Federal Register*[8] 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.
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> We anticipate teaching hospitals will need to submit claims associated with Medicare + Choice discharges to the fiscal intermediaries for purposes of receiving indirect and direct medical education payments. When the claims are processed, the fiscal intermediaries will make the IME payment associated with a Medicare + Choice discharge directly to the teaching hospital. Teaching hospitals will also be required to submit bills associated with Medicare + Choice organizations to the managed care plans. The inpatient encounter data from these bills will be submitted by the managed care plans to HCFA for purposes of implementing the risk adjustment methodology. The fiscal 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

[8] 63 Fed. Reg. 26,318 (May 12, 1998).

> 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, PMA-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 C.F.R. §424.30. The regulation explains the scope of claims for payment and states:

> This subpart sets forth the requirements, procedures, and time limits for claiming Medicare payments. Claims must be filed in all cases except when services are furnished on a prepaid capitation basis by a health maintenance organization, (HMO), a competitive medical plan (CMP), or a health care prepayment plan (HCPP).

Therefore, while claims for, *inter alia*, Part C and §1876 managed care services are not controlled by this section, a hospital must submit claims in conformity with 42 C.F.R. §424.30, *et seq.*, to be able to include managed care enrollees for the Part A IME and DGME payments from its intermediary. The timeframe for filing claims is set forth at 42 C.F.R. §424.44, which states that:

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

As the PM explained, filing a claim with the intermediary using the UB-92 form is required in order to generate data that may be used for payment. The procedures set forth in the PM are consistent with the Medicare Financial Management Manual (Pub. 100-6), which explains the role of the UB-92 form and claims processing in the settlement process. The claims system makes the required determination on eligibility rules and benefits available for Medicare, in contrast to the cost report settlement process. CMS provides each intermediary 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 additional amount for 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.[9]

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.

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[9] 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."

Relevant to this case, §1886(1) of the Act provided for an additional Part A nursing education payment based on, inter alia, Medicare+Choice inpatient days. In 1999, Congress further expanded the payment methodology associated with M+C enrollees to cover N&AH with the passage of the Balance Budget Refinement Act (BBRA), effective January 1, 2000.[10] Section 1886(1) of the Act, as added by §541 of Public Law 106-113, specified the methodology to be used to calculated these additional payments and placed a limitation on the total amount projected to be expended in any calendar year.[11] For calendar year 2000, the implementing regulation at 42 C.F.R. §413.87(d), calculated the additional payment as follows:

> (d) *Calculating the additional payment amount.* Subject to the provisions of paragraph (f) of this section relating to calculating a proportional reduction in Medicare+Choice direct GME payments, the additional payment amount specified in paragraph (c) of this section is calculated according to the following steps:
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> (1) *Step one.* Each calendar year, determine the hospital's total nursing and allied health education program payment from its cost reporting period(s) ending in the fiscal year that is 2 years prior to the current calendar year.
> (2) *Step two.* Determine the ration of the hospital's payments from step one to the total of all nursing and allied health education program payments across all hospitals for all cost reporting periods ending in the fiscal year that is 2 years prior to the current calendar year.
> (3) *Step three.* Multiply the ration calculated in step two by the amount determined in accordance with paragraph (e) of this section for the current calendar year. The resulting product is each respective hospital's additional payment amount.
> (e) *Calculation of the payment "pool."*
> (1) Subject to paragraph (e)(3) of this section, each calendar year, [CMS] will calculate a Medicare+Choice nursing and allied health payment "pool" according to the following steps:
> (i) Determine the ration of projected total Medicare+Choice direct GME payments made in accordance with the provisions of §413.86(d)(3) across all hospitals in the current calendar year to projected total direct GME payments made across all hospitals in the current calendar year.
> (ii) Multiply the ration calculated in paragraph (e)(1)(i) of this section by projected total Medicare nursing and allied health education reasonable cost payments made across all hospitals in the current calendar year.

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[10] Pub. L. No. 106-113, §541, 113 Stat. 1501, 1501A-321. 1501A-391-92 (1999).
[11] 65 *Fed. Reg.* 47026, 47037 (Aug. 1, 2000).

> (2) The resulting product of the steps under paragraph (e)91)(i) and (e)(1)(ii) of this section is the Meidcare+Choice nursing and allied health payment pool for the current calendar year.
> (3) The payment pool may not exceed $60 million in any calendar year.[12]

The Benefits Improvement and Protection Act of 2000 (BIPA)[13] revised the N&AH program payment methodology further to account specifically for each hospital's M+C utilization, based upon data from cost reports ending in the second preceding fiscal year with payments being made effective for cost reporting periods starting on or after January 1, 2001. For calendar year 2001, CMS issued Program Memorandum A-01-148, dated December 27, 2001, outlining the changes to process providers request for this additional payment associated with §512 of BIPA and §541 of BBRA. In PM A-01-0148, CMS revised the regulations at 42 C.F.R. §413.87 to reflect these changes. The regulations at 42 C.F.R. §413.87(e) calculated the additional payment as follows:

> (e) *Calculating the additional payment amount for portions of cost reporting periods occurring on or after January 1, 2001.* For portions of cost reporting periods occurring on or after January 1, 2001, subject to the provisions of §413.76(d) relating to calculating a proportional reduction in Medicare+Choice direct GME payments, the additional payment amount specified in paragraph (c) of this section is calculated according to the following steps:
> (1) *Step one.* Each calendar year, determine for each eligible hospital total -
> (i) Medicare payments received for approved nursing or allied health education programs based on data from the settled cost reports for the period(s) ending in the fiscal year that is 2 years prior to the current calendar year; and
> (ii) Inpatient days for that same cost reporting period.
> (iii) Medicare+Choice inpatient days for that same cost reporting period.
> (2) *Step two.* Using the data from step one, determine the ration of the individual hospital's total nursing or allied health payments, to its total inpatient days. Multiply this ratio by the hospital's total Medicare+Choice inpatient days.
> (3) *Step three.* CMS will determine, using the best available data, for all eligible hospitals the total of all -
> (i) Nursing and allied health education program payments made to all hospitals for all cost reporting periods ending in the fiscal year that is 2 years prior to the current calendar year;
> (ii) Inpatient days from those same cost reporting periods; and
> (iii) Medicare+Choice inpatient days for those same cost reporting periods.

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[12] 42 C.F.R. §413.87(d)(2000).
[13] Pub. L. No. 106-554, §512, 114 Stat. 2763, 2763A-463, 2763A-533-34(2000).

> (4) *Step four*. Using the data from step three, CMS will determine the ration of the total of all nursing and allied health education program payments made to all hospitals for all cost reporting periods ending in the fiscal year that is 2 years prior to the current calendar year, to the total of all inpatient days from those same cost reporting periods. CMS will multiply this ratio by the total of all Medicare+Choice inpatient days for those same cost reporting periods.
> (5) *Step 5*. Calculate the ratio of the product determined in step two to the product determined in step four.
> (6) *Step 6*. Multiply the ration calculated in step five by the amount determined in accordance with paragraph (f) of this section for this section for the current calendar year. The resulting product is each respective hospital's additional payment amount.[14]

To determine the above cost and implement the foregoing regulation pursuant to notice and comment, CMS stated in the *preamble* to the *Federal Register* that:

> We will use the best available cost reporting data for the applicable hospitals from the Hospital Cost Report Information System (HCRIS) for cost reporting periods in the fiscal year that is 2 years prior to the current calendar year. If the necessary data are not included in HCRIS because a hospital files a manual cost report, we will obtain the necessary data from the fiscal intermediaries that serve those hospitals. If a hospital has more than one cost reporting period ending in the fiscal year that is 2 years prior to the current calendar year, we will include all of the hospital's cost reports for those periods in our calculation….[15]

CMS then issued PM A-03-007, dated February 3, 2003, which modified PM A-98-21, to allow non-IPPS providers to submit their M+C claims to their intermediaries to be processed as no-pay bills so that the M+C inpatients days could be accumulated on the Provider Statistics & Reimbursement Report (PS&R) for DGME payment purposes through the cost report. Similarly, PM A-03-007 notified providers that operated an N&AH program and who qualified for the additional payment related to M+C enrollees that they too must submit nopay bills for the M+C enrollees to the intermediaries so that the M+C inpatients days could be accumulated on the Provider Statistics & Reimbursement Report (PS&R) for purposes of calculating the M+C N&AH payment through the cost report. PM A-03-007 instructed providers that the instructions for calculating this payment would be explained in a separate transmittal.

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[14] 42 C.F.R. §413.87(e)(2001).

[15] 66 Fed. Reg. 32179, (June 13, 2001). No comments where received regarding the proposed rule.

As such, CMS issued PM A-03-043, dated May 23, 2003. For periods beginning on or after January 1, 2001, PM A-03-043 required that intermediaries determine, for each eligible hospital, the total M+C inpatient days based on data from the settled cost reports for the periods(s) ending in the fiscal year that ends in the Federal Fiscal year that is two years prior to the current calendar year. PM A-03-043 also instructed intermediaries to obtain the number of M+C inpatient days from the PS&R report. PM A-03-043 also allowed providers to present additional documentation to revise the intermediaries determination on the number of M+C days provided they meet the time limitation for submitting provider claims at §3600.2 of the Intermediary Manual. Therefore, in this case under appeal, according to PM A-03-043 and the regulation at 42 C.F.R. §413.87, the Intermediary relied on the Provider's PS&R report from 1998 to determine their N&AH payment for 2001. Under PM A-03-043 the Provider was allowed to submit additional "days data" but only if that data had been submitted to the Intermediary prior to December 31, 2000.

In this case the Administrator finds that the issue concerns the basis for the M+C inpatient days used in the N&AH calculation. The Provider argued that they were not given notice of the source of the M+C inpatient days' data for purposes of calculating the N&AH M+C payments. However, the Intermediary contended that the Provider cannot be allowed to inflate the numbers in the numerator with the same numbers it did not submit to have placed in the denominator of the fraction through the HCRIS reporting process. The Intermediary maintained that to allow the provider the opportunity to submit data that has not gone through the edit process, and finally data that will only affect the numerator of the fraction, would go against fundamental principal behind the methodology for reimbursement of N&AH Budget Neutrality. Finally, the Intermediary argued that the Provider cannot be satisfied with the finalized figures on its 1998 cost report for DGME/IME managed care payments and now be dissatisfied with the exact same figures because the figures are used to calculate N&AH reimbursement.

Thus, applying the relevant law and program policy to the foregoing facts, the provider community was given notice of the need to file UB-92s directly with intermediaries for IME/DGME payments authorized by BBA of 1997 for services provided to M+C enrollees. The Administrator also finds that, filing a claim with intermediaries using the UB-92 form is required in order to generate data that may be used for payment. In 1999, Congress expanded the payment methodology associated with M+C enrollees to cover N&AH, with the passage of the BBRA, effective for January 1, 2000. The additional payment associated with M+C enrollees to cover N&AH was to be based on data obtained from "cost reporting periods ending in the fiscal year that is 2 years prior to the current calendar year." The Administrator also finds that in 2000, Congress passed BIPA which revised the N&AH payment formula to specifically account for each hospital's M+C utilization, effective 2001, the beginning of the cost year under appeal. This payment methodology as set forth in the proposed rule was to be based upon data from settled cost reports ending in the second preceding fiscal year with payment being made effective for cost reporting periods starting

on or after 2001 and specifically from the HCRIS, which reflects the same settled cost report data. Thus, for calendar year 2001, the fiscal period under appeal, the Administrator finds that the corresponding data period mandated by Congress was the period ending December 31, 1998. The PM-A-03-043, issued May 23, 2003 instructed intermediaries to obtain the number of M+C inpatient days from the PS&R report. It also provided that, "subject to the rules concerning time limitation for submitting provider claims at §3600.2 of the Intermediary Manual, additional documentation to revise the FI's determination [on the number of M+C days] may be submitted by the provider, but will be subject to audit by the FI." Therefore, according to PM A-03-043 the Provider was allowed to submit additional "days data" but only if that data had been submitted to the Intermediary prior to December 31, 2000.

In this case, the record shows that during FY 1998, the Provider submitted "no-pay" UB-92s claim forms to its Intermediary for services supplied to M+C enrollees during the FY 1998. The record further shows that the Provider made a business decision not to continue with the necessary efforts to ensure all M+C claims for services provided by the hospital in 1998 were successfully processed through the Intermediary's claim system due to the low payment for DGME and IME associated with M+C enrollees. Thus, for FY 1998, the Provider received an additional DGME/IME payment associated with M+C enrollees, based on the Provider's finalized cost report. The record further shows that, when CMS issued the proposed rules regarding the calculation of the additional payment associated with M+C enrollees to cover N&AH and the use of the settled cost reports and HCRIS as the bases for the data, no comments were received by CMS regarding this matter.

Accordingly, as the Intermediary processed the additional Medicare Part A N&AH payment in accordance with CMS instructions the Board's decision is reversed.

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: 5/14/12

/s/
Marilynn Tavenner
Principal Deputy Administrator and Chief Operating Officer
Centers for Medicare & Medicaid Services