PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2009-D20

PROVIDER -
Henry Ford Health System
Managed Care GME/IME Payments Group
Detroit, Michigan

Provider Nos.: See Attachment

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
National Government Services, LLC - WI

DATE OF HEARING -
November 14, 2008

Cost Reporting Periods Ended -
December 31, 1998; December 31, 1999;
December 31, 2000

CASE NO.: 04-1997G

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ISSUE:

Whether the Intermediary improperly disallowed direct graduate medical education (DGME) and indirect medical education (IME) payments with respect to discharges of Medicare beneficiaries who were enrolled in Medicare+Choice or other Medicare risk plans in fiscal years ended December 31, 1998, December 31, 1999 and December 31, 2000.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§ 1395-1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and interpretive guidelines published by CMS. See, 42 U.S.C. § 1395h; 42 C.F.R. §§ 413.20 and 413.24.

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. § 413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. § 405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. § 1395oo(a); 42 C.F.R. §§405.1835 – 405.1837.

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the Prospective Payment System (PPS). The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors. See, 42 U.S.C. 1395ww(d)(5). This case involves two of those provisions.

The provision at 42 U.S.C. §1395ww(h) prescribes the Medicare payment method for direct graduate medical education (GME) costs. In brief, the direct GME payment is the product of a hospital's average per resident amount, derived and updated from a 1984 base period, multiplied by the hospital's number of interns and residents in approved GME programs during the payment year, multiplied by the hospital's Medicare patient load. The Medicare patient load is a fraction

representing the percentage of a hospital's total patient days (denominator) attributable to Medicare patients (numerator).

The provision at 42 U.S.C. §1395ww(d)(5)(B) provides that teaching hospitals that have residents in approved GME programs receive an additional payment for each Medicare discharge to reflect the higher indirect patient care costs of teaching hospitals relative to non-teaching hospitals. 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.

DGME and IME payments for Medicare+Choice[1] beneficiaries

Prior to the enactment of the Balanced Budget Act of 1997 (BBA '97), the numerator of the Medicare patient load fraction included only the number of patient days attributable to the Medicare beneficiaries who were entitled to have payment made under the Medicare Part A fee-for-service program. CMS did not include inpatient days attributable to enrollees in Medicare risk plans (i.e., Medicare Health Maintenance Organizations (HMOs) or Competitive Medical Plans (CMPs) with risk sharing contracts under section 1876 of the Act). In 1989, when CMS promulgated the regulations implementing the prospective payment method for GME, the agency determined that these Medicare managed care plan days would not be counted as Medicare days in the Medicare patient load used to calculate Medicare payment for GME.[2]

Section 4624 of BBA '97 amended the DGME statute by adding a new provision in section 1395ww(h)(3)(D) for an additional GME payment with respect to patient days attributable to services furnished to Medicare beneficiaries enrolled in a Medicare+Choice plan. The regulations implementing this provision were codified at 42 C.F.R. § 413.86. Similarly, BBA '97 amended the IME statute by adding a new provision in 42 U.S.C. § 1395ww(d)(5)(B). The regulations implementing this provision are set forth in 42 C.F.R. § 412.105(g).

In addition, CMS issued Program Memorandum Transmittal No. A-98-21 which implemented the provision and mandated the same claims filing practices as used for all other claims. Accordingly, a hospital is to submit a "no-pay" claim for each managed care enrollee in UB-92 format with appropriate condition codes.

[1] The term Medicare+Choice will be used to represent "Medicare+Choice plan or any other Medicare managed care plan with a risk sharing contract under section 1876 of the Act."

[2] 54 Fed. Reg. 40286, 40294-95 (Sept. 29, 1989).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Henry Ford Health System[3](Provider) is a teaching hospital located in Detroit, Michigan. The cost reporting periods at issue in this appeal are the periods ending December 31, 1998, December 31, 1999 and December 31, 2000. National Government Services, LLC (Intermediary) audited each of the cost reports and made final determinations relating to the IME and DGME payments with respect to Medicare+Choice beneficiaries.

The parties have stipulated to the number of patient days and patient stays at issue. For FY 1998, the Provider is claiming 1,624 patient days with respect to 210 patient stays. For FY 1999, the Provider is claiming 11,703 patient days with respect to 1,968 patient stays. For FY 2000, the Provider is claiming 3,353 patient days with respect to 576 patient stays.

The Provider appealed the disallowances to the Board and met the jurisdictional requirements of 42 C.F.R. §§ 405.1835 - 405.1841. The Provider was represented by Christopher L. Keough, Esq., of King & Spalding, LLP. The Intermediary was represented by James R. Grimes, Esq., of Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Provider argues that the Intermediary improperly adjusted the settlement data used to determine DGME and IME payments with respect to Medicare+Choice beneficiaries in its cost reports. The Provider asserts that changes enacted in BBA '97 allowed the Provider to receive additional DGME and IME payments for hospital inpatients enrolled in Medicare+Choice or other Medicare risk plans. Nothing in the statute required the Provider to submit data directly to the Intermediary within a specified time, and no such requirement was ever approved by the Office of Management and Budget (OMB). The Provider claims that the Medicare+Choice plans submitted UB-92 data relating to Medicare risk plan discharges to the Intermediary before the audits of each of the fiscal years at issue were completed, and the Intermediary did not include that data in the settled cost reports. Moreover, the parties have stipulated that the Provider submitted paper copies of claims to the Intermediary in December 2002, prior to the issuance of the NPRs for the periods at issue. The Provider asserts that the Intermediary improperly rejected and excluded this data in the settled cost reports.

The Intermediary asserts that the Provider's submission of UB-92 claim forms to the Intermediary at the time of the audits of the Medicare cost reports was inconsistent with the CMS instructions and, therefore, the claims were properly rejected. The Intermediary argues that it was the Provider's responsibility to file a UB-92 claim form to its intermediary through the claims processing system and in the same time frame required for other claims in order to obtain the additional

[3] This group was initially formed with two providers: Henry Ford Hospital (Provider No. 23-0053) and Bi-County Hospital. Bi-County Hospital withdrew from the group appeal.

IME and DGME payment for managed care enrollees. Program Memorandum (PM) A-98-21, issued on July 1, 1998 to address the BBA '97 provision, instructed intermediaries as follows:

> 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. . . .
>
> * * * *
>
> PPS hospitals must submit a claim to the hospitals' regular intermediary in UB-92 format, with 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.

The Intermediary argues that this PM issued by CMS put the Provider on notice that it was required to bill its intermediary if it wanted to receive IME and DGME payments for its Medicare managed care enrollees.

Consistent with the Intermediary's position that the Provider had to submit a claim to the intermediary to receive IME/DGME payments for the Medicare+Choice beneficiaries, the Intermediary argues that the Provider's claims had to be submitted to the Intermediary in the time required by 42 C.F.R. § 424.44 which states:

> (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 a authority.

(2) The time will be extended through the last day of the 6th calendar month following the month in which the error or misrepresentation is corrected.

The Intermediary contends that the Provider submitted copies of these claims after the time period allowed under 42 C.F.R. § 424.44 had expired; and since the Provider did not properly bill the claims, they were appropriately rejected and not included in the final settled cost reports.

The Provider argues that the Intermediary's assertions are unsustainable. Since no law or regulation required the Provider to submit encounter data directly to the Intermediary or within a specified time period. The guidance and instructions issued by CMS and the Intermediary subsequent to BBA '97 include:

- December 24, 1997 – CMS issued an Operational Policy Letter (OPL No. 64) outlining a draft process for submission of hospital encounter data pursuant to BBA'97. (Provider Exhibit P-8)
- May 19, 1998 – CMS issued an Operational Policy Letter (OPL No. 70) a draft list of requirements for plans for data submission for the period July 1, 1997 through June 30, 1998. (Provider Exhibit P-9)
- June 26, 1998 - 42 C.F.R. § 422.257 was issued requiring that "each M+C organization must submit to CMS (in accordance with CMS instructions) all data necessary to characterize the context and purposes of each encounter between a Medicare enrollee and a provider, supplier, physician, or other practitioner."
- July 1, 1998 – Program Memorandum (PM) A-98-21 was issued to intermediaries. This PM directed intermediaries to notify providers of the following: "[t]eaching hospitals may submit bills for inpatient stays by managed care enrollees for payment of IME."
- June 29, 2000 – CMS published the final rule for the Medicare+Choice program, 65 Fed. Reg. 40170, and responded to comments regarding the June 1998 interim final rule. CMS acknowledged a "range of problems in the submission of encounter data . . ." including intermediary processing problems and confusion regarding hospital submission of encounter data. This final rule established a retrospective reconciliation process for encounter data submitted to the intermediaries by the Medicare risk plans after the deadline for submission by the plans.
- February 3, 2003 – Program Memorandum (PM) A-03-007 was issued acknowledging that the earlier July 1998 PM did not address GME payments for non-IPPS hospitals and units. The February 2003 PM states that these hospitals and units "must submit claims to their regular

> intermediary in UB-92 format" to obtain GME payments, but this was made effective prospectively beginning July 1, 2003.

The Provider asserts that prior to February 3, 2003, CMS had used the term "may" submit bills for IME payments, and that it was not until the February 3, 2003 PM was issued, well after the current years in question, that the term "must" submit separate bills was used to described how providers could receive DGME payments for their Medicare managed care enrollees. In addition, CMS had not directly or indirectly informed providers that the bills had to be submitted to their intermediaries (instead of the managed care plans) in order for hospitals to obtain the DGME or IME payments.

CMS failed to instruct intermediaries to give proper notice to the hospitals on how these bills were to be submitted (i.e., electronically or in paper form) or the time frame in which to submit them despite the fact that the Medicare regulation governing the requirements and time period for submission of Medicare claims for payment expressly does not apply with respect to services furnished to enrollees in Medicare risk plans. 42 C.F.R. § 424.30. Further, the Provider contends that even if the Provider was required to submit claims to their Intermediary to obtain the DGME and IME payments, the Provider was not provided fair notice of that requirement to afford it due process of law.

Finally, the Provider argues that it cannot lawfully be penalized for having failed to meet a requirement to submit claims directly to the Intermediary in order for it to obtain the IME and DGME payments with respect to discharges of patients enrolled in M+C plans, as no such requirement was ever approved by the Office of Management and Budget (OMB). The Provider asserts that the Federal Paperwork Reduction Act (PRA) would preclude CMS from imposing such a requirement to deny the Provider the benefit of the DGME and IME payments at issue without obtaining OMB's prior approval for the data collection. See, 44 U.S.C. § 3512(a).

The Intermediary avers that the Medicare managed care plans were under an obligation to file encounter data long before the enactment of BBA '97; therefore, the filing of these claims was not a new requirement that would have needed special OMB approval.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and program instructions, the evidence presented and the parties' contentions, the Board finds and concludes as follows:

BBA '97 provided IME and DGME payments for services provided under risk HMO contracts that, prior to the BBA, had not been available. The Secretary was given broad authority to provide for or devise a way to pay hospitals supplemental payments for DGME and IME. 42 U.S.C. § 1395ww(h)(3)(D) entitled "Payment for managed care enrollees" states:

> (i) *In general*. 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 1395mm of this title and who are entitled to part A of this subchapter or with a Medicare + Choice organization under part C of this subchapter.

42 U.S.C. § 1395ww(d)(11) entitled "Additional payments for managed care enrollees" states:

> (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) of this section hospital that has an approved medical residency training program.

The question before the Board is what conditions precedent must be satisfied to entitle a hospital to payment for the new additional benefit.

The Board finds that this dispute is governed by the regulations, 42 C.F.R. §424.30 et seq. Prior to the BBA '97, whether a "claim" (described elsewhere as a form UB92) filed for each patient stay was required was governed by 42 C.F.R. § 424.30 which 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 [HMOs].

42 C.F.R. § 424.32 et. seq. furnishes more detail regarding the "basic requirements" for filing all claims including the requirement that the claim be filed with the hospital's intermediary and within the time limits specified in 42 C.F.R. §424.44.

Therefore, prior to BBA '97, in order to receive payment for the services furnished to Medicare beneficiaries, the hospital filed its claim for payment directly with its Medicare intermediary. But if the beneficiary was a member of a risk HMO which had been prepaid by Medicare, the hospital filed its claim for payment for services furnished with the HMO, not the intermediary. The claims in question paid for by Medicare+Choice organizations or other Medicare risk plans, are specifically exempt from the requirements, procedures and time limits under this section. All information that would be needed to process these claims by

intermediaries may not be available from the data submitted to the Medicare HMO plans because the data is used for entirely different purposes.

In addition, prior to the BBA '97, despite the process for filing claims for payment for *services furnished*, hospitals were nevertheless required by the hospital manual to file 'no pay' bills for tracking or utilization purposes only, for example, to set capitated rates. These were referred to as 'no-pay' bills and the data assembled was referred to as 'encounter data.'

> A. No-Payment Situations Where Bills Must be Submitted.-- Situations for which bills are required include the following. If part of the admission will be paid and part not, prepare one bill covering the entire stay. . . .
>
> * * * *
>
> For services provided to an HMO enrollee for which an HMO has jurisdiction for payment. Since HCFA is instructing you to provide this information, negotiate an agreement with the HMO for submitting to it bills it pays. Include in your agreement with HMOs a clear statement of the data elements required for proper identification of Medicare HMO/CMP enrollees and accurate submission to the intermediary.
>
> Where the HMO does not have jurisdiction, prepare a payment bill.

CMS Program Manuals - Hospital (Pub. 10), Chapter IV - Billing Procedures 411. Submitting Inpatient Bills In No-Payment Situations.

The BBA '97 and the Secretary's implementing regulations clearly shifted the burden for filing encounter data squarely to the risk HMOs.

> In order to carry out this paragraph, the Secretary shall require Medicare+Choice organizations (and eligible organizations with risk-sharing contracts under section 1395mm of this title) to submit data regarding inpatient hospital services for periods beginning on or after July 1, 1997, and data regarding other services and other information as the Secretary deems necessary for periods beginning on or after July 1, 1998. The Secretary may not require an organization to submit such data before January 1, 1998.

42 U.S.C. § 1395w-23(a)(3)(B).

> *Data collection: Basic rule*. Each M+C organization must submit to CMS (in accordance with CMS instructions) all data necessary to characterize the context and purposes of each encounter between a Medicare enrollee and a provider, supplier, physician, or other practitioner.

42 C.F.R. § 422.257(a)

No changes were made to 42 C.F.R. § 424.30. Moreover, neither the regulatory changes implementing the new IME/DGME payment nor any other regulation gave notice that hospitals would be required to file a separate IME/DGME claim with the intermediary that was virtually identical to the claim filed with the HMO to recover payment for inpatient services.

When 42 C.F.R. § 424.30 governing claims filing was implemented, there was no contemplation of or any need for a "claim for payment" other than the claim to obtain payment for the inpatient *services furnished* to the beneficiary. When the additional payment for IME/DGME was authorized by the BBA' 97, it did not change the nature of the payment for "services furnished." Rather, the IME/DGME payment arises from "services . . . furnished on a . . . capitation basis . . ." for which filing a claim *with the intermediary* is excepted under 42 C.F.R. §424.30.

Citing the CMS Administrator's decision in Santa Barbara Cottage Hospital v. Blue Cross Blue Shield Association/National Government Services. LLC- CA,[4] the Intermediary argues that the Provider was required to file Part A "claims for an established reimbursement methodology for hospitals' costs associated with being a teaching hospital and not for services furnished to a managed care enrollees [*sic*]."[5] However, the Board finds that the IME and DGME payments at issue here were "additional payment amounts" provided for in the BBA '97, effective beginning with the 1998 period at issue here. 42 U.S.C. §§1395ww(d)(11)(A)-(B), 1395ww(h)(3)(D)(i). The Board further finds that these additional payment amounts are not "for hospitals' costs associated with being a teaching hospital." Rather, the statute provides that both of these additional payment amounts are "for" the services furnished to Medicare HMO enrollees. The 1997 amendments to the IME statute provide that "the Secretary *shall provide* for an additional [IME] payment amount *for each applicable discharge . . . of any individual who is enrolled*" with a M+C organization. 42 U.S.C. §1395ww(d)(11)(A)-(B) (emphasis added). Similarly, the 1997 amendments provide that "the Secretary shall provide for an additional [GME] payment amount under this subsection *for services furnished to individuals who are enrolled*" with a M+C organization. 42 U.S.C. § 1395ww(h)(3)(D)(i) (emphasis added).

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[4] Medicare & Medicaid Guide (CCH) ¶ 81,859 (Nov. 16, 2007).

[5] See Transcript at 36-37.

The Secretary has been given broad authority to implement procedures for payment. However, once the system was established by regulation linking the obligation to file an intermediary claim with the method of payment, CMS' effort to impose a contrary claims filing requirement via informal guidance (program memoranda) is insufficient to deprive a provider of its statutory right to payment.

The lack of formal notice is evident in the instant case. Nowhere does the Board find a directive to the Provider that states in order to receive IME and DGME supplemental payments, the Provider ***must*** bill the Intermediary within the timeframe specified in the regulations at 42 C.F.R. § 424.44. Likewise, the Intermediary has not identified any instance (other than the 2003 Program Memorandum directed to non-PPS hospitals) where CMS ever said that teaching hospitals had to submit separate bills for payment for M+C enrollees in order to receive the DGME supplemental payments.

Despite the fact that CMS had a very short timeframe to implement the provisions of BBA '97 specifically for the issue in question by the effective date of January 1, 1998, CMS should have followed the Administrative Procedure Act's (APA) prescribed "informal rulemaking" process and made provisions to handle the period from January 1, 1998 until the finalization of the rule. If the regulatory obligation to file a "claim" is to be bifurcated so that a provider has an obligation to file its claim for payment of services provided to the beneficiary with the HMO and to also file a virtually identical claim to its intermediary, then the Board believes that a regulatory notice is required.

The Intermediary does not dispute that the Provider complied with the requirements for timely filing its claims for payment for inpatient services with the HMO and, in fact, the Provider seeks to rely on those records as proof of entitlement and for calculation of its IME/DGME additional payment to be claimed (in the generic sense) via its cost report. The expense of graduate medical education that the hospital incurred in providing services furnished on a capitation basis is only one element of many costs properly reported and claimed on the cost report. The data contained 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 the Provider.

Furthermore, 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 (or claim) for these payments. For this reason, the Board finds that the Intermediary's disallowance of the subject days, based on the fact that the Provider did not bill and the data was not captured on the PS&R, is without basis. The Parties have stipulated that the Provider furnished to the Intermediary paper copies of the claims at issue here before the issuance of the NPRs for the years at issue. The Board finds the Intermediary's refusal to audit the data made available to support

the Provider's claim was improper and the case must be remanded to the Intermediary to complete the audit.

The Board considered the Provider's assertion that the public protection provision of the Paperwork Reduction Act (PRA), 44 U.S.C. 3501 et seq., precludes the Intermediary from denying the Provider the benefit of additional IME/DGME payments on the basis that duplicate claims were not submitted. The Board also noted that the Provider's assertion remained uncontroverted by the Intermediary. Nevertheless, the Board reached its conclusion on the merits of the case independently of PRA considerations and, accordingly reaches no conclusion on the Provider's PRA assertions.

DECISION AND ORDER:

The Intermediary improperly disallowed DGME and IME payments with respect to discharges of Medicare beneficiaries who were enrolled in the Medicare+Choice or other Medicare risk plans in fiscal years ending December 31, 1998, 1999 and 2000. The Intermediary's adjustments for FYs 1998, 1999 and 2000 are reversed. As the parties have stipulated as to the number of days at issue, this case is remanded to the Intermediary to calculate the IME and DGME payments due with respect to the patient days and stays at issue.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esq., Chairman
Yvette C. Hayes
Michael D. Richards, CPA
Keith E. Braganza, CPA

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: April 16, 2009

Henry Ford Health System
Managed Care GME/IME Payments Group
Case Number: 04-1997G

Schedule of Providers

Provider Number	Facility	Fiscal Year
23-0053	Henry Ford Hospital (Detroit, Wayne MI)	12/31/98 12/31/99 12/31/00
23-0204	Bi-County Hospital (Warren, Macomb, MI)	12/31/98