CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Sutter 98-99 Managed Care (CIRP) Group,	**Provider Cost Reimbursement Determination for Cost Reporting Periods Ending: 12/31/98; 12/31/99**
Provider	
vs.	**Review of:**
BlueCross BlueShield Association/ First Coast Service Options, Inc.,	**PRRB Dec. No. 2011-D34 Dated: June 16, 2011**
Intermediary	

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 (CM) and the Intermediary requesting a reversal of the Board's decision. Comments were also received by the Providers[1] stating that the Board's decision should be affirmed. Accordingly, this case is now before the Administrator for final administrative review.

ISSUE AND BACKGROUND

The issue concerns whether the Intermediary properly disallowed payments for indirect medical education (IME) and direct graduate medical education (DGME) payments related to managed care days, discharges, and simulated payments for the fiscal years in contention.

During the fiscal years ending December 1998 and 1999, the Providers allege the Intermediary imposed an unlawful condition - that the Providers may not receive GME and IPPS IME add on payments for Medicare managed care patients unless

[1] The Sutter 98-99 Managed Care (CIRF) Group includes Sutter Medical Center, Sacramento and Sutter Merced Medical Center, referred to as the Providers.

they have also completed UB-92 forms.[2] The Provider's claimed payment for amounts related to this add on payment on their 98/99 cost reports. As the Providers failed to submit UB-92 claims for Medicare managed care, those claims were not summarized on the Providers Statistical & Reimbursement Report (PS&R). Since the Medicare Cost Report instructions at PRM, Part 2 §3630 require the Intermediary to use the PS&R data to support this additional IME and DGME payments, the Intermediary disallowed the Providers claimed closts.

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 submit timely UB-92 forms to the Intermediary if they wanted to receive the IME and DGME payments for Medicare managed care enrollees.

The Provider contended that this is purely a legal issue as to whether or not filling out the UB-92 form is a necessary prerequisite to obtain payment. The Providers have supplied the Intermediary with the patient information regarding the IME and DGME add on payments related to Medicare managed care patients. However, both parties request that the legal question in this appeal be answered prior to the Intermediary reviewing the information supplied.

BOARD DECISION

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

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[2] See Providers' Position Paper, pg. 3.
[3] See Pub. L. No. 105-33.

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

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 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 further found that the IME and DGME payments at issue were "additional payment amounts" provided for in the BBA '97, effective beginning with 1998, which is the first period at issue in this appeal. The Board stated that these additional payment amount were not for hospital costs associated with being a teaching hospital, but rather, "for" the services furnished to Medicare HMO enrollees.

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 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 acknowledged the D.C. District Court decision in Cottage Health System v. Sibelius, (Cottage Health) came to an opposite conclusion as to whether the Secretary gave proper notice regarding submission of claims.[4] Specifically, the Court in that case concluded that "the Administrator's decision that the plaintiff had notice that claims were to be submitted to the fiscal intermediary, and that notice and comment rulemaking was unnecessary for this kind of interpretive rule, was supported by substantial evidence and was not arbitrary or capricious."[5] The Board respectfully disagreed and did not adopt the Administrator's or Court's position. The Board reiterated that 42 C.F.R. §424.30 specifically exempts providers from billing both before and after BBA '97. The Board noted that providers were required to bill only the Medicare HMOs to receive negotiated DGME and IME payments prior to the BBA '97 and that changing this policy would require a final rule change. The Board did not believe the anticipated policy in the Final PPS Rule for FY 1998, even if supported by the PM, the Medicare Bulletin, and the August 20th letter would override a clear directive in 42 C.F.R. §424.30.

The Board considered the Provider's assertion that the public protection provision of the Paperwork Reduction Act (PRA) precludes the Intermediary from denying the Providers the benefit of additional IME/DGME payments on the basis that duplicate claims were not submitted. However, the Board reached its conclusion on the merits of the case independent of the PRA considerations, and accordingly, reached no conclusion on the Providers' PRA assertions.

The Board concluded that the Intermediary improperly disallowed DGME and IME payments with respect to discharges of Medicare beneficiaries who were enrolled in

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[4] 631 F.Supp.2d 80 D.D.C. 2009, July 7, 2009.

[5] Id. and Providers' Position Paper, Exhibit P-21, page 14.

the Medicare + Choice or other Medicare risk plans in the fiscal years ended December 31, 1998 and 1999.

COMMENTS

CM 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. CM 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, CM 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.

CM explained 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. CM noted that the Intermediary is required to submit the UB-92 claims that it receives from the hospital to the Common Working File (CWF) where the claims are verified and the information on the claims eventually flows to the PS&R for the hospital. 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. CM 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.

The Intermediary commented, requesting that the Administrator reverse the Board's decision. The Intermediary argued the Providers failed to submit UB-92 claims for Medicare managed care days, with the result that the days did not appear on the Providers' Statistical & Reimbursement Report. The instructions at PRM Part 11, §3630 require the Intermediary to use the PS&R to determine the Medicare managed

care days. Therefore, the Intermediary argued that the Providers' request to add the days after the fact was not permitted under the applicable rules.

The Providers submitted comments, stating that it opposes reversal of the Board's decision by the Administrator and stated that the Board's thorough and well-reasoned decision should be upheld.

DISCUSSION

The entire record furnished by the Board has been examined, including all correspondence, position papers, exhibits, and subsequent submissions.
At its inception, the Medicare Program originally had two parts: Medicare Part A, which is Hospital Insurance and Medicare Part B, which is Supplemental Medical Insurance. Later, relevant to this case, and pursuant to the Balanced Budget Act of 1997 (BBA 1997)[6] discussed below, Medicare beneficiaries were given the option to receive their Medicare benefits through private health insurance plans, instead of through the original Medicare (Parts A and B). This option is referred to as Medicare "Part C" and is known as the "Medicare+Choice" Program

I. Medicare Part A

Until 1983, Medicare Part A 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 section 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 Part A historically has paid a share of the net costs of "approved medical education activities" under the reasonable cost provisions.[7] 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.[8] Under Medicare Part A, in 1983, section 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.[9] Under IPPS, providers are reimbursed their inpatient operating costs based on prospectively determined national and regional rates for each patient discharge (i.e., diagnosis-related groups or DRGs), rather than on the basis of reasonableness.

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[6] See Pub. L. No. 105-33.
[7] 20 CFR §405.421 (1966); 42 CFR §405.421 (1977); 42 CFR §413.85 (1986).
[8] 42 CFR §413.85(b). 54 Fed. Reg. 40,286 (Sept. 27, 1989).
[9] Section 601(e) of the Social Security Amendments of 1983. Pub. L. No. 98-21 (1983).

a. GME Payments-Statute and Regulation

Graduate medical education (GME) costs initially continued to be paid on a reasonable cost "pass-through" under Medicare Part A IPPS However, applicable for all periods beginning on, or after, July 1, 1985, pursuant to section 1886(h) of the Act,[10] Congress established a new payment policy for GME costs under Medicare Part A.[11] Section 1886(h) provides that:

> Notwithstanding section 1861(v), instead of any amounts that are otherwise payable under this title with respect to the reasonable costs of hospitals for direct graduate medical education costs, the Secretary shall provide for payments for such costs in accordance with paragraph (3) of this subsection. In providing for such payments the Secretary shall provide for an allocation of such payments between Part A and Part B (and the trust funds established under the respective parts) as reasonably reflects the portion of direct graduate medical education costs of hospital associations with the provisions of services under each respective part.

Generally, the amounts payable above for GME, as allocated between Medicare Part A and Part B, is a combination of a hospital's per resident amount and the hospital's Medicare patient load. The Part A portion of 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.[12]

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

[11] 54 Fed. Reg. 40,297 (September 27, 1989). (Revised payment method applies to all hospitals regardless of status under PPS.) See 50 Fed. Reg. 27,722 (July 1985)(Final rule that hospitals would be reimbursed lesser of allowable costs for current year or hospitals' approved GME costs incurred during 1984 FY; nullified by Section 1861(v)(1)(Q) pursuant to Section 9202 of COBRA 1985). Section 9314 of Omnibus Budget Reconciliation Act of 1986 (Pub. L. No. 99-509) added Section 1886(h)(4)(E).

[12] The Medicare patient load (a factor in the payment) at section 1886(h)(3)(C) means "with respect to a hospital's cost reporting period, the fraction of the total number of inpatient-bed-days (as established by the Secretary) during the period which are attributable to patients with respect to whom payment may be made under part A."

To implement the new payment policy, the Secretary promulgated regulations at 42 CFR §413.86, et seq, which likewise relies, on part, on inpatient bed days for payment as also further set forth below.

b. IME Payments-Statute and Regulation

Under Medicare Part A, section 1886(d)(5)(B) of the Social Security Act also provides that teaching hospitals that have residents in approved GME programs receive an additional payment, under Medicare Part A, for each Medicare discharge to reflect the higher indirect patient care costs of teaching hospitals relative to non-teaching hospitals. Section 1886(d)(5)(B) provides that:

> (B) The Secretary shall provide for an additional payment amount for subsection (d) hospitals with indirect costs of medical education, in an amount computed in the same manner as the adjustment for such costs under regulations (in effect as of January 1, 1983) under subsection (a)(2), except as follows:
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> (i) The amount of such additional payment shall be determined by multiplying
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> (I) the sum of the amount determined under paragraph (1)(A)(ii)(II)[[13]] (or, if applicable, the amount determined under paragraph (1)(A)(iii)[[14]], for cases qualifying for additional payment under subparagraph (A)(i), and the amount paid to the hospital under subparagraph (A), by
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> (II) the indirect teaching adjustment factor described in clause (ii).

In sum, the IME add-on is determined by multiplying the section 1886(d)(1)(A)(iii) Medicare Part A based IPPS determined DRG national rate as prescribed under section 1886(d)(3), times the IME adjustment factor. The regulations at 42 CFR 412.105 implements the IME provision as calculated under Medicare Part A. Generally, the additional payment, known as the IME adjustment factor is based on the indirect teaching adjustment factor, calculated using the hospital's ratio of FTE residents to beds. Generally, 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 by the applicable education adjustment factor. The regulation at 42 CFR 412.105 explains:

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[13] This provision sets forth the transition period phase-in of Medicare Part IPPS.

[14] This provision at section 1886(d)(1)(A)(iii) (under Part A) sets forth the IPPS DRG rate determined under section 1886(d)(3) as the basis for payment.

> [CMS] makes an additional payment to hospitals for indirect medical education costs using the following procedures:
> (a) Basic data. [CMS] determines the following for each hospital:
> (1) The hospital's ratio of full-time equivalent residents,…
> (2) The hospital's DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs, excluding outlier payments for inpatient operating costs determined under subpart F of this part and additional payments made under the provisions of Sec. 412.106 .
> (b) Determination of number of beds. ….
> ….
> (e) 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.

The Secretary also explained that the IME payment is made on a "bill by bill" basis as follows under Part A:

> Previously, under §412.116, payments for indirect medical education costs were on the basis of 26 equal biweekly payments, subject to a year-end adjustment. Because the Pricer program used by intermediaries to calculate payments already computes the indirect medical education interim payments on a bill-by-bill basis, we proposed to pay for indirect medical education costs on a bill-by-bill basis, effective with discharges on or after October 1, 1988. This is consistent with the way in which payments are made for the disproportionate share adjustment. Thus, we proposed to delete §412.116(d) from the regulations.
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> Comment: Several commenters objected to the elimination of periodic interim payments for indirect medical education costs because of the negative effects the proposal would have on the cash flow of teaching hospitals. Another commenter suggested that it be made clear that the indirect medical education payments, made on a bill-by-bill basis, are interim payments subject to adjustment at settlement.
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> Response: We do not believe in general that teaching hospitals will experience a substantial cash flow problem as a direct result of this change in policy. Furthermore, the advantages of paying for indirect

> medical education costs on a bill-by-bill basis are so compelling that we plan to implement it beginning with discharges on or after October 1, 1988. By linking the payment mechanism to the Pricer program, bill-by-bill payments will ensure more accurate payments, administrative expediency, and payments consistent with the Medicare inpatient services being furnished and billed by teaching hospitals. It is important to note, however, that, as appropriate, the Pricer must be updated during the year whenever changes in the parameters used in the Pricer program occur. Thus, if there is a change from the prior year in the intern and resident to-bed ratio, the new figure must be reflected in Pricer to ensure that the indirect medical education payments are as accurate as possible for the current cost reporting period. At the end of a hospital's fiscal year, any necessary adjustments in the indirect medical payment will be made at final settlement of the cost report. [53 FR 38476 (Sept. 30, 1988) "Medicare Program; Changes to the Inpatient Hospital Prospective Payment System and Fiscal Year 1989 Rates"]

The regulation at 42 CFR 412.116 sets forth the IPPS method of payment stating that: "General rules. (1) Unless the provisions of paragraphs (b) and (c) of this section apply, hospitals are paid for hospital inpatient operating costs and capital-related costs for each discharge based on the submission of a discharge bill." Thus, the IME payment is made under Medicare Part A based upon the IPPS Part A DRG payment and is made on a bill by bill basis which is ultimately reflected as an add on to a hospital's DRG operating revenue.

II. Balanced Budget Act of 1997 (BBA 1997)[15]

a. Medicare Part C

The BBA of 1997 made several changes including the addition of Medicare Part C, also referred to as the Medicare + Choice program, as set forth at sections 1851 through 1859 of the Social Security Act. Under Medicare Part C, Medicare beneficiaries are given the option to receive their Medicare benefits through private health insurance plans, instead of through the original Medicare fee-for service Parts A and B program. Medicare pays the Medicare+Choice" or "Part C" plans (i.e. the

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

private health plan) a capitation rate, or a set amount, every month for each enrollees health care services.[16]

Medicare Part C authorizes the private health plan, not the hospital or provider supplying the services to the enrollee, to receive the capitated payment. Nowhere under Part C does it provide for direct compensation of the provider of the services to the enrollee under the private health organization to receive a direct payment from the Medicare program. This is in contrast to the payments to hospitals for the teaching related costs for inpatient services through the GME and IME related payments, under sections 1886(d) and 18886(h), which is strictly authorized under Part A.

In implementing Part C, Congress specifically provided, under Section 1853 of the Act, "Payments to Medicare + Choice Organizations", the "carve out" of IME and GME payments. Between 1998 and 2002, IME and GME payments will be carved out of the area-specific base rate, on the following schedule: 20 percent in 1998, 40 percent in 1999; 60 percent in 2000; 80 percent in 2001; and 100 percent in 2002 and thereafter. Section 4001 of the BBA 1997 established at section 1853 (c) (3)(B) of the Act that:

> B) Removal of medical education from calculation of adjusted average per capita cost.—
> (i) In general.—In determining the area- specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 1998), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to exclude from the rate the applicable percent (specified in clause (ii)) of the payment adjustments described in subparagraph (C).
> (ii) Applicable percent.—For purposes of clause (i), the applicable percent for— (I) 1998 is 20 percent, (II) 1999 is 40 percent, (III) 2000 is 60 percent, (IV) 2001 is 80 percent, and (V) a succeeding year is 100 percent.

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[16] Payments for Medicare+Choice plans are unrelated to the plans underlying costs. Instead, payments are derived from costs in the fee-for-service (FFS) sector. Prior to the 1997 Balanced Budget Act (BBA), managed care payments were 95 percent of average costs in the FFS sector (the adjusted average per capita cost, or AAPCC). Since the BBA, Medicare+Choice payments have been established by a complicated formula that is the greater of a minimum payment (floor), a minimum update from the prior year's payment, or a blend of local and national rates, all of which are related to some degree to the 1997 AAPCC. The blend is subject to a budget-neutrality constraint, and no plan received the blended payment in 2001.

> (C) Payment adjustment.— (i) In general.—Subject to clause (ii), the payment adjustments described in this subparagraph are payment adjustments which the Secretary estimates were payable during 1997—
> (I) for the indirect costs of medical education under section 1886(d)(5)(B), and
> (II) for direct graduate medical education costs under section 1886(h).

b. <u>Medicare Part A GME and IME Payments for Medicare+Choice Enrollees Under BBA 1997</u>
1. <u>The GME Additional Payment</u>

In conjunction with the changes establishing the Medicare + Choice program at section 1853 and also requiring the carve out of IME/GME payments from the capitation payment under Part C, Section 4624 of BBA 1997 amended the Social Security Act by amending Section 1886(h) controlling GME payments. Under Medicare Part A, with respect to inpatient bed days attributable to Medicare beneficiaries enrolled in a Medicare+Choice plan or any other Medicare managed care plan with a risk sharing contract under section 1876 of the Act, Section 1886(h)(3) of the Act states that:

> (D) Payment for Managed Care Enrollees.
> (i) For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount under this subsection for services furnished to individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1876 and who are entitled to part A or with a Medicare + Choice under part C. The amount of such a payment shall equal the applicable percentage of the product of-
>> (I) the aggregate approved amount (as defined in subparagraph (B)) for that period; and
>> (II) the fraction of the total number of inpatient-bed days (as established by the Secretary) during the period which are attributable to such enrolled individuals.
>> (ii) Applicable Percentage - For purposes of clause (i), the applicable percentage is -
>> (I) 20 percent in 1998,
>> (II) 40 percent in 1999,
>> (III) 60 percent in 2000,
>> (IV) 80 percent in 2001… [Emphasis added.]

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

> (a) 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……[17] [Emphasis added.]

Thus the inpatient day attributable to the Medicare + Choice enrollee is the basis for the calculation of the additional Part A GME payment.

2. The IME Additional Payment

Similarly, the BBA 1997 amended the Social Security Act by adding a new provision at Section 1886(d)(11), under Medicare Part A, addressing the IME payment, with respect to managed care enrollees, 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

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[17] 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.]

> 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 not been enrolled as described in subparagraph (B).[18] [Emphasis added.]

Thus, for discharges on, or after, January 1, 1998, the provisions of the BBA 1997 required the recognition of an additional payment for Medicare managed care enrollees who are entitled to benefits under Part A under the Medicare Part A IME and DGME payments "as if the individual had not been enrolled as described in subparagraph (B)."

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. [Emphasis added.]

A review of the foregoing provisions demonstrate that the additional payments at issue are made under Medicare Part A and not as a payment for a service provided under Part C. Congress specifically provided for a "carve out" from the Medicare Part C calculation of the capitation payments made to Medicare + Choice organizations (which are derived from the fee for service sector) of the IME/GME payments. Congress specifically authorized the additional payment under Medicare

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[18] The regulations implementing this provision were codified at 42 CFR §412.105(g).

Part A of the Medicare Act to hospitals. In addition, Congress specifically instructed the Secretary pursuant to the IPPS Part A portion of the statute, to make the IME payment as if the Medicare + Choice enrollee (entitled to Medicare Part A) was not enrolled in Medicare Part C and to identify the related inpatient hospital days for the calculation of the GME payment under Part A. That is Congress linked the additional payment to the already existing methodology relating to the Medicare Part A IPPS DRG and the Part A inpatient bed day statistics. Medicare Part C does not authorize the direct payment of providers, but only authorizes the payment of the capitation rate to the managed care organizations (which is not the type of payment here); in contrast, these additional payments involve a direct payment to the hospitals (not the managed care organizations) for the Part A inpatient IME/GME costs they incurred. Consequently, the Administrator concludes, as set forth in the foregoing provisions and as further discussed below, that the payments at issue fall under Medicare Part A and are not for capitation payments to managed care organizations for services under Medicare Part C as contended by the Provider.

c. <u>The Secretary's Treatment, Pursuant to the BBA, of the Additional Payment as a GME/IME Medicare Part A Payment</u>

Consistent with the statutory provision allowing for the additional payment for managed care enrollees under Medicare Part A for GME and IME, the Secretary addressed the method of receiving payment. The IME/GME payment for Medicare managed care enrollees was specifically addressed in the May 12, 1998 <u>Federal Register</u>[19] which promulgated the IPPS FFY 1998 rule and BBA changes. In response to comments regarding the claims process to be implemented for the DGME and IME payments, the Secretary stated that:

> Under section 4622 and 4624 of the BBA, teaching hospitals may receive indirect and direct GME payments associated with Medicare + Choice discharges. Since publication of the final rule with comment 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.
>
> <u>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.</u> 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 <u>will also</u> be required to

[19] 63 Fed. Reg. 26,318 (May 12, 1998).

> submit bills associated with Medicare + Choice organizations to the manage 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, the CMS Program Memorandum (PM) A-98-21[20] was issued 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 <u>must</u> 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]

Provider Reimbursement Manual, Part 2, (CMS Pub 15-2), Transmittal No. 4 issued November 1, 1998 stated that:

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[20] <u>See</u> Provider Exhibit P-19.

> Hospitals receive payments for indirect medical education for managed care patients beginning on January 1, 1998. Therefore, further subscripts are required to report the DRG payment that would have been made if the service had not been a managed care service. The PS&R will capture in conjunction with the PPS pricer the simulated payments."

III. General Payment of Claims Under Part A and the Documentation of Patient Days and the BBA 1997

Relevant to the method of the payment of IME under Part A and the collection of the inpatient bed day statistic for the GME patient load are the claims processing procedures set forth at 42 CFR 424.30, et seq. The submission of claims to intermediaries for, inter alia, Part A payment, is controlled by the regulation at 42 CFR 424.3, et seq. 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).

The claims at issue are not for "services furnished on a prepaid capitation basis by a health maintenance organization." The services are related to the IME/GME teaching costs attributable to inpatient services provided to managed care enrollees. The payment at issue has been specifically carved out of the Part C capitation rates and is specifically being made to hospitals under the authority set forth in Part A. The intent of the exclusion is to prevent the double payment for the same service under Medicare fee-for-service (Parts A and B) and also under Part C. A hospital (not a managed care organization) must submit claims in conformity with 42 CFR 424.30, et seq., to be able to receive managed care enrollees for the Part A IME and GME payments from its intermediary.

The regulation at 42 CFR 424.32 sets forth the basic requirements for all claims stating that:

> (a) A claim must meet the following requirements:
> 1) A claim must be filed with the appropriate intermediary or carrier on a form prescribed by CMS in accordance with CMS instructions.
> 2) A claim for physician services, clinical psychologist services, or

> clinical social worker services must include appropriate diagnostic coding for those services using ICD9CM.
> 3) A claim must be signed by the beneficiary or the beneficiary's representative (in accordance with 424.36(b)).
> 4) A claim must be filed within the time limits specified in 424.44.
> a) All Part B claims for services furnished to SNF residents (whether filed by the SNF or by another entity) must include the SNF's Medicare provider number and appropriate HCPCS coding.
> b) The prescribed forms for claims are the following: CMS 1450 [UB-92] Uniform Institutional Provider Bill. (This form is for institutional provider billing for Medicare inpatient, outpatient and home health services.)[21]

Thus, inpatient hospital claims are always filed by the provider. 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.

[21] Paragraph (d) addresses the submission of electronic claims, a transaction defined at 45 CFR 162.1101(a), which is effective October 16, 2003, and applies to claims submitted on or after October 16, 2003.

The Medicare Financial Management Manual (Pub. 100-6) explains the role of the CMS1450/UB-92 form[22] 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 and Reimbursement System or the "PS&R" to interface with billing form UB-92. This system provides reports to be used in developing and auditing provider cost reports and related data accumulation operations. The providers also must use the reports in preparing cost reports and must be able to explain any variances between the PS&R report and the cost report. The intermediary uses information on such items as Medicare patient days (relevant for GME), discharges and DRGs. The statistical reports produced are the Payment Reconciliation Report; Provider Summary Report and DRG Summary Report. Thus, when a provider bills in accordance with the instructions for payment of the DGME and IME, the claims system would determine a DRG payment upon which the IME add-on is based and also charges for inpatient days and issue a payment, all of which would be summarized on the PS&R.

Relevant to this case, claims are processed by Medicare contractors [Fiscal Intermediaries and Carriers] who are also responsible for a variety of activities that support the business relationship between Medicare fee for service providers and the Medicare Program. In addition to the PS&R Summary Report, the Medicare contractors use the standard Remittance Advice (RA) as a means to communicate to providers claim processing decisions such as payments, adjustments, and denials. A RA is a notice of payments and adjustments sent to providers, billers, and suppliers. After a claim has been received and processed, a Medicare contractor produces the RA, which may serve as a companion to a claim payment(s) or as an explanation when there is no payment. The RA explains the reimbursement decisions including the reasons for payments and adjustments of processed claims. The purpose of an RA is to provide detailed payment information relative to a health care claim(s) and, if applicable, to describe why the total original charges have not been paid in full. This remittance information is provided as "justification" for the payment, as well as input to the payee's patient accounting system/accounts receivable (A/R) and general ledger applications. The codes listed on the RA help the provider identify any additional action that may be necessary. For example, some RA codes may

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[22] The CMS 1450/UB-92 form was adopted pursuant to the Uniform Billing Committee which was brought together by the American Hospital Association in 1972 and involves various national payers and provider organizations. http://www.nubc.org/history.html (The history of the National Uniform Billing Committee and the origin of the UB-92) The Nation Uniform Billing Committee also approved codes as it did in this case when it approved the code for operating IME payments only.

indicate a need to resubmit a claim with corrected information, while others may indicate whether the payment decision can be appealed.

The timeframe for the issuance of the RA, in contrast to the PS&R, is that once a claim has been received and accepted, it is processed and the appropriate payment is determined. The Medicare contractor generates the RA and sends it to the provider. If a claim does not meet coverage, medical necessity, or policy requirements, providers may have the right to appeal the claim with additional information for redetermination based on RA guidance. Providers can use the RA to post payments and to review claim adjustments. The RA also contains detailed and specific claim decision information. An adjustment may be made for any number of reasons. These reasons are identified on the RA through standardized code sets which include Group Codes, Claim Adjustment Reason Codes, and RA Remark Codes.[23]

As the CMS Program Memorandum (PM) A-98-21 explained, filing a claim with the intermediary using the UB-92 (formerly CMS 1450) is required in order to generate data that may be used for payment consistent with CMS general claims processing information. The CMS PM-A-98-21 explained with respect to GME and IME payments for managed care enrollees 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

[23] Although RAs are furnished in either electronic or paper formats, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandates that a standard format be used if transactions are performed electronically. The Accredited Standards Committee (ASC) X12N 835 version 4010A1 is the standard Electronic Remittance Advice (ERA) that complies with HIPAA requirements. The HIPAA-compliant fields and codes apply universally to all entities that transmit health care information. In addition, Medicare requires that the same codes be included in both the ERA and the Standard Paper Remittance Advice (SPR) formats.

> fee-for-service, the sum of these interim payment amounts are subject to adjustment upon settlement of the cost report.

Thus, the Administrator finds that claiming costs on the costs report alone is not sufficient to make a GME or IME payment for managed care enrollees. If no claim is filed, no IME payment will be made and no data relating to days will be generated on the PS&R that can be reconciled with the claimed cost report amounts.

The Administrator finds the foregoing statutory provisions authorizing the additional payments under Medicare Part A, while removing the payment from the Part C rates, did not implement a new payment methodology, but specifically relied upon the existing Medicare Part A methodology in place for payment. Congress specifically provided that the IME payment for the managed care enrollee shall be made as if the beneficiary were not so enrolled in Medicare + Choice for purposes of the Part A IME payment, relying on the IPPS DRG rate, and specifically provided for the use of the existing inpatient IPPS bed day statistic methodology for payment under GME.

For example, for the additional IME teaching payment, the amount of payment under section 1886(d)(11) sets forth (under the Part A portion of the statute), that payment: "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 not been enrolled as described in subparagraph (B)." (Emphasis added.) Under the pre-existing IME payment methodology, a claim is made for a discharge and the IME payment is an add-on to the hospital's DRG revenue. Section 1886(d)(5)(B) provides that the IME payment for the cost years involved here will be made by multiplying the sum of the amount determined under section 1886(d)(1)(A)(iii) by the indirect teaching adjustment. In turn, section 1886(d)(1)(A)(iii) is based on the IPPS DRG national rates as prescribed under section 1886(d)(3)[24] of the Act under Medicare Part A.

Likewise, regarding the additional GME teaching payment, under section 1886(h) (under the Part A portion of the statute) relies on "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." The existing methodology at section 1886(h) of the Act defines the Medicare patient load (a factor in the payment) at (3)(C) as meaning "with respect to a hospital's cost reporting period, the fraction of the total number of inpatient-bed-days (as established by the Secretary) during the

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[24] Section 1886(d)(3) states that the: "Secretary shall determine a national adjusted DRG prospective payment rate for each inpatient discharge …."

period which are attributable to patients with respect to whom payment may be made under part A." Hence, the IME/GME teaching payment related to the managed care enrollees (based on the projected DRG discharges and inpatient bed day statistics) are Part A teaching payments and not payments to managed care organizations for services to enrollees under Part C.

The Part A teaching payment for IME/GME was an already established payment methodology for teaching hospitals that was already linked to the claims processing system. The foregoing discussion on the statutory, regulatory basis for the additional payment and CMS' existing claims processing procedures as they relate to GME and IME payments support a finding that the provision for this additional payment for managed care enrollees is within framework of a pre-existing methodology for IME/GME payments under Medicare Part A and not under the exception at 42 CFR 424.30 provided for Medicare Part C claims.

As such, 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 May 1998 preamble language published in the Federal Register anticipated this requirement. In addition, the PM A-98-21 explicitly stated that a "hospital must submit a claim to the hospital's regular intermediary."

The Federal Register preamble language and the PM A-98-21 plainly instructed a hospital to bill its intermediary so that the claims could be processed. The Administrator finds that providers were informed of the billing policy as early as the May 1998 Federal Register publication that hospitals would be required to file claims for payment with their intermediary. The Administrator finds that the Providers' failure to comply with the instructions was an error on its part.

The Administrator finds that the requisite claims were reasonably required to be submitted to the Intermediary pursuant to 42 CFR §424.30, §424.32 and §424.44. The requirement that a Provider submit a claim UB-92 form cannot be separated from the requirement that it be filed within the prescribed timeframes for such a form under 42 CFR 424.30, et seq,. To suggest that a requirement to submit a UB-92 Form does not also include the related timeframes in which to do so is contrary to a natural reading of the regulation and the overall claims processing system upon which payment is made. The processing of the IME/GME claims is based on a simulated DRG for the applicable period and, thus, the Providers should have filed the claims needed to be made consistent with the claims process. The IME/GME Claims must rely upon the same program edits and data sets as all other inpatient claims which change each Federal fiscal year and is reliant upon the set deadlines

for filing claims.[25] In addition, there is no default deadline which would be more lenient upon which a provider may rely, in the absence of the obviously applicable deadlines provided by the claims processing procedures when filing the UB-92.[26] To suggest that a provider might believe there are no deadlines would be unwarranted. That is contrary to every provider's general practice and experience in receiving payment under Medicare and contrary to Medicare's general overarching rules governing annual payments of amounts due at section 1815(a) of the Act and the collection of requested data in order to determine those amounts due (which is the statutory basis for the claim processing regulation as set forth at 42 CFR 424.1). To suggest that a provider could submit claims up to the settlement of the cost report would create an indefinite elastic timeline dependent upon the submission of the very documents required for the final settlement (the deadline) under that scenario.

Likewise, the teaching hospital community and its associations knew the filing of the UB-92 form was, like all other claims, required to be done within the usual timeframes. The irrefutable connection between using the UB92 form and need to timely file the form within the normal filing deadlines is evident in the November 2, 1999 "Memorandum from the American Association of American Medical Colleges" to COTH Chief Financial Officers and Reimbursement Managers, which specifically referenced the timeframes and including section 268.1 of the Hospital Manual.[27] This notice specifically indicated that claims for services rendered in 1998 must be filed by December 31, 1999; notably the same timely filing deadline at issue as some of the claims for payment. This Memorandum states:

> This Memorandum is to remind you that December 31, 1999 is the deadline for submitting Medicare + Choice claims to your Fiscal

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[25] For example, the problem with the untimely filing is that an Intermediary's claims system is not capable of processing the claims in the UB-92 format when presented so late in the cost report and claims settlement process. See, CMS System Pub 100-04 Medicare Claims Processing, Transmittal 1067, Change request 5276, Sept 25, 2006 identifying various software changes; Id. at 242 ("In addition the Pricer is updated once a year and covers a four year period therefore on October 1, 2007 the Pricer will only be able to process discharges after October 1, 2001 Each subsequent year will change the ability of Pricer to process old claims.")

[26] If the UB-92 Forms for IME/GME payment (not encounter data) were argued to only need to be filed with the intermediary within the timeframe for filing cost reports, 42 CFR 413.24 requires the cost report to be filed on or before the last day of the fifth month following the end of the cost reporting period.

[27] See, e.g., Administrator's Decision, UPHS 99 Medicare + Choice Beneficiaries Group and UPHS 00 Medicare + Choice Beneficiaries Group, PRRB Dec. No. 2008-D29 at pg. 26.

> Intermediary for purposes of receiving Direct Graduate Medical Education and Indirect Medical Education payments for the period January to September 1998.
>
> As you know, teaching hospitals are entitled to receive DGME and IME payments for Medicare managed care enrollees effective January 1, 1998. According to Medicare Program Memorandum A-98-22, teaching hospitals must submit these claims in the UB-92 format, modified to include condition codes 04 and 69…
>
> Section 268.1 of the Hospital Manual (attached) states that in order to receive payment, claims must be filed on or before December 31 of the calendar year following the year in which the services were provided
>
> Accordingly, the Medicare + Choice claims for which service were furnished between January - September 1998, the shadow claims must be submitted by December 31, 1999.[28]

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 as set forth above is not at issue here. Among other things, as noted above, Congress specifically statutorily excluded the payment under Part C, Congress specifically included the payment under the Medicare inpatient Part A section of the Medicare Act; Congress specially linked the payment to already existing methodology relating to the IPPS DRG and the inpatient day statistic, Medicare Part C does not authorize the direct payment of providers but only authorizes the payment of a capitation rate to managed care organizations (which is not the type of payment here); and these payments involve a direct payment to the hospital (not the managed care organization) for the Part A inpatient IME/GME costs.

Requiring a standard claim format, which determines whether the claim belongs in the calculation, is also a reasonable method of implementing the requirements of the BBA 1997 for submitting information. The Administrator finds that the PM A-98-21 was an appropriate means to implement program payments pursuant to the applicable IME and GME statutes and regulations. The Secretary has the responsibility of ensuring proper program payments to providers of services, and utilizes various processes such as the issuance of regulations and manual instructions, as well as program memorandums. CMS notified its intermediaries and

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[28] Id. at page 26.

the public regarding the claims processing instructions for the Medicare managed care enrollees IME and GME payments. The standard claim format is reasonably required as the claims must be reflected in the PS&R and processed as the PS&R is the necessary mechanism for the intermediaries and providers to reconcile the cost report settlement for payments for claims and the accurate identification of inpatient days.[29]

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.[30] The payment of IME and DGME claims was an already established payment methodology for teaching hospitals that was already linked to the claims processing system and did not require the promulgation through notice and comment of specific instructions. 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.

A. Paperwork Reduction Act

The Provider also argued that the use of the UB-92 form violated the Paperwork Reduction Act. Section 3507 of the Paperwork Reduction Act of 1995 (Pub. Law No. 104-13) states that:

> a) An agency shall not conduct or sponsor the collection of information unless in advance of the adoption or revision of the collection of information— (1) the agency has— (A) conducted the review established under section 3506(c)(1); (B) evaluated the public comments received under section 3506(c)(2); (C) submitted to the

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[29] The "encounter data" required by the BBA to be submitted to the managed care plan and then to CMS is related to the risk adjustment methodology and not to a claims determination process required of the IME/GME payment methodology. As noted that is data submitted by the managed care organization for encounter data and not for claims payment and is not related to the PS&R claims processing system as CMS clearly stated in the 1998 preamble.

[30] The Secretary also 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.

> Director the certification required under section 3506(c)(3), the proposed collection of information, copies of pertinent statutory authority, regulations, and other related materials as the Director may specify; and (D) published a notice in the Federal Register— (i) stating that the agency has made such submission; and (ii) setting forth—(I) a title for the collection of information; (II) a summary of the collection of information; (III) a brief description of the need for the information and the proposed use of the information; (IV) a description of the likely respondents and proposed frequency of response to the collection of information; V) an estimate of the burden that shall result from the collection of information; and (VI) notice that comments may be submitted to the agency and Director; (2) the Director has approved the proposed collection of information or approval has been inferred, under the provisions of this section; and (3) the agency has obtained from the Director a control number to be displayed upon the collection of information.

Section 3512 of the Paper Work Reduction Act of 1995 provides that:

> Public protection. (a) Notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information that is subject to this chapter if— the collection of information does not display a valid control number assigned by the Director in accordance with this chapter;…. (b) The protection provided by this section may be raised in the form of a complete defense, bar, or otherwise at any time during the agency administrative process or judicial action applicable thereto.

The regulation at 5 CFR 1320.6, implementing the Paperwork Reduction Act, correspondingly, sets forth that:

> Public protection. (a) Notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information that is subject to the requirements of this part if:(1)The collection of information does not display, in accordance with Sec. 1320.3(f) and Sec. 1320.5(b)(1), a currently valid OMB control number assigned by the Director in accordance with the Act;… (b) The protection provided by paragraph (a) of this section may be raised in the form of a complete defense, bar, or otherwise to the imposition of such penalty at any time during the agency administrative process in which such penalty may be imposed or in any judicial action applicable thereto. (c)Whenever an agency has imposed a collection of information

> as a means for proving or satisfying a condition for the receipt of a benefit or the avoidance of a penalty, and the collection of information does not display a currently valid OMB control number … the agency shall not treat a person's failure to comply, in and of itself, as grounds for withholding the benefit or imposing the penalty. The agency shall instead permit respondents to prove or satisfy the legal conditions in any other reasonable manner…. (d) Whenever a member of the public is protected from imposition of a penalty under this section for failure to comply with a collection of information, such penalty may not be imposed by an agency directly, by an agency through judicial process, or by any other person through administrative or judicial process. (e) The protection provided by paragraph (a) of this section does not preclude the imposition of a penalty on a person for failing to comply with a collection of information that is imposed on the person by statute—e.g., 26 U.S.C. Sec. 6011(a) (statutory requirement for person to file a tax return), 42 U.S.C. Sec. 6938(c) (statutory requirement for person to provide notification before exporting hazardous waste).

The Administrator finds that the Paperwork Reduction Act does not afford the Provider the type of relief requested in this proceeding. The Administrator finds that the UB-92 form (also referred to as the CMS 1450 form), which was required to be used to seek the additional Part A GME/IME payment, has been approved by OMB for the purpose for which it is being used and displays a valid OMB control. Consequently, CMS conformed to the Paperwork Reduction Act in its use of the UB-92 form and no defense which would relieve the Provider of the obligation to use the UB-92 may be allowed.[31]

While the UB-42 form is approved for Part A claims, CMS also specifically sought approval for use for an alternative purpose in Federal Register Notice, dated June 26, 1998 (63 Fed. Reg. 34903). The Notice at issue requests the extension of the use of the UB-92 form to implement the BBA of 1997. The Notice explained that Section 1853(a)(3) of the BBA 1997 requires Medicare + Choice organizations, as well as eligible organizations with risk sharing contracts under section 1876, to submit encounter data. The BBA 1997 also requires the Secretary to "implement a risk adjustment methodology that accounts for variation in per capita costs based on health status." In implementing the requirements of the BBA 1997, "hospitals will

[31] United States v. Holden, 963 F.2d 1114, 1116 (8th Cir. 1992), quoting United States v. Dawes, 951 F.2d 1189, 1193 (10th Cir. 1991)("An OMB control number is clearly displayed at the top of each form. If the Form 1040 displays the control number required by § 3512, "nothing more is required.")

submit data to the managed care plan for enrollees who have a hospital discharge using the HCFA -1450 (UB-92)."

Unlike the use of the form for IME/GME managed care claims, the use proposed in the Notice of June 26, 1998, is a new use of the form. Section 3507(h) of the Paperwork Reduction Act, requires extensive review which includes seeking public comment, to extend the use of previously approved collection of information. In that Notice, CMS proposed that the hospital is to submit the UB-92 form to the managed care plan (not CMS/the intermediary) for the collection of encounter data (not for payment). The use described in the Notice is in contrast to the use here. Generally, approval for use of the UB-92 has been based on use described "as a claim form by institutional providers of Medicare inpatient and outpatient services."[32] In this case, the UB-92 form is being submitted by the hospital to the Intermediary for a Part A GME/IME payment that is based on an inpatient hospital Part A discharge. CMS has never sought a separate approval of the use of the UB-92 form for IME/GME payments dependent upon inpatient hospital Part A discharges and related inpatient bed days. The Secretary, when explaining, generally, in 1988, that the IME payment would be made on a "bill by bill" (i.e., claim basis), did not seek additional approval of the UB-92 form for that use simultaneous with that proposal. The IME payment being made on a "bill by bill" basis was part of the IPPS inpatient service payments under section 1886(d) of the Act and, thus, already approved for that use. Consistent with past practice, CMS has also not sought approval in this case. As discussed in the first section of this opinion, the payments in this case likewise involve the payment of the IME/GME aspect of Part A inpatient services to a hospital. Consistent with the past approved use of the UB-92, the use of the UB-92 form here falls under the approved use as a standardized form for reimbursement for "inpatient and outpatient services."

In addition, the Secretary, in the Cottage Health System case, presented alternative arguments concerning the impact of the Paperwork Reduction Act on the Provider's claims. The Administrator respectfully herein incorporates those bases for denying

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[32] See, e.g., 55 Fed. Reg. 28830 (July 13, 1990) (Where CMS submitted the following proposals for the collection of information in compliance with the Paperwork Reduction Act (Pub Law 96-511). Type of Request: Reinstatement: Title of Information collection: Medicare unformed institutional provider bill;: Form Number: HCFA 1450 [UB-92]; Use: The form is used as a claim form by institutional providers of Medicare inpatient and outpatient services …"; 60 Fed Reg. 45487 (August 31, 1995) (Type of Request: Revision; "Use: This form is the standardized form used in the Medicare/Medicaid program to apply for reimbursement for covered services by all providers that accept Medicare/Medicaid assigned claims."); 56 Fed. Reg. 47757 (September 20, 1991)(revision).

the Provider's Paperwork Reduction Act claims. Briefly, concerning section 1815(a) of the Social Security Act, as the Secretary noted, an exception has been read into the Act by the courts for information mandated by statute. With respect to the Medicare Act, Section 1815(a) of the Act provides that: "The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, …, except that no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period." Consequently, as the Secretary has argued, the Paperwork Reduction Act cannot be raised as a defense, where, as here, the statute requires the Provider to "submit such information as the Secretary determines is necessary to determine the amount due" the provider for this period. In this case, the Secretary determined that the Provider was required to timely submit the UB-92 forms in order for the Secretary to determine the amount due for these payments. The Secretary also pointed out that the request for the proof that UB-92 forms had been submitted timely arose as a result of an audit of the Provider's claim for costs requested on the cost report for IME/GME payments related to the inpatient Part A stays for managed care enrollees. The request for documentation, as a result of an audit/investigation for a specific entity, is specifically exempted from the Paperwork Reduction Act and, thus, would not apply here.

Accordingly, the Administrator finds that the Intermediary properly denied the supplemental IME and DGME payments for Medicare managed care enrollees in the fiscal years 1998 and 1999 cost reporting periods. The Administrator finds that the Provider specifically limited the legal issue to whether the UB-92 form was required to be filed for payment. The Provider does not contest that if a UB-92 form was required, the UB-92 form must be filed within the regulatory time frames and thus, that issue has not been preserved. Thus, the Administrator reverses the Board's decision.

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: 8/16/11 /s/

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