PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2007-D78

PROVIDER –
Santa Barbara Cottage Hospital
Santa Barbara, California

Provider No.: 05-0396

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
National Government Services, LLC - CA

DATE OF HEARING –
November 8, 2006

Cost Reporting Periods Ended -
December 31, 1998; December 31, 1999;
December 31, 2000 and December 31, 2001

CASE NOs.: 02-0328; 03-0383; 04-0283;
and 05-1327

INDEX

ISSUES:

1. 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 the Medicare + Choice or other Medicare risk plans in fiscal years ending December 31, 1998, 1999, 2000 and 2001.[1]

2. Whether the Intermediary improperly disallowed residents' time spent in non-provider settings within the scope of the Provider's approved medical residency training programs from the Provider's full-time equivalent resident counts for DGME and IME purposes.

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 out 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(b) and 413.24(b).

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.

Section 1886(h) of the Social Security Act (Act) prescribes the Medicare payment method for direct GME costs. 42 U.S.C. §1395ww(h). In brief, the direct GME payment

[1] Per stipulations received by the Board on July 12, 2007, the parties' have stipulated that PRRB Case Number 05-1327, Santa Barbara Cottage Hospital, FYE 12/31/2001, has identical issues, material facts and legal issues as presented in those cases heard by the Board in November 2006, (02-10328, 03-0383 and 04-0283) and requested that FY 2001 be included in the Board's decision on the same issues for the prior three fiscal years. The Board has agreed to include the FYE 12/31/2001 appeal in its decision.

is the product of a hospital's average per resident amount, derived and updated from a 1984 base period, times the hospital's number of interns and residents in approved GME programs during the payment year, times the hospital's Medicare patient load.

The Act at section 1886(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[2] 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.[3]

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 or any other Medicare managed care plan with a risk sharing contract under section 1876 of the Act. 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).

Non-Provider Settings

The calculation for DGME and IME reimbursement requires a determination of the total number of FTEs in the teaching programs. The Medicare statute at 42 U.S.C. §1395ww(h)(4)(E) entitles a hospital to count the time its residents spend in patient care activities in non-hospital settings on or after July 1, 1987 for purposes of calculating the direct GME payment. The statutory provisions prescribe the content of implementing regulations as follows:

[2] 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."

[3] 54 Fed. Reg. 40286, 40294-95 (Sept. 29, 1989)

> Such rules shall provide that only time spent in activities relating to patient care shall be counted and that all the time so spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting.

Likewise, for discharges occurring on or after October 1, 1997, the Medicare statute at 42 U.S.C. §1395ww(d)(5)(B)(iv) entitles hospitals to count the time their residents spend in patient care activities in non-hospital settings for purposes of calculating the IME payment:

> Effective for discharges occurring on or after October 1, 1997, all the time spent by an intern or resident in patient care activities under an approved medical residency training program at an entity in a nonhospital setting shall be counted towards the determination of full-time equivalency if the hospital incurs all, or substantially all, of the costs for the training program in that setting.

CMS issued implementing regulations 42 C.F.R. §413.86 (DGME payments) and 42 C.F.R. §412.105 (IME payments). The regulations additionally mandated that the hospital have a written agreement with the outside entity documenting the hospital's assumption of all or substantially all of the training costs at the non-hospital setting. Medicare DGME regulations at 42 C.F.R. §413.86 (f)(4) thus permitted a hospital to claim residents at a non-hospital setting if the residents trained in an approved program and:

On or after July 1, 1987, and for portions of cost reporting periods occurring before January 1, 1999:

(i) The resident spends his or her time in patient care activities.

(ii) There is a written agreement between the hospital and the outside entity that states that the resident's compensation for training time spent outside of the hospital setting is to be paid by the hospital.

For portions of cost reporting period occurring on or after January 1, 1999 and before October 1, 2004:

(i) The resident spends his or her time in patient care activities.
(ii) The written agreement between the hospital and the nonhospital site must indicate that the hospital will incur the cost of the resident's salary and

fringe benefits while the resident is training in the nonhospital site and the hospital is providing reasonable compensation to the nonhospital site for supervisory teaching activities. The agreement must indicate the compensation the hospital is providing to the nonhospital site for supervisory teaching activities.

(iii) The hospital must incur all or substantially all of the costs for the training program in the nonhospital setting in accordance with the definition in paragraph (b) of this section.

The same requirements were also incorporated by reference in the IME regulations at 42 C.F.R. §412.105(f)(1)(ii)(C).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Santa Barbara Cottage Hospital (Provider) is a Medicare certified teaching hospital located in Santa Barbara, California. The Provider has three approved medical residency training programs in the areas of internal medicine, general surgery and diagnostic radiology. During the cost reporting periods at issue in this appeal: December 31, 1998, December 31, 1999, December 31, 2000, and December 31, 2001, National Government Services, LLC. (Intermediary) audited each of the cost reports and made final determinations relating to the Provider's DGME and IME FTE counts for non-provider settings as well as for IME and DGME payments with respect to Medicare + Choice beneficiaries.

The Provider appealed the disallowance to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835 - 405.1841. The Provider is represented by Christopher L. Keough, Esq. of Vinson & Elkins, L.L.P. The Intermediary is represented by James R. Grimes, Esq., of Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

Issue #1 DGME and IME payments for Medicare + Choice beneficiaries

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 or Office of Management and Budget (OMB) standards required the Provider to submit data directly to the Intermediary within a specified time. The Provider claims that the Medicare risk 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 Provider asserts that it also provided the encounter data in UB-92 format, relating to Medicare risk plan discharges, to the Intermediary before the audits for each of the fiscal years at issue were

completed, and the Intermediary improperly rejected and excluded the data in the settled cost reports.[4]

The Intermediary asserts that the Provider's submission of UB-92 claims 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 timely UB-92 claim form to its Intermediary through the claims processing system in order to obtain the additional IME and DGME payment for managed care enrollees. The Intermediary argues that Program Memorandum (PM) A-98-21 was issued on July 1, 1998 to address the BBA provision. The PM 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. Section 4622 and 4624 of the Balanced Budget Act of 1997 states that hospitals may now request a supplemental payment for operating IME for Medicare managed care enrollees. . . .

The PM goes on to say:

> 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.

On August 20, 1998, the Intermediary responded to the Provider's written request to receive Medicare IME and DGME reimbursement for its managed care enrollees stating that "to bill for the IME supplemental payment, PPS hospital must submit a claim to the hospital's regular intermediary. . ." The Intermediary argues that between the PM issued by CMS and the letter written specifically to the Provider, it is clear that the Provider 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 timely submitted to the Intermediary as required by the timely filing standards. Those standards are defined in 42 C.F.R. §424.44:

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[4] For FY 1998, the Intermediary allowed the Medicare managed care days from the UB-92 submission in its original NPR. The Intermediary then issued a revised NPR dated February 14, 2003 to remove those days and take back the payments made for this issue. The Intermediary rejected the data prior to the issuance of the initial NPRs for the FYs 1999, 2000 and 2001 cost reports.

> (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 day of the 6th calendar month following the month in which the error or misrepresentation is corrected.

The Intermediary argues that since the Provider did not even attempt to submit the UB-92 claims with the Intermediary until after the filing deadline for the claims, the hard copy submission of these claims to the Intermediary for its review and inclusion in the cost report was insufficient to cure the Provider's failure to bill. The Intermediary argues that without the Provider properly billing the claims to the Intermediary, the claims were not entered into the Common Working File, were not verified for coverage and eligibility, and did not go through the pricing system.[5] The Intermediary asserts that since the Provider did not properly bill the claims, the claims were properly rejected and were not included in the final settled cost reports.

The Provider argues that the Intermediary's assertion that the DGME and IME payments should be denied because the Provider did not submit the claims within the time period allowed for submission of Medicare claims for payment is unsustainable. The Provider asserts that no law required the Provider to submit this data directly to the Intermediary 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. (Provider Exhibit P-21)
- May 19, 1998 – CMS issued an Operational Policy Letter (OPL No. 70) drafting a list of requirements for plans for data submission. (Provider Exhibit P-22)

[5] Tr., page 171.

- 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."[6]
- July 1, 1998 – Program Memorandum (PM) A-98-21 was issued to intermediaries. This PM directed intermediaries to notify providers of the following: "Teaching hospitals may submit bills for inpatient stays by managed care enrollees for payment of IME."
- July 13, 1998 - Intermediary's Medicare Bulletin 416 was issued by the Intermediary. The bulletin only addressed IME costs for services to Medicare + Choice enrollees; it did not address DGME payments. The Bulletin read "teaching hospitals may submit bills for inpatient stays by managed care enrollees for payment of IME." (Provider Exhibit P-17)
- June 29, 2000 – CMS published the final rule for Medicare + Choice program, 65 Fed. Reg 40170, in response 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.
- February 3, 2003 – Program Memorandum (PM) A-03-007 was issued acknowledging that the early July 1998 PM did not address GME payments for non-IPPS hospitals and units. The February 2003 memorandum 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 it was not until the February 3, 2003 PM was issued, well after the current years in question, that the term "must bill" was used to describe how providers could receive DGME and IME payments for the managed care enrollees. CMS routinely used the term "may" bill. CMS also did not directly inform the providers that the bills had to be submitted to the intermediaries (instead of the managed care plans) in order for hospitals to obtain the DGME and IME payments. In addition, CMS failed to instruct the intermediaries to give proper notice to the hospitals on how these bills were to be submitted (i.e., electronically or in paper format) or the time frame in which to submit them.

Further, even if the Provider was required to submit claims to the Intermediary to obtain the IME and DGME payments, the Provider was not provided fair notice of that requirement to afford the Provider due process of law. It was not until 2002 or 2003, when the revised NPR for FY 1998 was issued, that the Intermediary gave notice that the Provider was required to submit claims for these stays to the Intermediary electronically and within the time periods applicable to the filing of Medicare claims for payment.

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[6] The Provider claims that this regulation requires Medicare managed care plans to submit encounter data to the intermediaries that includes pertinent information such as that is needed for an intermediary to compute the additional IME and DGME payments due a hospital for discharges of patients enrolled in Medicare risk plans. See, Provider Post Hearing Brief, page 34.

In addition, the Provider argues that the Medicare regulation governing the requirements and time period for submission of Medicare claims for payment expressly do not apply with respect to services furnished to enrollees in Medicare risk plans. 42 C.F.R. §424.30. CMS provided no guidance as to a time frame in which these claims had to be submitted.

Finally, the Provider argues that it cannot 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, as no such requirement was ever approved by the Office of Management and Budget (OMB). The Provider asserts that the federal Paperwork Reduction Act would preclude CMS from applying such a requirement to deny the Provider the benefit of the DGME and IME payments at issue without obtaining OMB approval for the data collection. See, 44 U.S.C. § 3512(a).

The Intermediary avers that the managed care plans were under an obligation to file encounter data long before the issuance of BBA '97; therefore, the filing of these claims was not a new requirement that would have needed special approval.[7]

Issue #2 Non-Provider Settings

The Provider argues that it met each of the specific requirements set forth in 42 C.F.R. §413.86(f)(4). The Provider asserts that: (1) the residents' training involves the direct care of patients; (2) it has incurred all or substantially all of the costs of the residents training in the non-provider settings; and (3) it has written agreements, including the Medical Staff Bylaws and the memoranda of understanding (MOU), that document the Provider's ongoing commitment to incur the costs of training its residents.

Since the inception of the internal medicine training program in 1977, the non-hospital site rotations at issue in this appeal have been an integral part of the Provider's approved residency training programs. The Provider asserts it has always borne substantially all of the cost of the residents' training during their rotations to physician offices or clinics. The Provider alone pays the full amount of the residents' salaries and benefits through resident contracts including while the residents rotate to non-hospital settings.[8]

The Provider asserts that the physicians and the non-hospital sites incur no costs associated with the resident rotations. During these rotations the residents typically work with a teaching physician (preceptor), who mentors the residents. The preceptor either sees the patient right after the resident sees the patient, or jointly examines the patient with the resident. The Provider asserts that its preceptors have no formal lecturing or other didactic responsibilities towards the residents and beyond allowing the residents to participate in the diagnosis and treatment of patients, perceptors are only expected to complete a short evaluation form at the end of the rotation. The Provider notes that it surveyed its teaching physicians in 2005 to determine the amount of time, if any, that was spent teaching or completing other administrative activities related to the residents' training but unrelated to patient care activities. The responses showed that the physicians

[7] Tr., pages 172-173.
[8] See, Signed Resident Contracts, Provider Exhibit P-41.

worked an average of 50 hours per week and an average of less than three hours per week on educational activities or administrative tasks related to the residents' training and unrelated to the care of an individual patient.

The Provider contends that the perceptors receive in-kind consideration from the Provider for their teaching services as a member of the hospital's medical staff. Each perceptor is a member of the Provider's medical staff, and therefore enjoys privileges conferred under the terms of its Medical Staff Bylaws and other intangible benefits. The Provider claims that none of the teaching physicians have ever claimed to be dissatisfied with the "compensation" received for their supervisory teaching services.

The Provider asserts that each physician admitted to its medical staff agrees to abide by the terms and conditions as set forth in the Provider's Medical Staff Bylaws in place during the periods at issue. The Bylaws impose a number of responsibilities on each physician, including the responsibility to "aid in any medical staff approved educational programs for medical students, interns, resident physicians, resident dentists, staff physicians and dentists, nurses and other personnel."[9] The Provider contends that the Bylaws are sufficient to document the existence of a longstanding and ongoing commitment on the Provider's part to incur the costs of resident teaching and supervision.

In addition, the Provider submitted additional documentation to support the understanding and practices of the parties with respect to off-site hospital rotations that memorialized, restated and clarified in the form of letter agreements entitled "Agreement regarding Supervision of Interns ad Residents" (referred to as "MOUs").[10] These MOUs were executed in 2005 by the Provider and each of the supervising physicians. The purpose of the MOU was to "reiterate and confirm the terms of [the parties'] agreement for [the preceptor's] continued participation in [the Provider's] intern and resident training programs." Although the MOU was created and signed by the physicians several years after the FYEs in question, the Provider argues that that the timing of when those documents were signed is irrelevant, according to CMS correspondence by the Administrator, which indicates that "retroactive" written agreements would be sufficient if a "hospital can document that there was a commitment to incur the training costs before the time that the residents began training . . ."[11] The Provider maintains that the signed MOUs not only cured any defects in the written agreements that were in place during the periods at issue (i.e. Bylaws, resident agreements), but also, independently satisfy the written requirement agreements.

The Intermediary argues that the Provider did not have written agreements with the non-hospitals sites that specifically addressed the responsibilities of the parties and the costs associated with the outside rotations to be incurred by the Provider until 2005. The Intermediary contends that 42 C.F.R. §413.86(f)(4) requires the Provider to have a written agreement in place between the Provider and the non-provider setting prior to the residents rotating to the non-provider setting. The Intermediary argues that the purpose of

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[9] See, Provider exhibit P-37, Article II, §2.5(G).
[10] See, Provider Exhibit P-38.
[11] See, Provider Exhibit P-43.

this regulatory requirement is to ensure that the providers receive proper reimbursement and also to protect against the possibility of double payment for the outside rotation.

The Intermediary contends that the Bylaws and the physicians' MOU do not satisfy the written agreement regulatory requirement. The Bylaws merely cover the relationship between the physician and the hospital, and do not address, nor were they intended to address, whether or not the hospital or a non-hospital entity intended to bear the cost of the medical residency training program. The Intermediary asserts that the physician MOUs signed after the fiscal years in questions are insufficient to meet the requirements of the regulations as they were not contemporaneous. The Intermediary cites the Board's decision in Chestnut Hill Hospital v. Blue Cross Blue Shield Association/Veritus Medicare Services, PRRB Dec. No. 2004-D22, May 6, 2004, Medicare and Medicaid Guide (CCH) ¶ 81,157, decl'd. rev. CMS Administrator July 6, 2004 as support for its position. The Intermediary asserts that the facts in Chestnut Hill appear identical to the facts in this case, and the Board found in Chestnut Hill that the MOUs signed after the fiscal years in question failed to satisfy the regulation because the agreement must be in place at the time of the non-provider setting rotation.

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:

Issue #1 DGME and IME payments for Medicare + Choice beneficiaries

The Balanced Budget Act of 1997 (BBA '97) provided for 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. 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.

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) 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 majority finds that this dispute is governed by the regulation, 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 §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, for services furnished by and paid for by Medicare + Choice organizations or other Medicare risk plans, are specifically exempt from the requirements, procedures and time limits under this section. The information that would be needed to process these claims by intermediaries is contingent upon the Medicare HMO plans' payment processing methods which are entirely disparate from the fee-for-service plan.

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) (interim final rule was published in June 1998). No changes were made to 42 C.F.R. §424.30, however, neither the regulatory changes implementing the new IME/DGME payment nor any other regulation gave notice that hospitals would now 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.

The Secretary has been given extremely 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 guidance in an Administrative Bulletin is insufficient to deprive a provider of its statutory right to payment.

The lack of formal notice was evident in the instant case by the Provider's direct inquiry to its Intermediary in a letter dated July 17, 1998.[12] This letter was offered by the Provider as its formal written request "to receive Medicare reimbursement for its [direct] GME and IME managed care enrollees" and sought out further details on how and when this payment would be implemented. The Intermediary responded in a letter dated August 20, 1998 (date of 'Actual Notice').[13] In this letter, the Intermediary referenced the Medicare Bulletin No.416 dated 7/13/98.[14] This Bulletin states that "teaching hospitals may submit bills for inpatient stays by managed care enrollees for payment of IME." (Emphasis added). This Bulletin only addressed 'IME cost' payments and did not specify a definite date when this billing should begin or make any reference to PM A-98-21 for further guidance. As far as the "actual notice" is concerned, it appears to convey that the details were still being worked out at the Intermediary level on how "to process claims related to these payments" but that the burden to bill was not on the Intermediary (as originally mentioned by the Provider in its correspondence) but on the Provider. In addition, the guidance spoke to a need to bill for IME (to receive interim payments) but that no such 'interim' relief was available for DGME because of system limitations related to the accumulation of the inpatient days.

Nowhere does the Board majority find a directive to the Provider that states that in order to receive IME and DGME supplemental payments provider ***must*** bill the Interemdiary. The Medicare Bulletin states you 'may' bill and the 8/20/98 letter states 'how' to bill.

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 1/1/98, CMS should have followed the Administrative Procedures Act (APA) prescribed "informal rulemaking" process and made provisions to handle the period from 1/1/98 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 the intermediary, then the Board majority believes that a regulatory notice is required.

The Intermediary does not dispute that the Provider complied with 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

[12] Exhibit P-15.
[13] Exhibit P-16
[14] Exhibit P-17

IME/DGME additional payment 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 1/1/98 up until the date of notice (constructive or actual), 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 majority 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 Provider furnished to the Intermediary a detailed log of the Medicare Managed Care enrollees it serviced during the periods at issue from its records for verification and inclusion in the Medicare cost report. The Intermediary's refusal to audit the data made available to support the Provider's claim was a misuse of its discretion and the case must be remanded to the Intermediary to complete the audit.

Issue #2 Non-Provider Settings

The DGME and IME statutes, 42 U.S.C. §§1395ww(h)(4)(E) and 1395ww(d)(5)(B)(iv) have the following criteria that must be met in order for a Provider to include time spent in a non-hospital setting:

> (1) The resident is participating in an approved residency program;
> (2) the residents' time is spent in activities related to patient care; and
> (3) the hospital incurs all, or substantially all, of the costs for the resident's training in that [non hospital] setting.

The Medicare regulations for DGME and IME, 42 C.F.R §413.86(f)(3)-(4) and 42 C.F.R. §412.105 add an additional criteria, the written agreement requirement:

> (ii) The written agreement between the hospital and the nonhospital site must indicate that the hospital will incur the cost of the resident's salary and fringe benefits while the resident is training in the nonhospital site and the hospital is providing reasonable compensation to the nonhospital site for supervisory teaching activities. The agreement must indicate the compensation the hospital is providing to the nonhospital site for supervisory teaching activities.

42 C.F.R. §413.86(f)(4)(ii).

The Intermediary never reached a determination of whether the provider met all the necessary criteria because it based its disallowance solely on the Provider's failure to have a written agreement in place during the cost report period that, ". . . indicates that the hospital will incur the cost of the resident's salary and fringe benefits while the resident is training in the nonhospital site and the hospital is providing reasonable compensation to the nonhospital site for supervisory teaching activities. The agreement must [also] indicate the compensation the hospital is providing to the nonhospital site for supervisory teaching activities."[15]

The crux of the issue is whether the MOUs executed after the cost reporting periods at issue satisfy the regulation's requirements. The Board majority finds that it does not. Medicare reimbursement is determined on a cost year basis. The Board majority concludes that the agreement must be in place at the time of the non-provider setting rotations in order to ensure proper payment and protect the Medicare program against the possibility of double payment. This finding is consistent with the Board's decision in Chestnut Hill Hospital v. Blue Cross Blue Shield Assocation/Veritus Medicare Services, PRRB Dec. No. 2004-D22, May 6, 2004, Medicare and Medicaid Guide (CCH) ¶ 81,157, decl'd. rev. CMS Administrator July 6, 2004.[16]

The Board majority further concludes that the other contemporaneous documents (By-laws, the physician agreements to be bound by the By-laws and the signed resident contracts), when considered collectively, still fail to meet the regulation's requirement for a written agreement. The thrust of the regulation is that the written agreement must be between the provider and the non-hospital site and must specify who bears the cost. The Board finds that the Bylaws did not address who would be responsible for compensating the teaching physicians cost, if any, for supervisory duties. Although, the Provider argues that the physician's agreement to be bound by the Bylaws in which the physicians agree to take on the responsibility for training of the residents is an implied quid pro quo for their membership on the medical staff, the Board finds that the document still falls short of the specificity required in the regulation in that it does not identify the costs or make any reference to who will provide reasonable compensation to the nonhospital site for supervisory teaching activities. The resident contracts, which are the only documents that address payment of training costs, are not agreements between the requisite parties and, moreover, does not address supervisory teaching costs, if any.

The Provider offered a 2005 physician survey to document that there was insignificant time spent and costs associated with the supervisory teaching activities. The Board

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[15] 42 C.F.R. §413.86(f)(4)(ii) was effective for portions of cost reporting periods occurring on or after January 1, 1999. On or after July 1, 1987 and for portions of cost reporting periods occurring before January 1, 1999, 42 C.F.R §413.86(f)(3)(ii) is controlling. 42 C.F.R. §413.86(f)(3)(ii) requires that "There is a written agreement between the hospital and the outside entity that states that the resident's compensation for training time spent outside of the hospital setting is to be paid by the hospital."

[16] The Board's decision has been upheld by the Chestnut Hill Hospital v. Thompson, U.S. District Court for the District of Columbia, No. 04-1128 (Aug. 15, 2006), Medicare and Medicaid Guide (CCH) ¶301,886.

majority finds that although the survey shows that the time spent and the costs are minimal, it does not obviate the need for a contemporaneous written agreement.

The Provider also offered a letter written by the former CMS Administrator, Thomas A. Scully, as evidence that CMS itself interpreted the regulation as permitting a non-contemporaneous written agreement. However, the Board majority does not find the Scully letter inconsistent with its findings. The Scully letter requires documentation of a commitment which is consistent with the regulation. The Provider argues that post-dated documents are sufficient as long as a "hospital can document that there was a commitment to incur the training costs before the time the residents began training [at the non-hospital site]." The Board majority does not find the argument persuasive. The language from the Scully letter must be put in context as it also states, "written agreements that are retroactive to the time the residents begin training at the non-hospital site do not demonstrate an ongoing commitment by the hospital to incur the training costs." There is no evidence in the record of what the Administrator may have found acceptable in that particular instance. The documents, when taken collectively, do not demonstrate the commitment referenced in the Scully letter.

DECISION AND ORDER:

Issue #1 DGME and IME payments for Medicare + Choice beneficiaries

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, 2000 and 2001. The Intermediary's adjustment for FY 1998 is reversed and FYs 1999, 2000 and 2001 cost reports are remanded to the Intermediary to include the days applicable to the Medicare + Choice enrollees.

Issue #2 Non-Provider Settings

The Intermediary's adjustments to disallow residents' time spent in non-provider settings were proper and are affirmed.

BOARD MEMBERS PARTICIPATING

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S. (Dissenting as to issue #1)
Elaine Crews Powell, C.P.A. (Dissenting as to issue #1)
Anjali Mulchandani-West
Yvette C. Hayes (Concurring as to issue #2)

FOR THE BOARD:

Suzanne Cochran
Chairperson

DATE: September 28, 2007

Dissenting Opinion of Gary B. Blodgett and Elaine Crews Powell as to Issue #1

The Board majority found that the Intermediary improperly excluded the subject Medicare managed care days from the calculation of the Provider's additional IME and GME reimbursement authorized by sections 4622 and 4624 of the BBA of 1997. We respectfully disagree.

We find that the Provider did not submit the specially coded UB-92s required by Transmittal No. A-98-21 and that these claims must have been submitted within the time limitations set forth at 42 C.F.R. §424.44. Additional reimbursement was made available to teaching hospitals by the BBA. Providers could elect to follow the methodology CMS prescribed for claiming the reimbursement or ignore the instructions and forgo the additional reimbursement as Santa Barbara Cottage did.

Fundamentally, we find that Transmittal No. A-98-21 was an appropriate means to implement program payments pursuant to the applicable IME and GME statutes and regulations. Moreover, the requisite claims were not exempt from submission to the Intermediary pursuant to 42 C.F.R. §424.30 which applies to claims for services furnished on a prepaid capitation basis by a health maintenance organization, a competitive medical plan, or a health care prepayment plan. While our analysis of this matter may extend beyond the parties' arguments and contentions, it is as follows:

CMS is charged with the responsibility of ensuring proper program payments to providers of service. To accomplish this mandate, CMS employs various vehicles and

processes such as the issuance of regulations and manual instructions as well as program memorandums. CMS notified intermediaries and the public regarding the added payments for Medicare managed care enrollees when it formally modified the IME and GME regulations on August 29, 1997 (62 Fed. Reg. No. 168). CMS' publication of Transmittal A-98-21 instructed intermediaries to notify their hospitals of the right to request the additional payments and the methodology that was required to secure them. Contrary to the Board majority's opinion, we find that there was no need for CMS to publish a new regulation with the required notice and comment period. CMS clearly intended to get the additional reimbursement to teaching hospitals as soon as possible, and we find that the use of a transmittal was a well established, efficient way to do so.

Intermediaries have processes in place to manage the receipt of information and instructions from CMS and for the dissemination of that information to their affected providers, and this Intermediary followed those procedures. Moreover, in this particular instance, the Provider had one-on-one written communication with the Intermediary (P-16) where the Intermediary discussed the additional payments for both IME and GME and explained how the claims were to be billed. This August 20, 1998 letter also referred the Provider to the Medicare Bulletin No. 416 that had been issued on July 13, 1998. Finally, we note that Commerce Clearing House published the entire text of the Transmittal in its New Developments section one week after the Transmittal was released by CMS. Clearly, the Provider received adequate notice of its right to claim additional reimbursement and simply elected not to follow the mandated procedure for doing so. Therefore, we find the Provider's inadequate notice argument disingenuous.

The added IME and GME payment for Medicare managed care discharges was effective for portions of cost reporting periods beginning on or after January 1, 1998, and Transmittal No. A-98-21 was issued by CMS on July 1, 1998. Therefore, teaching hospitals had adequate time to comply with CMS' instructions regarding the submission of the specially coded UB-92 billing forms. Notably, hospitals had at least 15 months to submit the required claims. See, 42 C.F.R. §424.44.

We find that the regulatory exception for filing claims does not apply to the specially coded UB-92s required for payment of the additional IME and GME reimbursement. Therefore, the time limits for filing claims clearly applied to the claims at issue because they were "claims for payment" of the additional teaching costs.[17] Regulation 42 C.F.R. §424.30 states in relevant part:

> [c]laims 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 (HCCP). (Emphasis added.)

[17] In Saint Anthony's Health Center v. Blue Cross Blue Shield Association/AdminiStar Federal Illinois, PRRB Dec. No. 2006-D22, May 25, 2006, rev'd. CMA Administrator, July 19, 2006, the Board held that the time limitations for filing claims contained in 42 C.F.R. §424.30 did not apply to HMO claims. We distinguish our findings in Saint Anthony's from that of the instant case by the fact that the argument in Saint Anthony's pertained to the submission of HMO "encounter data" as opposed to the submission of specially coded UB-92 billing forms which we find are "claims for payment" and are, therefore, subject to the claim timeliness requirement.

We find that the claims at issue here were claims for additional reimbursement for the hospital's costs associated with being a teaching hospital and not for services furnished by any of the aforementioned health plans on a prepaid capitation basis.

We also find that providers have long been required to file claims when reimbursement of the particular claim was not expected. Section 411 of Medicare's Hospital Manual (HCFA Pub.-10) which was effective August 1, 1988, states in relevant part:

> [t]he benefit days available to a beneficiary depend upon the status of his/her utilization of services during the benefit period described in §215 and the lifetime reserve days described in §219. Submit bills for all stays, including those for which no program payment can be made. This assists the intermediary and HCFA in maintaining utilization records and determining remaining eligibility. Even though these bills are noncovered, a bill is required because hospitalization could extend a benefit period.

As discussed above, hospitals have been required to submit bills for "all stays" since 1988 (HCFA Pub.-10 §411); therefore, the UB-92 filing requirement posed little or no added burden on the hospitals. The Paperwork Reduction Act defines "burden" as the time, effort, and financial resources needed to review instructions, acquire and install technology and systems, search for data, and transmitting information, etc. Therefore, we

conclude that the Transmittal's billing requirement is not subject to Office of Management and Budget approval pursuant to the Paperwork Reduction Act of 1995.

Finally, we agree with the Intermediary's contention that the data used to calculate the IME and GME payments for regular Medicare patients is processed by the claims payment system and captured on the PS&R. It was, therefore, reasonable to include the additional claims data for the Medicare Managed care patients in the same claims processing system. While the Provider furnished hard copy claims to the auditors before the cost reports were settled, the claims were never entered into the claims processing system where eligibility could be verified and the claims run through the system's pricer program.

The Provider ignored the program's claims filing requirement to its detriment, and its numerous arguments are, at bottom, aimed at shifting the burden for ensuring accurate IME and GME payment to the Intermediary. We find that the Provider was responsible for claiming all the reimbursement to which it was entitled and that it received timely notification of the manner in which that reimbursement was to be claimed.

The Intermediary's refusal to accept the manual UB-92s after the filing deadline prescribed by 42 C.F.R. §424.44 was proper.

Gary B. Blodgett, DDS

Elaine Crews Powell, CPA

Separate Opinion of Yvette Hayes, concurring in part:

I concur with the majority's determination that the contemporaneous documents (By-laws, Physician Agreements (acknowledging their acceptance of the By-laws) and Resident Contracts), when considered collectively, fail to meet the regulation's requirements for a written agreement, for the reasons cited.

However, I disagree with the Board majority's determination that the written agreements must be in place prior to or at the time the of the non-provider setting rotations.

Although, I find that the MOUs provided in the record have all the essential data needed to meet the written agreement requirement of the Medicare regulations at 42 C.F.R. §413.86 and §412.105, the data is incomplete. The MOUs provided were only for physicians who were participating in the program from 1998 to 2000, and still available in 2005, even though representative of the majority of the teaching physicians.[18] I find that partial support is not adequate support.

In addition, the MOUs were executed in 2005 almost 7 years after the first cost reporting periods under appeal. The fact that these agreements did not come into existence until well after the cost reporting periods at issue in support of the graduate medical education costs incurred, is contrary to program manual provisions.

> The manual addresses the "availability of records of providers" and states that… "a participating provider of services must make available to its intermediary…its records for the purpose of determining its record keeping capability. The intermediary's examination of such records and documents are necessary to ascertain information pertinent to the determination of the proper amount of program payments due the provider." CMS Pub 15-1, Section 2304.1.

I find this lapse in time excessive and the Provider was not able to offer any explanation as to why such an oversight had occurred.

I also find that this instant case highlights precisely what the former CMS Administrator, Thomas A. Scully was concerned about in his November 1, 2000 letter when he commented about written agreements that are retroactive, he stated that…"[t]he retroactive application of this provision would appear to be solely a vehicle to increase GME payments to the hospital for a period when training at the non-hospital location was already occurring without the hospital's facilitation or commitment to pay for the costs of this training." [19]

For the reasons stated above, I concur with the majority's determination that the MOUs are also insufficient to satisfy the regulatory requirements for a written agreement.

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[18] See Transcript at 82.
[19] See Provider Exhibit P-43.

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Yvette C. Hayes