**Whether the Provider’s Medicare Managed Care Days are accurately stated, specifically as it relates to the Provider’s Health Information Technology (HITECH) Incentive Payments.**

**A. Facts**

The Provider contends that its Health Information Technology (HIT or HITECH) incentive payment was understated due to the exclusion of some Medicare Managed Care (Part C) claims from the Provider Statistical and Reimbursement (PS&R) data used to settle the cost report. The MAC adjusted the Electronic Health Record (EHR) HIT payment factors with audit adjustment numbers 6 and 7, and the Medicare Managed Care (Part C) claims with adjustment numbers 8 and 9 (Exhibit C-2). See Exhibit C-7 for the MAC adjustment workpaper L-J1, with the MAC adjustment to Medicare Part A Managed Care days shown on page 2.

The Provider included the estimated reimbursement effect of unbilled Medicare Managed Care patients on its HIT payment, in its filed Protested Amounts on its cost report. The MAC adjusted to remove these Protested Amounts in adjustment 21 (Exhibit C-2, page 11). See Exhibit C-3 for support of the filed Protested Amounts.

The Provider asserts that its Health Information Technology (HIT) payment was understated due to the exclusion of some Medicare Managed Care cases from the PS&R data. The Provider contends there are additional Medicare Part C paid days that need to be considered in the HIT payment calculation. The Provider contends those days were accurately billed to the MAC but were not included in the Medicare Managed Care Part C paid days on the PS&R. The Provider estimated this to be 2,256 additional days, as stated in its Final Position Paper, page 7. This is in addition to the 1,783 Medicare Managed Care patient days allowed on the Audited Medicare Cost Report.

The MAC asserts the Provider’s HIT payment has been properly determined based on the information available to the MAC at the time of the settlement of this cost report.

**B. Argument**

**1. The Provider’s HIT payments have been properly calculated based on the data on the cost report.**

In accordance with the American Recovery and Reinvestment Act (ARRA) of 2009, Section 4102, inpatient acute care services under IPPS (providers subject to §1886(d) of the Act) and Critical Access Hospitals (CAHs) are eligible for HIT payments. Title IV of Division B of ARRA amends Titles XVIII and XIX of the Social Security Act (the Act) by establishing incentive payments to eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs), and Medicare Advantage Organizations to promote the adoption and meaningful use of interoperable health information technology (HIT) and qualified electronic health records (EHRs). These provisions, together with Title XIII of Division A of ARRA, may be cited as the "Health Information Technology for Economic and Clinical Health Act" or the "HITECH Act." These incentive payments are part of a broader effort under the HITECH Act to accelerate the adoption of HIT and utilization of qualified EHRs. Section 4102(a) of the HITECH Act adds a new subsection (n) to Section 1886 of the Act. Section 1886(n) of the Act establishes incentives payments for demonstration of meaningful use of certified EHR technology by subsection (d) hospitals, as defined under section 1886(d)(1)(B) of the Act, participating in the Medicare FFS program beginning in Federal fiscal year (FFY) 2011 (75 FR 44316, Exhibit C-8).

The Final Rule for the Electronic Health Record Incentive Program was published in the July 28, 2010 Federal Register (75 FR 44313 – 44588). (See Exhibit C-8 for 75 FR 44314 – 44316, 44450 – 44456.) HIT payments for hospitals are determined as explained in that Federal Register, starting at page 44450:

b. Incentive Payment Calculation for Eligible Hospitals: Initial Amount

Section 1886(n)(2) of the Act, as amended by 4102(a) of the HITECH Act, describes the methodology for determining the incentive payment amount for eligible hospitals that are meaningful users of certified EHR technology during the EHR reporting period for a payment year. In general, that section requires the incentive payment for each payment year to be calculated as the product of: (1) An initial amount; (2) the Medicare share; and (3) a transition factor applicable to that payment year.

As amended by section 4201(a) of the HITECH Act, section 1886(n)(2)(A)(i) of the Act defines the initial amount as the sum of a "base amount," as defined in section 1886(n)(2)(B) of the Act, and a "discharge related amount," as defined in section 1886(n)(2)(C) of the Act. The base amount is $2,000,000, as defined in section 1886(n)(2)(B) of the Act. The term "discharge related amount" is defined in section 1886(n)(2)(C) of the Act as "the sum of the amount, estimated based upon total discharges for the eligible hospital (regardless of any source of payment) for the period, for each discharge up to the 23,000th discharge as follows:

(i) for the first through the 1,149th discharge, $0.

(ii) for the 1,150th through the 23,000th discharge, $200.

(iii) for any discharge greater than the 23,000th, $0."

In addition to the base amount, the discharge related amount provides an additional $200 for each hospital discharge during a payment year, beginning with a hospital's 1,150th discharge of the payment year, and ending with a hospital's 23,000th discharge of the payment year. No additional payment is made for discharges prior to the 1,150th discharge, or for those discharges subsequent to the 23,000th discharge. We proposed to implement the "initial amount" within the formula as that term is defined in the statute.

The determination of “the Medicare share” is discussed further on pages 44452 – 44456 of this Federal Register, stating on page 44453:

Section 1886(n)(2)(D) of the Act, as amended by section 4102 of the HITECH Act, defines the numerator and denominator of the Medicare share fraction for an eligible hospital in terms of estimated Medicare FFS and managed care inpatient bed-days, estimated total inpatient bed-days, and charges for charity care. Specifically, section 1886(n)(2)(D)(i) of the Act defines the numerator of the Medicare share fraction as the sum of –

– The estimated number of inpatient-bed-days (as established by the Secretary) which are attributable to individuals with respect to whom payment may be made under part A; and

– The estimated number of inpatient-bed-days (as so established) that are attributable to individuals who are enrolled with a MA organization under Part C.

We proposed to determine the numbers of Medicare Part A and Part C inpatient-bed-days using the same data sources and methods for counting those days that we employ in determining Medicare's share for purposes of making payments for direct graduate medical education costs, as provided under section 1886(h) of the Act and § 413.75 of our regulations. Specifically, we proposed to derive "the estimated number of inpatient-bed-days \* \* \* attributable to individuals with respect to whom payment may be made under part A" from lines 1, 6 through 9, 10, and 14 in column 4 on Worksheet S-3, Part I of CMS Form 2552-96, Hospital and Hospital Health Care Complex Cost Report. We stated that the data entered on these lines in the cost report include all patient days attributable to Medicare inpatients, excluding those in units not paid under the IPPS and excluding nursery days.

The Provider’s HIT payments have been properly determined in accordance with the above instructions, based on the Medicare days reported on the cost report.

**2. The Medicare Managed Care Days reported on the cost report must be accurately billed by the Provider.**

CMS Pub. 15-2, Section 4031.2 (Exhibit C-9) provides instructions for the completion of the Medicare cost report as it relates to HIT payments. Specifically, the instructions to line 3 of Worksheet E-1, Part II - Calculation of Reimbursement Settlement for Health Information Technology, state:

Line 3--Transfer the Medicare HMO days from Worksheet S-3, Part I, column 6, line 2.

The Provider states in its Final Position Paper, page 6:

The Provider claims there are additional Medicare Managed Care days which were not captured and omitted in the PS&R utilized at audit but should have been included in the audited cost report. The MAC adjusted the Provider’s Medicare Managed Care days in the audited cost report to agree with the PS&R dated July 24, 2018. The Provider claims the Medicare Managed Care days reflected in the audited cost report are understated in the PS&R on Report 118 as it does not include all the shadow claims as reflected in Exhibit P-6. NOTE: These shadow claims were submitted to and paid by the respective Medicare Advantage Plans.

and

Based on the explanation above from the Provider, the primary reason for the shadow claims not being included in the PS&R is due to the patient accounting department being told that Medicare patients were NOT to carry their Medicare identification cards, which would be an important piece of document (reflecting the patient’s social security number) needed to bill the shadow claims. In addition, the Provider did not have access to the MAC’s portal system to look up the patient’s social security number. The social security number is essential for Medicare claims to be billed, therefore, since this information was not available to the Provider, the shadow claims were not billed to Medicare, therefore, not included in the Medicare PS&R.

To resolve this issue, the Provider has included its internal records reflecting the Medicare Managed Care days that should have been reflected in the detailed PS&R dated July 24, 2018.

The Provider does not explain what efforts, if any, it has made to work with the MAC claims processing area to ensure these claims were properly billed to the Medicare Program so that they could be properly processed through the Medicare Part A claims processing system to report on the PS&R.

The Provider’s FPP discusses its asserted reasons why it was unable to obtain the information needed to bill these Part C patients to the Medicare Program, such as the Medicare HIC number. The MAC contends that the Provider is responsible to overcome these difficulties and properly bill the required information to the MAC.

The MAC is in agreement with the Provider that days for individuals enrolled in Medicare cost plans (§ 1876) should be included on line 2 of Worksheet S-3, Part I. In order for these days to be reported on the Medicare Cost Report, the Provider must properly submit bills to the MAC so that the appropriate data may be captured on the Provider Statistical and Reimbursement (PS&R) report type 118. The days that the Provider properly submitted on bills to the MAC have been included on the Medicare Cost Report.

**3. The MAC properly used the PS&R to settle the cost report.**

The Provider Statistical and Reimbursement (PS&R) System is a key tool for institutional healthcare providers, MACs and CMS. The system accumulates statistical and reimbursement data applicable to the processed Medicare Part A claims – that is, claims submitted by providers to the MACs on the standard Uniform Billing Form. This data is summarized in various reports, which are used by providers to prepare Medicare cost reports and by MACs during the audit and settlement process. The providers must use the reports in preparing cost reports and must be able to explain any variances between the PS&R report and the cost report. The MACs use information on such items as Medicare patient days (relevant for HIT), discharges, and DRG amounts. The main report used is the PS&R Provider Summary Report.

Critical for achieving complete and accurate data for preparing a Medicare cost report is the PS&R system’s reliance on data from processed and finalized Medicare claims. The accuracy of the system-generated reports is, in relevant part, dependent on whether or not a provider timely and accurately files its Medicare claims.

The burden is on the Provider to support that the adjustments in question are not proper. The MAC asserts that the Provider has not substantiated its claim that the use of the information from the PS&R Report has not resulted in proper settlement of its cost report.

**4. The Provider must file the standard Uniform Billing Form through the claims processing system for recording the days for Managed Care (M+C) enrollees, and the Provider’s claims must be timely submitted as required by 42 C.F.R. § 424.44.**

Relevant to capturing the days at issue under Part A are the claims processing procedures set forth at 42 C.F.R. § 424.30. The submission of claims to MACs for Part A payment is controlled by the regulation at 42 C.F.R. § 424.30 (Exhibit C-17). 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 an MA organization, or through cost settlement with either a health maintenance organization (HMO), a competitive medical plan (CMP), or a health care prepayment plan (HCPP), or as part of a demonstration. Therefore, claims must be filed by hospitals seeking IME payment under § 412.105(g) of this chapter, and/or direct GME payment under § 413.76(c) of this chapter, and/or nursing or allied health education payment under § 413.87 of this chapter associated with inpatient services furnished on a prepaid capitation basis by an MA organization. Hospitals that must report patient data for purposes of the DSH payment adjustment under § 412.106 of this chapter for inpatient services furnished on a prepaid capitation basis by an MA organization, or through cost settlement with an HMO/CMP, or as part of a demonstration, are required to file claims by submitting no pay bills for such inpatients. Special procedures for claiming payment after the beneficiary has died and for certain bills paid by organizations are set forth in subpart E of this part.

It is important to note that the M+C claims at issue are not for “services furnished on a prepaid capitation basis by a health maintenance organization.” The payment at issue has been 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 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 C.F.R. § 424.30 to be able to receive Part A Graduate Medical Education (GME) and Indirect Medical Education (IME) payments from its MAC for M+C enrollees, as well as to report the days needed to calculate the HIT payments. Section 424.32 (Exhibit C-18) sets forth the basic requirements for all claims:

(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 ICD-9-CM.

(3) A claim must be signed by the beneficiary or on behalf of the beneficiary (in accordance with § 424.36).

(4) A claim must be filed within the time limits specified in § 424.44.

(5) 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 - Uniform Institutional Provider Bill. (This form is for institutional provider billing for Medicare inpatient, outpatient and home health services.)

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

When a provider bills for M+C enrollees in accordance with CMS instructions, the claims system determines the DRG payment (i.e., a simulated PPS payment) upon which the IME add–on is based, as well as covered Program charges and inpatient days, all which would be summarized on the PS&R.

Regulations require that Medicare claims be submitted on a timely basis. Specifically, 42 C.F.R. § 424.44 (Exhibit C-10) states:

424.44 Time limits for filing claims.

(a) *Time limits*. (1) Except as provided in paragraphs (b) and (e) of this section, for services furnished on or after January 1, 2010, the claim must be filed no later than the close of the period ending 1 calendar year after the date of service.

(2) Except as provided in paragraphs (b) and (e) of this section and except for services furnished during the last 3 months of 2009, for services furnished before January 1, 2010, the claim must be filed —

(i) On or before December 31 of the following year for services that were furnished during the first 9 months of a calendar year; and

(ii) On or before December 31st of the second following year for services that were furnished during the last 3 months of the calendar year.

(3) For services furnished during the last 3 months of CY 2009 all claims must be filed no later than December 31, 2010.

(b) *Exceptions to time limits*. Exceptions to the time limits for filing claims include the following:

(1) The time for filing a claim will be extended if CMS or one of its contractors determines that a failure to meet the deadline in paragraph (a) of this section was caused by error or misrepresentation of an employee, Medicare contractor (including Medicare Administrative Contractor, intermediary, or carrier), or agent of HHS that was performing Medicare functions and acting within the scope of its authority.

(2) The time for filing a claim will be extended if CMS or one of its contractors determines that a failure to meet the deadline in paragraph (a) of this section is caused by all of the following conditions:

(i) At the time the service was furnished the beneficiary was not entitled to Medicare.

(ii) The beneficiary subsequently received notification of Medicare entitlement effective retroactively to or before the date of the furnished service.

(3) The time for filing a claim will be extended if CMS or one of its contractors determines that a failure to meet the deadline in paragraph (a) of this section is caused by all of the following conditions:

(i) At the time the service was furnished the beneficiary was not entitled to Medicare.

(ii) The beneficiary subsequently received notification of Medicare entitlement effective retroactively to or before the date of the furnished service.

(iii) A State Medicaid agency recovered the Medicaid payment for the furnished service from a provider or supplier 6 months or more after the service was furnished.

(4) The time for filing a claim will be extended if CMS or one of its contractors determines that a failure to meet the deadline in paragraph (a) of this section is caused by all of the following conditions:

(i) At the time the service was furnished the beneficiary was enrolled in a Medicare Advantage plan or Program of All-inclusive Care for the Elderly (PACE) provider organization.

(ii) The beneficiary was subsequently disenrolled from the Medicare Advantage plan or Program of All-inclusive Care for the Elderly (PACE) provider organization effective retroactively to or before the date of the furnished service.

(iii) The Medicare Advantage plan or Program of All-inclusive Care for the Elderly (PACE) provider organization recovered its payment for the furnished service from a provider or supplier 6 months or more after the service was furnished.

**(5) Extension of time**. (i) If CMS or one of its contractors determines that a failure to meet the deadline specified in paragraph (a) of this section was caused by error or misrepresentation of an employee, Medicare contractor (including Medicare Administrative Contractor, intermediary, or carrier), or agent of HHS that was performing Medicare functions and acting within the scope of its authority, the time to file a claim will be extended through the last day of the sixth calendar month following the month in which either the beneficiary or the provider or supplier received notification that the error or misrepresentation referenced in paragraph (b)(1) of this section was corrected. No extension of time will be granted for paragraph (b)(1) when the request for that exception is made to CMS or one of its contractors more than 4 years after the date of service.

(ii) If CMS or one of its contractors determines that both of the conditions are met in paragraph (b)(2) of this section but that all of the conditions in paragraph (b)(3) are not satisfied, the time to file a claim will be extended through the last day of the sixth calendar month following the month in which either the beneficiary or the provider or supplier received notification of Medicare entitlement effective retroactively to or before the date of the furnished service.

(iii) If CMS or one of its contractors determines that all of the conditions are met in paragraph (b)(3) of this section, the time to file a claim will be extended through the last day of the sixth calendar month following the month in which the State Medicaid agency recovered the Medicaid payment for the furnished service from the provider or supplier.

(iv) If CMS or one of its contractors determines that all of the conditions are met in paragraph (b)(4) of this section, the time to file a claim will be extended through the last day of the sixth calendar month following the month in which the Medicare Advantage plan or Program of All-inclusive Care for the Elderly (PACE) provider organization recovered its payment for the furnished service from the provider or supplier.

It appears the Provider failed to accurately submit the claims in question to the MAC’s Medicare claims processing system in a timely manner as required by 42 C.F.R. § 424.44. Providers must properly submit these claims to the required claims processing systems so that they can be subjected to eligibility verification and proper adjudication. By simply submitting a listing of the additional patients the provider claims to be eligible Medicare Managed Care patients, the provider is placing the burden of manually verifying this information on the audit area of the MAC. The Medicare claims system is designed to efficiently, effectively, and accurately perform these functions. The audit function does not have the resources to manually perform these functions. The audit area cannot accurately duplicate the role of the claim processing system. Attempting to do so would entail a very substantial burden and would result in inaccurate payments.

It is the Provider's responsibility to determine eligibility of its patients and to properly bill for those stays in a timely manner, so that the claims can be properly processed by the claims processing system. This burden cannot be shifted to the audit function of the MAC years after the patient care was provided.

The Provider asserts that “…the Medicare Managed Care days reflected in the audited cost report are understated in the PS&R on Report 118 as it does not include all the shadow claims as reflected in Exhibit P-6.” (Provider Final Position Paper, page 6). However, the Provider has not submitted any documentation to support its assertion that the days in contention were properly billed. The Provider has simply submitted a listing of the total days it asserts are Medicare Managed Care days, including the days it asserts are missing from the report, and has attempted to shift the burden of determining the veracity of the days to the MAC. The Provider should have worked with the MAC’s Medicare claims processing area as soon as it realized that the days in question were not on the PS&R Report 118. The Provider should have verified that the claims were properly submitted and investigated why the claims were not processed in the manner that the Provider expected. The Provider has not submitted any documentation to show that it attempted to determine why the billing and processing of these claims resulted in the days not reporting as Medicare Managed Care days on the PS&R Report 118.

SSA Section 1886(n)(2)(D)(i) and (ii) refer to the "estimated number of inpatient-bed days **(as established by the Secretary**)..." And further, the last sentence of paragraph (D) states, "In the absence of data, with respect to a hospital, necessary to compute the amount described in clause (i)(II), the amount under such clause **shall be deemed to be 0.**" (emphasis added)

In this case, if there is an absence of data, it is because the Provider did not properly bill for the days in contention. Proper billing allows for the determination of whether the inpatient stay is appropriately billed for an enrollee, and not merely claimed as a Part C day by the hospital. Appropriately billed, as discussed above, includes timely billed to the Medicare program.

The MAC properly used the information reported on the PS&R, based on the information billed by the Provider, to settle the cost report.

**C. Conclusion**

The Board should affirm the MAC’s determination. The Provider’s HIT payment has been properly determined based on the information available to the MAC at the time of the settlement of this cost report. The Provider has not documented that there are additional allowable Medicare Managed Care claims that should be considered in the determination of the Provider’s HIT payment. The asserted additional Medicare Managed Care claims cannot be allowed for purposes of determining the Provider’s HIT payment as the Provider failed to properly submit these claims to the Medicare Part A claims processing system in a timely manner as required by 42 C.F.R. § 424.44.