PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2004-D44

PROVIDER –
Wayne County General Hospital

Provider No.: 23-0098

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
United Government Services, LLC-WI

DATE OF HEARING –
June 4, 2003

Cost Reporting Period Ended -
August 13, 1984

CASE NO.: 94-2187

INDEX

ISSUE:

Whether the costs of terminating Provider's retirement benefits and retirees' health and life insurance benefits, which were allowed and approved by the Intermediary, should be allocated to prior cost reporting periods and reimbursed to the Provider as a below-the-line adjustment in its final cost report.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Wayne County General Hospital (Provider) operated an acute care, publicly owned, not for profit, general hospital in Westland, Michigan. On August 13, 1984, less than nine months after the start of the Provider's first year under the Prospective Payment System (PPS), the Provider terminated both its operations and its participation in the Medicare program. As a result of this termination, over 1,700 of the Provider's employees retired in 1984. On September 28, 1989, Blue Cross Blue Shield of Michigan (Intermediary) issued a Notice of Program Reimbursement (NPR) for the Provider's final cost reporting period. The Provider appealed several of the adjustments made by the Intermediary in the NPR (First Appeal), including the disallowance of certain pension costs and retirees' health and life insurance costs. By the end of 1992, the parties reached an administrative resolution of the adjustments under appeal, the administrative resolution was approved by Blue Cross Blue Shield Association (BCBSA) and the First Appeal was dismissed. The Intermediary issued a corrected NPR recognizing $22,088,615 of additional allowable costs, including $4,979,315 in additional retirement costs, $11,026,444 of retirees' health and life insurance costs, and $838,242 of accrued pension costs.

When the settlement was implemented, the Intermediary treated all the costs as if they were attributable only to 1984 liabilities. For reasons not relevant to the decision, because the Provider was now under PPS,[1] it received only $451,697 of additional Medicare reimbursement for the $22,088,615 of additional recognized costs. The Provider filed an appeal to protest the corrected NPR to the Provider Reimbursement Review Board (Board) contending that since a significant portion of the pension and related retirement costs relate to cost reporting periods prior to 1984, these costs should be allocated to prior years and reimbursed based on the Provider's Medicare utilization in those years.

The Provider was represented by Thomas J. McGraw, Esquire of Dykema Gossett PLLC. The Intermediary was represented by Bernard M. Talbert, Esquire of Blue Cross Blue Shield Association. The Provider's filing met the jurisdictional requirements of 42 C.F.R. §§405.1835-1841. The Medicare reimbursement effect is $2,349,691.

[1] See Medicare Statutory Regulatory Background below for a discussion of the changes in Medicare payment methodology.

FACTS:

There are no factual disputes in the case. The parties have entered into Joint Stipulations as to all factual matters, including the reimbursement effect in the event that the Board rules in favor of the Provider. The Joint Stipulations are part of the record in the case. The following stipulations are of particular relevance to this Decision:

1. The Provider operated a 310-bed acute care general hospital in Westland, Michigan. The Hospital was owned by the County of Wayne (Wayne County), a governmental unit located in southeast Michigan, which includes the City of Detroit.

2. The Provider participated in the Medicare program from 1967 until 1984, furnishing hospital services to Medicare beneficiaries for over 18 years. Its Medicare provider number was 23-0098. The Provider had a December 1 cost reporting year.

3. The Provider's fiscal intermediary until January 31, 1994 was Blue Cross Blue Shield of Michigan (Intermediary or Blue Cross Blue Shield of Michigan). The fiscal intermediary currently responsible for this appeal is United Government Services, a subsidiary of Blue Cross Blue Shield of Wisconsin .

4. On August 13, 1984, less than nine months after the start of its first year under the Prospective Payment System (PPS), ownership of the Hospital was transferred to Southwest Detroit Hospital, and the Provider terminated its participation in the Medicare program. As a result, 1,702 Hospital employees retired in 1984. A listing of the employees, their hire dates, their retirement dates and their total years of service is set forth in Exhibit P-11.

5. The Provider filed a final short-period cost report covering December 1, 1983 to August 13, 1984 (1984 Final Cost Report).[2]

6. On September 28, 1989, the Intermediary issued a Notice of Program Reimbursement for this final cost reporting period (1989 NPR).[3]

7. On March 9, 1990, the Provider timely filed a request for a Board hearing (First Appeal) disputing several audit adjustments made by the Intermediary in the 1989 NPR, including adjustment #8A disallowing certain pension costs, and adjustment #8 disallowing certain retirees' health and life insurance costs.

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[2] See Exhibit P-1.

[3] See Exhibit P-2.

8. By the end of 1992, an administrative resolution of several issues raised in the First Appeal was reached with the Intermediary and approved by BCBSA (Administrative Resolution). In the Administrative Resolution, BCBSA approved $22,088,615 of additional allowable costs, including $4,979,315 of additional retirement costs, $11,026,444 of retirees' health and life insurance costs, and $838,242 of accrued pension costs.

9. In the Administrative Resolution, the retirement costs and retirees' health and life insurance costs were excluded from reasonable costs for the purposes of the lower of cost or charges (LCC) comparison. These costs relate to retirement benefits and retirees' health and life insurance benefits that were earned by the Provider's employees while providing services to Medicare beneficiaries and other patients at Wayne County General Hospital.

10. The entitlement to and amount of the pension and retirees' health and life insurance benefits are a function of duration of employment and were not earned solely by reason of employment between December 1, 1983 and August 13, 1984. Incurrence of the pension and retirees' health and life insurance costs was the direct result of closing the hospital and the retirement of 1,702 employees. Retirees' health and life insurance benefits are earned only after a certain number of years of service. In the aggregate, the 1,702 Hospital employees who retired in 1984 had 36,982 years of service. Approximately 75% of those years of service (27,887 years out of 36,982 years) were worked while the Hospital participated in the Medicare program. The remaining 25% were worked prior to the Hospital's participation in the Medicare program. The employee with the most seniority was hired in 1958 and had 42 years of service at the Hospital. That employee began accruing pension benefits in 1958 and earned benefits in each of the 42 years the employee worked at the Hospital.

11. The agreed-upon Administrative Resolution did not specify any methodology by which the amount of reimbursement associated with the agreed-upon allowances would be calculated. In a letter dated May 15, 1992, Provider Counsel asked BCBSM to confirm in writing an agreement that the amount of reimbursement for the Employee Benefit costs would be (a) calculated as a below the line adjustment similar to the gain or loss on disposal of assets,[4] (b) based on the Provider's Medicare utilization in the cost reporting years prior to 1984, and (c) included in the Provider's 1984 cost report (Cost Allocation and Reimbursement Methodology). There is no evidence of a written BCBSM response, either positive or negative, to the May 15, 1992 letter.

12. In January of 1993, the Intermediary informed the Provider for the first time that it would not utilize the Allocation and Reimbursement Methodology without further guidance. The Provider objected to the Intermediary's action in a letter dated February 12, 1993.[5]

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[4] See Exhibit P-8.

[5] See Exhibit P-13.

13. By letter dated July 21, 1993, the Intermediary wrote the Health Care Financing Administration (HCFA)[6] recommending use of the Cost Allocation and Reimbursement Methodology as an equitable means of reimbursing the Provider and asked HCFA to concur in this recommendation.[7]

14. By letter dated August 11, 1993, HCFA notified the Intermediary that it would not concur in the Cost Allocation and Reimbursement Methodology.[8]

15. On September 17, 1993, the Intermediary issued a Notice of Correction - Period of Reimbursement for the Cost Report Period from December 1, 1983 to August 13, 1984 (Corrected NPR) to implement the terms of the Administrative Resolution.[9]

16. In the Corrected NPR, the Intermediary recognized $22,088,615 of additional allowable costs, including $4,979,315 in additional retirement costs and $11,026,444 of retirees' health and life insurance costs. The recognition of $22,088,615 in additional costs increased the Provider's total allowable costs from $38,396,007 to $60,484,622. Of the $22,088,615 of additional allowable costs recognized in the Corrected NPR, the Intermediary determined that the Provider was entitled to $451,697 of additional Medicare reimbursement. See Exhibit P-16. The Corrected NPR did not utilize the Cost Allocation and Reimbursement Methodology. Instead, the Corrected NPR recognized all of the $22,088,615 of additional allowable cost in 1984, the Provider's final year of operation.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

Prior to 1984, the Medicare statute required that providers be reimbursed the "reasonable cost" of providing services to Medicare beneficiaries, including hospital inpatients. The term "reasonable cost" was defined as "the cost actually incurred, excluding therefrom any part of the incurred cost found to be unnecessary in the efficient delivery of needed health services." 42 U.S.C. §1395x(v)(1)(A). The Secretary was required to take into account all direct and indirect costs and was prohibited from causing costs properly allocable to the care of Medicare patients to be shifted to non-Medicare patients. These statutory limitations are reflected in regulations duly promulgated by the Secretary which state:

[6] HCFA is now called the Centers for Medicare and Medicaid Services (CMS).

[7] See Exhibit P-14.

[8] See Exhibit P-15.

[9] See Exhibit P-16.

> All payments to providers of services must be based on the reasonable cost of services covered under Title XVIII of the Act and related to the care of beneficiaries…. The objective is that under the methods of determining costs, the cost with respect to individuals covered by the program will not be borne by individuals not so covered, and the cost with respect to individuals not so covered will not be borne by the program.

Total costs must be apportioned "so that the share borne by the program is based upon actual services received by program beneficiaries." 42 C.F.R. §413.53(a). The regulations emphasize that Medicare reimbursement principles should provide "fair and equitable reimbursement for services rendered to beneficiaries of the program. 42 C.F.R. §413.5(a). The Medicare statute also requires the Secretary to "provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." 42 U.S.C. §1395(v)(1)(A)(ii).

The Social Security Amendments of 1983 instituted a "major change in the method of payment under Medicare for inpatient hospital services." S. Rep. No. 23, 98th Cong., 1st Sess. 47, *reprinted in* 1983 U.S. Code Cong. & Admin. News 143, 187. As a result, starting with 1984 fiscal years, providers were reimbursed under PPS. Under PPS, with few exceptions, acute care hospitals are no longer reimbursed for inpatient care provided to Medicare beneficiaries on the basis of reasonable costs incurred; instead, they are paid a predetermined amount for each discharge, depending on the "diagnosis related group" (DRG) into which the patient's diagnosis and treatment is classified. 42 U.S.C. §1395ww(d).

There are no statutory or regulatory provisions that specifically address the treatment of costs in these circumstances.

PARTIES CONTENTIONS:

The Provider contends that since these costs are a function of duration of employment and because they relate to services rendered to Medicare beneficiaries throughout the Provider's 18 years of participation in the Medicare program, they should be allocated to cost report years prior to 1984. The Provider advocates using its Cost Allocation and Reimbursement Methodology, which allocates these costs over the 18 years of program participation similar to the treatment of a gain or loss on the disposal of a depreciable asset. For the 1984 cost report year, the Provider would be subject to the provision of PPS and would receive no Part A reimbursement for these costs. For all prior years, reimbursement would be determined under cost reimbursement rules.

The Intermediary contends that CMS Pub. 15-1 §§2305 and 2176.1 require all of these costs to be allocated to the Provider's final 1984 cost report year. The result would be that the provisions of PPS would apply to eliminate most of the Medicare reimbursement for these costs.

Section 2305 provides that "Where the liability (1) is not liquidated within the 1-year timelimit, or (2) does not qualify under the exceptions specified in §2305.1 and §2305.2, the cost incurred for the related goods and services is not allowable in the cost reporting period when the liability is incurred, but is allowable in the cost reporting period when the liquidation of the liability occurs."

Section 2176 provides, in relevant part:

* * * * *

2176.1 Allowable Direct Administrative Costs to be included in Final Cost Report. --The allowable direct administrative costs, to the extent they are necessary, proper, and reasonable are to be included in the provider's final cost report for the period ending with the date of termination of its participation in the program or change of ownership and are subject to cost allocation and apportionment . . . .

2176.2 Allowable Direct Administrative Costs Incurred After Final Cost Report is Filed. –When a provider incurs additional allowable direct administrative costs after filing a final cost report, the provider should notify the intermediary. The intermediary may adjust the final cost report or required the provider to file an amended cost report, depending on the materiality of the adjustments . . .

The Intermediary contends that these manual provisions require that the pension and related retirement costs at issue be included in the Provider's final 1984 cost report.

The Provider contends that neither CMS Pub. 15-1 §§2176 nor 2305 prevent the use of the proposed Cost Allocation and Reimbursement Methodology in this case. According to the Provider, a close examination of these provisions makes it clear that they deal with very specific cost reporting and allowable cost issues that have nothing to do with the allocation issue presented in this case. Section 2176 deals with administrative costs incurred *after* a provider terminates participation in the Medicare program. According to the Provider, these costs have nothing to do with provision of care to Medicare beneficiaries. Costs associated with the preparation of cost reports, salaries and legal fees are cited as examples of such costs. The Provider contends that CMS Pub. 15-1 §2176 does not address or otherwise dictate the treatment of pension and retirement related costs that arose out of benefits earned over a period of time and throughout the course of employment of hospital employees *while* the provider was participating in the Medicare program.

The Provider further contends that Section 2305 specifically deals with whether the costs associated with a liability are allowable when the liability is *incurred* or when it is *liquidated*.

There is absolutely no issue as to the proper liquidation or allowability of the pension and retirement related costs in this case. It is undisputed that these costs were allowed by the Intermediary and Blue Cross Blue Shield Association in the Administrative Resolution and the Corrected NPR.[10] Therefore, the rules cited by the Intermediary clearly do not apply in this case.

FINDINGS OF FACT, CONCLUSIONS OF LAW & DISCUSSION:

After consideration of the Medicare law and guidelines, evidence presented and contentions of the parties', the Board finds and concludes as follows:

The facts in this case are undisputed. The parties have entered into Joint Stipulations as to all factual matters, and the Joint Stipulations are hereby accepted by the Board as its findings of fact. The following facts are of particular relevance to this decision:

1. The pension and retirement costs at issue in this case were related to retirement benefits that were earned by the Provider's employees while providing services to Medicare beneficiaries.

2. The entitlement to and amount of these benefits are a function of duration of employment and were not earned solely by reason of employment during the Provider's last cost reporting year.

The Board concludes that the proposed Cost Allocation and Reimbursement Methodology should be used in this case given the undisputed fact that the costs at issue relate to multiple cost report years prior to 1984 and the lack of a specific rule to deal with the situation presented by this case. Due to the unforeseen number of retirements in 1984, the Provider's estimates of post-retirement benefits turned out to be substantially less than its actual liability. §2305, relied on by CMS, contemplates that a liability will accrue in one cost year and be liquidated in the next. It simply does not address situations where, as here, the liability cannot be determined until an event occurs in the future. Moreover, strictly applying that provision would cause a violation of the statute's prohibition of cross-subsidization.

In a case involving the refund of workers' compensation premiums that had been paid over several years, the D.C. District Court was faced with a similar dilemma of whether the entire refund should be recognized only in the year received. The Court found that "the policy concern in jeopardy is the congressional mandate that the costs of Medicare services not be borne by non-Medicare patients and vice-versa. Pursuant to the statute, the Secretary, in promulgating

[10] See Exhibits P-4, P-5, P-7, P-16 and ¶ 8 of the Joint Stipulations.

regulations for the reimbursement of reasonable costs of Medicare providers, must make certain that costs properly allocable to the care of Medicare patients are not shofted to non-Medicare patients." Howard University v. Bowen, No. 85-3342 (DDC April 4, 1988), Medicare & Medicaid Guide (CCH) ¶ 37,057, at 16,579 (Howard).

This situation is similar to the depreciation of an asset where a provider estimates the amount of depreciation each year. Until the provider actually disposes of the asset, it does not know whether its estimates have been accurate. Prior to December 1, 1997, Medicare recognized a gain or loss when a provider's assets were disposed of for a price different than their net book value (*i.e.*, basis minus depreciation). An asset disposed of for less than net book value indicated that Medicare had not allowed enough depreciation on the asset, and the provider was allowed to claim an adjustment on its cost report to reflect the loss. An asset disposed of for more than net book value indicated that Medicare had previously allowed too much depreciation and the provider was required to adjust its cost report to reflect the excess amount previously allowed as depreciation. Under the applicable regulations, the reimbursement impact is calculated in a manner that reflects the Medicare utilization rate in each of the cost reporting periods in which the asset was held. The actual reimbursement adjustment for the gain or loss, however, is recognized in the cost reporting period in which the asset is disposed of. 42 C.F.R. §413.134(f). This process is designed to produce the most accurate allocation of the expense to reflect the actual cost of providing Medicare services. It is very similar to the Cost Allocation and Reimbursement Method which, the Board finds, would also produce the most accurate determination of costs of providing services to Medicare beneficiaries.

Similar adjustments have been permitted in prior decisions in circumstances where a change in reimbursement methodology would have unfairly penalized the provider. In Rockingham Memorial Hospital v. Blue Cross Association/Blue Cross of Virginia and Immanual-St. Joseph's Hospital of Mankate, Inc. v. Blue Cross Association/Blue Cross and Blue Shield of Minnesota, PRRB Dec. Nos. 77-D37 and 78-D39, Medicare and Medicaid Guide, (CCH) ¶ 29,202, declined rev. CMS Administrator, July 22, 1997 and August 7, 1978,[11] the provider received a refund of FICA taxes during a period in which its Medicare utilization was higher than the period in which the taxes were paid. As a result, offsetting the refund against current period costs as required by the regulations resulted in less reimbursement than the provider would have received had there been an accurate calculation and payment of FICA taxes initially. The Board reached a solution which both gave effect to the terms of the regulation and recognized the change in circumstances between the time the costs were paid and refunded:

> The Board holds that a combination of arguments should be considered. Accordingly, the refund of FICA taxes should be offset in the year received, but using the applicable Medicare utilization percentage for each year involved (1971-1974). This compromise effectively recovers costs the

[11] Exhibit P-22.

> Medicare program would be entitled to, but would be constrained from recovering if the limitation of the three-year reopening provision (§405.1885) applies and, at the same time, it limit[s] the providers' exposure to only that amount which it received as to each year.

¶ 29,202 at 10,293.

Similarly, in Alliance City Hospital v. Blue Cross Blue Shield Association, HCFA Deputy Administrator Decision, rev'g PRRB Dec. No. 84-1775, Medicare & Medicaid Guide (CCH) ¶ 34,109, the HCFA Administrator ruled that a provider which received a rebate of malpractice insurance premiums relating to pre-1979 years when malpractice costs were included in the Administrative & General (A&G) cost center should offset those amounts against A&G costs rather than against malpractice costs as required under current regulations.

The HCFA Deputy Administrator acknowledged that a "strict reading" of the Manual required that the rebate be offset against current malpractice insurance costs. However, as a result of changes in reimbursement methodology, this would inappropriately penalize the provider. Accordingly, the rebate should be offset based on the regulation in effect when the costs were paid:

> [T]he better interpretation of this rule is to require direct offset of a rebate against total malpractice costs only if the rebate applies to years beginning on or after July 1, 1979. This prevents a provider from being unfairly penalized because it happened to receive a rebate for years governed by the pre-1979 malpractice rules after the new regulation went into effect . . . . [A] provider which receives a rebate for cost years beginning on or after July 1, 1979, is required to offset the rebate directly against its malpractice costs because this is how they were claimed by the provider.

¶ 34,019 at 9582.

At least two district courts have held that apportionment over several years is the appropriate method for determining and reimbursing the costs of terminating providers. In St. Joseph's Hospital (San Francisco, Calif.) v. Blue Cross Blue Shield Association, PRRB Dec. No. 83-D104,[12] the provider ceased operations in 1979 and sought an adjustment to its final cost report to obtain reimbursement for unemployment and pension costs. Since the provider was subject to the LCC limitation, the intermediary refused to reopen the cost report to make an adjustment for these costs. The Board ruled in favor of the intermediary. The Deputy Administrator of HCFA reversed the Board's decision regarding unemployment insurance costs, holding that such costs were allowable in the final cost report period subject to the LCC limitation. The Deputy Administrator affirmed the Board's decision on pension plan costs. St. Joseph's Hospital v. Blue Cross and Blue Shield Association/Blue Cross of California, HCFA Deputy Administrator Dec.

[12] Exhibit P-19.

(September 6, 1983).[13] The provider appealed to the district court and the court remanded the case to the Board with express instructions:

> What is in question is the Secretary's treatment of termination costs – costs that are unique to closing – and our obligation to treat them within the meaning of Sec. 1395x(v)(1)(A)(ii). *The Secretary may choose to allocate unemployment compensation and pension liability over the earlier cost years or she may devise a reasonable procedure for treating them as termination costs. Whatever procedure is used, [St. Joseph's] is entitled to reimbursement in an equitable amount* in accordance with paragraph (ii). The Secretary may not, however, disregard the provision of that section.

St. Joseph's Hospital v. Blue Cross and Blue Shield Association/Blue Cross of California, United States Department of Health and Human Services, No. C-83-4041-MHP (USDC ND Calif, September 4, 1984).

In Sisters of St. Francis Health Services, Inc. v. Schweiker, 514 F. Supp. 607 (1981),[14] the court held that unemployment costs incurred by a provider following termination of participation in the Medicare program should be allocated to other years in addition to the year of termination:

> Based upon the evidence of record, the Court concluded that Defendant's disallowance of unemployment compensation costs is not proper. These unemployment costs that were paid in 1975 represent reimbursement to the state of Indiana for unemployment compensation benefits paid to former employees attributable to services rendered to [St. Francis] while it was participating in the Medicare program. Therefore, these items constitute allowable costs to [St. Francis].
>
> The unemployment benefits were earned by employees when providing services to Medicare beneficiaries and other patients. The costs were accrued at the time of notices of termination of employment which were issued prior to the date of final closing of the Hospital. Even though the precise amounts of those costs were not known at the time of closing, their costs accrued before termination. *Since the benefits were a function of the duration of employment, the costs should be allocated to other years in addition to the termination year and to that extent should not be included in "reasonable cost" for purposes of the comparison of "reasonable costs and customary charges."*

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[13] Exhibit P-20.

[14] Exhibit P-18.

Sisters of St. Francis at pp. 614-15 (emphasis added).

The Board finds that the facts in the present case are virtually identical to the facts in Sisters of St. Francis. Just as the unemployment benefits in Sisters of St. Francis were earned while providing services to Medicare beneficiaries, it is undisputed that the pension and retirees' health and life insurance benefits provided by Wayne County were earned while its employees provided services to Medicare beneficiaries.[15] Just as the unemployment benefits in St. Francis were a function of duration of employment, it is undisputed that the pension and retirees' health and life insurance benefits provided by Wayne County were a function of duration of employment.[16]

Because a significant portion of the costs allowed by the Intermediary in the Corrected NPR relate to services rendered to Medicare beneficiaries in years prior to 1984 (a fact which is undisputed), these costs should be allocated to cost reporting years prior to 1984. Once so allocated, these costs are no longer subject to the rules governing PPS and, since they have been excluded from the determination of reasonable costs for purposes of the LCC limitation, it is not necessary to reopen prior cost reports in order to calculate the Medicare reimbursement due the Provider.

DECISION AND ORDER:

The Board finds that the benefits at issue in this case were a function of the duration of employment and as such should be allocated to other years in addition to the termination year.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Martin W. Hoover, Jr., Esquire
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West

FOR THE BOARD:

DATE: September 24, 2004

Suzanne Cochran
Chairman

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[15] See Joint Stipulations, ¶ 9.

[16] See Joint Stipulations, ¶ 10.