PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2005-D65

PROVIDER -
Hill Country Health Services, Inc.
Killeen, TX

Provider No.: 45-7661

vs.

INTERMEDIARY -
Blue Cross Blue Shield Association/
Palmetto Government Benefits
Administrators

DATE OF HEARING -
May 24, 2005

Cost Reporting Period Ended -
December 31, 1996

CASE NO.: 00-3600

INDEX

ISSUE:

Whether the Intermediary properly disallowed interest expense incurred in connection with the Provider's deferred compensation plan.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper amount of Medicare reimbursement to 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 under interpretive guidelines published by CMS. See, 42 U.S.C. §1395(h), 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 proportion 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.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Hill Country Health Services, Inc. (Provider) is a home health agency that provides services to patients in Central Texas. In 1994, the Provider implemented a Deferred Compensation Trust Plan (the Plan) for the benefit of its employees. The firm that designed and marketed the Plan applied for and received approval of its provisions from CMS, subject to a number of corrections and a caveat regarding the reasonableness of the overall compensation paid to employees. The version of the Plan used by the Provider contained the corrections specified by CMS' approval letter. (exhibit P-2). The Plan called for compensation to be paid to the sponsor of the plan for reasonable administrative and custodial costs and interest to be paid on all sponsor liabilities applicable to the Provider's cost reporting period but not paid until such time as required to be liquidated by the Plan. For its cost reporting period ended December 31, 1996, Palmetto Government Benefit Administrators (Intermediary) denied $17,137 of interest expense incurred in connection with Provider's deferred compensation plan.

The Intermediary concluded that the interest expense associated with the deferred compensation plan was unnecessary because the Provider had not borrowed any funds and that the expense was avoidable in the same manner as a penalty. The Intermediary, therefore, disallowed the interest under C.F.R. §413.153 and PRM-1 §202.2.

The Provider appealed the adjustment to the Board pursuant to 42 C.F.R. §§405.1835-1841 and met the jurisdictional requirements of those regulations. The amount of Medicare funds in controversy is approximately $16,966.

The Provider was represented by Rebecca K. Lambeth, Esq., of Lambeth and Berliner, PLLC. The Intermediary was represented by Bernard M. Talbert, Esq., of the Blue Cross and Blue Shield Association.

PARTIES' CONTENTIONS:

The Provider contends that the interest incurred in connection with funding its deferred compensation plan is a reasonable and necessary expense required to be reimbursed under 42 C.F.R. §413.9(c)(3) and that the Intermediary's disallowance of interest is based upon a flawed reading of 42 C.F.R. §413.153 and PRM-1 §202.2. The Provider argues that the provisions cited relate to the purpose of a loan, i.e., whether it is made to satisfy a financial need of the provider and reasonably related to patient care, and whether other investment income is available to the Provider. The Provider asserts that the primary determinant of the existence of interest is whether the provider borrowed funds.

The Provider places heavy emphasis on the Plan's prior approval by CMS. The Intermediary acknowledges that CMS generated a letter indicating that the plan appears to conform to Medicare regulations for the recognition of costs associated with a deferred compensation plan. However, the Intermediary points out that the CMS letter also states that "the costs associated with the plan can be recognized only if the intermediary determines that the costs of the plan plus all other forms of compensation for the employees are reasonable." Both parties rely on section 3.3 of the Plan to support their position. It states:

> Employer is required to annually pay interest to the Plan at the rate of Prime Plus 1% for all contribution liabilities determined to be applicable for the Employer's cost reporting year end but which are not deposited until such times as are subsequently mandatorily required to be liquidated as specified in the above paragraph of the Section. The annual contribution liability created under this Section shall be considered a note payable until such time as it and the related interest are paid in full. (Emphasis added)

The Provider argues that, under the approved Plan, once it committed to making a contribution, the liability constituted a borrowing from the Plan until it was funded.

The Intermediary contends that the interest expense was unnecessary because the Plan gave the Provider a year in which to make the deposit, which generated interest, regardless of the Provider's financial need to defer payment. It also likens the interest incurred on these circumstances to a penalty, citing two prior Board decisions.

Troy Community[1] involved interest and penalties incurred on late payment of FICA taxes. The Board found that:

> [T]o be allowable under C.F.R §405.419(a)(1), interest expense must be necessary and proper. 42 C.F.R. §405.419(b) requires that the interest be incurred on a loan made for a purpose related to patient care. The interest expense incurred in this issue was not in relation to a loan, and was not incurred for a purpose related to patient care.

Although this particular case deals with interest and penalties resulting from the late payment of taxes, the Intermediary contends that the underlying principle is the same as in the case at issue: that the interest incurred was an avoidable cost, and, therefore, does not meet the criteria of "necessary" set forth in 42 C.F.R. §413.9, which states in part:

> Necessary and proper costs are costs that are appropriate and helpful in developing and maintaining the operation of patient facilities and activities. They are usually costs that are common and accepted occurrences in the field of the provider's activity.

In Baptist Medical Center,[2] the Administrator reviewed the Board's decision and concluded that:

> Regardless of the nature of these costs, the interest and penalties incurred were avoidable costs and, therefore, do not meet the criteria of necessary in 42 C.F.R. §405.419 and 405.451. The interest and penalties were not costs related to patient care, but were related to unfortunate business circumstances encountered by the providers.

The Intermediary contends that the interest required by the Provider's deferred compensation plan was an expense that could have been avoided if the contribution had been paid annually instead of being held and creating a liability that is not payable until the latest date authorized by Medicare regulations.

The Provider counters that the cases relied on are inapposite because the provision permitting a delayed deposit, but which generates interest, is part of the funding mechanism specifically approved by CMS and there was, therefore, no delinquency as in the cases cited. The Provider also cites its repayment plan to Medicare and the periodic

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[1] Troy Community Hospital vs. Blue Cross Blue Shield Association; PRRB 87-D102, 9/18/87.

[2] Baptist Medical center Group Appeal vs. Empire Blue Cross and Blue Shield, HCFA Administrator Decision; PRRB 86-D99, 9/17/86.

withholding of its Medicare payment as illustrating the need to defer payment of its contribution.

In the alternative, the Provider argues that, even if no borrowing occurred, the costs are still allowable as administrative and custodial costs under Medicare guidelines in PRM-1 2140.3(B)(1)(d) and 2102.2. Those provisions address reasonable trustee or custodial fees as administrative costs related to patient care.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of Medicare law and guidelines, the parties' contentions and the evidence contained in the record, finds and concludes that the Plan interest expense claimed is not a necessary or proper cost.

For interest to be allowable, it must be both necessary and proper. 42 CFR §413.9(b)(2) defines reasonable and proper cost as ". . . costs that are common and accepted occurrences in the field of the provider's activity." The Board's examination of the terms and conditions of the Plan indicates that Section 3.3 calls for employer contributions to be paid when required by Medicare regulations, i.e., one year after the fiscal year in which the liability accrues. The funding mechanism is not based on provider needs but rather upon a plan provision that allows the employer to postpone funding the agreement. The note payable created under the Plan is an obligation that is at the control of the Provider and does not establish that any funds were actually borrowed. Further, the Board can find nothing in the record that indicates that any money actually changed hands at the time the initial liability was created, nor can the Board establish from the record that the Provider had a financial need to postpone funding the Plan at year end. Absent such evidence, the Board finds that the interest incurred was an expense that could have been avoided and, therefore, was unnecessary.

The Board's examination also indicates that the Provider initially established a $102,000 funding liability for the Plan in December, 1996, and discharged the entire liability, including interest charges of $17,000, within six months of the year's end. Although the Plan calls for interest to be assessed at prime plus 1%, the interest incurred far exceeds that amount and is beyond that which the Board expects would be incurred by a prudent borrower. The Board can find nothing in the record that explains or justifies the high interest assessed and absent such information, the Board concludes that the interest claimed is not proper.

Although the Provider likened the cost claimed to administrative and service fees, the Board's examination revealed that the annual service fees specified in the agreement were already paid and were not at issue in the appeal. Further, the Board could find no evidence supporting a relationship between such fees and the interest claimed.

The Provider claimed that its plan was approved by CMS and that such approval precludes a challenge from the Intermediary relative to the nature of the payment as interest. However, the Board notes that the approval presented in the record was for a

different provider. The Board could find no approval for the Provider's Plan and cannot consider the Plan approved. Even if CMS had approved the Plan, the approval does not constitute a determination of covered costs. All actual costs are subject to Medicare reimbursement principles and intermediary review. Indeed, the approval contained in the record reiterates that "the costs associated with the plan can be recognized only if the intermediary determines that the costs of the plan plus all other forms of compensation for the employees are reasonable."

DECISION AND ORDER:

The Intermediary's adjustment is affirmed.

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 2, 2005

Suzanne Cochran, Esquire
Chairperson