PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2006-D44

PROVIDER –
DCH Regional Medical Center
Tuscaloosa, Alabama

Provider No.: 01-0092

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
BlueCross BlueShield of Alabama

DATE OF HEARING -
August 5, 2005

Cost Reporting Period Ended -
September 30, 2004

CASE NO.: 04-0643

INDEX

ISSUE:

Whether the Fiscal Intermediary/Centers for Medicare and Medicaid Services' (FI/CMS) denial of the request to include additional pension costs as wage-related costs for purposes of the Provider's FY 2004 wage index was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper 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 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.

The Social Security Amendments of 1983, Pub. L. No. 98-21, 1983 U.S.C.C.A.N. (97 Stat.) 65, created a Prospective Payment System (PPS) to reimburse hospitals for operating costs incurred in providing acute care inpatient services to Medicare patients. Under this system, hospitals are paid a fixed amount for each patient treated, depending upon the diagnosis and the type of treatment provided.

To calculate payment amounts under the PPS, the Secretary initially determines a standardized, nationwide "federal rate," which is the nationally-calculated average costs of a typical inpatient stay. See 42 U.S.C.A. §1395ww(d)(3) (West Supp. 2005). The federal rate consists of two components: (a) the portion of costs that can be attributed to labor-related costs and (b) non-labor related costs. The Secretary then adjusts the labor-related portion of the federal rate to account for geographic-area differences in hospital wage levels. See 42 U.S.C.A. §1395ww(d)(3)(E). Specifically, the statute states that "the Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs, of the

DRG prospective payment rates . . . for area differences in hospital wage level by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." Id. Each hospital is located in either a Metropolitan Statistical Area (MSA) or a statewide rural area. See 42 U.S.C.A. §1395ww(d)(3)(D).

Pursuant to the above statutory mandate requiring a factor to "reflect the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level," CMS developed a "wage index" methodology. The wage index for each MSA or rural area is based on the ratio of the hospital wage levels in that area compared to the national average wage level, and is derived from the wage and wage-related costs reported by those hospitals in a prior cost year. To determine hospital wage levels, CMS collects data from hospitals through worksheet S-3 of the cost report. This data consists of a variety of costs and hours. An average hourly wage (AHW) is calculated for each hospital each year. 42 C.F.R. §412.63(x) (2003).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

DCH Regional Medical Center (Provider) is a 610-bed, acute care hospital located in Tuscaloosa, Alabama that is owned and operated by DCH Healthcare Authority (Authority). The Authority is incorporated as a public hospital corporation and also owns and operates Northport Medical Center (Northport). This appeal involves DCH's wage index for Fiscal Year 2004 (FY 2004). The FY 2004 wage index is based upon wage data collected from hospital cost reports in FY 2000. In developing the wage index for FY 2004, CMS used a process whereby intermediaries verify the wage data on cost reports and hospitals can request changes to their wage data from their FY 2000 cost reports. See Exhibit P-4.

According to CMS' wage data verification process, DCH submitted a timely request to its Fiscal Intermediary, Blue Cross and Blue Shield of Alabama, and later to CMS as a request for intervention, requesting changes to its FY 2000 wage data used in determining the FY 2004 wage index for the Tuscalossa, Alabama MSA. See Exhibits P-5, P-6 and P-7.

During the Provider's fiscal year ended September 30, 2000, the Authority sponsored a defined benefit pension plan that covered all eligible employees of both facilities. The plan's pension costs were allocated between the Provider and Northport based upon the relative percentage of total salaries paid by each entity. For both financial and cost reporting purposes, pension costs were computed and reported in accordance with the provisions of the Governmental Accounting Standards Board's (GASB) Statement 27 (GAS 27) entitled *Accounting for Pensions by State and Local Governmental Employers* (Nov. 1994).[1] Based upon an analysis of the plan's funding requirements under GAS 27, the pension plan was overfunded. As a result, the Provider was not required to make a contribution to the pension plan for the FYE 09/30/00.[2] However, it did incur and report

[1] Provider's Position Paper, Exhibit P-35.
[2] Intermediary's Position Paper, page 21; Provider's Position Paper Exhibit P-27.

actual pension costs of $149, 270.[3] These costs were included in the wage-related costs used to compute the wage index for the Provider's MSA.

The Provider petitioned both the Intermediary and CMS for an adjustment of its wage-related costs, contending that reporting pension costs in conformity with GAS 27 produced significant wage inconsistencies compared to non-governmental hospitals that report their pension costs in accordance with the Financial Accounting Standards Board's (FASB) Statement of Financial Accounting Standards No. 87 (FAS 87), entitled Employers' Accounting for Pensions (Dec. 1985).[4] As another alternative methodology, the Provider sought to recompute its pension costs for 2000 using Standard & Poor's Core Earnings, which is neither GASB or FASB, but is a measurement of pension costs routinely accepted by bond rating companies.[5]

The Provider's request was denied; consequently, CMS used the Provider's actual pension costs reported in its FYE 09/30/00 cost report for calculation of the 2004 wage index.

At issue in this case is whether a governmental hospital is required to use GAS 27 to compute its pension costs for wage index purposes or whether it may use an alternative method to compute these costs.

The Provider filed an appeal on January 22, 2004 with the Provider Reimbursement Review Board (Board) pursuant to 42 CFR §§405.1835-405.1841, and has met the jurisdictional requirements of those regulations. The Provider was represented by Carel T. Hedlund, Esquire, of Ober, Kaler, Grimes & Shriver. The Intermediary was represented by James R. Grimes, Esquire of Blue Cross Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider argues that CMS rules do not require governmental providers to use GAS 27 for wage index purposes. The Provider contends, rather, that CMS anticipated the use of Generally Accepted Accounting Principles (GAAP) when it issued the first wage index requirements in September, 1994,[6] since no GASB pronouncement specifically addressing pension costs was in place until November, 1994.

The Provider also argues that the Medicare statute requires a uniform wage index, and that the Eleventh Circuit's decision in Sarasota Memorial Hospital v. Shalala, 60 F.3rd 1507 (11th Cir. 1995) supports the Provider's position that pension costs of all hospitals must be calculated in the same manner for wage index purposes to be consistent with the

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[3] Intermediary's Post-Hearing Brief, page 3; Intermediary's Position Paper, Exhibit I-3; Provider's Position Paper, Exhibit P-27.

[4] Provider's Position Paper, pages 21-22, Exhibit P-29.

[5] Provider's Position Paper, pages 21-22, Exhibit P-29; Provider's Revised Position Paper, Volume I of II. Exhibit P-6 at p 5.

[6] 59 Fed.Reg. 45330, 45356-59 (Sept. 1, 1994) (exhibit P-12)

Medicare Act's mandate requiring a uniform wage index. Consequently, CMS may not make arbitrary distinctions between the same costs among different providers.

The Provider argues further that use of FAS 87 is consistent with Congressional intent requiring uniform measurement of wage-related costs. FAS 87 includes specific requirements for pension cost accounting and allows meaningful comparison among reporting entities. The Provider contends that most hospitals report pension cost under FAS 87, while GAS 27 applies to only 20% of acute care hospitals. Furthermore, no data is available regarding the number of governmental acute care hospitals that actually report their pension costs in accordance with GAS 27. As part of its emphasis on consistency between funding methodologies and annual pension costs, the GASB rejected comparability as a guiding principle in determining pension costs. Therefore, GAS 27 does not permit a meaningful comparisons of pension costs among entities that report under its terms.

The Provider also sought permission to report its pension costs using Standard & Poor's Core Earnings approach, which the Provider asserts is designed to compensate for the differences between how pension costs are computed under GAS 27 versus FAS 87. The Provider points out that bond rating companies recognize the disparity of GAAP computations of pension costs under GASB and FASB pronouncements and have adopted the use of the Standard & Poor's Core Earnings methodology to determine a more comparable measurement of pension costs. S&P's objectives for establishing this approach were to provide consistency and transparency to earnings analyses and make it easier for investors to make comparisons between companies and over different time periods.[7]

INTERMEDIARY'S CONTENTIONS:

The Intermediary does not dispute CMS' requirement for GAAP in the wage index process. The Intermediary maintains, however, that the data used in the process should reflect actual costs – wages and wage- related costs actually incurred by a provider during its cost reporting period. The September 1, 1994 Federal Register defines core wage-related costs as those "that are readily identifiable on the hospital's records."[8] The Intermediary argues that the Provider's request to compute its pension costs under FAS 87 imputes costs that do not exist, which is contrary to the regulations.[9]

The Intermediary also argues that the Provider's use of FAS 87 is inconsistently applied within its own reporting practices. The Provider wishes to use FAS 87 to compute pension costs for Medicare wage index purposes, but it never actually incurred and reported these costs under FAS 87 for financial reporting purposes. Such an inconsistent application violates GAAP's requirement for consistent reporting as set forth in the pronouncements of both the GASB and FASB.

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[7] See Provider's Revised Position Paper and Exhibits, Volume I of II Exhibit P-7 at p. 4.
[8] Id
[9] 42 C.F.R. §413.20(a)

The Intermediary further argues that GAS 27 is the proper standard for governmental entities to use in the wage reporting process. GAS 27 recognizes the specific operating exigencies of governmental entities and allows flexibility that recognizes the long-term viability of their programs and operations.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of Medicare law and guidelines, the parties' contentions and the evidence contained in the record, the Board finds and concludes that the denial of the Provider's request to include additional pension costs as wage-related costs for purposes of DCH Regional Medical Center's FY2004 wage index was proper.

The Intermediary/CMS denial was predicated on the foundation that GASB pronouncements, not FASB pronouncements, are the proper reporting standards for governmental entities in the wage reporting process and all other accounting matters. The Board examined the structure of the accounting hierarchy to determine the authorities of both accounting pronouncements, as well as their appropriate application within the wage reporting process.

The Financial Accounting Foundation (FAF) is the national organization responsible for the oversight and funding as well as the selection of board members and advisory councils of both the FASB and the GASB. These two boards formulate accounting principles and reporting standards that assure accounting consistency and comparability among the entities subject to their pronouncements. The pronouncements, instructions and guidance issued by FASB and GASB constitute the official body of accounting principles collectively referred to as GAAP. The boards also have the authority to recognize the specific accounting needs of established reporting communities and to provide guidance that is directed at their specific or unique accounting circumstances.

GASB was created in 1984 as an independent, professional body, whose mission was to establish and improve governmental accounting and reporting standards.[10] Since then, GASB has been responsible for the development of generally accepted accounting principles and reporting standards for government entities. Only where GASB has not specified the accounting treatment of a given issue may governmental entities default to the applicable FASB pronouncement.

There is no dispute that CMS called for the use of GAAP in the wage index process. The Provider argued that the GAAP requirement allows the use of FASB pronouncements (i.e., FAS 87) in the calculation of pension costs for wage index purposes. The Board disagrees. The Board's review of the accounting hierarchy indicates that for governmental entities, the GASB Pronouncements *are* GAAP. Only in the absence of a GASB pronouncement may a governmental entity rely on FASB pronouncements. In

[10] GASB was formed by an agreement with the Financial Accounting Foundation, the American Institute of Certified Public Accountants, the Government Finance Officers Association, the National Association of State Auditors, Comptrollers and Treasurers and the seven organizations representing state and local government officials.

this case, GAS 27 specifically addresses the computation of pension costs for governmental entities, and accordingly, its use is required under GAAP. The Provider's use of FAS 87 in lieu of GAS 27 is inconsistent with GAAP applicable to governmental entities and is, therefore, inappropriate for use in the development of pension costs for CMS' wage index purposes. Likewise, the Provider's proposed use of Standard & Poor's Core Earnings methodology is also improper in that Medicare policy requires using GAAP for wage index purposes.[11] The S & P Core Earnings methodology is a complete departure from GAAP in the treatment of pension costs and, therefore, is not a permissible alternative.

We have considered the Provider's assertion that the Eleventh Circuit's rationale in Sarasota Memorial Hospital, supra., is equally applicable here. In Sarasota, the government hospital, which was not subject to the mandatory FICA contribution requirements that applied to private hospitals, chose to participate in FICA but the hospital paid the employee's portion of the contribution. The Intermediary treated the employer's payment of the employee's contribution as a fringe benefit rather than a salary expense and that reclassification reduced Sarasota's wage index. The Court found that uniformity of the wage index is compromised if the Secretary does not classify the same items of costs as wages for all providers. The exclusion of FICA taxes from wages for some hospitals and not others for wage index purposes was, therefore, arbitrary and capricious.

This case is distinguishable from Sarasota in that the pension costs at issue here are treated as fringe benefits for both government and private hospitals; there is no disparity as to classification of an expense. The only question here is how to calculate the actual costs of the pension benefit. As the Intermediary points out, the additional amount the Provider proposes be included is simply not the actual pension cost reflected in the Provider's financial records. In this instant case, the FI is allowing pension costs reported and claimed by the Provider in accordance with GAAP.

DECISION AND ORDER:

The Provider's request to use FAS 87 in lieu of GAS 27 in developing its pension costs for wage index purposes is inappropriate. The Fiscal Intermediary/Centers for Medicare and Medicaid Services' denial of the request to include additional pension costs (imputed under FAS 87) as wage-related costs for purposes of DCH Regional Medical Center's FY 2004 wage index was proper.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West
Yvette C. Hayes

[11] 59 Fed. Reg. at 45,357 (Sept 1, 1994) (Exhibit P-12); PRM §3605.2-3 (Exhibit P-33).

FOR THE BOARD:

DATE: August 29, 2006

Suzanne Cochran, Esquire
Chairperson