PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2007-D32

PROVIDER -
John L. Doyne Hospital
Milwaukee, Wisconsin

Provider No.: 52-0174

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
United Government Services, LLC (n/k/a
National Government Services, LLC)

DATE OF HEARING -
March 9, 2006

Cost Reporting Period Ended -
December 22, 1995

CASE NO.: 00-2803

INDEX

ISSUE:

Whether the Intermediary's determination disallowing post-retirement health benefits costs for a terminated provider 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 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.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

John L. Doyne Hospital (Provider) was a general, acute care hospital located in Milwaukee, Wisconsin. The Provider and United Government Services, LLC and Blue Cross Blue Shield Association (Intermediary) stipulated to the following facts:[1]

1. During the cost reporting period at issue, the cost reporting period ending December 22, 1995, Milwaukee County (the "County"), a government entity, owned and operated the Hospital, a general acute care hospital located in Milwaukee, Wisconsin.

2. The Hospital terminated its Medicare provider agreement effective December 22, 1995. The cost report for the cost reporting period ending December 22, 1995 is the Hospital's terminating cost report.

[1] The Parties also stipulated to other matters that the Board does not deem necessary to our decision.

3. Upon termination of the Hospital's Medicare provider agreement, the assets of the Hospital were sold to Froedtert Memorial Lutheran Hospital. As a result of the Hospital's closure, some Hospital employees retired, some transferred to other County departments, and others were terminated from employment with the County.

4. As required by Milwaukee County Code Chapter 17, Sections 17.4(7) and (8) and Chapter 21, Section 5.10 and union contracts, employees of the Hospital hired before January 1, 1994 who worked for the Hospital and other County departments for 15 years are entitled to receive post-retirement health insurance benefits from the County. These post-retirement health benefits vested for individual employees after 15 years of service to the County. The health benefits are the same regardless of the time an employee worked for the County after 15 years. The health benefits extend to spouses and dependent children.

5. In accordance with Accounting Principles for Government Entities and Medicare regulation 42 C.F.R. §413.24(a), the County recorded expenses for the post-retirement health benefits on a cash basis, and reported related costs to the Medicare program in the year in which the expenses were paid under the accrual method of accounting, these costs would have been accrued as earned by the employees.

6. The County is required by Milwaukee County Code Chapter 17, Section 17.4(7) and (8) and Chapter 21, Section 5.10 and union contracts to make payment for liabilities associated with the County's retiree health benefit program. After closure of the Hospital, the County continued to make these payments in 1996 for retired employees (and their eligible dependents) whose vesting time was all or in part based upon employment at the Hospital. The County will continue to make payments for County retirees (and their eligible dependents) who retired after the Hospital sale . . . or who will retire in the future and whose vesting time was all or in part based upon their employment at the Hospital. To the extent employees' vesting time was based upon employment at the Hospital, the services rendered by the employees provided a direct benefit to the Medicare program.

7. In May 1996, the County filed the Hospital's final cost report with Medicare. In this cost report, the County made a claim for reimbursement based on liabilities that had been incurred through the date the County terminated Medicare participation.

8. On July 31, 1998, (before a notice of program reimbursement [NPR] was issued), the County transmitted a letter to the Intermediary containing an "Amendment to Final Medicare Cost Report – John L. Doyne Hospital" ("Amended Cost Report").

9. The Amended Cost Report claimed the following additional expenses: (1) cost of an appraisal study, (2) legal expenses related to closure, and (3) additional post-

retirement health benefit costs. With the Amended Cost Report, the County provided supporting information and/or documentation for each category of revised costs.

10. Specific to the post-retirement health benefits, the County's Amended Cost Report adjusted the previously reported costs to add the actual retiree health benefit expenses paid by the County for qualifying Hospital employees during 1996 and 1997 and a projection of Hospital retiree health benefit expenses for future years.

11. The County claimed a total of $139,961,673 in net present value costs for the retiree health benefits at issue. This amount consisted if $13,392,120 paid by the County for retirees in 1996 and 1997 and a future years projection of $126,569,553 (both amounts reflected net present value). The applicable Medicare recovery percentage was 5.816% making the Medicare claim as presented to be $8,140,171.

12. On January 18, 2000, the Intermediary issued an NPR to the County captioned "Medicare Cost Settlement for FYE 12/22/95." The NPR identifies specific audit adjustments that were made to the cost report filed by the County, which includes adjustments to revised costs claimed and accepted on the Amended Cost Report. Adjustment 45A to the NPR disallowed the claimed post-retirement health benefit costs as [u]nreasonable and [un]necessary.

13. On July 11, 2000, the County submitted a Notice of Appeal and Request for Hearing by letter to the Provider Reimbursement Review Board (PRRB), which appealed the Intermediary's initial determination that failed to recognize certain post-retirement health benefit costs as reasonable and necessary.

14. The Intermediary subsequently raised a jurisdictional challenge to the PRRB's authority to hear this case.

15. In a decision dated December 3, 2003, the PRRB ruled that it has jurisdiction over the Hospital's claim for [the] post-retirement health care costs issue for fiscal year December 22, 1995.

16. By letter dated April 26, 2004, the County submitted an updated claim to the Intermediary related to the 1998[2] amended cost report calculations for retiree health benefits. The updated claim reflects actual retiree health benefit expenses incurred from 1996 through 2002. This cost data was not available when the County's reimbursement claim was first filed. The updated claim also reflects certain refinements to the assumptions used in developing the first reimbursement claim based upon current data and analysis.

[2] This refers to FYE 12/22/95 Medicare cost report revised or amended in calendar year 1998.

17. The updated claim shows that the County paid post-retirement health care costs for former Hospital employees of $44,331,623 for the years 1996 through 2002. The updated claim also includes a calculation of future costs, for the years 2003 through 2044, of $393,692,826. The net present value, in 1997 dollars, of the total retiree health costs of $438,024,449 for Hospital retirees was $208,170,377. Applying the Medicare recovery percentage of 5.816% against the costs resulted in an updated claim of $12,107,189.

The Provider's filing met the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841. The Provider was represented by Lena Robins, Esquire, of Foley & Lardner, LLP. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and guidelines, the evidence, and the parties contentions, the Board finds and concludes that the Provider's claimed post-retirement health benefit costs are not allowable. On June 27, 1995, CMS published a final rule to revise the Medicare regulations to clarify the concept of accrual basis of accounting. CMS states that this rule did not signify a change in policy but, rather, incorporated Medicare's longstanding policy regarding the circumstances under which to recognize, for Medicare payment purposes, a provider's claim for costs for which it has not actually expensed funds during the cost reporting period. See 60 FR 33126. The provisions of this new rule were incorporated in a new section of the regulations as 42 C.F.R. §413.100 entitled: Special Treatment of Certain Accrued Costs.

Effective on July 27, 1995, the regulation makes it clear that the type of post-retirement health benefit costs at issue in this case is considered deferred compensation. Therefore, the Medicare reimbursement treatment of the Provider's post-retirement health benefit costs is dictated by 42 C.F.R. §413.100(c)(2)(vii) – *Deferred Compensation*, which states:

(A) Reasonable provider payments made under unfunded deferred compensation plans are included in allowable costs only during the cost reporting period in which actual payment is made to the participating employee.

(B) Accrued liability related to contributions to a funded deferred compensation plan must be liquidated within 1 year after the end of the cost reporting period in which the liability is incurred. An extension, not to exceed 3 years beyond the end of the cost reporting year in which the liability was incurred, may be granted by the intermediary for good cause if the provider, within the 1-year time limit, furnishes to the intermediary sufficient written justification for non-payment of the liability.

(C) Postretirement benefit plans (including those addressed in Statement of Financial Accounting Standards No. 106 (December 1990), are deferred compensation arrangements and thus are subject to the provisions of this section regarding deferred compensation and to applicable program instructions for determining Medicare payment for deferred compensation.

Applying the controlling regulation to the facts in this case, the Board finds that the costs in dispute may not be reimbursed by the Medicare program.

DECISION AND ORDER:

The Intermediary's adjustment is affirmed.

BOARD MEMBERS PARTICIPATING:

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

DATE: May 10, 2007

FOR THE BOARD:

Suzanne Cochran
Chairperson