PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2007-D37

PROVIDER -
High Country Home Health Care, Inc.
Laramie, Wyoming

Provider No.: 53-7025

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Cahaba Government Benefit
Administrators

DATE OF HEARING -
January 16, 2007

Cost Reporting Period Ended -
June 30, 1997

CASE NO.: 00-0774

INDEX

ISSUE:

Whether the Intermediary's disallowance of accrued employee benefit costs that were not liquidated within one year after the end of the Provider's cost reporting period was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a health care provider.

The Medicare program provides health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare & 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 the program's administration. 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 interpretative 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.

Medicare reimbursement is governed by 42 U.S.C. §1395x(v)(1)(A). In part, the statute provides that the reasonable cost of any service shall be the actual cost incurred excluding any part of such costs found to be unnecessary in the efficient delivery of needed health services.

Provider costs that are incurred but not paid during a cost reporting period are allowable program expenses. However, in order for these costs to be recognized in the cost reporting period in which they were incurred, they must be liquidated timely. Program regulations at 42 C.F.R. §413.100, which address this matter, state in pertinent part:

> (c) *Recognition of accrued costs*. (1) *General*. Although Medicare recognizes, in the year of accrual, the accrual of costs for which a provider has not actually expended funds during the current cost reporting period, for purposes of payment Medicare does not recognize the accrual of costs unless the related liabilities are liquidated timely.

> (2) *Requirements for liquidation of liabilities*. For accrued costs to be recognized for Medicare payment in the year of the accrual, the requirements set forth below must be met with respect to the liquidation of related liabilities. If liquidation does not meet these requirements, the cost is disallowed, generally in the year of accrual, except as specified in paragraph (c)(2)(ii) of this section.
>
> (i) *A short-term liability.*
>
> (A) Except as provided in paragraph (c)(2)(i)(B) of this section, a short-term liability, including the current portion of a long-term liability. . ., must be liquidated within 1 year after the end of the cost reporting period in which the liability is incurred.
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> (B) If, within the 1-year time limit, the provider furnishes to the intermediary sufficient written justification (based upon documented evidence) for nonpayment of the liability, the intermediary may grant an extension for good cause. The extension may not exceed 3 years beyond the end of the cost reporting year in which the liability was incurred.

In addition, 42 C.F.R. §413.100(c)(2)(vii)(B) provides rules specific to the treatment of accrued deferred compensation expenses:

> [a]ccrued 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.

Program instructions contained in the Provider Reimbursement Manual, Part I (HCFA Pub. 15-1) §2305, Liquidation of Liabilities, provide further guidance, as follows:

> A. General.-A short-term liability must be liquidated within 1 year after the end of the cost reporting period in which the liability is incurred, subject to the exceptions specified in §§2305.1 and 2305.2. . . . Where the liability (1) is not liquidated within the 1-year time limit, 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.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

High Country Home Health Care, Inc. (Provider) is a Medicare certified home health agency located in Laramie, Wyoming. During its cost reporting period ended June 30, 1997, the Provider maintained an employee deferred compensation program through Maggio Oranato and Associates, Inc (MOA). Cahaba Government Benefit Administrators (Intermediary) audited the Provider's cost report and made an adjustment disallowing $20,297 of accrued MOA plan costs claimed by the Provider. The Intermediary concluded that the Provider had not liquidated these accrued expenses within one year after the end of the cost reporting period.

The Provider appealed the Intermediary's adjustment to the Board pursuant to 42 C.F.R. §§405.1835-405.1841 and met the jurisdictional requirements of those regulations.

The Provider was represented by Charles F. MacKelvie, Esq., of MacKelvie and Associates, P.C. The Intermediary was represented by James R. Grimes, Esq., Associate Counsel, Blue Cross Blue Shield Association.

STIPULATION OF FACTS:

On September 16, 2004, the Provider and Intermediary submitted the following Stipulation of Facts:

1. The Provider maintained an employee benefit program (a deferred compensation program) through Maggio, Onorato (sic) and Associates, Inc. ("MOA plan").

2. The Provider accrued certain costs related to the MOA plan at 1997 year end based upon the FY 97 wages paid, and included an accrual of $199,160.00 in its 6/30/97 Medicare cost report.

3. The Intermediary made certain adjustments to the MOA plan accrual, including disallowance of $20,297.00 as not timely liquidated.

4. Issue number 2, in the above captioned case concerns the disallowance of $20,297.00 of MOA plan costs, and is the only issue remaining in this appeal.

5. The Provider terminated the MOA plan as of 6/30/97.

6. The Provider's accrual of $20,297.00 was liquidated on August 7, 1998.

7. The Provider requested an exception to the one year liquidation rule by correspondence dated July 22, 1999, noting the actual bill from MOA was dated in 1998.

8. The Intermediary denied the exception request by correspondence dated August 9, 1999.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of Medicare law and guidelines, parties' contentions, and evidence presented, the Board finds and concludes that the Intermediary's adjustment was proper. The accrued MOA plan costs at issue may not be included in the Provider's 1997 cost report for the purpose of program reimbursement.

The Provider contends that it was not possible to liquidate the MOA plan accrual within the program's 1-year time limit due to discrepancies that existed as to the final amount owed to MOA. Moreover, the Provider contends that it was not possible to request an extension to the 1-year rule within one year from the end of its cost reporting period, as required by 42 C.F.R. §413.100(c)(2)(i)(B), because the issue was not raised until the time of the fiscal intermediary's audit.

The Provider explains that it experienced cash flow problems as a result of the implementation of the Interim Payment System (IPS) and decided not to renew the MOA plan in 1998. This "winding down" of the MOA plan was complicated because of HCFA's requirement that contributed funds could not be returned to the Provider but could be used to reduce any amounts owed or distributed amongst the employees left in the MOA plan. In addition, the Provider did not receive a final bill from MOA nor did it know the actual amount owed to the program until after June 30, 1998.

Regarding its request for an extension to the one-year liquidation rule, the Provider explains that the Intermediary's audit did not take place until after the one-year time limit had expired. Therefore, the Provider had no way of knowing, nor was it put on notice, of the accrual in issue until that time.

The Board believes the Provider presents several equitable concerns. However, the Board is bound by program regulations, and the pertinent rules in this case are clear. In order for the Provider to include the subject MOA plan accrued costs in its 1997 cost report, it either had to liquidate the accrual within one-year from the end of the cost reporting period at issue or request an extension within that time frame. As noted above, the Provider did not comply with either of these program requirements. See 42 C.F.R. 413.100(c)(2)(i)(A) and (B) pertaining to short-term liabilities and 42 C.F.R. § 413.100 (c)(2)(vii)(B) pertaining directly to deferred compensation.

DECISION AND ORDER:

The Intermediary's adjustment disallowing the Provider's accrued employee benefit costs was proper. 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 23, 2007

FOR THE BOARD:

Suzanne Cochran, Esq.
Chairman