PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2011-D25

PROVIDER –
John L. Doyne Hospital
Milwaukee, Wisconsin

Provider No.: 52-0174

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
National Government Services - WI

DATE OF HEARING -
April 1, 2010

Cost Reporting Period Ended -
December 22, 1995

CASE NO.: 00-2803

INDEX

ISSUE:

Whether the Provider's post-retirement health benefit costs are allowable costs in the Provider's terminating cost report under Provider Reimbursement Manual (PRM) §2176.

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 to insurance companies known as fiscal intermediaries (Intermediaries) and Medicare administrative contractors (MACs). Intermediaries/MACs determine payment amounts due providers under Medicare law and interpretative guidelines published by CMS. See, 42 U.S.C. §1395(h), 42 C.F.R. §§413.20 and 413.24.

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 NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

During the cost reporting period at issue, the operating costs of inpatient hospital services were reimbursed by Medicare primarily through the Prospective Payment System (PPS). 42 U.S.C. § 1395ww(d)(2). The costs of outpatient hospital services were reimbursed by Medicare based on the lower of a hospital's customary charges or the reasonable cost of providing services to Medicare beneficiaries. 42 U.S.C. § 1395f(b)(1). The costs of inpatient hospital services provided in inpatient rehabilitation and psychiatric units were reimbursed by Medicare based on the reasonable cost of providing services to Medicare beneficiaries, subject to the limit imposed by the Tax Equity and Financial Responsibility Act (TEFRA). 42 U.S.C. § 1395ww(b).

The Medicare statute defines reasonable costs as "the cost actually incurred, excluding therefrom any part of incurred costs found to be unnecessary in the efficient delivery of needed health services." 42 U.S.C. § 1395x(v)(1)(A). The methods for determining reasonable and necessary costs (which encompasses both direct and indirect costs) of providing services to Medicare beneficiaries should ensure that those costs related to Medicare beneficiaries are not borne by individuals without Medicare coverage, and that the costs of services rendered to non-Medicare patients are not borne by the Medicare program (referred to as the prohibition against cross-subsidization).

A hospital's reasonable costs are determined based on a cost report filed after the end of a provider's accounting period. 42 C.F.R. § 413.20(b). Medicare regulations specify the methods by which a provider's costs may be determined, as well as the accounting requirements for the cost reports. 42 C.F.R. § 413.24. The general rule is that the cost report must be based on an approved method of cost finding and on the accrual basis of accounting. 42 C.F.R. § 413.24(a). Under the accrual basis of accounting, revenue is reported in the period in which it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid. 42 C.F.R. § 413.24(b).

The Medicare program recognizes employee post-retirement health benefit costs as allowable costs under certain circumstances. 42 C.F.R. § 413.100(c)(2)(vii)(C). For providers which continue to participate in the Medicare program, post-retirement benefit plans are recognized as "deferred compensation" arrangements subject to the provisions of 42 C.F.R. § 413.100(c)(2)(vii) and applicable program instructions. The Provider Reimbursement Manual (PRM) § 2140.1 defines "deferred compensation" as "remuneration currently earned by an employee but which is not received until a subsequent period, usually after retirement." Deferred compensation plans can be funded or unfunded. Reasonable provider payments made under an unfunded deferred compensation plan are accepted as allowable costs only during the cost reporting period in which the actual payments are made to participating employees. 42 C.F.R. § 413.100(c)(2)(vii)(A).

PRM §2176[1] addresses the allowability of costs incurred after a provider terminates its participation in the Medicare program. The section provides that certain costs incurred by a provider after termination, but which are related to the services provided while it was a participant in the program, are allowable. PRM §2176 states in pertinent part:

> ADMINISTRATIVE COSTS INCURRED AFTER PROVIDER TERMINATES PARTICIPATION IN PROGRAM
>
> When a provider terminates its participation in the program…administrative costs associated with the preparation and settlement of cost reports with an intermediary and other third parties will be incurred after the effective date of termination. The direct administrative costs that are reasonable and related to the settlement of reimbursement for patient care rendered while the provider was participating in the program and bad debts resulting from coinsurance and deductibles billed to Medicare patients are allowable. Examples of allowable direct administrative costs are salaries and those costs associated with such salaries, i.e., fringe benefits, workmen's compensation insurance and payroll taxes; accounting and legal fees which are incurred for bill preparation, and cost report preparation; and where applicable, hearing fees and

[1] Exhibit P-8.

> expenses incurred for settlement with an intermediary and other third parties…

PRM §§ 2176 to 2176.2 directs providers that incur these costs after their final cost reports have been filed to notify the intermediary and file amended cost reports if the amounts in question are material.

This case involves the application PRM §2176 to the costs claimed by the Provider for its pension costs.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

John L. Doyne Hospital was a general acute care hospital located in Milwaukee, Wisconsin. The Provider was owned and operated by Milwaukee County (County). On December 22, 1995 the County sold the hospital's assets to Froedtert Memorial Lutheran Hospital at which time it closed the hospital and terminated its participation with Medicare. As a result of the Provider's closure, some Provider employees retired, some transferred to other County departments, and others were terminated from employment with the County.

As required by Milwaukee County Code and union contracts, employees of the Provider hired before January 1, 1994 who have worked for the Provider and other County departments for 15 years are entitled to receive post-retirement health insurance benefits from the County. The post-retirement health benefits vest for individual employees only after 15 years of service to the County, and are the same regardless of how long an employee works for the County beyond 15 years.

Traditionally, the County recorded its post-retirement health benefits expense on a cash basis and the Provider claimed these costs in its Medicare cost report in the year in which the expenses were paid by the County. The Intermediary allowed those costs that were paid during the cost reporting year. In May 1996, the Provider filed its terminating cost report for the period January 1, 1995 to December 22, 1995. The Provider included in allowable costs the retiree health benefit costs that had been paid through December 22, 1995, the date the Provider terminated its participation in Medicare. On July 31, 1998, the Provider submitted an amended cost report, in which it claimed post-closing post-retirement health benefit costs for the actual expenses paid for qualifying employees during 1996 and 1997, as well as the projected retiree health benefit expenses for future years.

On January 18, 2000, the National Government Services (Intermediary) issued its NPR, in which it disallowed the claimed post-retirement health benefit costs as unreasonable and unnecessary. On July 11, 2000, the Provider submitted its appeal.

On April 26, 2004, the Provider submitted an updated claim for the retiree health benefit expenses paid by the County from 1996 thru 2002 as well as an actuarial projection of future costs. The liability to the Medicare program was approximately at $12.1 million.

The PRRB held a hearing on March 9, 2006. In its position papers and at the hearing, the Provider contended that the costs in question were allowable costs, either as deferred compensation costs under 42 C.F.R. §413.100(c)(2)(vii), or as post-termination costs under PRM §2176.

On May 10, 2007, the Board issued Decision No. 2007-D32, in which it concluded that the costs in dispute were not allowable as deferred compensation costs under 42 C.F.R. §413.100. The Board decision did not address allowability under PRM §2176. The CMS Administrator did not review the decision rendered by the Board.

The Provider filed an appeal of the Board's Decision in the United States District Court for the District of Columbia. In briefs submitted to the Court, the Provider argued that the post-retirement employee health benefit costs are allowable under two separate provisions of the Medicare reimbursement rules. First, the Provider argued that the costs were allowable as deferred compensation costs. The Provider noted that the Medicare deferred compensation regulation at 42 C.F.R. §413.100(c)(2)(vii) does not address how post-retirement employee health benefits should be treated after a provider terminates its participation in the Medicare program. As such, it cannot be applied to disallow those costs. Second, the Provider contended that the post-retirement employee health benefits were allowable as post-termination costs under PRM §2176.

In 2007 and 2008, while the appeal of the Board Decision was pending in District Court, the County updated the claim for post-retirement health benefit costs to account for the actual expenses paid from 1996 through 2007. The County calculated that its actual payments during the years 1996 through 2007 for retiree health benefits for Provider employees were $89,084,159. The projected costs for 2008 through 2044 for Provider employees were $334,036,664. The total costs of actual and future retiree health benefits for the Provider were therefore $423,120,823. The net present value of these costs in 1995 dollars was $189,990,495. Using a Medicare utilization percentage of 5.816%, the Provider calculated it would be entitled to $11,049,847 of additional Medicare reimbursement if the retiree health costs were allowed.

On March 30, 2009, the District Court issued its Memorandum Opinion.[2] The Court first concluded that the Board reasonably applied the deferred compensation regulation at 42 C.F.R. §413.100 to disallow payment for the Provider's post-retirement health benefit costs after its termination from the Medicare program. Accordingly, the Court issued an Order granting summary judgment in favor of the Secretary of the Department of Health and Human Services (Secretary).

However, the District Court noted that the Board did not address the Provider's argument that these costs are allowable as post-termination costs under PRM §2176. Accordingly, the Court issued an Order remanding this case to the Secretary for further proceedings on the Provider's argument that the post-retirement employee health benefit costs are allowable as post-termination costs pursuant to PRM §2176. The District Court stated that on remand, the Board and CMS should, at a minimum, explain whether the Medicare

[2] *John L. Doyne Hospital v. Johnson*, 603 F.Supp.2d 172 (D.D.C. 2009).

program has consistently disallowed post-retirement health benefit plan costs as termination costs under PRM § 2176, and should also explain how the Board decisions referenced in the District Court's opinion can be reconciled with that disallowance.[3]

On June 17, 2009, the Deputy Administrator of CMS remanded the case to the Board and ordered the Board to take action in accordance with the District Court's remand order and issue a decision on the remand. On August 27, 2009, the Board issued a Notice of Reopening and Order.

The Board held a second hearing on this matter on April 1, 2010. The Provider was represented by Jeffrey R. Bates, Esq., of Foley & Lardner, LLP. The Intermediary was represented by Bernard M. Talbert, Esq., of Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the post-retirement employee health benefit costs for employees who worked during the time it participated in the Medicare program are allowable as post-termination costs pursuant to PRM §2176. PRM §2176 specifically provides that certain costs incurred by a provider after it terminates its participation in the Medicare program are allowable in the provider's terminating cost report as post-termination costs.

After the Provider was closed, the County continued to have the obligation to make payments for health benefits for retired employees (and their eligible dependents). The County has made such payments and will continue to be responsible to make such payments. The Provider contends the Intermediary's refusal to allow such payments as post-termination costs was improper.

The Provider also contends that the post-retirement costs are of the same nature as the examples of allowable post-termination costs listed in PRM §2176, which includes salaries and costs associated with salaries, including fringe benefits, workmen's compensation insurance, and payroll taxes.

In support of its position that the post-retirement health benefit costs are allowable as post-termination costs under PRM §2176, the Providers cites to *Wayne County General Hospital v. Blue Cross Blue Shield Association/United Government Services.*[4] The hospital in that case was also a county-owned and operated hospital that terminated its participation in Medicare. The hospital sought reimbursement for certain employment benefits, including pension costs and post-retirement health and life insurance costs. After the Provider appealed, the parties reached an administrative resolution on the issues. Based on the parties' administrative resolution, the first PRRB appeal was dismissed.

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[3] *John L. Doyne Hospital v. Johnson*, 603 F.Supp.2d 172, 183, Fn.13(D.D.C. 2009).

[4] *Wayne County General Hospital v. Blue Cross Blue Shield Association/United Government Services*, PRRB Dec. No. 2004-D44 (September 24, 2004), Medicare and Medicaid Guide (CCH) ¶ 81,197 (herein after "*Wayne County*").

The intermediary issued a revised NPR, increasing the hospital's total costs in its terminating cost report from approximately $38 million to $60 million. The provider filed another appeal, contending that a significant portion of the pension and related retirement costs should be allocated to prior years and reimbursed based on the provider's Medicare utilization in those prior years. The intermediary contended that PRM §§2305 and 2176 required that all of the costs be allocated to the provider's final terminating cost report, and not to prior cost reporting periods. The Board ruled that the costs in question should be allocated to prior years in addition to the termination year. Upon review, the CMS Administrator reversed the Board's decision and held that all of the costs should be included in the terminating cost report. The District Court for the Eastern District of Michigan affirmed the CMS Administrator decision.[5]

The Provider's position is that the issue in the second *Wayne County* appeal, *i.e.*, whether all of the costs should be included in the terminating cost report or whether they should be allocated to prior years as well as the termination year, is not at issue in this case. Nevertheless, the Provider contends that *Wayne County* is highly relevant because it reflects an agreement by Blue Cross Blue Shield Association – the same intermediary as in the present case – to allow post-retirement costs in the terminating cost report. Furthermore, the CMS Administrator agreed in the *Wayne County* case that it is appropriate to include such costs in the provider's terminating cost report. Given these facts, the Board should recognize the retiree health benefit costs at issue in this case.

The rulings of the Board and the court in *St. Joseph Hospital (Logansport, Indiana)*[6] further support the allowability of post-retirement health benefit costs under PRM §2176. In that case, the provider claimed as allowable costs on its terminating cost report certain unemployment compensation and pension payments made after it terminated from the Medicare program. The intermediary disallowed the expenses because they were paid after the hospital's termination from the Medicare program. The Board noted that the unemployment benefits and pension plan vesting were earned by employees when providing services to Medicare beneficiaries and other patients, and concluded that the intermediary's disallowances were not proper.

The HCFA Administrator reversed the Board's ruling in *St. Joseph Hospital (Logansport, Indiana)* that unemployment compensation paid after the hospital terminated its participation in Medicare was an allowable cost under PRM §2176.[7] The Administrator noted that CMS Pub 15-1 §2176 recognizes that a provider may pay administrative costs after its termination which relate to the settlement of reimbursement for patient care rendered in the provider's final cost reporting period. The Administrator concluded that the unemployment compensation costs incurred by the hospital after termination from Medicare do not relate to the settlement of reimbursement for patient care rendered while the provider participated in the program. Thus, the Administrator held that the CMS Pub. 15-1 §2176 could not be relied on by the provider to include the unemployment

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[5] *Wayne County General Hospital v. Leavitt*, 470 F.Supp.2d 775 (E.D. Mich. 2007).

[6] *St. Joseph Hospital (Logansport, Indiana)*, PRRB Dec. No. 78-D5 (January 24, 1978), Medicare and Medicaid Guide (CCH) ¶ 28,883.

[7] HCFA Admin. Dec. (March 24, 1978), Medicare and Medicaid Guide (CCH) ¶ 28,967 .

compensation costs at issue in the provider's cost report. However, the Administrator upheld the allowance of the pension costs based on his conclusion that the liability for these costs accrued at termination.

The Sisters of St. Francis, who owned and operated the St. Joseph Hospital facility, appealed the Administrator's decision to the District Court for the District of Columbia.[8] In its decision, the court held that unemployment compensation benefit costs paid by a hospital to the state after the hospital terminated its Medicare participation were allowable costs because they were earned by employees while providing services to Medicare beneficiaries. [9] Thus, the court reversed the Administrator's decision on the unemployment compensation benefit costs, and held that unemployment costs paid after a provider terminates from the Medicare program are allowable costs under CMS Pub. 15-1 §2176.

The Provider contends that the facts in *St. Joseph Hospital (Logansport, Indiana)* are similar to the facts in this case. Milwaukee County has paid benefits, and will continue to pay benefits, to former Provider employees based upon their service. Accordingly, consistent with the decisions of the Board and the court in the *St. Joseph Hospital (Logansport, Indiana)* case, the Board should conclude that the post-retirement employee health benefit costs at issue are allowable costs in the Provider's terminating cost report.

The Administrator's decision in *St. Joseph's Hospital (San Francisco) v. Blue Cross and Blue Shield Association/Blue Cross of California*[10] also supports the inclusion of post-retirement health benefit costs as allowable costs in the Provider's terminating cost report. In that case, the hospital, which ceased operations in 1979, sought an adjustment to its terminating cost report for unemployment compensation and pension costs incurred by the hospital after its termination from the Medicare program. The Board found that the unemployment insurance costs were incurred subsequent to the provider's termination of hospital services, and were not includable in allowable costs for the terminating cost reporting period or any earlier period. The Board further found that the unemployment insurance costs were not those covered under the provisions of CMS Pub. 15-1 §2176 because they did not relate to salaries and fringe benefit costs incurred to effect the settlement of reimbursement for patient care rendered while the provider was participating in Medicare.

The Administrator reviewed the *St Joseph's Hospital (San Francisco)* decision with regard to the unemployment benefit payments issue. The Administrator noted that an issue with facts similar in all material respects to the facts in that case had been addressed in the *St. Joseph Hospital (Logansport, Indiana)/Sisters of St. Francis Health Services v. Schweiker* case, in which the district court had ruled that the unemployment benefits were allowable costs in the provider's terminating cost report. The Administrator concluded

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[8] *Sisters of St. Francis Health Services, Inc. v. Schweiker*, 514 F.Supp. 607(D.D.C. 1981).
[9] Id., at 614-615.
[10] *St. Joseph's Hospital (San Francisco) v. Blue Cross and Blue Shield Association/Blue Cross of California*, PRRB Dec. No. 83-D104 (July 5, 1983), Medicare and Medicaid Guide (CCH) ¶ 33,096

that both pension costs and unemployment benefits were allowable costs in the provider's terminating cost report.[11]

The Administrator in *St. Joseph's Hospital (San Francisco)* ruled that the provider's reimbursement was subject to the Lesser of Costs or Charges ("LCC") principle. The provider appealed the LCC issue to the District Court for the Northern District of California. The District Court remanded the unemployment benefit and pension benefit payments issues to the Secretary to either allocate the costs over the earlier cost years or treat them as termination costs. Upon remand to the Board, it ruled that both unemployment benefit payments and pension plan benefit payments incurred by the provider after closure of the hospital are reimbursable costs in the provider's terminating cost report.

The Board's decision in *Gateway Community Hospital v. Blue Cross and Blue Shield Association/Blue Cross of Florida*[12] further supports the Provider's position. In that case, the provider terminated its participation in Medicare and purchased malpractice insurance tail coverage to pay for claims made and paid after termination. The provider claimed the cost of the tail coverage as an allowable cost in its terminating cost report. The intermediary, however, contended that the tail coverage was unallowable under CMS Pub. 15-1 §2176 based on its assertion that it was a cost incurred in the sale of the facility.

The Board in *Gateway Community Hospital* found that the cost incurred by the provider to purchase the malpractice insurance tail coverage policy was an allowable reimbursable cost related to patient care. The Board noted that a wide variety of costs associated with the termination of a provider had been found to be allowable as post-termination costs.

The Provider notes that at the hearing, counsel for the Intermediary made the assertion that CMS Pub. 15-1 §2176 only covers costs that were incurred and paid that would not have been paid had the provider stayed operational; or costs or expenses that were incurred and paid that were accelerated because the Provider terminated its participation in the Medicare program. However, the Intermediary provided no support for this argument. In fact, the cases discussed above show that there is no such limitation to the costs allowable under CMS Pub. 15-1 §2176.

The Provider believes that the entire amount of the post-retirement costs are allowable under CMS Pub. 15-1 §2176, and that its calculation of such costs is reasonable. However, in the event that the Board concludes that a portion of such costs are not allowable, it should direct the Intermediary to allow the portion of such costs that it determines are allowable.

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[11] *St. Joseph's Hospital (San Francisco) v. Blue Cross Blue Shield Association/Blue Cross of California*, HCFA Admin. Dec. (September 6, 1983), Medicare and Medicaid Guide (CCH) ¶ 33,424.

[12] *Gateway Community Hospital v. Blue Cross and Blue Shield Association/Blue Cross of Florida*, PRRB Dec. No. 92-D50 (August 20, 1992), Medicare and Medicaid (CCH) ¶ 40,834.

The Provider contends that the evidence demonstrates that its claim for post-retirement health benefit costs is reasonable and actuarially supportable. The testimony at the April 1, 2010 PRRB hearing established that there are four components to the total postretirement health benefit costs: (a) the actual amounts paid in 1996 and 1997; (b) the actual amounts paid from 1998 to 2002; (c) the actual amounts paid from 2003 to 2007; and (d) the future costs from 2008 to 2044.[13] The costs of each period consist of four elements: (a) the cost for retirees enrolled and HMO plan; (b) the cost retirees enrolled in a PPO plan; (c) the cost of Medicare Part B monthly premiums; and (d) administrative overhead.[14]

The Provider calculated the actual costs for post-retirement health benefits for 1996 to 2007 for former employees of the Provider by calculating the costs related to two groups for former employees. The "investigated" group consisted of 940 former County employees who were receiving post-retirement health benefits. The percentage of time that an employee was employed by the Provider during the vesting period (*i.e.*, the employee's 15 years) was calculated, and this percentage was applied against the individuals' costs to arrive at the post-retirement health benefit costs attributable to the Provider.

The remainder of the County employees and former employees were designated the "non-investigated" group. The County took a sample of the people in the non-investigated group to determine the average amount of time spent by these persons at the Provider. The County determined that for the period 1996 to 2002, the average amount of time spent by these persons at the Provider was 23.65% of the time that they worked for the County. This percentage was used to calculate the costs attributable to the non-investigated group for 1996 to 2002.

In 2004, the County submitted an updated calculation of the post-retirement health benefit costs paid. This calculation is referred to as the "2004 Claim." The County added together the actual costs of the investigated group and the calculated costs of the non-investigated group.

The County calculated that the actual amount that it paid during the period from 1996 to 2002 for post-retirement employee health benefit costs for former employees of the Provider was $44,331,624. The net present value in 1995 dollars was $37,393,542. Using a Medicare reimbursement percentage of 5.816%, the additional Medicare reimbursement due for the costs actually incurred and paid from 1996 through 2002 is $2,174,750. The recovery percentage of 5.816% represents the rate at which the retiree health costs would be reimbursed if they had been included in the Provider's final cost report. It was calculated as the increase in Medicare reimbursement resulting from inclusion of one year of the retiree health costs on the final cost report divided by the retiree health care costs for that one year. The percentage, therefore, reflects only services provided on a cost basis and services furnished to Medicare beneficiaries. Thus, for every dollar of increased costs, the Provider would receive 5.816 cents. This

[13] Transcript, pp. 121-124.
[14] Transcript, pp. 143-146.

percentage was communicated to the Intermediary by the County in a letter dated July 31, 1998 and the Intermediary has never raised any objections to the validity of the percentage.

In 2008, the County submitted a further updated calculation, referred to as the "2008 Claim." In order to calculate the actual amount that it paid during the period 2003 to 2007 for post-retirement employee health benefit costs for former employees of the Provider, the County did a new sample of the non-investigated group, and determined the average amount of time spent by these persons at the Provider during the period 2003 to 2007 was 12.58% of the time that they worked for the County. Using this revised percentage, the County determined that actual amount paid for the period 2003 to 2007 was $44,752,536. The net present value in 1995 dollars was $30,029,782. Using the Medicare reimbursement percentage of 5.816%, the additional Medicare reimbursement due for the costs actually incurred and paid from 2003 to 2007 is $1,746,532.

The County's analysis shows projected costs for 2008 through 2044 of $334,036,664. The total costs of actual and future retiree health benefits for the Provider was $423,120,823. The net present value of these costs in 1995 dollars was $189,990,495. Using a Medicare reimbursement percentage of 5.816%, the Provider is entitled to $11,049,847 of additional Medicare reimbursement for the retiree health costs.

At the Board hearing held on March 9, 2006, Mr. Barry Cohen, an independent actuary, presented expert testimony on behalf of the County that the methodology used to develop the reimbursement claim was reasonable and actuarially sound. Mr. Cohen testified that he closely reviewed the Provider's calculations. He testified that based on his review of the 2004 Claim for post-retirement employee health benefit costs, in his professional opinion, the County's 2004 claim was reasonable and appropriate for this type of program from an actuarial standpoint, and actually fell slightly on the low side.

At the April 1, 2010 hearing, Mr. Randy Kelley, an independent actuary, presented expert testimony on behalf of the County that the methodology used to develop the reimbursement claim was reasonable and actuarially sound. He testified that he reviewed the Provider's claim for post-retirement health benefit costs in Exhibit P-23 in great detail, including the underlying Excel files. Mr. Kelley concluded that the Provider's calculations of the actual costs for 1996 to 2007 and for future costs for 2008 to 2044 were reasonable, and that the costs were derived in a very logical and reasonable manner.[15]

Although the Intermediary questioned the Provider's witnesses at the Board hearing regarding the calculation of the post-retirement health benefit costs, it stated in its Remand Position Paper that it "has not taken issue with the methodology."

[15] Transcript, pp. 305-315.

INTERMEDIARY'S CONTENTIONS;

The Intermediary contends that the post-retirement employee health benefit costs claimed by the Provider are not allowable under CMS Pub. 15-1 §2176. The Intermediary argues that this manual section focuses narrowly on expenses attributable to staff or consultants working on closing out the financial affairs of a provider after its doors have been locked. The Manual provision is as follows:

> §2176. ADMINISTRATIVE COST INCURRED AFTER PROVIDER TERMINATES PARTICIPATION IN PROGRAM
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> When a provider terminates its participation in the program, either voluntarily or involuntarily, or a change of ownership occurs (see Health Insurance Regulations section 405.626), administrative costs associated with the preparation and settlement of costs reports with an intermediary and other third parties will be incurred after the effective date of termination. The direct administrative costs that are reasonable and related to the settlement of reimbursement for patient care rendered while the provider was participating in the program and bad debts resulting from coinsurance and deductible billed to Medicare patients are allowable. Examples of allowable direct administrative costs are salaries and those costs associated with such salaries, i.e., fringe benefits, workmen's compensation insurance, and payroll taxes; accounting and legal fees which are incurred for bill preparation, bill processing, and cost report preparation; and, where applicable, hearing fees and expenses incurred for settlement with an intermediary and other third parties …

The Intermediary argues that the specific point at issue on remand is whether the costs claimed are allowable, not how the costs claimed might be calculated.

The Provider has highlighted four cases to support its position:

- *Sisters of Saint Francis, Inc.*;[16]
- *St. Joseph's Hospital*;[17]
- *Gateway Community*;[18]
- *Wayne County Hospital*.[19]

[16] Fn. 8, supra.
[17] Fn. 10, supra.
[18] Fn.11, supra.
[19] Fn. 5, supra.

The Intermediary argues that under *Sisters of Saint Francis, St. Joseph's Hospital* and *Gateway Community* a clear pattern emerges that supports allowance of closing costs. Allowable closing costs represent those expenses for which the entity responsible for the debts of the provider that has terminated its Medicare participation has incurred a liability and has satisfied that liability with a real commitment and surrender of assets (*i.e.*, payment). For CMS Pub. 15-1§2176 to apply, it is essential that the surrender of assets would not have occurred had the closure or sale not taken place.

The Intermediary contends that the manner in which Milwaukee County, in this instance case, financed its obligations to its employees and their eligible dependents did not change merely because the County abandoned the hospital business. Before and after the sale, Milwaukee County funded retirement health care costs out of the current year's revenues and tax levies. The sale itself did not generate a liability that needed to be satisfied by any type of payment to a third party or placed in a protected trust. The Intermediary contends that the absence of a relevant liability was the controlling and prevailing argument at the administrative decision and judicial review under the 42 C.F.R. §413.100(c)(2)(vii) argument after the first hearing. The Intermediary argues further that the same rationale applies with equal force when the question is considered under CMS Pub. 15-1 §2176.

The Intermediary also challenges the relevance of the *Wayne County* case to the facts and circumstances of this case. The Intermediary contends that it is not possible to tell from either the administrative or judicial decision whether the pension was funded or unfunded. However, based on a comparison of total dollars and employee head counts between *Wayne County* and the Provider, it appears likely that *Wayne County* did not deal with an unfunded benefit financing mechanism.[20] Therefore, the two cases are not at all similar and *Wayne County* cannot be used to support the Provider's position.

The Intermediary concludes that the Provider incurred no allowable closing costs. The Provider's attempted quantification of potential future County payments for employees who worked at the hospital does not create an allowable cost. The Intermediary argues further that there is no need to address the Provider's quantification of its retired health benefits claim because the underlying claim is not an allowable cost.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of Medicare law and guidelines, the parties' contentions, and evidence presented in the record, finds and concludes as follows:

The primary issue presented on remand for the Board's consideration is whether the Provider's post-retirement health benefits costs are allowable in the Provider's terminating cost report under CMS Pub. 15-1 §2176. The language of CMS Pub. 15-1 §2176 states:

[20] Intermediary Remand Position Paper, p.7.

> When a provider terminates its participation in the program…administrative costs associated with the preparation and settlement of cost reports with an intermediary and other third parties will be incurred after the effective date of termination. The direct administrative costs that are reasonable and related to the settlement of reimbursement for patient care rendered while the provider was participating in the program and bad debts resulting from coinsurance and deductibles billed to Medicare patients are allowable. (Emphasis added)

The costs referred to in CMS Pub. 15-1 §2176 relate to the settlement of reimbursement which arises when a provider terminates participation in the Medicare program. In this case, Milwaukee County had an obligation to pay post-retirement health care benefits. That obligation was totally independent of whether or not the provider continued to participate in the Medicare program.[21] The costs referred to in the language of §2176 do not include those that are totally independent of a provider's termination. The Board therefore concludes that the amounts claimed for future health benefits are not reimbursable under CMS Pub. 15-1 §2176.

In *John L. Doyne Hospital v. Johnson*, 603 F. Supp. 2d 172, 183, FR. 13 (D.D.C. 2009), the Court directed the Board to explain whether the Medicare program has consistently disallowed post-retirement health benefit plan costs as termination costs under CMS Pub. 15-1 §2176, and how the Board decisions referenced in the District Court's opinion can be reconciled with that disallowance.[22] The cases referenced by the court and the Board's analysis of each are as follows:

1. *Sisters of St. Francis Health Services, Inc. v. Schweiker*[23]

> This case involved pension plan payments that were paid by a provider subsequent to its termination from the Medicare program. The costs were accrued prior to the termination and resulted from the plan's requirement to vest on the closing and termination of the provider. The Board held that pension plan vesting was an allowable administrative expense that fell within the intent and purpose of CMS Pub. 15-1 §2176 and was therefore, an allowable cost to the provider. The Administrator subsequently modified the Board's holding. The Administrator concluded that the payments made for pension plan vesting and administrative cost after December 31, 1974 were reasonable costs related to patient care and incurred in the cost reporting period ending December 31, 1974.[24] However, the Administrator concluded that the costs for pension plan vesting and

[21] Transcript, pp.230-237.
[22] Fn. 3, supra.
[23] Originally, the Board heard the Sisters of St. Francis case under the title of *St. Joseph Hospital (Logansport, Indiana)*, PRRB Dec. No. 78-D5 (January 24, 1978), Medicare and Medicaid Guide (CCH) ¶ 28,883.
[24] *Sisters of St. Francis Health Services, Inc. v. Schweiker*, 514 F.Supp. 607, 611(D.D.C. 1981).

administrative costs were not direct administrative costs related to settlement of reimbursement incurred after termination. The Administrator concluded that CMS Pub. 15-1 §2176 did not apply.

Notwithstanding the Administrator's modification, the Board notes that the facts and circumstances of the *Sisters of St. Francis* case were substantially different from those under *John Doyne.* In *Sisters,* the provider's pension plan vested and created an actual expense at the provider's termination that required liquidation through an actual expenditure of the provider's funds. In *Doyne*, the pension costs claimed are contingent upon the vesting of rights under the pension plan. Such pension rights may vest subsequent to the Provider leaving the program or may never vest. Thus, if the Provider's position is upheld, the Medicare program may pay currently for accrued liabilities that either may not be liquidated timely or may never be liquidated. Accordingly, the pension claims in *John Doyne* are not allowable costs and are beyond the application of CMS Pub. 15-1 §2176.

2. *St. Joseph's Hospital (San Francisco) vs. Blue Cross and Blue Shield* [25]

In this case the issues were related to unemployment insurance and pension plan benefits. *St. Joseph's Hospital* elected to be self-insured for unemployment insurance costs. Under its state unemployment plan, the provider was legally obligated to pay the state directly for unemployment compensation benefits paid to former employees attributable to their service with the provider. Employees who lost their jobs as a result of the provider's termination became eligible to claim and receive unemployment compensation. The Board found that as a self-insurer, the provider incurred the actual liability for the cost claimed subsequent to the provider's termination when the state billed the provider for payments made to former employees. Therefore, the Board concluded that the costs were not allowable for the period. The Board also concluded that the costs could not be claimed as termination costs under CMS Pub. 15-1 §2176 because they did not relate to salaries and fringe benefit costs incurred to effect the settlement of reimbursement for patient care costs while the provider was participating in the program.

St. Joseph's Hospital also had been a member of a multi-employer pension trust from which it withdrew at the time of its termination. Pending litigation precluded the determination of the provider's pension plan expense at termination and so pension expenses were excluded from the final cost report. The litigation settled over a year after the final cost reporting period and the provider sought inclusion of the settlement as allowable termination costs reimbursable under CMS

[25] Fn.11, supra.

Pub. 15-1 §2176. In the Board's decision, it found that the provider's pension costs were incurred before termination and were allowable costs that were includable in the provider's final cost report. The Board concluded that the pension plan costs qualified as administrative costs under CMS Pub. 15-1 §2176.

The Administrator reviewed the Board's decision[26] and concluded that the unemployment costs did not relate to the settlement of the provider's reimbursement and were not administrative costs as defined in CMS Pub. 15-1 §2176. The Administrator also affirmed the Board's conclusions relative to the provider's pension costs.

The current Board believes that the nature of the liabilities claimed in *St. Joseph* were fundamentally different from those claimed in *John Doyne*. *St. Joseph's* costs did not qualify as administrative costs under CMS Pub. 15-1 §2176. Rather, an actual liability existed prior to the termination for which the provider was responsible and which was therefore properly allowable in the final cost report. The Board finding in *St. Joseph* that the costs did not apply to the settlement of reimbursement is consistent with the Board's finding in *John Doyne*.

3. *Gateway Community Hospital v. Blue Cross and Blue Shield Association/Blue Cross of Florida*[27]

In *Gateway*, the provider terminated its participation in Medicare and purchased insurance coverage to pay for malpractice insurance claims made and paid after termination. The provider claimed the cost of the tail coverage as an allowable cost in its terminating cost report. The intermediary challenged the coverage and asserted that it was a cost incurred in the sale of the facility that was unallowable under CMS Pub. 15-1 §2176. The Board found that the cost incurred by the provider to purchase the malpractice insurance coverage policy was an allowable reimbursable cost related to patient care.

In the Board's decision, it did not base its findings upon an application of CMS Pub. 15-1 §2176 and, indeed, considered the intermediary's reliance on CMS Pub. 15-1 §2176 misplaced. The Board also found that, while a wide variety of costs associated with the termination of a provider had been found to be allowable as post-termination costs, the costs involved in the case were not the type of administrative costs that a provider would normally incur after termination and were not subject

[26] *St. Joseph Hospital (San Francisco) v. Blue Cross Blue Shield Association/Blue Cross California*, CMS Admin. Dec. (September 6, 1983), Medicare and Medicaid Guide (CCH) ¶33,424; See also Exhibit P-34.

[27] *Gateway Community Hospital v. Blue Cross and Blue Shield Association/Blue Cross of Florida*, PRRB Dec. No. 92-D50 (August 20, 1992), Medicare and Medicaid (CCH) ¶ 40,834.

to the conditions of CMS Pub. 15-1 §2176. Rather, the Board based its finding on its analysis of the controlling regulation at 42 C.F.R. §413.9 which provides that costs which are reasonable, necessary and related to patient care are allowable. The Board analysis indicated that the provider retained liability for potential malpractice claims related to patient care services supplied during the provider's participation in Medicare. The Board reasoned that such claims occur regularly in the normal course of business and it was reasonable to assume that future claims were probable. Accordingly, the Board found that the costs for the insurance were related to patient care and constituted an allowable cost that was incurred in the final period of the provider's participation in the Medicare program.

Therefore, the current Board finds the facts in *Gateway* were completely different from those in *John Doyne*. The cost was not contingent and, unlike in *John Doyle*, was actually incurred in the final cost reporting period.

4. *Wayne County General Hospital v. Blue Cross Blue Shield Association/United Government Services*[28]

Wayne County was a county-owned and operated hospital that terminated its Medicare participation. As a result of its termination, over 1700 of the provider's employees retired. The hospital sought reimbursement for certain employment benefits, including pension costs and post-retirement health and life insurance costs. The parties agreed and stipulated that the post-retirement costs at issue related to retirement benefits earned by hospital employees while the hospital participated in the Medicare program, and that the entitlement to and amount of benefits were related to the duration of employment. In the Board's decision, it concluded that the facts and circumstances of *Wayne County* were similar to those in *Sisters of St. Francis*[29] and based its analysis upon the conclusions formed in that case. The Board found that the benefits at issue in the case were a function of duration of employment and as such were allowable costs in the terminating and prior fiscal periods.

The current Board draws the same differentiation in *Wayne County* as it did in *Sisters of St. Francis.* In both *Wayne County* and *Sisters of St. Francis,* the provider's pension plan vested and created an actual expense at the provider's termination that required liquidation through an actual expenditure of the provider's funds. In *John Doyne,* the

[28] *Wayne County General Hospital v. Blue Cross Blue Shield Association/United Government Services*, PRRB Dec. No. 2004-D44 (September 24, 2004), Medicare and Medicaid Guide (CCH) ¶ 81,197 (herein after "*Wayne County*"); see also Exhibit P-13.

[29] Fn. 25, supra.

> pension costs claimed are contingent upon pension rights that may vest after the provider has left the program or may never vest. The contingent nature of the liability required the Medicare program to pay currently for accrued liabilities that either may not be liquidated timely or may never be liquidated. Accordingly, the Board believes that neither *Sisters of St. Francis* nor *Wayne County* provide a basis upon which to conclude that the pension claims in *John Doyne* are allowable costs under the application of CMS Pub. 15-1 §2176.

DECISION AND ORDER:

The Provider's post-retirement health benefit costs are not allowable under CMS Pub. 15-1 §2176. The Intermediary's adjustments are affirmed.

Board Members Participating:

Yvette C. Hayes
Keith E. Braganza, CPA
John Gary Bowers, CPA

FOR THE BOARD:

Yvette C. Hayes
Acting Chairperson

DATE: April 13, 2011