PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2011-D47

PROVIDER -
DMC Hospitals FFY 2010 Wage Index Pension Group

Provider Nos.: 23-0024, 23-0104, 23-0273 and 23-0277

vs.

INTERMEDIARY -
BlueCross BlueShield Association/ National Government Services, Inc.

DATE OF HEARING -
October 15, 2010

Cost Reporting Period Ended – 12/31/2006

Wage Index Federal Fiscal Year (FFY) 2010

CASE NO.: 09-2261GC

INDEX

ISSUE:

Whether the Intermediary properly disallowed the Providers' pension costs for the fiscal year ended December 31, 2006 in determining the Medicare geographical wage index for federal fiscal year (FFY) 2010.

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. *See* 42 U.S.C. §§1395 *et seq*. 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 to organizations known as fiscal intermediaries (FIs) and Medicare administrative contractors (MACs). FIs and MACs[1] determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. *See* 42 U.S.C. § 1395h and § 1395kk-1, 42 C.F.R. §§ 413.20 and 413.24.

Providers are required to submit cost reports annually, with reporting periods based on the provider's accounting year. The cost reports show the costs incurred during the fiscal year and the portion of those costs allocated to Medicare. *See* 42 C.F.R. § 413.20. Each 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). *See* 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 receipt of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §§405.1835-405.1837.

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the Prospective Payment System (PPS). 42 U.S.C. §1395ww(d). As part of the methodology for determining prospective payments to hospitals, the Medicare statute requires the Secretary to adjust the standardized amounts for the wage level in the geographical location of the hospital compared to the national average hospital wage level. *See* 42 U.S.C. §1395ww(d)(3)(E), *see also* 42 C.F.R. § 412.64(h)-(k). The Secretary establishes a wage index for each Core Based Statistical Area (CBSA) and for each statewide area that is not within a CBSA (i.e., rural areas). Beginning October 1, 1993, the statute required HCFA (now CMS) to update the wage index annually. CMS develops the annual update from a survey of wages and wage related costs taken from cost reports filed by each hospital paid under the PPS. Wage related costs include the pension costs at issue in this appeal.

[1] FIs and MACs are hereinafter referred to as intermediaries.

Pension Costs:

The Medicare pension cost requirements are described in detail in § 2140 *et seq* of the Provider Reimbursement Manual, CMS Pub. 15-1, Part 1 ("PRM 15-1" or "Manual"). One such requirement pertains to the regulations that speak generally about costs and the liquidation of liabilities. *See* 42 C.F.R. § 413.9 and § 413.100 (2005).

PRM 15-1 §2142.4 (1996) states in part:

> Plan Requirements.—The Plan must meet all the requirements of a deferred compensation plan. The implementation of procedures for the allowability of pension plan payments in §2142.6 below are effective with cost reporting periods beginning on or after September 1, 1981.
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> A. Data Required. – The provider, without regard to its taxable or tax exempt status, must have available actuarial data containing at a minimum an analysis of both the ERISA minimum and tax deductible maximum pension cost specifying the normal (current service) cost and the unfunded actuarial accrued liability. If pension costs in a previous year were charged to the Medicare program based on actuarial costs which differ from the pension costs actually funded for such year, the provider must also have data available reconciling the prior year's pension cost with the pension cost actually funded in the year the funding occurs. . . .

PRM 15-1 §2142.5 (1996) "Pension Costs" states:

> A. Actuarial Accrued Liability. – The actuarial accrued liability is that portion of pension costs, actuarially determined, that is not provided for by current and future normal costs. Actuarial accrued liabilities as well as any increases or decreases in actuarial accrued liabilities must be amortized ratably over a minimum of 10 years, or such shorter period prescribed by ERISA for particular actuarial liability adjustments, subject to the payment requirements in §2142.6A.
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> B. Normal (Current Service) Costs.—Normal (current service) cost is that portion of pension costs, actuarially determined, which is allocated to the current year, exclusive of any payment toward the unfunded actuarial accrued liability. Provider payments of a pension plan liability for normal costs are allowable in the year accrued, provided the payment requirements in §2142.6A are met.

PRM 15-1 §2142.6 (1996) "Allowability of Payments" states in part:

> A. Payment Requirements. – The provider must make payment of its current liability for both normal costs and actuarial accrued liability costs to the fund established for the pension plan in accordance with the provisions covering liquidation of the liabilities established in §2305. The instructions require full liquidation of the liability 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 (based upon documented evidence) for non-payment of the liability.
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> C. Excessive Payments.—Where the payment made is more than the lesser of the tax deductible maximum or the total normal cost plus ratable amortization of the unfunded actuarial accrued liability, the excess may be carried forward and considered as payment against the liability to the fund of the future period.

The parties dispute the amount of the funded pension cost that is allowable under Medicare for the Providers' FYE December 31, 2006.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The four Providers represented in this group appeal are filing as a Common Issue Related Party (CIRP) group appeal pursuant to the Medicare Act, 42 U.S.C. § 1395oo(b). The Providers appealed the final determination of the CMS regarding the computation of the federal fiscal year (FFY) 9/30/2010 wage index for the Core Based Statistical Area (CBSA) for Detroit (19804) and Warren (47644), Michigan. The Providers are also requesting the recomputation for the reclassified wage index for Ann Arbor CBSA (11460) since Provider Nos. 23-0273, 23-0104 and 23-0024 have been reclassified to this CBSA; and for the Flint CBSA since Provider No. 23-0277 has been reclassified to this CBSA.

It is uncontested that the Providers have exhausted remedies for seeking reimbursement for the pension costs in controversy, as prescribed by the CMS. This process culminated in the Providers' appeal to CMS which was denied on August 10, 2009[2]. On September 10, 2009 the Providers requested a hearing with the Board. On March 4, 2010[3] and April 27, 2010[4] the Providers requested an accelerated hearing to be held during the week of

[2] *See* Letter denying the Providers' request to reverse the Intermediary's adjustments, Providers Exhibit 4.
[3] *See* Providers Exhibit 8.
[4] *See* Providers Exhibit 10.

August 9, 2010. On April 22, 2011 the Provider submitted a Notice of Supplemental Authority containing proposed rule changes for wage index pension costs.[5]

The Providers in this case have met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-405.1841. The Providers were represented by Kenneth R. Marcus, Esquire of Honigman Miller Schwartz and Cohn LLP. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

PROVIDERS' CONTENTIONS:

The Providers believe PRM § 2142.5A should be interpreted to allow pension funding in compliance with the Internal Revenue Service (IRS)/ERISA[6] Minimum Required Contribution (MRC)[7] to be reimbursed under Medicare as a reasonable cost. The Providers believe it is reasonable to conclude from historical acceptance of pension costs claimed by the Providers that the Intermediary's interpretation of PRM § 2142.5A was consistent with the Providers' interpretation. The Providers assert the cash contribution they made to their pension plan during FYE 12/31/2006 of $59,241,068[8] was based upon the IRS MRC. In accordance with the IRS MRC a contribution of $46,664,041[9] was made for FYE 12/31/2006 based on the recommendation of the Providers' actuary.[10] The Providers point out that neither the Intermediary nor CMS contested the accuracy of the as filed IRS Form 5500[11], the Actuarial Report[12], the cash contribution amount or the MRC.

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[5]The Notice of Supplemental Authority submitted excerpts from "Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2012 Rates" pp. 290-295 as posted on the CMS website on April 19, 2011. These excerpts were subsequently published at 76 Fed. Reg. 25874-25876, May 5, 2011. *See* Supplemental Authority exhibits including the Providers' April 22, 2011- Notice of Supplemental Authority, the Intermediary's May 20, 2011- Response to the Notice of Supplemental Authority, the Providers' May 24, 2011- Reply to Intermediary's Response to Providers' Notice of Supplemental Authority, the Intermediary's May 27, 2011- Response to the Providers' May 24, 2011 Response and the Providers' June 9, 2011- Reply to Intermediary's Further Response to Providers' Notice of Supplemental Authority.

[6] Employee Retirement Income Security Act of 1974 (ERISA).

[7] Tr. p. 146 describes the calculation of the minimum required contribution as: "the sum of the following four items: the accrued liability normal cost – well, we've already defined these terms. So it's accrued liability normal cost, its net amortization charges to the funding standard account. That amount is a little over $14.3 million, the additional funding charge, which increased the minimum required by $31 million, a little over, and then the rules required an interest adjustment to the end of the year which added another $1.2 million, so the total minimum required contribution was $46,664,041."

[8] *See* Providers Exhibit 22. Tr., p. 95.

[9] The difference between the $59,241,068 cash contributions **made during FYE 12/31/2006** being claimed by the Providers and the IRS MRC of $46,664,041 **made for FYE 12/31/2006** as calculated by the Providers' actuary is due to the actuarial amount being paid over two calendar years. Of the $59,241,068 cash contributions made during FYE 12/31/2006, $30,210,444 related to FYE 12/31/2005 IRS MRC contributions and $29,030,625 related to FYE 12/31/2006 IRS MRC contributions. The remainder of the FYE 12/31/2006 IRS MRC contributions were paid in FYE 12/31/2007. *See* Providers Exhibit 22, p. 3 for cash contributions by FY.

[10] *See* Providers Exhibit 15, p. 3.

[11] *See* Intermediary Exhibits 1 and 2.

[12] *See* Providers Exhibit 15.

The Providers assert the March 2008 revision of PRM § 2142.5A was a substantive change in policy to the historically correct interpretation which was procedurally unlawful and inconsistent with the Medicare Act, regulations governing reasonable costs, and was impermissibly retroactive rulemaking.[13] Similarly the Providers argue the unpublished worksheets and instructions used to "educate" the Intermediary regarding the proper interpretation and application of PRM § 2142.5A were not properly published changes in policy. The Providers note the Intermediary's interpretation of PRM § 2142.5A was consistent with the Providers for FYEs 1996 through 2005. The Providers argue that any changes to this plausible interpretation that had been applied over an extended period, must comply with statutory requirements for implementing change in Medicare payment policy.

The Providers note that it appears likely they will never recapture the disallowed pension payments. The Providers base this assertion on the "Input Worksheet for Pension Cost Calculations" at Providers Exhibit 14 and projected funding under the Pension Protection Act of 2006 (PPA).[14]

The Providers argue the wage index pension proposed rule changes submitted in its April 22, 2011 "Notice of Supplemental Authority" support their position that ERISA required actual funding should be used to determine allowable pension costs.[15] The Providers also believe this proposed rule contradicts the position of the Intermediary. *Id.*

INTERMEDARY'S CONTENTIONS:

The Intermediary interprets its position as supported by the Provider Reimbursement Manual (PRM) § 2142.5A and B, before and after the 2008 revision.[16] The Intermediary believes the PRM requires a deficiency in the funding of a defined benefit pension plan in order to recognize the payments into a pension fund as allowable costs. The Intermediary calculates the funding deficiency/surplus by comparing the "Actuarial Value of the Assets[17]" (AVA) to the "Actuarial Accrued Liability[18]" (AAL). Based upon this formula

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[13] *See, Bowen v. Georgetown University Hospital*, 488 U.S. 2004 (1988) and 42 U.S.C. § 1395hh(e)(1)(A) for prohibitions against retroactive rule making.

[14] *See* Providers' Final Position Paper and Response to Intermediary's Final Position Paper p. 16.

[15] *See* Supplemental Authority correspondence dated April 22, 2011.

[16] *See* PRM-I, Transmittal Nos. 395 (July 1996) and 436 (March 2008). Intermediary Exhibit 3 and Providers Exhibit 11, respectively.

[17] The Actuarial Value of Asset calculation made by the Providers' actuary for the period in question is found at Providers Exhibit 15, p. 12 of 43. A description of the calculation method found in the same report on p. 38 of 43 states: "market value gains or losses are smoothed over a five-year period. A gain or loss for a year is determined by calculating the difference between the expected value of assets and the market value. The expected value of assets is the market value of assets at the prior valuation date brought forward with interest at the valuation interest rate plus contributions and disbursements adjusted with interest at the valuation rate. The asset value determined under this method will be adjusted to be no greater than 120% and no less than 80% of the market value."

[18] Definitions for Actuarial Accrued Liability can be found in the PRM § 2142.5 A (1996) as follows: "The actuarial accrued liability is that portion of pension costs, actuarially determined, that is not provided for by current and future normal costs," in testimony of the Intermediary's actuary at Transcript (Tr.), pp. 213-215 and 311-312 and testimony of the Providers' actuary at Tr., pp. 169-170.

the Intermediary believes the Providers' pension plan was overfunded and had a surplus of $77.5 million at the end of calendar year 2006 and a surplus of $148.7 million at the end of calendar year 2007. Since the Providers' pension fund had a surplus, none of the contributions to the pension fund would be recognized as allowable costs.

The Intermediary notes the Providers' comparison of the Asset Value to the Retirement Protection Act of 1994 (RPA 94) current liability, which resulted in a deficit that required funding, is not referenced or implied from the PRM. The Intermediary believes the AAL and the RPA 94 current liability are calculated based on fundamentally different premises. The AAL treats the employer as a going concern while the RPA 94 views the employer as if it's going out of business and paying off all pension claims immediately. The Intermediary argues the result of the RPA 94 current liability calculation is not a "reasonable cost" measure for the fiscal year and would distort wage index results. The Intermediary notes using the AAL in lieu of the RPA 94 current liability has a long term history in other areas of Federal contracting, specifically, the Cost Accounting Standards[19] and Federal Acquisition Regulations[20] (CAS and FAR). Therefore, the Intermediary believes its application of the PRM in this case has a rational basis.

The Intermediary believes the "normal costs" are nominal (approximately $70,000) and not worth discussion. The Intermediary defines "normal costs" as, "the annual costs associated with pension eligibles earning additional rights through longer service and wage increases."[21] The Intermediary asserts the Providers' complaint, that the pension contribution disallowance for 2006 will never be fully recognized, is wrong.[22] Finally, the Intermediary believes the proposed rule submitted in the Supplemental Authority is entirely consistent with the information and testimony previously presented to the Board.[23]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and program instructions, parties' contentions and the evidence presented, the Board finds and concludes that only the "normal cost" of the pension plan is allowable in the Providers' fiscal year ended 12/31/2006, for wage index purposes, due to the overfunding of the actuarial accrued liability.

The controversy in this case centers on whether pension costs funded under ERISA/IRS MRC are entirely allowable under Medicare reimbursement principles.

The regulations at 42 C.F.R. § 412.64(h)-(k) (2005) state in pertinent part:

> (h) Adjusting for different area wage levels. CMS adjusts the

[19] *See* Intermediary Exhibit 6 (definitions and section 9904.412-40, Exhibit 7, and Exhibit 8. *See also*, Tr., pp. 229-233.
[20] *See* Intermediary Exhibit 9.
[21] *See* Intermediary's Post Hearing Brief p. 7.
[22] Tr., pp. 224-225.
[23] *See* Supplemental Authority correspondence dated May 20, 2011 pg. 4.

> proportion of the Federal rate for inpatient operating costs that are attributable to wages and labor-related costs for area differences in hospital wage levels by a factor (established by CMS based on survey data) reflecting the relative level of hospital wages and wage-related costs in the geographic area (that is, urban or rural area as determined under the provisions of paragraph (b) of this section) of the hospital compared to the national average level of hospital wages and wage-related costs. The adjustment described in this paragraph (h) also takes into account the earnings and paid hours of employment by occupational category.
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> (1) The wage index is updated annually.
> (2) CMS determines the proportion of the Federal rate that is attributable to wages and labor-related costs from time to time, employing a methodology that is described in the annual regulation updating the system of payment for inpatient hospital operating costs.
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> . . .

This case relates to the "wage-related costs" that are a part of calculating area wage indices.

The Board finds the Providers have met the funding requirements of 42 C.F.R. § 413.100 (2005). The Board finds the accrued liability related to pension contributions were liquidated within the required time period.[24] In fact, the controversy revolves around alleged overfunding of the pension plan.

The Medicare pension cost requirements are delineated in more detail in the PRM 15-1 §2140 *et seq*. The Board finds the PRM 15-1 §2142.4 (1996) "Plan Requirements" outlines the data required to determine allowable pension costs:

> A. Data Required. – The provider, without regard to its taxable or tax exempt status, must have available actuarial data containing at a minimum an analysis of both the ERISA minimum and tax deductible maximum pension cost specifying the normal (current service) cost and the unfunded actuarial accrued liability. If pension costs in a previous year were charged to the Medicare program based on actuarial costs which differ from the pension costs actually funded for such year, the provider must also have data available reconciling the prior year's pension cost with the pension cost actually funded in the year the funding occurs.

. . .

[24] The Providers' IRS MRC of $46,664,041 made for FYE 12/31/2006 was paid over two calendar years: Cash contributions made during FYE 12/31/2006 of $29,030,625 and the remainder paid in FYE 12/31/2007. *See* Providers' Exhibit 22, p. 3 for cash contributions by FY.

The Board finds the Providers have supplied this data in the "Actuarial Report as of January 1, 2007 for the Plan Year Ending December 31, 2007." *See* Providers Exhibit 15.

The Manual describes two types of pension costs that Medicare recognizes as reimbursable. PRM 15-1 §2142.5 (1996) "Pension Costs" states:

> A. Actuarial Accrued Liability. – The actuarial accrued liability is that portion of pension costs, actuarially determined, that is not provided for by current and future normal costs. Actuarial accrued liabilities as well as any increases or decreases in actuarial accrued liabilities must be amortized ratably over a minimum of 10 years, or such shorter period prescribed by ERISA for particular actuarial liability adjustments, subject to the payment requirements in §2142.6A.
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> B. Normal (Current Service) Costs.—Normal (current service) cost is that portion of pension costs, actuarially determined, which is allocated to the current year, exclusive of any payment toward the unfunded actuarial accrued liability. Provider payments of a pension plan liability for normal costs are allowable in the year accrued, provided the payment requirements in §2142.6A are met.

The Manual then specifies additional requirements to determine the allowability of the pension payments. PRM 15-1 §2142.6 (1996) "Allowability of Payments" states in part:

> A. Payment Requirements. – The provider must make payment of its current liability for both normal costs and actuarial accrued liability costs to the fund established for the pension plan in accordance with the provisions covering liquidation of the liabilities established in §2305. The instructions require full liquidation of the liability 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 (based upon documented evidence) for non-payment of the liability.
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> C. Excessive Payments.—Where the payment made is more than the lesser of the tax deductible maximum or the total normal cost plus ratable amortization of the unfunded actuarial accrued liability, the excess may be carried forward and considered as payment against the liability to the fund of the future period.

The Board finds the Manual instructions above consistent with the Regulations and give them great weight. [25] The Board finds the Providers' argument regarding retroactive rule making moot since its decision is based upon rules in effect during the year in controversy. *Id.*

The Board finds PRM 15-1 § 2142.6.C (1996) which defines "Excessive Payments" limits the amount of pension payments that can be claimed in a given fiscal year. This Manual section limits payments to the "lesser of the tax deductible maximum or the total normal cost plus ratable amortization of the unfunded actuarial accrued liability." It is uncontested that the IRS MRC payment for FYE 12/31/2006 of $46,664,041[26] was not in excess of the "tax deductible maximum" of $640,412,676.[27] However, the Board finds the IRS MRC payments excessive because the $46,664,041 in payments exceeded total normal costs of $70,031[28] plus ratable amortization of the unfunded actuarial accrued liability as stated in the Manual. Since the actuarial accrued liability was overfunded by $77,549,948[29] there was no unfunded actuarial accrued liability. Therefore, any payments over the normal costs of $70,031 are not allowed in the current year but "may be carried forward and considered as payment against the liability to the fund of the future period." The Board finds the normal costs of $70,031 are the only pension costs that can be allowed for the FYE December 31, 2006 in determining the Provider's Medicare geographical wage index for FFY 2010.

The Board also finds the Manual instructions clear and therefore, contrary treatment by the Intermediary in prior years is moot and not determinative of CMS policy. Finally, the Board finds the Supplemental Authority (*see* 76 Fed. Reg. 25837, 25874-25876, May 5, 2011) submitted by the Providers to be consistent with these findings.

DECISION AND ORDER:

The Providers have allowable pension costs of $70,031 for the FYE December 31, 2006. The Intermediary's adjustment is modified.

BOARD MEMBERS PARTICIPATING:

Yvette C. Hayes
Keith E. Braganza, C.P.A.
John Gary Bowers, C.P.A.

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[25] 42 C.F.R. § 405.1867 and § 405.1871(a). Although the Board gave great weight to the Manual sections outlined above as found in Transmittal No. 395, July 1996 (*see* Intermediary Exhibit 3) the Board did not give weight to the same Manual sections as found in Transmittal No. 436 since its effective date of March 28, 2008 was after the period in question (*see* Providers Exhibit 11).
[26] *See* Providers' Exhibit 22. Tr., p. 95-96.
[27] *See* the Providers' Actuarial Report as of January 1, 2007 for the Plan Year Ending December 31, 2007, Providers Exhibit 15, page 3 of 43, line 1c. *See also*, Intermediary's Position Paper at page 6, table line "TDM."
[28] *Id.* at line 4.
[29] *Id.* at line 8. The Board notes the overfunding is calculated by taking the excess of the Actuarial Value of [Pension Plan] Assets (line 7, $696,898,142) over the [Actuarial] Accrued Liability (line 6, $619,348,194).

FOR THE BOARD:

Yvette C. Hayes
Acting Chairperson

DATE: September 28, 2011