

PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2007-D26

PROVIDER -

St. Francis Hospital
Greenville, South Carolina

Provider No.: 42-0023

vs.

INTERMEDIARY -

BlueCross BlueShield Association/
Palmetto Government Benefits
Administrators

DATE OF HEARING -

September 28, 2006

Cost Reporting Period Ended -

August 31, 2000

CASE NO: 04-1774

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ISSUES:

1. Whether the Intermediary properly adjusted the Provider's Medicare bad debts.
2. Whether the Intermediary properly adjusted the Provider's medical benefit plan costs.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA) is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under 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:

St. Francis Hospital (Provider) is a non-profit, general acute care hospital located in Greenville, South Carolina. The Provider timely filed its cost report for the eight month period ended August 31, 2000. Palmetto Government Benefits Administrators (Intermediary) audited the cost report and issued a NPR that disallowed the amounts claimed by the Provider for bad debts and health insurance payments.

The Provider appealed the Intermediary's disallowances to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841. The Provider was represented by Robert L. Roth, Esquire, of Crowell and Moring, LLP. The Intermediary was represented by Bernard M. Talbert, Esquire, Associate Counsel, Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

Issue 1: Hospital Charity Care Bad Debts

The Provider claimed \$397,851 for inpatient Charity Care bad debts and \$326,428 for Outpatient Charity Care bad debts for FYE 8/31/00.¹ The Intermediary performed a statistical sampling of the bad debt universe resulting in an error rate of approximately 59%. The Intermediary applied its "extrapolation policy" that established that if the error rate of a sample exceeded 15%, then the results of the sample would not be extrapolated to the rest of the universe of such claims. The Intermediary disallowed the bad debts in total, but immediately prior to the hearing, revised the adjustment to reflect the allowed sample claims. There is no dispute that the regulations addressing bad debts at 42 C.F.R. §413.80(e) and the program guidelines in the Provider Reimbursement Manual (PRM) Pub. 15-1 §300 are controlling. At issue is the propriety of the Intermediary's policy of disallowing all bad debts if the sample indicates an error rate in excess of 15%.

The Provider acknowledges that the Intermediary has offered to resolve this issue by revising its disallowance in accordance with the Provider's Exhibit P-32, but argues that the Intermediary would not agree to discontinue applying its audit policy to any other years, thus forcing the Provider to appeal the same issue multiple years. The Provider argues further that the Intermediary's pattern of continued application of the policy and withdrawal just prior to the hearing harms the provider by withholding reimbursement for months or years, but prevents administrative and judicial review of the legality of the policy. The Provider contends that HCFA Ruling 86-1² established the use of statistical sampling as a lawful method of determining overpayments in the Medicare reimbursement process and fully anticipated that the results of statistical sampling would be extrapolated to the universe of claims from which the sample was derived. The Provider argues further that the United States Court of Appeals for the District of Columbia addressed the extrapolation of sampling results to the universe of claims in its decision on *Chaves County Home Health Service*,³ wherein the court found:

HCFA Ruling 86-1 details the type of audit that is appropriate...the fiscal intermediary examines a randomly selected and statistically significant number of sample claims along with their supporting documentation to determine whether they involved non-covered services that the provider knew or should have known were not covered. These results are then extrapolated to the entire universe of claims from the provider for a given time period. The full amount of the provider's overpayment liability is calculated from the percentage of claims denied in the sample.

Based upon the Court's finding, the Provider contends that the Intermediary's failure to extrapolate the results of its sample to the universe of such claims and deny the

¹ See Intermediary's Exhibit I-6 at pages 4 and 6.

² Use of Statistical Sampling to Project Overpayments to Medicare Providers and Suppliers; HCFA Ruling No. HCFAR-86-1, Feb. 20, 1986.

³ *Chaves County Home Health Service, Inc. v. Sullivan*; 931 F.2d 914, 915 (D.C. Circuit 1991).

appropriate number of claims in the universe is unlawful and must be set aside, because it is arbitrary, capricious, an abuse of discretion or otherwise not in accordance with the law under 5 U.S.C. §706(2)(C) of the Administrative Procedure Act.

The Intermediary contends that, subsequent to the filing of the appeal, the parties negotiated an extrapolation methodology and applied it to the universe of bad debts. Because the Intermediary has offered to modify the adjustment, the Intermediary questions the propriety of soliciting the Board's opinion on an issue that is no longer in dispute in this instant case. The Intermediary further challenges the Board's jurisdiction to apply its decision to any other year.

Issue 2: Medical Benefits Plan Costs

The Provider sponsored a health, dental and drug Plan (Plan) to provide medical benefits for its employees and their dependents. During FY 2000 the Provider contracted with Optimum Health Network (OHN), a third party administrator (TPA), to process and pay the Plan's claims for services that were rendered to its enrollees, including those services furnished by the Provider itself. These claims were paid with the Provider's funds. OHN was owned by the Provider and, therefore, was a related party under 42 C.F.R. §413.17. Separately, the Provider contracted with ReliaStar Life Insurance Company, a commercial insurance carrier unrelated to the Provider, to provide "stop-loss" insurance for certain claims arising under the Plan in FY 2000. The Intermediary considered the arrangement inconsistent with the risk sharing provisions of HCFA Pub. 15-1, §2162.7(A) and disallowed the health insurance payments made to the Provider. At issue is whether the Provider's Plan meets the requirements of §2162.7 for a self-funded insurance plan.

The Provider contends that PRM §2161 makes clear that these costs are allowable where "the health care services are rendered by a provider to its own employee and the provider is remunerated for these services under the provisions of the purchased insurance plan." The Provider argues that its Plan qualifies as a purchased insurance plan under the standards prescribed at PRM §2162.7(A), which states in pertinent part:

If a provider enters into an agreement with an unrelated party that does not provide for the shifting of risk to the unrelated party, such an agreement shall be considered self-insurance. . . There may be situations in which there is a fine line between self-insurance and purchased or commercial insurance. This is particularly true of "cost-plus" type arrangements. As long as there is at least some shifting of risk to the unrelated party, even if limited to situations such as provider bankruptcy or employee termination, the arrangement will not be considered self-insurance.

The Provider contends that it entered into an agreement with an unrelated party (ReliaStar) that provided for the shifting of some health insurance risk to ReliaStar. Accordingly, its Plan cannot properly be considered "self-insurance," and the entire costs should be allowable for Medicare reimbursement purposes.

The Intermediary argues that the Provider's Plan is actually two distinct plans with severable reimbursement outcomes rather than a "single" insured program. PRM §2162(A) recognizes that liability protection or health care protection coverage can simultaneously be provided through more than one source. The manual noted alternatives to full insurance coverage from commercial sources to obtain employee health care insurance protection. The Intermediary contends that the Provider's Plan is a combination of self-insurance and purchased insurance for premium financed stop-loss coverage.

The Intermediary acknowledges that the Provider executed a contract for stop-loss coverage with ReliaStar Life Insurance Company (ReliaStar) that, in fact, transferred the risk for losses over an established threshold to ReliaStar, and the Intermediary allowed the premiums for this coverage. However, the Intermediary contends that §2162.7 requires that a determination of "will not be considered self-insurance" be made where there is a shifting of risk to the cost-plus administrator. Under the agreement with ReliaStar, the TPA (Optimum Health Network) bears no such risk; therefore, there is no shifting of risk as required under §2162.7. Further, the Intermediary argues that under the Provider's Plan, the Provider purchases health care services for its employees from itself, and therefore is subject to the rules regarding related parties. Under those rules, the proper measure of allowable costs is the actual costs of the services provided. The Intermediary argues that the allowable amount of claims paid through OHN for services provided by the hospital to its employees must be reduced from charges to costs to eliminate the mark-up in excess of the hospital's actual costs.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering Medicare law and guidelines, the parties' contentions and the evidence, the Board finds and concludes as follows:

Issue 1: Hospital Charity Care

The Board examined the regulations, program guidance and professional audit standards that address statistical sampling. HCFA Ruling 86-1 established the use of statistical sampling as an acceptable method for evaluating overpayments in the Medicare reimbursement process. The HCFA Ruling anticipated that the results of a statistically valid sample would be extrapolated to the universe of claims from which the sample was derived, and that the sample would be expanded to assure its statistical validity and reliability. Nothing in the Ruling, the regulations or the program guidance supports the Intermediary's policy of a 15% threshold. Further, the threshold has no foundation in established audit standards and was applied with no notice to the provider community regarding its application. Consequently, the Board concludes that its use as a final determination of allowable costs is improper and finds that the Provider's charity care bad debts should be reimbursed in the amounts stipulated by the parties.

The Provider argues that the Intermediary's last minute withdrawal of the adjustment is an illegal attempt to moot the Provider's position, an abuse of the Provider's rights and a

perversion of the appeals process. Accordingly, the Provider petitioned the Board to find that the Intermediary's application of the audit policy is illegal per se and inappropriate for any audit application. The Board acknowledges that the Intermediary's audit policy is not supported by law or regulation and that it is a significant deviation from standard/accepted audit procedures. However, the Board does not reach the question of "illegality." The Board's authority is limited to the dispute for the specified cost reporting periods. It may affirm, modify or deny an intermediary determination, but the Board has no injunctive powers and holds no authority beyond this specific case. Accordingly, the Board's findings are limited to this case.

Issue 2: Medical Benefits Plan Costs

The pivotal issue presented for the Board's consideration is whether the Provider's Plan qualifies as a self-insurance plan under the standards prescribed at §2162.7. This section outlines the conditions applicable to self-insurance, and one such condition requires that where a Provider enters into an agreement with an unrelated party that does not provide for the "shifting of risk" to the unrelated party, the agreement shall be considered self-insurance. As long as there is at least some shifting of risk to the unrelated party, the arrangement will not be considered self-insurance.

The Provider executed a contract for stop loss-coverage with ReliaStar Life Insurance Company, an unrelated party, that transferred the risk for losses over an established threshold to ReliaStar. The Intermediary properly allowed the premiums for this coverage.

However, the Provider also claimed the full amount of the charges levied by the hospital for the services rendered to its employees. The Provider asserts that its agreement with ReliaStar qualifies its entire Plan, including the charges by the hospital for services provided to its employees, as purchased insurance. However, the agreement with ReliaStar assigns no risk to the TPA (Optimum Health Network), so there is no shifting of risk as required under §2162.7. Even if the agreement had called for the transfer of some risk to the TPA, the transfer would have been among operating components of the same entity and would have generated no change in the Provider's risk acceptance. Consequently, the Board concludes that the charges imposed by the Provider for health care services furnished to its employees satisfies §2162.7 requirements and must be considered self-insurance.

The PRM §2144.4 recognizes the cost of health insurance premiums paid (or incurred) as an allowable fringe benefit if the benefits of the policy inure to employees. However, this section recognizes no special exclusion from the related party rules for fringe benefits. Accordingly, the limits on costs incurred between related parties are not overridden by the nature of the expenditure being employee health care costs. Under its Plan, the Provider purchased services for its employees from itself, and is therefore subject to the rules for related parties at 42 C.F.R. §413.17. Under those rules, the proper measure of allowable costs is the actual costs of the services provided. Accordingly, the Board finds that the allowable amount of claims paid through OHN for services provided

by the hospital to its employees must be reduced from charges to costs in order to eliminate the mark-up in excess of the hospital's actual costs. The Intermediary's adjustment is affirmed.

DECISION AND ORDER:

1. Hospital Charity Care Bad Debts:

The Intermediary's extrapolation policy has no foundation in law, regulations or established audit standards, and its use as a final determination of allowable costs is improper. The Provider's charity care bad debts should be reimbursed in the amounts stipulated by the Parties.

2. Medical Benefits Plan Costs

The allowable amount of claims paid through OHN for services provided by the hospital to its employees must be reduced from charges to costs to eliminate the mark-up in excess of the hospital's actual costs. 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: April 19, 2007

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson