CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Hall Render Wage Index Group Appeals	**Cost Reporting Periods Ending: Various**
Provider	
vs.	
BlueCross BlueShield Association/ National Government Services and Wisconsin Physicians Services	**Review of:**
	PRRB Dec. No. 2012-D1
Intermediary	**Dated: October 6, 2011**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period mandated in § 1878(f)(1) of the Social Security Act (Act), as amended (42 U.S.C. § 1395oo(f)). The parties were notified of the Administrator's intention to review the Board's decision. The Providers submitted comments requesting that the Administrator affirm the Board's decision. The Intermediary and CMS' Center for Medicare (CM) submitted comments requesting that the Administrator reverse the Board's decision. Accordingly, this case is now before the Administrator for final agency review.

ISSUE NO. 1 AND BOARD'S DECISIONS

Issue No. 1, referred to by the Board as the "Short Term Disability Issue", was whether the Fiscal Intermediary and CMS properly determined the Wage Indexes for St. Elizabeth Medical Center; St. Luke Hospital East; St. Luke Hospital West; Mercy Hospital Anderson; University Hospital, Inc.; Jewish Hospital; Mercy Hospital Fairfield; Mercy Franciscan Hospital Western Hills; Fort Hamilton Hospital; Christ Hospital; Mercy Franciscan Hospital—Mt. Airy; Mercy Hospital Clermont; and the Cincinnati-Middletown, OH-KY-IN CBSA for Federal Fiscal Year (FFY) 2009.

This was a Medicare Group Appeal involving the FFY 2009 hospital wage index established for twelve hospitals using the Cincinnati-Middleton, Ohio-Kentucky-Indiana Core Based

Statistical Area (CBSA) wage index.[1] The Board noted that the hospital[s] involved in this group appeal compensated their employees who qualified for short term disability by paying them directly via the payroll accounting system.[2] This differs from the vast majority of

[1] This case (PRRB Case No. 09-1426G) is substantively similar to the issue in PRRB Case. No. 09-1248G, a Group Appeal which involved the FFY 2009 Hospital Wage Index for Mercy Medical Center-North Iowa (Mercy), Provider No. 16-0064, and for the Rural Iowa CBSA for Medicare IPPS purposes and the hospitals utilizing this Wage Index. Mercy was reclassified under §508 of the Medicare Modernization Act, and therefore utilizes its own Wage Index, however, Mercy's wage data and resulting Wage Index affect the Wage Index of the Rural Iowa area. *See* Providers' Final Position Paper on Rural Iowa CBS FFY 2009 Wage Index (Short Term Disability), p. 2. The Board's decision, PRRB Dec. No. 2012-D1, includes both of these cases, and thus the Board's decision in regards to the "Short Term Disability Issue" applies equally to the Rural Iowa FFY 2009 Wage Index group, despite only discussing the Cincinnati-Middletown, OH-KY-IN CBSA FFY 2009 Wage Index group.

[2] It is unclear from the Board's decision and the record how many of these twelve hospitals used this method of paying short term disability. St. Elizabeth's Medical Center was the only one specifically discussed that compensated their employees who qualified for short term disability by paying them directly via the payroll accounting system. *See* Providers' Final Position Paper on Cincinnati-Middleton, OH-KY-IN CBSA FFY 2009 Wage Index (Short Term Disability), p. 3; Exhibit P-6; Exhibit P-7. It was also the only hospital discussed in the hearing before the Board. However, the Intermediary noted that it had removed the short term disability salaries from Wage Related Costs and included the related salaries and hours in Salaries for St. Elizabeth, and that five other hospitals (St. Luke Hospital East, St. Luke Hospital West, the Jewish Hospital, Fort Hamilton Memorial Hospital, and Christ Hospital) submitted a request to the Intermediary to "correct" their respective wage index to remove the salary and hours from wages and include the amount in wage related cost. *See* Intermediary's Final Position Paper on Cincinnati-Middleton, OH-KY-IN CBSA FFY 2009 Wage Index (Short Term Disability), p. 5-6. The Intermediary noted that the Group submitted no evidence that Mercy Hospital Anderson, University Hospital, Inc., Mercy Hospital Fairfield, Mercy Franciscan Hospital Western Hills, Mercy Franciscan Hospital-Mt. Airy, and Mercy Hospital Clermont timely submitted a request for CMS intervention in accordance with the Wage Index FFY 2009 Hospital Wage Index Development Table. *See* Id. at p. 3. The Intermediary also submitted a jurisdictional challenge to the Board on May 21, 2010 regarding these five hospitals, noting that they failed to exhaust the administrative remedies as required for Board jurisdiction. In its decision, the Board noted that Counsel for the Intermediary and Providers agreed that these five hospitals did not have the short term disability issues as an issue for their wage data, and joined the appeal due to the adverse impact on the wage index to their MSA from the hospitals with this issue. The parties stipulated that at issue in the case are the "total paid hours" used by the Intermediary to determine the wage index "*for at least one hospital in*

hospitals, that contract with private insurers to provide short-term disability coverage for employees. [3] When the short term disability related costs are incurred through insurance, there are no corresponding hours that match the short term disability premiums paid out. In the case of the hospitals in this appeal, however, by paying short term disability through payroll, CMS attributes hours to the payments, similar to paid time off hours, and includes them in the wage index calculations. The inclusion of those hours lowers the wage index, and reduces Medicare payments for hospitals using the Cincinnati-Middleton, OH-KY-IN CBSA wage index.

The Board noted that the common issue affecting the Providers in this Group Appeal was whether the Intermediary properly included short term disability hours in the "paid hours" for the wage indexes for St. Elizabeth's and the Cincinnati-Middleton, OH-KY-IN CBSA for Federal Fiscal Year 2009.

The Board found that the Fiscal Intermediary and CMS did not properly determine the Wage Index, as short-term disability should be classified as "wage related costs" to calculate the Provider's average hourly wage rate.

The Board noted that the short term disability issue was not new to it, as it had addressed the same issue in *Rochester General Hospital*, PRRB Dec. No. 2007-D67 and *Rochester 2004 MSA Wage Index Group*, PRRB Dec. No. 2009-D2. In both of these cases, the Board stated that it had examined CMS' Program Instructions for cost report preparation that require salary and wages paid to hospital employees to be included in the wage index calculation. The Board claimed that the pivotal question was whether the short term disability expense should be included as "salaries and wages", which are directly associated with hours worked by employees, or "wage related costs", which are costs for which there are no directly associated hours worked. Salaries and wages include direct compensation for employees, as well as holiday, vacation, and sick pay. Wage related costs are things such as payroll taxes

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each of the appealing wage index MSAs or state rural areas." Emphasis added. Further, the stipulations note, "Rather than contract with an insurance carrier to pay employees for such disabilities, the *Hospitals at issue* continued paying such employees through standard payroll procedures that recorded hours as 'paid hours' but where no work was performed ('disability hours')." Emphasis added. Consequently, the issue would be limited to a hospital who timely perfected its wage data appeal. The Board would not have to consider any individual untimely appeal of a challenge to its average hourly wage data. Other hospitals may challenge the effect of that alleged error on their wage index if other jurisdictional prerequisites are met.

[3] St. Elizabeth's Medical Center did this as a business decision, hoping to reduce costs associated with short term disability by eliminating the "middle man". *See* Transcript of Oral Hearing (Tr.) at 39-40.

and bonus pay, life and health insurance, workers compensation insurance, and fringe benefits.

The Board stated that based upon its analysis in *Rochester Rochester 2004 MSA Wage Index Group*, PRRB Dec. No. 2009-D2, short-term disability insurance costs should be treated as a wage related cost in order to ensure consistent treatment for all providers. The Board concluded that the fact that the Provider opted to pay the short-term disability cost through its payroll system does not change the nature or type of the cost, and that CMS program instructions require treating the cost as a "wage related" cost.

ISSUE NO. 2 AND BOARD'S DECISIONS

Issue No. 2, referred to by the Board as the "Baylor Plan Issue", was whether the Fiscal Intermediary and CMS properly determined the Wage Indexes for St. Elizabeth Medical Center and the Cincinnati-Middletown, OH-KY-IN CBSA for Federal Fiscal Year 2009. This was a Medicare Group Appeal involving the FFY 2009 hospital wage index established for St. Elizabeth Medical Center (St. Elizabeth) and for the Cincinnati-Middleton, OH-KY-IN CBSA, and the hospitals using this wage index.[4] St. Elizabeth has certain "Baylor Plan" employees who are contractually obligated to work two twelve-hour shifts (for a total of 24 hours) on weekends and holidays. As an incentive for working these shifts, the employees are paid for 32 hours of work, with the extra eight hours being "Baylor Hours" or "bonus hours".[5] St. Elizabeth sought to have the additional 8 hours removed from the hours worked

[4] This case (PRRB Case No. 09-1447G) is substantively similar to the issues in Cincinnati-Middletown FFY 06 Wage Index Group, PRRB Cases No. 05-0636G and Cincinnati-Middletown FFY 06 Wage Index Group, 06-0679G. Both of these cases also involved the inclusion of St. Elizabeth's "Baylor Hours" in the wage index calculation for hospitals using the Cincinnati-Middleton, OH-KY-IN CBSA wage index. This case is also substantively similar to the issues in Rural Iowa FFY 2006 Wage Index Group, PRRB Case No. 06-0681G; Rural Iowa FFY 2007 Wage Index Group, PRRB Case No. 07-1375G; Rural Iowa FFY 2008 Wage Index Group, PRRB Case No. 08-0849G; and Rural Iowa FFY 2009 Wage Index Group, PRRB Case No. 09-1222G. The Board's decision, PRRB Dec. No. 2012-D1, includes all of these cases, and thus the Board's decision in regards to the "Baylor Issue" applies equally to all, despite only discussing the Cincinnati-Middletown, OH-KY-IN CBSA FFY 2009 Wage Index group.

[5] The Provider claimed this was done, instead of paying a higher hourly wage to "Baylor Plan" employees, in order to keep down the average hourly wage of all employees at the hospital. *See* Tr. at 136-139. *See also* Providers' Final Position Paper for Cincinnati-Middletown, OH-KY-IN CBSA FFY 2009 Wage Index (Baylor Plan), Exhibit P-7. However, because of this treatment, the employee also receives full-time benefits, despite only working a part-time schedule. *See* Tr. at 134, 136. *See also* Providers' Final Position Paper for Cincinnati-Middletown, OH-KY-IN CBSA FFY 2009 Wage Index (Baylor Plan),

on its cost report, citing CMS Pub. 15, Part II, §3605.2 which notes that "no hours are required for bonus pay". However, CMS denied the request and published the final wage index, which included the Baylor Plan bonus hours in the calculation of St. Elizabeth's average hourly rate. The inclusion of these "Baylor Hours" in the wage index reduced the total reimbursement for St. Elizabeth and for the hospitals using the Cincinnati-Middleton, OH-KY-IN CBSA wage index.

The Board found that the Fiscal Intermediary and CMS did not properly determine the Wage Index, as the Baylor Plan paid hours should be adjusted to remove the inflated hours used to calculate the Provider's average hourly wage rate.

The Board noted that it extensively examined CMS guidance, and that CMS Pub. 15, Part II, §3605.2 states that for employees who work a regular work schedule, no hours are required for bonus pay. The Board considered this significant, claiming that the language of the section makes clear that paid hours related to bonus and premium pay should be excluded.

The Board noted that the additional hours paid to the employees of St. Elizabeth were neither worked hours, nor should they properly be considered paid hours, but were merely a mechanism that allowed the Provider's accounting system to record the proper payment amount. The Board stated that the Provider attempted to adjust the hours to reflect those that were actually paid, but that the Intermediary continued to use the inflated hours, resulting in a disparate treatment of paid hours with in the wage index calculation, despite statutory requirements that the Secretary adjust hospital costs to reflect relative hospital wages uniformly.

SUMMARY OF COMMENTS

The Providers commented, urging the Administrator to affirm the Board's decision on both issues. The Providers noted that in both issues, the parties agreed that there were no material facts in dispute, and stipulated as to a variety of facts relevant to the case.

In regards to Issue No. 1, the "Short Term Disability Issue", the Providers noted that the short term disability hours are not "paid hours" in any true sense, but rather hours merely used for accounting purposes to calculate the appropriate short term disability payment to the employee. The Providers argued that it created an inconsistency to have costs related to short term disability matched with paid hours, while other hospitals that pay short term disability through a third party do not have costs matched with paid hours. The Providers claimed that this inconsistent treatment violates the mandate in the statute that the wage index shall reflect "the relative hospital wage level in the geographic area of the hospital

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Exhibit P-6 ("The 24/36 program is to provide an alternative work schedule that includes full time benefits in exchange for working weekends.").

compared to the national average hospital wage area." The Providers noted that in *ViaHealth of Wayne County* v. *Johnson*,[6] the judge found that "when determining the averagely hourly wage of each hospital", the Secretary must "treat the costs and hours of each hospital in the same manner, so that the average hourly wages of all hospitals may be accurately compared against one another."

Regarding Issue No. 2, the "Baylor Plan Issue", the Providers stated that the Baylor Plan hours were not "paid hours", but rather an accounting mechanism used by the hospital to calculate a premium per hour incentive for employees who work undesirable shifts.

The Providers noted that the Intermediary in an October 28, 2011 letter requesting Administrator review of the Board's decision, the Senior Medicare Counsel stated that the Baylor Plan Issue "revolved around a system designed to pay a premium for working undesirable shifts. Under the Baylor Plan, the hospital compensated for working certain shifts by paying an additional 8 hour shift as bonus time." The Providers argued that the characterization by the Senior Medicare Counsel of the Baylor hours at issue as "bonus time" should resolve the matter, as CMS Pub. 15, § 3605.2 states that "No hours are required for bonus pay" when calculating "total paid hours" for wage index purposes.

The Intermediary commented, requesting that the Administrator reverse the Board's decision on both issues. The Intermediary noted that paid hours is the correct basis for reporting wages and hours for wage index purposes, and that this policy has been clearly enunciated by CMS. The Intermediary also pointed out that consistency in treatment of wage information is fundamental to the wage index process.

The Center for Medicare (CM) commented, stating that it disagreed with the Board's decision on both issues, and requested that the Administrator to reverse the Board's decision on both issues.

On Issue No. 1, the "Short Term Disability Issue", CM noted that it has been longstanding CMS policy that short-term disability cost can be included in the wage index in two distinct ways, depending on how the provider is funding the payments. First, if a provider uses an outside insurance carrier or self-insures in accordance with section 2162.7 of the Medicare Provider Reimbursement Manual (PRM), Part I, then CMS considers the cost to be an insurance cost and, therefore, a wage-related cost for the wage index (similar to health insurance). Wage-related costs are included in the wage index with no associated hours. Second, if a provider funds short-term disability cost directly from its payroll (that is, the hospital uses general operating funds with no defined plan and dedicated funds), then CMS considers the short-term disability cost to be extended sick leave, similar to any other paid leave category, and CMS includes both the salaries and associated hours in the wage index.

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[6] 2009 WL 995611 (W.D.N.Y. 2009) (vacated on other grounds).

CM stated that it would have been inconsistent and inappropriate, based on the Medicare cost reporting and wage index guidelines in PRM, Part I, section 2162.7 and Part II, section 3605.2, respectively, for the Intermediary to treat the Providers' short-term disability costs as insurance (wage-related) cost, as they did not meet Medicare's requirements for allowable insurance cost and, thus, did not meet the wage index requirements for an allowable wage-related cost. CM further pointed out that salary cost and wage-related or fringe benefit cost have always been treated as two distinct types of costs for both Medicare cost finding purposes and the wage index, and thus there is no merit to the argument that the wage index is compromised if the same items of costs are not categorized as wages for all providers.

Finally, CM noted that the Federal District Court's decision in *ViaHealth of Wayne County v Sebelius* was later vacated by the Court, and thus, has no merit in the arguments of this case.

Regarding Issue No. 2, the "Baylor Plan Issue", CM stated that it has been CMS' longstanding policy that the wage index is based on paid hours, not hours worked.[7] By way of example, CM noted that, if an employee was on paid vacation for 40 hours during an 80-hour bi-weekly pay period, the employee's paid hours for the wage index would be recorded as 80 hours for that period, although the employee only worked 40 hours. CMS' policy of basing a provider's average hourly wage on paid hours provides for a consistent measure of average hourly wages for the wage index. Thus, in this case, the Intermediaries appropriately adjusted St. Elizabeth's hours to reflect the documented 32 paid hours.

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[7]CM cited 59 Fed. Reg. 45,330, 45,353-54 (Sept. 1, 1994), which notes, "We have always used total paid hours as opposed to total hours worked for calculating the average hourly rate. Total paid hours more accurately reflect all elements of total salary. We clarified the definition of total hours in the cost reporting instructions to specify that total hours mean total paid hours. Paid hours include regular hours, overtime hours (counted as a regular hour), and paid holiday, vacation, and sick leave hours or any other hours associated with paid time off such as jury duty or bereavement pay. These are included to achieve comparability among hospitals and to recognize all work hours for which the hospital paid wages. Salaries are based on a standard work period (such as 40 hours or 37.5 hours per week) that is specified by the hospital employer. This work period includes any time covered by paid leave, as well as any non-productive time for which the employee receives a salary (such as a paid lunch period or a 15-minute break). Hospitals are not asked to account for and/or subtract this non-productive time, because the employee is being paid for the time. If a hospital elects to pay its employees based on a 7.5 hour day because employees are not paid for lunch and are free to leave the work site, and the overtime rate and other fringe benefits are based on the hourly rate computed based on the 7.5 work day, the hospital's labor distribution report would appropriately report hours based on 37.5 hours per week. Additionally, we emphasize that hours reported must correspond to the salaries reported. If a salary is paid there should be corresponding hours."

CM also pointed out that many providers have similar plans, but without the same nomenclature or treatment as St. Elizabeth. Some providers do not account for the difference between the paid hours and the actual hours worked as "bonus pay", and may record in its payroll records the paid plan hours, rather than the worked plan hours, for other reasons, including an employee's eligibility for full fringe benefits or for IRS reporting purposes. CM noted that, in these instances, the inclusion of paid plan hours in the wage index is consistent with the providers' accounting of paid plan hours for other purposes. Other providers include on their payroll systems the 24 hours as paid hours and acknowledge that employees on such plans are paid a higher hourly rate due to weekend/shift pay differentials. In instances where the payroll record actually reflects 24 paid hours, the hours included in the wage index data are 24 hours.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

The Medicare program was established to provide health insurance to the aged and disabled. 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.

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 proportion of those costs to be allocated to Medicare. 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). A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Board within 180 days of the issuance of the NPR.

The Social Security Amendments of 1983 created an inpatient prospective payment system (IPPS) to reimburse hospitals for operating costs incurred in providing acute care inpatient services to Medicare patients. Under this system, hospitals are paid a fixed amount for each patient treated, depending upon the diagnosis related group (DRG) and the type of treatment provided.

To calculate payment amounts under the IPPS, the Secretary initially determines a standardized, nationwide "Federal rate," which is the nationally-calculated average costs of a typical inpatient stay. The Federal rate consists of two components: (a) the portion of costs that can be attributed to labor-related costs and (b) non-labor related costs. The Secretary then adjusts the labor-related portion of the Federal rate to account for geographic-area differences in hospital wage levels. Specifically, the statute states that "the Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals' costs which are attributable to wages and wage-related costs, of the DRG prospective payment rates . . . for area differences in hospital wage level by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." Each hospital is located in either a Metropolitan Statistical Area (MSA)[8] or a statewide rural area.

Pursuant to the above statutory mandate requiring a factor to "reflect the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level," CMS developed a "wage index" methodology. The wage index for each MSA or rural area is based on the ratio of the hospital wage levels in that area compared to the national average wage level, and is derived from the wage and wage-related costs reported by those hospitals in a prior cost year. To determine hospital wage levels, CMS collects data from hospitals through worksheet S-3 of the cost report. This data consists of a variety of costs and hours. An average hourly wage (AHW) is calculated for each hospital each year.

CMS is required to update the wage index annually and bases the annual update on a survey of wages and wage-related costs taken from cost reports filed by each hospital paid under IPPS. Based on the substantial amount of time that is needed for providers to compile and submit cost reports and for intermediaries to review these reports, there is generally a four-year lag between the filing of cost reports and the reporting of wage data and the date when the wage index is published for use in a particular FFY.

The Secretary described in great detail the methodology used to compute the FFY 2009 area wage indices from data collected from hospitals' fiscal year (FY) 2005 Medicare cost reports. First, the Secretary determined the cost of each hospital's total salaries and fringe benefits as reported on a hospital's cost report. Next, the Secretary determined each hospital's total labor hours, also based on data reported on the hospital's cost report. Wage costs and the related hours are included in these computations, whereas wage-related costs

[8] In the Federal fiscal year 2005 Hospital Inpatient Prospective Payment System Rule, CMS discussed and adopted changes to the metropolitan statistical area (MSA) criteria used to define hospital labor market areas based on the new Core-Based Statistical Areas or CBSA definition announced by OMB on June 6, 2003 which are based on 2000 Census data. *See, e.g.*, 69 Fed. Reg. 28,196, 28,248–28,252, 28,321 (May 18, 2004); 69 Fed. Reg. 49,026, 49,034, 49,077 (Aug. 11, 2004).

have no corresponding hours. The Secretary then added together the salaries and fringe benefits for all the hospitals within each labor market area, to arrive at a total figure of salary and fringe benefits for each area. The Secretary divided the total salaries plus fringe benefits for each area by the sum of the total hours for all hospitals in each area to determine an average hourly wage for the area. Finally, the Secretary added the total salaries plus fringe benefits for all hospitals in the nation and then divided that sum by the national sum of total labor hours to arrive at a national average hourly wage. The Secretary then calculated the wage index value for each urban or rural labor market area by dividing the area average hourly wage by the national average hourly wage.

CMS uses total paid hours, rather than total hours worked, in the computation of the wage index, as total paid hours more appropriately reflect what is included in total salary.[9]

Regarding Issue No. 1, the short-term disability issue, the PRM, Part I, Chapter 21 discusses costs related to Patient Care that are allowed, and notes in §2161, "The reasonable costs of insurance purchased from a commercial carrier…are allowable if the type, extent, and cost of coverage are consistent with sound management practice." Section 2162 notes that:

> Where provider costs incurred for protection against malpractice and comprehensive general liability, or for protection against malpractice liability only, unemployment compensation, workers' compensation coupled with second injury coverage, and employee health care insurance, do not meet the requirements of §2161.A, costs incurred for that protection under other arrangements will be allowable under the conditions stated below.

Section 2162.3 notes that self-insurance costs are allowable costs if the self-insurance program meets the conditions specified in §2162.7. The relevant portions of this section specify:

> 2162.7 Conditions Applicable to Self-Insurance.--
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> A. Definition of Self-Insurance.--Self-insurance is a means whereby a provider(s), whether proprietary or nonproprietary, undertakes the risk to protect itself against anticipated liabilities by providing funds in an amount equivalent to liquidate those liabilities.
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> 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. For example, any agreement designed to provide administrative services only shall be considered self-insurance and must meet

[9] *See, e.g.*, 58 Fed. Reg. 46,299 (Sep. 1, 1993). *See also* 68 Fed. Reg. 45,397 (Aug. 1, 2003).

the requirements specified below. If administrative services agreements do not meet these requirements, any amounts funded as part of the agreement will not be allowed. Payments from the fund, however, will be treated on a claim-paid basis as specified in §2162.3.

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B. Self-Insurance Fund.--The provider or pool establishes a fund with a recognized independent fiduciary such as a bank, a trust company, or a private benefit administrator. In the case of a State or local governmental provider or pool, the State in which the provider or pool is located may act as a fiduciary. The provider or pool and fiduciary must enter into a written agreement which includes all of the following elements:

1. General Legal Responsibility.--The fiduciary agreement must include the appropriate legal responsibilities and obligations required by State laws.

2. Control of Fund.--The fiduciary must have legal title to the fund and be responsible for proper administration and control. The fiduciary cannot be related to the provider either through ownership or control as defined in Chapter 10, except where a State acts as a fiduciary for a State or local governmental provider or pool. Thus, the home office of a chain organization or a religious order of which the provider is an affiliate cannot be the fiduciary. In addition, investments which may be made by the fiduciary from the fund are limited to those approved under State law governing the use of such fund; notwithstanding this, loans by the fiduciary from the fund to the provider or persons related to the provider are not permitted. Where the State acts as fiduciary for itself or local governments, the fund cannot make loans to the State or local governments.

3. Payments by Fiduciary.--The agreement must provide that withdrawals must be for malpractice and comprehensive general liability or unemployment or workers' compensation insurance losses, or employee health benefits coverage only and those expenses listed in §2162.8. Any rebates, dividends, etc., to the provider from the fund will be used to reduce allowable cost. Furthermore, evidence of a practice of payments from the fund for purposes unrelated to the proper administration of the fund may result in a withdrawal of recognition of the self-insurance fund by the Medicare program. In such instances, payments into the fund will not be considered an allowable cost. Intermediaries will submit incidents of impropriety to the appropriate regional office.

> 4. Termination.--The agreement must state that upon termination from the Medicare program, the provider must obtain a determination of the adequacy of the fund balance as of the date of termination from an independent actuary, insurance company, or broker (as defined in B below). Any reserves that are deemed excessive must be offset against the provider's allowable costs in the provider's final cost report. If the reserve fund is deemed inadequate, additional contributions to the fund subsequent to the date of termination are not allowable.
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> 5. Reporting.--The agreement must require that a financial statement be forwarded to the provider or pool members by the fiduciary no later than 60 days after the end of each annual insurance reporting period. This statement must show the balance in the fund at the beginning of the period, current period contributions, and amount and nature of final payments, including a separate accounting for claims management, legal expenses, claims paid, etc., and the fund balance. This report and fiduciary's records must be available for intermediary review and audit.
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> 6. Income Earned.--The agreement must provide that any income earned by the fund must become part of the fund and used in establishing adequate fund levels.

Thus, had St. Elizabeth[10] pursued the normal route of paying an insurance provider to handle the disability insurance, the costs would not have been a part of the salary, but instead would have been wage-related costs, and thus the associated hours would not have been included. Similarly, if St. Elizabeth had been able to demonstrate that their self-funded disability plan met the requirements of PRM 15-1-2162.7 for allowable self-insurance funds, then the expense of their disability self-insurance plan would have been properly reflected on line 13 of Worksheet S-3 Part II as a wage-related cost, and the hours would not have been included on line 1 of Worksheet S-3 Part I. However, St. Elizabeth failed to meet these criteria.[11] Thus, because it is not properly considered an insurance cost, the costs and hours

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[10] Or any other hospital using the method of payment of short-term disability at issue in this case. As was previously noted, it is unclear which, if any, of the other hospitals did this. *See* n. 2, regarding the only documented provider that had timely appealed the wage data determination.

[11] *See also* Tr. at 81, where it is noted, "What this hospital's doing is not a self-funded plan as described in Medicare guidelines." In the case of Mercy, CMS' denial letter, sent in reply to a request for an adjustment to the FFY 2005 wage data for Mercy Medical Center-North Iowa specifically noted that only short-term disability insurance cost (either self-funded or purchased) that meets the requirements of allowable insurance cost for Medicare cost finding purposes, as noted in the Provider Reimbursement Manual, Part I, section 2161, can

attributable to employees must be considered paid time off. As such, the paid time off costs and hours must be reflected on line 1 of Worksheet S-3 Part II and no amounts should be reflected on Worksheet S-3 Part II as wage-related costs.

Additionally, the Administrator finds that the Providers' argument that including the hours is inconsistent is contradictory to actions taken by the Intermediary in this case, and in other cases. First, as the Provider did not arrange for a third party insurer and did not properly self-insure, the Intermediary's treatment is consistent with other cases. Moreover, at least one hospital in the Cincinnati-Middletown, OH-KY-IN CBSA, and at least one hospital in the Rural Iowa CBSA that paid short-term disability directly out of payroll were treated in a similar manner by the Intermediary in this case. This is the also same treatment that was given to Rochester General Hospital.[12] There is no evidence that all hospitals that pay short-term disability out of the payroll system, rather than through an insurance carrier or proper self-insurance fund, are not handled the same way. To the contrary, a distortion to the wage index would occur if St. Elizabeth's direct payment of short-term disability was handled differently from other hospitals that chose the same payment method.

Accordingly, after review of the record and applicable law, the Administrator finds that the Intermediary properly included the short-term disability hours paid by St. Elizabeth on Worksheet S-3, Part II, Line 1, Column 4 on its cost report and thus properly determined the Cincinnati-Middletown, OH-KY-IN wage index for FFY 2009[13] in a manner that reflected the relative hospital wage level in that geographic area as compared to the national average.

Regarding Issue No. 2, the Baylor Plan Hours, it has been CMS' longstanding policy to use paid hours rather than hours worked for calculating the wage index, because paid hours more appropriately reflect the basis of a salary, which includes paid leave as well as any non-productive time for which the employee receives a salary. The Administrator notes that the importance of using paid hours rather than hours actually worked is especially important for the Baylor Plan Hours, since part of the reason the additional hours are recorded is that it allows the employee to receive benefits, something to which a part time employee would not be entitled.

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be included in the wage index as a wage-related cost without associated hours. CMS noted that Mercy's short-term disability benefits did not qualify as an insurance plan. *See* Providers' Final Position Paper on Rural Iowa CBSA FFY 2009 Wage Index (Short Term Disability), Exhibit P-7. Similar language was used in CMS' denial letter, sent in reply to a request for an adjustment to the wage data for St. Elizabeth Medical Center. *See* Providers' Final Position Paper on Cincinnati-Middleton, OH-KY-IN CBSA FFY 2009 Wage Index (Short Term Disability), Exhibit P-7.

[12] *See Rochester 2004 MSA Wage Index Group*, PRRB Dec. No. 2009-D2.

[13] This decision applies equally to the Rural Iowa FFY 2009 Wage Index, Group PRRB Case. No. 09-1248G.

Finally, the Administrator notes that Baylor Plan hours at all hospitals are treated in a similar manner,[14] and a distortion to the wage index would occur if St. Elizabeth's Baylor Plan Hours were handled differently from other hospitals that use Baylor Plan Hours.

Accordingly, after review of the record and applicable law, the Administrator finds that the Intermediary was correct in its treatment of the Baylor Plan hours, and thus properly determined the wage indexes for St. Elizabeth Medical Center and the Cincinnati-Middletown, OH-KY-IN CBSA for Federal Fiscal Year 2009.[15]

[14] *See* Intermediary's Position Paper for Rural Iowa FFY 2006 Hospital Wage Index, Exhibit I-3. This letter from Cahaba Government Benefit Administrators notes that they received similar requests to remove the Baylor hours from other providers, and thus forwarded the issue to CMS, who cited PRM Part II, Section 3605.2, column 4, and also September 1, 1994 Final Rule (59 Fed Reg 45353) which notes, "we have always used total paid hours as opposed to total hours worked for calculating the average hourly rate."

[15] This decision applies equally to the Cincinnati-Middletown FFY 06 Wage Index Group, PRRB Cases No. 05-0636G ; Cincinnati-Middletown FFY 06 Wage Index Group, 06-0679G; Rural Iowa FFY 2006 Wage Index Group, PRRB Case No. 06-0681G; Rural Iowa FFY 2007 Wage Index Group, PRRB Case No. 07-1375G; Rural Iowa FFY 2008 Wage Index Group, PRRB Case No. 08-0849G; and Rural Iowa FFY 2009 Wage Index Group, PRRB Case No. 09-1222G.

DECISION

Issue No. 1: The decision of the Board is reversed consistent with the foregoing opinion.

Issue No. 2: The decision of the Board is reversed consistent with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 11/29/2011

/s/
Marilynn Tavenner
Principal Deputy Administrator and Chief Operating Officer
Centers for Medicare & Medicaid Services