CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Rochester 2004 MSA Wage Index Group **Providers** **vs.** **Blue Cross Blue Shield Association/ National Government Services-NY** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Year Ending: December 31, 2000** **Review of:** **PRRB Dec. No. 2009-D2** **Dated: November 10, 2008**

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 USC 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 CMS Centers for Medicare Management (CMM) submitted comments requesting that the Administrator reverse the Board's decision. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue was whether the Intermediary properly determined the Rochester New York MSA wage index for fiscal year 2004 in a manner that reflected the relative hospital wage level in that geographic area as compared to the national average.

The Board noted that the pivotal question in this case was whether the short-term disability expense should be included as "salaries and wages" versus "wage-related costs". Citing to Exhibit 6, Part I – Wage Related Cost (Core List) of the CMS Program Instructions for Form CMS-339, which lists "disability insurance" as a wage-related cost, the Board found that the short-term disability hours should have

been excluded from the wage index data used to calculate the FFY 2004 Wage Index for the Rochester, New York MSA. The Board found that the method of payment does not affect the nature of the underlying costs in that it remains a wage-related cost.

Thus, the Board found that the inclusion of the disability insurance costs as salaries and wages and the inclusion of related hours was not the proper treatment for these types of costs. Rather, these costs should be treated as wage-related costs as required by the cost reporting instructions to ensure consistent treatment by all providers for the sake of uniformity and comparability.

The Board noted that, in its earlier decision on this issue, it made a distinction between providers based simply on their method of payment, holding that short-term disability payments should be classified based on how the payment was processed—either through the hospital's payroll or general accounting systems. However, the Board claimed, this created a disparity in how these types of costs are treated and classified for wage index purposes, since that would depend on how providers chose to fund the benefit to their employees. The Board cited Sarasota Memorial Hospital, et. al. v. Shalala, 60 F.3d 1507 (11th Cir., 1995), which it said made clear that such a distinction is improper and that the uniformity of the wage index is compromised if the Secretary does not classify the same items of costs as wages for all providers. Thus, the Board concluded, the fact that this one Provider (Rochester General Hospital or RGH) opted to pay an employee benefit through its payroll systems does not change the nature or type of the underlying cost, and the classification of short-term disability expenses as "wage-related costs" is required according to CMS program instructions.

SUMMARY OF COMMENTS

CMM submitted comments requesting that the Administrator reverse the Board's decision. CMM explained that instructions on the Provider Cost Report Reimbursement Questionnaire, Form CMS-339, require that a "wage related cost reported on Part II of Exhibit 7, must…be recognized as a wage related costs in conformity with published criteria." They noted that the instructions in Publication 15-1 "The Provider's Reimbursement Manual- Part I" (PRM), Chapter 21, part 2162 details the requirements for acceptable insurance costs not purchased from a commercial carrier for "protection against malpractice and comprehensive general liability, or for protection against malpractice liability only, unemployment compensation, workers' compensation coupled with secondary injury coverage, and employee health care insurance." This section includes instructions at 2162.7 for establishing a self-funded insurance program. CMM observed that the RGH

failed to document that it met these requirements, specifically the requirement that the "provider or pool establishes a fund with a recognized independent fiduciary such as a bank, a trust company, or a private benefit administrator", as well as other conditions necessary to establish a self-insurance plan, and other alternative insurance plans, described throughout part 2162.

CMM stated the funds disbursed by RGH to employees did not meet the requirements to be acceptably deemed as an "insurance" cost for the wage index. Thus the costs were correctly categorized by the Intermediary as general "salary and wages" costs and the associated hours must be included in the average hourly wage calculations.

The Providers submitted comments noting that at issue are the hours reported as "paid hours" for purposes of calculating payments under RGH's short-term disability policy. To determine the amount of benefit payments, RGH multiplied the wages by the usual work week hours. RGH did not fund an insurance pool, but rather paid the short-term disability costs directly out of its current payroll. The Providers argued that the hours at issue were initially included in RGH's payroll system simply for accounting purposes as a means to calculate the amount of disability paid to individuals. The Providers argued that these short-term disability benefits are not only typical, but are mandated by State law. The Providers argued that the short-term disability payments are distinguishable from "Paid Time Off" (PTO), or typical sick days, because employees do not have to explain or justify PTO. If they have sufficient PTO accrued, they can use that to receive pay. By contrast, employees seeking the short-term disability payments must document that the reason for their absence is a disability or illness, with that documentation subject to review by the hospital's staff. The Providers also stated that, starting with the 2002 cost report, RGH excluded the short-term disability hours at issue before filing its cost report, without a challenge from the Intermediary.

The Providers noted that §1886(d)(3)(E) of the Act requires that the wage index be established in a manner creating a uniform picture of area wage levels for IPPS providers, and that such uniformity is compromised by inconsistent treatment of wage data across providers. The Providers claimed that in this case, the recording of paid hours was not uniform, as RGH's wage determination included "paid hours" related to costs for a short-term disability program and that those hospitals that paid an outside insurance carrier to administer such a disability program did not. The Providers stated that this situation was analogous to the situation in Sarasota Memorial Hospital, where the subject hospital paid the employee share of FICA taxes directly to the government instead of paying the employee and then withholding the tax, which is the more routine practice. The Court determined that it was arbitrary and capricious for the Secretary to classify FICA taxes as fringe

benefits for one hospital and as wages for other hospitals. The Providers noted that the uniformity requirement that was articulated in Sarasota was given a boost by the District Court for the District of Columbia in Anna Jacques Hospital et. al., v. Leavitt, 537 F.Supp. 2d (D.D.C. Feb. 26, 2008). In Anna Jacques, the court was adamant that Congress required "the area wage index accurately reflect the relative hospital wage level in the geographic area of the hospital when compared to the national average." Thus, the Providers claimed, the courts in Sarasota and Anna Jacques made clear the proposition that uniform measurements must be applied and that it is not permissible to match costs with hours for a category of costs for some providers but not for others.

Next, the Providers argued that the testimony of the Intermediary showed that the hours at issue were counted not due to Medicare principles, but rather because they were initially included within the payroll system due to computer system limitations, and that hospitals without such limitations would not have had such hours included. The Providers claimed that whether such hours are to be included in the entire MSA's wage index determination should not depend on the eccentricities of one hospital's computer system.

The Providers also argued that the Intermediary's approach penalized RGH's efforts to reduce costs, as the hospital was able to cut out the "middle man" which the Providers hypothesized would reduce overall costs.

The Providers also urged that the Board had properly reversed its prior decision involving the same issue and Providers in PRRB Dec. No. 2007-D67. In that decision, the Providers noted, the Board Majority had focused on the form of the payments, rather than their substance, ignoring the fact that the only purpose for the hospital recording the hours was simply to calculate the amount that would be paid to the employee. By contrast, in the case at issue, the Board properly focused on the substance of the costs involved. The Providers also noted that the Board in the present case appropriately focused on Form CMS-339 and its mandate that disability related costs not be treated as "wages and salaries" but rather as "wage related costs."

Finally, the Providers addressed CMM's comments as "irrelevant" as they did not address the Sarasota case or Form CMS-339, but instead focused on the "undisputed point that Rochester General Hospitals' short-term disability program did not meet the definition of a 'self-insurance' plan in PRM §2162," noting that this fact "says absolutely nothing about whether it is nonetheless a 'wage-related cost' pursuant to Form CMS-339 and PRM §3605.2."

DISCUSSION

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

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.[1]

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.[2] 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).[3] 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.[4]

The Social Security Amendments of 1983[5] 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.[6] The Federal rate consists of two components: (a) the portion of costs that can be attributed to labor-related costs and (b) non-labor

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[1] Section 1816 of the Act.
[2] 42 C.F.R. §413.20.
[3] 42 C.F.R. §405.1803.
[4] Section §1878(a) of the Act; 42 C.F.R. §405.1835.
[5] Pub. L. No. 98-21
[6] See §1886(d)(3) of the Act.

related costs. The Secretary then adjusts the labor-related portion of the Federal rate to account for geographic-area differences in hospital wage levels.[7] 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) or a statewide rural area.[8]

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.[9]

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.[10] 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 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 2004 area wage indices from data collected from hospitals' fiscal year (FY) 2000 Medicare cost reports.[11] 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,[12] also based on data

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[7] See §1886(d)(3)(E) of the Act.
[8] See §1886(d)(3)(D) of the Act.
[9] 42 C.F.R. §412.63(x).
[10] Section §1886(d)(3)(E) of the Act.
[11] 68 Fed. Reg. 45,346, *45,398.
[12] CMS has noted, "We have always used total paid hours because they more appropriately reflect what is included in total salary. For example, if an individual takes paid sick leave, the corresponding hours need to be included in the total hours. This is appropriate because salaries are based on a specified work period

reported on the hospital's cost report. Wage costs and the related hours are included in these computations, whereas wage-related costs 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.

The Providers in this case are nine hospitals that participate in the Medicare program and that are part of the Rochester, New York Metropolitan Statistical Area (MSA). New York State[13] has a non-occupational injury or illness benefits law which mandates that all employers (with certain exceptions) pay short-term disability payments to employees in certain circumstances. While the vast majority of hospitals contract with private insurers to provide short-term disability coverage for employees, one of the hospitals in the group, Rochester General Hospital, or "RGH", paid short-term disability payments to its employees out of its current payroll operating funds. In completing its Medicare cost report, RGH included the hours related to the short-term disability payment paid to its employees on Worksheet S-3, Part II, Line 1, Column 4 on its cost report for FY 2000, the cost year used to make the FFY 2004 wage index determinations.

Pursuant to the wage index correction process, on February 14, 2003, RGH submitted a timely request to its Intermediary for an adjustment to its FY 2000 wage index data by eliminating the hours related to the short-term disability payments. The Intermediary denied this request, claiming that "per CMS instructions, leave hours should be included in Line 1, Column 4, as paid hours." On March 20, 2003, RGH requested that the Intermediary reconsider this decision, stating that the hours reflected a "fringe benefit", rather than paid time off, and thus the hours should be excluded. The Intermediary notified the Hospital by email that it was not changing it initial denial, but that RGH could appeal the decision to CMS. On April 1, 2003, RGH wrote CMS requesting review of the

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(such as 40 hours per week) that includes any time during that period covered by paid leave, as well as any non-productive time for which the employee receives a salary (such as a paid lunch period)." 58 Fed. Reg. 46,270, *46,299.

[13] New Jersey, Rhode Island, California, Hawaii and Puerto Rico also have similar statutes.

Intermediary's decision, arguing that the hours would not have been counted had the Hospital used an outside carrier for disability insurance. Since it self-insured, the disability insurance cost should be a wage-related cost (thus no hours included), rather than a salary cost. CMS responded that it agreed with the Intermediary's determination, and therefore denied RGH's request to reduce the number of paid hours listed on line 1, column 4. As a result of including these hours and costs, the per hour wage costs for the Hospitals subject to the Rochester MSA FFY 2004 wage index was less than what it would have been had the hours been excluded. CMS' decision was appealed to the Board.[14]

In New York State, short-term disability payments are required by State statute and are governed by the State's Worker's Compensation board.[15] 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,

[14] The Board previously addressed the same issue for these providers for an earlier cost report period, with the majority deciding the issue in favor of the Intermediary and CMS. PRRB Dec. No. 2007-D67 (August 31, 2007). The Administrator declined to review this previous decision by the Board. It is currently on appeal in the United States District Court for the Western District of New York as ViaHealth of Wayne Co., et al v. Leavitt (07-CV-6638T).

[15] Article 9, Disability Benefits, falls under the New York Annotated Code for Worker's Compensation Law.

undertakes the risk to protect itself against anticipated liabilities by providing funds in an amount equivalent to liquidate those liabilities.

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 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.

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.

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 RGH gone 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 RGH 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, RGH failed to meet these criteria, and even admitted that their program was not self-insured, noting it was an "undisputed point that Rochester General Hospitals' short-term disability program did not meet the definition of a 'self-insurance' plan in PRM §2162".[16] Thus, because it is not properly considered an insurance cost, the costs and hours 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 "arbitrary and capricious" is contradictory to RGH's actions. RGH chose to include these costs and the associated hours in its original cost report. It did not ask to have these hours "backed out" until after meeting with a consultant who determined that the wage index would be higher if these hours were removed. RGH's short-term disability program was described in their own documents as a "salary continuation program" and it was shown that these payments were subject to tax and Social Security withholdings. These payments were recorded on RGH's payroll report, paid to the employee on their paycheck, and reported as salary on the employee's W2s. This dispute did not result from some action that the Intermediary took against RGH. Rather, the Intermediary accepted the cost report as filed by RGH. RGH originally submitted its short-term disability payments in the payroll account, and did not list them as wage-related costs. RGH's own actions demonstrate that the Intermediary's determination to include the hours was reasonable, as RGH originally included the hours as wage costs.

Finally, while the Providers argue that the hours associated with the short-term disability payments must be "backed out" for "consistency", 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. For example, a distortion to the wage index would occur if RGH's direct payment of short-term disability was handled differently from other hospitals that chose the same payment method.

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[16] See Providers' Comments to the Administrator, page 10.

Accordingly, after review of the record and applicable law, the Administrator finds that the Intermediary properly included the short-term disability hours paid by RGH on Worksheet S-3, Part II, Line 1, Column 4 on its cost report for FY 2000 and thus properly determined the Rochester New York MSA wage index for FFY 2004 in a manner that reflected the relative hospital wage level in that geographic area as compared to the national average.

DECISION

The Administrator reverses the decision of the Board in accordance with the foregoing opinion.

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

Date: **1/9/09** **/s/**

Herb B. Kuhn
Deputy Administrator
Centers for Medicare & Medicaid Services