CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Youngstown-Warren 02 Wage Index	**Cost Reporting Periods Ending: Various; 2002**
Provider	
vs.	
BlueCross BlueShield Association/ National Government Services, Inc.	**Review of:**
	PRRB Dec. No. 2012-D5
Intermediary	**Dated: January 06, 2012**

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 submitted comments requesting that the Administrator reverse the Board's decision concerning the removal of bonus hours from the wage index calculation. Accordingly, this case is now before the Administrator for final agency review.

BACKGROUND

The Providers (Western Reserve Care System and Trumbull Memorial Hospital) filed a group appeal on January 21, 2002, with the Board challenging the Youngstown-Warren Metropolitan Statistical Area (MSA) Wage Index applicable to the Federal Fiscal year 2002. The Providers raised a total of six (6) issues that were addressed by the Board. Western Reserve Care System raised the first five (5) issues concerning (Issue No.1) employee "bonus hours", (Issue No.2) medical director salary, (Issue No.3) contracted pathologist costs, (Issue No.4) contracted perfusionist costs, and (Issue No.5) legal expenses from the operation of a self-insured worker's compensation fund. Trumbull Memorial Hospital raised

the final issue concerning (Issue No.6) operating costs for an on-site day care center for the hospital's employees.[1]

ISSUE NO. 1 AND BOARD'S DECISIONS

Issue No.1, was whether the Fiscal Intermediary erred in refusing to exclude the Provider's "bonus" or "call back" hours paid from its Federal Fiscal Year (FFY) 2002 wage index calculations.

The Western Reserve Care System pays employees under a "bonus hour" system for working during critical or undesirable times, or when called back for an emergency or sudden need. Employees are paid a minimum of four hours for any time worked up to four hours and a minimum of eight hours for any time worked over four hours. Therefore, if an employee was called back for an emergency and worked only one hour, the employee would be paid for four hours. The extra three hours would be the bonus hours. The hospital's particular payroll system records these bonus hours as hours worked in order to be able to pay employees for these hours. For bonus/call back hours paid for radiology and lab technicians, the Provider reflected only the call back hours actually worked in its statement of hours submitted. The Intermediary included all of the bonus hours paid to these employees. At issue is whether these bonus hours, i.e., hours paid, versus the hours actually worked, should be included in the wage index calculation.

The Board found that the call back hours at issue should be excluded when calculating FFY 2002 Wage Index for the Youngstown-Warren MSA, stating that the call back hours represent a premium payment to employees. However, the Provider's payroll system could not process multiple wage rates per employee; and so, in order to effectuate the additional payment, employee hours were increased. Those additional hours do not represent hours worked and should not be included when calculating the wage index.

The Board noted 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 also noted that the additional hours paid to the employees were a mechanism that allowed the Provider's accounting system to record the proper payment amount.

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[1] The Board reversed the Intermediary's adjustment on Issue Nos. 1 through 5 and affirmed the Intermediary's adjustment on Issue No.6. The Administrator summarily affirms the Board's decision on Issue Nos. 2, 3, 5 and 6.

ISSUE NO. 4 AND BOARD'S DECISIONS

Issue No.4, was whether the Fiscal Intermediary erred in refusing to include provider's costs for contracted perfusionist services in its FFY 2002 wage index calculations.

Western Reserve Care System executed an Open Heart Surgery Program Support Services agreement with Allegheny General Hospital (Allegheny), a tertiary care and teaching hospital with an established open-heart surgery program. Allegheny agreed to provide cardiovascular perfusionist services to the hospital in exchange for certain fees. The Provider submitted a copy of the contract and several invoices from time studies in support of these costs. The Intermediary excluded all of the costs on the basis that the hourly rate was not reasonable and on the basis of lack of documentation.

The Board reversed the Intermediary's adjustment and found that the costs resulting from the perfusionist agreement with Alleghany were not unreasonable and the total cost was properly included in the Provider's wage index calculation.

SUMMARY OF COMMENTS

The Intermediary commented, requesting that the Administrator reverse the Board's decision stating that the Board incorrectly instructs the Intermediary to revise the Youngstown-Warren wage index to remove bonus hours from the wage index calculation, and in other cases, to include costs and hours that were not properly supported.

The Providers commented, urging the Administrator to affirm the Board's decision on Issue Nos. 1 through 5 and did not contest the Board's decision in favor of the Intermediary for Issue No.6.

According to the Provider, Issue No.2 through 5 are documentation issues, and hence, the basis of the Intermediary's denial had to do with the adequacy of documentation. Since the Board examined the documentation and determined that the Providers' documentation was sufficient, the Administrator should affirm the Boards' decision on these issues.

Regarding Issue No.1, the call back hours, the Providers stated that the issue focuses on circumstances where Western Reserve Case System paid employees "bonus hours" for working during critical or undesirable times, or when called back for an emergency or sudden need. The Provider stated that the Intermediary's request for review is determinative of this issue since its January 17, 2012 letter to the Administrator, requested review on the grounds "the PRRB decision incorrectly instructs the Intermediary to revise the Youngstown-Warren wage index to remove bonus hours from the wage index calculation."

The Intermediary's argument cannot be reconciled with the mandate of PRM 15-2 §3605.2 that "no hours are required for bonus pay."

The Intermediary acknowledges the hours at issue are "bonus hours" and therefore since the PRM section mentioned above does not require counting such hours, the Administrator should affirm the Board's decision on this issue.

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) 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 area wage indices at issue from data collected from hospitals' relevant fiscal year (FY) 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 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.[2]

Improvements in the wage data have allowed for easier identification of contract labor costs and hours. As a result, effective with the FY 1994 wage index, costs for direct patient care contract services were included in the wage index calculation. With the FY 1999 wage index, costs for certain management contract services were also included in the wage index calculation.[3] The definition of contract labor was expanded for purposes of determining the hospital wage index to include the personnel costs and hours associated with certain contract management personnel. Contract management services would be limited to individuals working in the top four positions in the hospital: the Chief Executive Officer/Hospital Administrator, Chief Operating Officer, Chief Financial Officer, and Nursing Administrator. For cost reporting periods beginning on or after October 1, 2000, contract pharmacy and laboratory costs furnished under contract could be included in the calculation.

The PRM 15-2, §3605, allows providers to enter amounts paid for services furnished under contracts, rather than by employees, for direct patient care, and management services. The Worksheet S-3, Part II consists of detailed information for use in the hospital wage index including contract labor for direct patient care services. In the instructions for completing this worksheet, contract labor costs and hours are limited to labor-related payments and hours attributable to direct patient care contract services. Specifically, hospitals are instructed to exclude indirect patient care contract services (for example, management and housekeeping services), nonlabor-related expenses (equipment and supplies), and any contract services for which labor-related payments and hours could not be accurately determined. The instructions emphasize that providers are not to include cost for equipment, supplies, travel expenses, and other miscellaneous or overhead items. The Instructions for line 9 explicitly state, in pertinent part, that:

> Direct patient care services include nursing, diagnostic, therapeutic, and rehabilitative services... report only personnel cost associated with these contracts... Eliminate all supplies, travel expenses, and other miscellaneous items... Direct patient care contracted labor, for the purposes of this worksheet, does not include ... management and consultant contracts... or any other service not directly related to patient care.

Management services furnished under contract rather than by employees may be included under limited circumstances but only those personnel costs associated with the contract can be reported. Providers are instructed to eliminate all supplies, travel expenses, and other miscellaneous items. The contract management services are limited to the personnel costs

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[2] *See, e.g.*, 58 Fed. Reg. 46,299 (Sep. 1, 1993). *See also* 68 Fed. Reg. 45,397 (Aug. 1,2003).
[3] 61 Fed. Reg. 46181 (August 30,1996).

for those individuals who are working at the hospital facility in the capacity of chief executive officer, chief operating officer, chief financial officer, or nursing administrator. The Instructions at line 9 go on to state that:

> For purposes of this worksheet, contract management services do not include... other management or administrative services... consultative services. .. physician services. .. or any other services other than the management contracts.

The amounts paid for pharmacy services furnished under contract, rather than by employees may also be reported, but cannot include services paid under Part B, management and consultant contracts, clerical and billing services, legal and accounting services, housekeeping services, security personnel, planning contracts, independent financial audits, or any other service not directly related to patient care. Providers are to report only personnel costs associated with contracts, and exclude all indirect costs.

Regarding Issue No.1, the bonus or call back 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. This longstanding policy is not only memorialized in the controlling policies and regulations, but has also been affirmed as appropriate in Federal Court. *See*, Adventist GlenOaks Hospital v. Sebelius, U.S. Court of Appeals, 7th Cir., (Dec. 15, 2011). The Adventist GlenOaks Hospital Court found that:

> The policy of counting all paid hours, including paid unworked hours, serves the important purpose of administrative simplicity. Under 42 U.S.C. §1395ww(d)((3)(E)(i), the Secretary is required to adjust the proportion of a hospital's costs attributable to wages and wage-related costs of the diagnosis related groups for area differences by a factor that reflects the relative wage level in the geographical areas of the hospital compared to the national average hospital wage level. The all-paid-hours approach is a "reasonable and statutorily permissible" method....

The Administrator notes that call back / bonus[4] hours at all hospitals are treated in a similar manner, and a distortion to the wage index would occur if the Western Reserve Care System's call back hours were handled differently from other hospitals that use call back / bonus hours.

[4] The call back/bonus hours was described as a system for working during critical or undesirable times, or when called back for an emergency or sudden need.

In contrast, the Board relies on the Court's decision in Sarasota Memorial Hospital, et. at v. Shalala, 60 F.3d. 1507 (11th Cir. 1995) to argue that the Intermediary's treatment of "bonus hours" in this case would create a disparity, and thus, the uniformity of wage index would be compromised if the Secretary does not classify the same items of costs as wages for all providers.

The Administrator finds that the facts in Sarasota Memorial, are different and distinct from those under review and therefore, not controlling. The case at bar is more akin to the facts in the Adventist GlenOaks Hospital v. Sebelius, U.S. Court of Appeals, 7th Cir., (Dec. 15, 2011). In *Sarasota Memorial*, the Secretary argued unconvincingly that the hospital's payments met HHS's definition of fringe benefits and that "the uniformity of the wage index would be compromised if she were required to determine which, if any, fringe benefits could be reclassified as wages." Id. at 1512.

However in Adventist GlenOaks Hospital, in contrast to Sarasota Memorial, the Secretary provided justification for her policy of counting all paid hours, and in doing so, the Adventist Court concluded that the Secretary's policy:

> is a bright-line rule that is comparatively easy to administer. It avoids the costs associated with tracking certain kinds of paid unworked time that payroll systems do not record. And it avoids the slippery slope that comes with trying to exclude certain types of paid leave but not others. In sum, the Secretary's justifications for the paid-hours policy are '''rational and consistent with the statute.''' *See Bd. of Trs. of Knox Cnty. Hosp. v. Sullivan*, 965 F.2d 558, 564 (7th Cir. 1992) (quoting *Sullivan v. Everhart*, 494 U.S. 83, 89 (1990)). *Id.*

As such, the Administrator finds that the Intermediary's treatment of bonus hours does not cause a disparity among other providers. The Intermediary properly used 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.

Accordingly, after review of the record and applicable law, the Administrator finds that the Intermediary was correct in its treatment of the call back / bonus hours,[5] and thus properly determined the Youngstown-Warren wage index for Federal Fiscal Year 2002.

Regarding Issue No.4, contracted perfusionist services, PRM 15-1, §2118 recognizes payments for services that are related to patient care and rendered under a fee-for service arrangement as an allowable cost for Medicare purposes. However, PRM 15-2, §3605.2, Part

[5] The administrator also notes that "call back / bonus hours" are distinguishable from "on-call" hours.

II, instructs the providers to include only the payment for services furnished under contracts for direct patient care in the provider's wage index calculations. The provider is instructed to report only personnel costs associated with these contracts.[6] For the purposes of calculating the wage index, personnel costs are not to include supplies, travel expenses and other miscellaneous items.

Of particular relevance to this case, the PRM 15-2, §3605.2, line 9 instructions specifically state that hospitals must "report only personnel costs associated with the contract" and must "eliminate all supplies travel expenses, and other miscellaneous or overhead items." The instructions for completion of the wage index information explicitly state that only amounts paid for direct patient care services and management under contract are to be entered on line 9 of the worksheet. Accordingly, the costs for equipment, supplies, travel expenses and other miscellaneous or overhead items are not to be included. This section also indicates that a breakdown of the contract cost is required in order to insure the exclusion of any indirect cost.

The Administrator finds that the Provider failed to properly eliminate all the travel expenses and miscellaneous items from the total cost reported for contracted perfusionist services and thus, these extrananeous items were improperly included in the Provider's wage calculation. The Provider's contract for perfusionist services included costs of cell phones, travel and other miscellaneous costs. The Board improperly minimizes the significance of eliminating inappropriate costs. Even if the perfusion expense, as stated by the Board, is approximately $392,000 with the miscellaneous expenses making up less than one percent of the total, inclusion of such miscellaneous costs conflicts with the existing policies, regulations and recent court precedents on this issue. The Provider's failure to carve out these miscellaneous expenses is not immaterial and if allowed systemically as a matter of policy would result in inappropriately high Medicare costs. The Administrator's previous decision to exclude ineligible expenses under perfusion services agreements that were appealed by the Provider in this case for a different cost year was upheld and supported by the courts.[7]

Furthermore, it is the Provider's responsibility to maintain and furnish the intermediary sufficient documentation for a proper determination of costs payable under the program,

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[6] PRM 15-2, §3605.2, Part II - Wage Index Information; Form CMS-2552-96; Instructions for line 9.

[7] *See*, Western Reserve Care System v. Leavitt, U.S. District Court, Northern District Of Ohio, Case No. 4:07CV1979, (7/25/08), where the District Court found that the Administrator did not err by excluding all costs under the perfusion services agreement. In Western Reserve Care System, the Court stated that decision to exclude the entire contract cost based on inadequate documentation is supported by Daviess v. Bowen, 811 F.2d 338, 345-346 (7th Cir. 1987), and Battle Creek Health System v. Leavitt, 498 F.3d 401, 410 (6th Cir. 2007) and is not arbitrary, capricious, or an abuse of discretion.

pursuant to 42 CFR §413.20 and §413.24. In the absence of sufficient documentation[8] that distinguishes the personnel cost from the indirect cost, the Intermediary cannot ensure that it has correctly eliminated those costs which tend to overstate the area's wage index. In addition, due to the fact that the wage index is applied in a budget neutral manner, an overstatement of an area's wage index would increase program payments to hospitals in that labor market area and decrease payments to all other hospitals in the country. The Administrator finds that, for the foregoing reasons, it is proper for an intermediary to exclude the total costs associated with a hospital's contract services if a hospital fails to exclude the associated indirect costs from its wage costs and does not provide sufficient documentation to enable the intermediary to adjust the hospital's wage costs to exclude these indirect cost.

Thus, contrary to the Board's findings, the Administrator finds that the principles governing the construction of the wage index, Medicare documentation rules, and the PRM 15-2, §3605.2 requires further breakdown of the costs incurred by Allegheny to provide these personnel services claimed under the agreement, which did not occur in this case. Consequently for the foregoing reasons, the perfusionist costs were properly excluded by the Intermediary.

[8] Id.

DECISION

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

Issue No. 4: The decision of the Board is reversed consistent with the foregoing opinion.

Issue Nos. 2, 3, 5 and 6: The decision of the Board is summarily affirmed.

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

Date: 2/29/12

/s/
Marilynn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services