PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2020-D14

PROVIDER –
Ozarks Community Hospital of Gravette

PROVIDER NO. –
04-1331

vs.

MEDICARE CONTRACTOR –
Novitas Solutions, Inc.

DATE OF HEARING –
July 31, 2018

Cost Reporting Periods Ended–
12/31/2010, 12/31/2011

CASE NOS.: 17-0654, 17-0656

INDEX

ISSUE STATEMENTS:[1]

1. Whether the use of total costs, rather than patient days, as a statistic to allocate home office pooled costs was proper;

2. Whether the use of gross revenues, rather than patient days, as a statistic to functionally allocate business office costs was proper; alternatively, whether business office costs should be in the home office pooled costs; and

3. Whether the use of gross revenues, rather than patient days, to functionally allocate transcription costs was proper; alternatively, whether transcription costs should be in the home office pooled costs.

DECISION:

After considering the Medicare law and regulations, the parties' contentions, and the evidence admitted, the Provider Reimbursement Review Board ("Board") makes the following findings for fiscal years ("FYs") 2010 and 2011:

1. The Medicare Contractor properly used total costs, rather than patient days, as a statistic to allocate pooled home office costs to the components of the chain.

2. The Medicare Contractor improperly used gross revenues as a statistic to functionally allocate both business office costs and transcription costs to the components of the chain.

Accordingly, the Board directs that, for FYs 2010 and 2011, the Medicare Contractor include both business office costs and transcription costs in pooled home office costs and then allocate pooled home office costs to components of the chain based on total costs pursuant to the Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1"), § 2150.3(D)(2)(b) (*i.e.*, "all chain components will share in the pooled home office costs in the same proportion that the total costs of each component (excluding home office costs) bear to the total costs of all components in the chain").

INTRODUCTION:

The provider in these consolidated appeals is Ozarks Community Hospital of Gravette ("Gravette" or "Provider"). Gravette and Ozarks Community Hospital of Springfield

[1] In Case No. 17-0654, the original Issue 1 challenged whether the establishment of OCH, LLC and DHS, LLC as "non-healthcare components" on the home office cost statement and the allocation of home office costs to these components was proper. In both Case Nos. 17-0654 and 17-0656, the original Issues 5 and 4, respectively, were the same issue and challenged whether the Medicare Contractor's disallowance of employee health insurance costs was proper. Immediately prior to the hearing, the parties reported joint stipulations regarding the Issues 1 and 5 in Case No. 17-0654 and Issue 4 in Case No. 17-0656 and, on March 29, 2019, the parties filed a Partial Administrative Resolution that resolved these issues and withdrew them from the respective appeals. As a result, Case Nos. 17-0654 and 17-0656 have the same three issues which the Board heard at the hearing and which this decision addresses.

("Springfield") comprise the only two components in the chain organization SGOH Acquisition ("SGOH"). During FYs 2010 and 2011, Gravette was a Critical Access Hospital ("CAH") paid by Medicare based on its costs, while Springfield was an acute care hospital paid by Medicare's inpatient prospective payment system ("IPPS").

For FYs 2010 and 2011, SGOH filed home office cost statements allocating certain home office costs to Gravette and Springfield. The Medicare contractor[2] assigned to the home office, *i.e.*, SGOH, is Wisconsin Physician Services ("WPS"). WPS audited the FY 2010 and 2011 home office cost statements and these home office audits reduced the home office costs allocated to Gravette.

Novitas Solutions, Inc. ("Novitas") is the Medicare Contractor assigned to Gravette and will be referred to as the "Medicare Contractor." Following WPS' home office audits of SGOH, the Medicare Contractor reopened Gravette's FY 2010 and 2011 cost reports and issued revised Notices of Program Reimbursement ("NPRs") in order to adjust the allowable home office costs to those amounts allowed in SGOH's audited home office cost statements.[3]

Gravette timely appealed its revised NPRs for FYs 2010 and 2011 and met the jurisdictional requirements for a hearing before the Board. On July 31, 2018, the Board held a consolidated live hearing on both FYs 2010 and 2011. Gravette was represented by Barbara Straub Williams, Esq. and Leela Baggett, Esq. of Powers, Pyles, Sutter and Verville PC. The Medicare Contractor was represented by Bernard Talbert, Esq. and Ed Lau, Esq. of Federal Specialized Services.

STATEMENT OF THE FACTS AND RELEVANT LAW:

The home office of a chain of commonly-owned health care providers is not a "provider" for purpose of the Medicare program and, as such, does not and cannot directly receive Medicare reimbursement.[4] Nevertheless, inasmuch as a chain's home office may perform certain centralized services for each chain provider, Medicare treats those support services as though "obtained from [the provider] itself."[5] The general process by which a home office allocates costs to components of a chain for inclusion on the cost reports of the chain's providers is as follows:

> To obtain reimbursement for home office support functions related to the care of Medicare patients, the provider's home office files a cost statement, which identifies the allowable home office costs and how they are allocated among each of its subsidiary companies

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[2] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate.

[3] *See* Provider's Final Position Paper, 1-3 (Mar. 29, 2018) (Case No. 17-0654). The Board notes that, while the Board held a consolidated hearing for Case Nos. 17-0654 and 17-0656, both parties filed separate final position papers for each case. Since the substantive arguments are identical in each case, the Board has chosen to only cite to the parties' final position papers in Case No. 17-0654 unless otherwise noted.

[4] *See* 42 U.S.C. § 1395cc.

[5] 42 C.F.R. § 413.17(c)(2). *See also* Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1"), § 2150.3.

> (also called "components"). *See* PRM [15-1] § 2150.3. First, the home office totals all of its own costs, including those that it incurred on behalf of its subsidiary companies, and deletes from that total all unallowable costs. *See id.* at § 2150.3(A). Second, the home office uses "direct allocation" to allocate as many of its costs as possible. Direct allocation accounts for home office costs that are for the benefit of, or directly attributable to, its Medicare subsidiary or its other subsidiaries. *See id.* at § 2150.3(B). Third, the home office must allocate as many of the remaining costs as possible on a "functional basis." *See id.* at § 2150.3(C).
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> After the home office allocates as many home office costs as possible to its subsidiaries by direct and functional allocation, a "pool" of allowable costs for general management or administrative services remains ("pooled costs"). *See id.* at § 2150.3(D).[6]

The Provider Reimbursement Manual, CMS Pub. No. 15-1 ("PRM 15-1"), § 2150.3(D)(2) provides guidance on the allocation of pooled home office costs and states, in pertinent part:

> a. Pooled home office costs must be allocated on the basis of inpatient days, *provided the entire chain consists solely of* ***comparable*** *inpatient health care facilities* (e.g., the entire chain is composed solely of short term inpatient hospitals). Where this situation exists, each facility in the chain would share in the pooled costs in the same proportion that its total inpatient days bears to the total inpatient days of all the facilities in the chain.
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> b. Pooled home office costs must be allocated to chain components on the basis of *total costs* if the chain is composed of either ***unlike*** health care facilities (e.g., a combination of short-term hospitals, long-term hospitals, and home health agencies) or a combination of health care facilities and nonhealth care facilities (i.e., facilities engaged in activities other than the provision of health care). Under this basis, all chain components will share in the pooled home office costs in the same proportion that the total costs of each component (excluding home office costs) bear to the total costs of all components in the chain. Total costs are costs before Medicare adjustments are made.[7]

The Provider Reimbursement Manual, CMS Pub. 15-2, ("PRM 15-2"), Chapter 39 contains instructions for completing the home office cost statement.[8] In particular, §§ 3902(C) and (D) contain the following general instructions for allocating functional and pooled home office costs to components in the chain:

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[6] *See Mercy Home Health v. Leavitt*, 436 F.3d 370, 373 (3rd Cir. 2006).
[7] (Emphasis added.)
[8] PRM 15-2, Ch. 39, Transmittal 1, Form CMS 287-05 (Sept. 2005) (*available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1P239.pdf).

> C. Costs of Home Office Operations.--Allocate among the providers the allowable costs not directly allocable on a basis designed to equitably allocate the costs over the chain components or activities receiving the benefits of the costs and in a manner reasonably related to the services received by the entities in the chain. Chain home offices may provide certain centralized services, e.g., central payroll or central purchasing, to the chain components. Where practical and the amounts are material, allocate these costs on a functional basis. For example, costs of a central payroll operation could be allocated to the chain components based on the number of checks issued. The costs of a central purchasing function could be allocated based on purchases made or requisitions handled. Otherwise, these costs may be appropriately included in the pooled costs and allocated as described in subsection D. The functions or cost centers used to allocate home office costs and the unit bases used to allocate the costs (including those for the pooled costs described in subsection D) must be used consistently from one home office accounting period to another.
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> D. Pooled Costs in Home Office -- In each home office, there is a residual amount, or pool of costs incurred for general management or administrative services which cannot be allocated on a functional basis.
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> Pooled costs are allocated between chain components on a reasonable allocation basis. Pooled costs must be allocated first between health care and non-health care component groups based on costs. After this initial allocation, *the pooled costs allocated to the health care facilities are based on inpatient days, **or** total costs **in accordance with CMS Pub. 15-1, §2150.3.D.2***. (See §3917.A.) Statistics must be gathered from each component for the period concurrent with that of the home office and must be separately identified. The statistics are based on unadjusted cost (including direct home office costs) and exclude previously allocated home office pooled and functional costs.[9]

Additionally, PRM -15-2 § 3917 provides specific instructions for Home Office Cost Statement Worksheet G – Allocation of Pooled Cost to Chain Components. These instructions state:

> A. Where Chain Consists Solely of Health Care Facilities. -- The pooled costs allocated to the health care facilities as a group are allocated to the individual components on the basis of inpatient days, or total costs. The statistics must be gathered from each component for the period concurrent with that of the home office and separately identified throughout Schedule G.

[9] (Emphasis added.)

> **NOTE**: Inpatient days may only be used when all of the components of the chain are the same type, e.g., short term acute hospitals.[10]

For FYs 2010 and 2011, SGOH allocated its pooled home office costs based on patient days. Included in SGOH's pooled home office costs were business office and transcription costs.[11] When auditing SGOH's home office cost statements, WPS removed business office and transcription costs from SGOH's pooled costs, and functionally allocated these costs to Springfield and Gravette based on gross revenues.[12] Additionally, WPS adjusted SGOH's allocation methodology for pooled costs, changing the allocation basis from patient days to total costs.[13]

On July 29, 2016, the Medicare Contractor issued revised NPRs for Gravette's FYs 2010 and 2011 cost reports in order to adjust the allowable SGOH home office costs to the amount that WPS allowed in SGOH's audited home office cost statements.[14] Gravette appealed these revised NPRs because it disagrees with its allocated share of home office cost from SGOH's audited home office cost statements.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW:

Gravette maintains that the Medicare Contractor incorrectly revised the NPR to incorporate WPS' revisions to the FY 2010 and 2011 home office cost statements. In this regard, Gravette argues that WPS improperly used total cost as an allocation statistic for SGOH's pooled home office costs and that this resulted in Gravette receiving an inaccurate allocation of SGOH's pooled home office costs. Gravette points out that, per PRM 15-1 § 2150.3(D)(2), pooled home office costs must be allocated on the basis of inpatient days when the chain consists of "*comparable* inpatient health care facilities,"[15] and total cost is only used as a statistic if the chain is composed of "*unlike* health care facilities"[16] or has a combination of healthcare and non-healthcare facilities.[17]

Gravette maintains that, during FYs 2010 and 2011, Gravette and Springfield were the only two components of the SGOH chain. Gravette further maintains that both it and Springfield are two "comparable" short-term inpatient hospitals and, as such, that it was proper to use patient days to allocate pooled home office costs.[18] Gravette points out that, even though it is a CAH and Springfield is an IPPS hospital, "[t]he PRM does not state that *comparable* inpatient health care

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[10] PRM 15-2 § 3917(A).
[11] Provider's Final Position Paper at 13, 19, 22.
[12] Medicare Administrative Contractor's Final Position Paper at 11, 13-14, 17. *See also* Provider's Final Position Paper at 19, 22.
[13] Medicare Administrative Contractor's Final Position Paper at 11. *See also* Case No. 17-0654 Exhibit I-4; Case No. 17-0656 Exhibit I-3 at 2.
[14] *See* Provider's Final Position Paper at 3; Provider's Final Position Paper (Case No. 17-0656) at 2.
[15] (Emphasis added.)
[16] (Emphasis added.)
[17] Provider's Final Position Paper at 13-14.
[18] *Id.* at 14.

facilities must be certified as the same type of hospital, nor does it state that the facilities must be reimbursed under the *same* payment system."[19]

In support of its position that Gravette and Springfield are "comparable" inpatient healthcare facilities, Gravette claims the following similarities exist between these two facilities:

1. In FY 2010, the two facilities had an almost identical length of stay for patients receiving general acute care services, with Springfield averaging 4.86 days within its Adult and Pediatrics unit and Gravette averaging 4.51 days for patients within its Adult and Pediatrics unit.

2. Both facilities were staffed to serve 25 inpatient beds and had similar staffing requirements, with Springfield reporting 28.67 full time equivalents ("FTEs") in its medical/surgical unit and 27.10 FTEs in its geriatric psychiatric unit, while Gravette reported 28.36 FTEs in its medical/surgical unit and 21.94 FTEs in its geriatric psych unit.

3. Both facilities principally provide general acute care services while also offering psychiatric care,[20] and that neither hospital had an intensive care unit or a significant amount of specialty care.[21]

Gravette argues that the Medicare Contractor's adoption of WPS's adjustment to functionally allocate SGOH's business office and transcription costs based on the gross revenues of the chain components was also improper. Gravette claims that the relative gross revenue of a chain component has no rational relationship to the amount of business office costs or transcription costs incurred for those components. Gravette's witness explains that, based on Springfield's charge master, the gross charges for Springfield were two times higher than Gravette's gross charges[22] for the same services and, therefore, using gross revenue as a statistic unfairly allocates more costs to Springfield.[23]

Finally, Gravette asserts that patient days are a more accurate statistic for its business office and transcription costs than gross revenue, because transcription and business office cost are directly related to patient care and the number of days logically results in additional business office and transcription costs,[24] while gross revenue "does not equitably allocate the cost over the chain components receiving the benefits of the costs."[25] Accordingly, Gravette requests that the Board

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[19] *Id.* at 15 (emphasis added).
[20] *Id.* at 16-17. For FY 2011, the figures were similar: Springfield averaged 4.74 days for patients in its Adult and Pediatrics Unit, with Gravette averaging 3.99. Both facilities were still staffed to serve 25 inpatient beds, with Springfield reporting 24.43 FTEs in its medical/surgical unit and 26.24 in its geriatric psych unit, while Gravette reported 29.94 and 20.46 FTEs in the corresponding units, respectively. Provider's Final Position Paper at 6-7 (Case No. 17-0656).
[21] *See* Transcript ("Tr.") at 41-42. *See also* Medicare Contractor's Final Position Paper at 12.
[22] Charge Description Master contains all supplies, procedures, *etc*., that potentially could be charged to a patient.
[23] *See* Tr. at 74-77.
[24] Provider's Final Position Paper at 21, 24.
[25] Provider's Final Position Paper at 19-20, 23.

order WPS to either change the functional allocation statistic for SGOH's business office and transcription costs to patient days; or, alternatively, if the Board finds that the SGOH's pooled home office costs should be allocated using patient days, simply return the business office and transcription costs to pooled costs, so these cost can be allocated based on patient days.[26]

Conversely, the Medicare Contractor argues that the PRM 15-1 § 2150.3(D) requires SGOH to use *total costs*, not patient days, as the allocation statistic for pooled costs because the chain's two healthcare facilities are *not* comparable. Specifically, the Medicare Contractor claims Gravette and Springfield are not "comparable" because:

1. Springfield is "an acute care PPS hospital, with an inpatient psychiatric facility subunit and six outpatient clinics," while Gravette is a cost reimbursed CAH with two outpatient clinics.[27]

2. 38 percent of Springfield's costs are "reported directly in the outpatient cost centers," while Gravette's outpatient percentage is only 25 percent.[28]

3. Springfield is an IPPS hospital that is licensed for 45 beds and does "not have an average length of stay threshold," while Gravette as a CAH that is limited both in the number of beds (no more than 25) and length of stay (not to exceed, on an annual average, 96 hours per patient).[29]

Further, the Medicare Contactor argues that revenue is a reasonable statistic for Gravette's business office and transcription costs. For business office costs, the Medicare Contractor argues that revenue is inherently related to business activity. In support of its position, the Medicare Contractor uses SGOH's department descriptions to demonstrate that the business office activity primarily relates to revenue. Specifically, department descriptions provide the following definition of SGOH's business office activity:

> Provides centralized charge entry, billing, and receipt posting services to all facilities. Additional services include payor mix analysis and collection services and account receivable maintenance.[30]

Likewise, the Medicare Contractor asserts that gross revenue is reasonably related to the amount of transcription costs each chain component used. In support of its position, the Medicare Contractor again points to the following definition of SGOH's transcription activity:

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[26] *Id* at 21, 24-25.
[27] Medicare Administrative Contactor's Final Position Paper at 11.
[28] *Id.*
[29] *Id.* at 11-12.
[30] *Id.* at 14-15 (quoting Exhibit I-6, SGOH Department Descriptions).

> Provides electronic transcription services to Providers located system hospital and clinic facilities.[31]

The Medicare Contractor explains that using patient days instead of gross revenue for business office and transcription costs "improperly skews the costs to the CAH as it fails to consider the much greater level of outpatient activity conducted by the PPS facility[.]"[32] With regard to Gravette's alternative request – to simply put the business office and transcription costs back into the SGOH's pooled home office costs (which Gravette hopes to have allocated based on patient days) – the Medicare Contractor maintains that this runs afoul of PRM 15-1 § 2150.3(D) which states that pooled costs consists of costs "which cannot be allocated on a *functional* basis."[33] Accordingly, the Medicare Contractor argues that SGOH's business office and transcription costs are not eligible to be placed in pooled costs because it is, in fact, feasible and proper to *functionally* allocate those business office and transcription costs based on gross revenues (or another easily measurable statistic).[34]

The Board reviewed PRM 15-1 and 15-2 to determine what costs should be included in pooled home office costs and the recommended statistic for allocating pooled home office costs to the chain components. As noted in these manuals, pooled home office costs must be allocated based on patient days ***only*** when "the entire chain consists solely of *comparable* inpatient health care facilities."[35] Otherwise total cost must be used to allocate pooled home office costs.[36] As explained below, for FYs 2010 and 2011, the Board finds that Gravette and Springfield were *not* comparable inpatient health care facilities and, therefore, the Medicare Contractor was correct to adopt WPS' use of total cost to allocate SGOH's pooled home office costs on the FY 2010 and 2011 home office cost statements.

The Board notes that Gravette is a CAH while Springfield is an IPPS hospital. The Board finds that this difference is significant and material because the Medicare program considers a hospital and a CAH two different provider types for purposes of participation in the Medicare program. The "CAH" provider type is the successor to the "essential access community hospital" or "rural primary care hospital" (a/k/a "RPCH") provider type, which was established by the Omnibus Budget Reconciliation Act of 1989.[37] In this regard, the Secretary noted that the RPCH was a new, "***separate*** *provider type* under Medicare law" which had similarities to both hospitals and rural health clinics, but was also unique and "subject to conditions of participation and other regulations that are specific to them."[38] Unlike an acute care hospital, RPCHs were "expected to help meet community needs for primary and preventive health care, triage, treatment or transport for emergency care, diagnostic and therapeutic outpatient care, and limited inpatient care."[39] Initially, the RPCH program was limited to seven states. In 1997, Congress replaced the RPCH

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[31] *Id.* at 16-17 (quoting Exhibit I-6, SGOH Department Descriptions).
[32] *Id.* at 15.
[33] (Emphasis added.)
[34] *Id.* at 15, 17.
[35] PRM 15-1 § 2150.3(D)(2) (emphasis added).
[36] *Id.*
[37] Pub. L. 101-239, §§ 6003(g), 6116, 103 Stat. 2106, 2145 (1989); 58 Fed. Reg. 30630, 30630 (May 26, 1993).
[38] 58 Fed. Reg. at 30631 (emphasis added).
[39] *Id.* at 30632.

program with a new, nationwide "Rural Hospital Flexibility Program" which allowed states to designate rural facilities as "CAHs" if they met certain criteria.[40] The CAH criteria include being a sufficient distance from other hospitals, the availability of 24 hour emergency care, and a 96 hour maximum length of stay. CAHs are not required to meet all of the Medicare conditions of participation for hospitals.[41]

Further, the Board points out that 42 U.S.C. § 1395x defines the term "hospital" and specifically excludes CAHs from that definition by stating in § 1395x(e)(9) that "[t]he term hospital does not include, unless the context otherwise requires, a critical access hospital (as defined in subsection 1395x(mm)(1))." Additionally, § 1395x(u) defines the term "provider of services" stating, in pertinent part, "the term provider of services means a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility . . . ." The separation of "hospitals" from "critical access hospitals" by Congress further emphasizes that a CAH is a unique provider type, different than the "hospital" provider type. To this end, the Medicare program does not include CAHs in its Inpatient or Outpatient Hospital Prospective Payment System. Rather, the Medicare program pays CAHs at 101 percent of reasonable costs.[42] The Board finds that these differences are both significant and material when determining if Gravette and Springfield are "comparable" inpatient health care facilities.

Indeed, these "provider type" differences are borne out in how the Medicare program pays Springfield as a "hospital" versus Gravette as a CAH. The Medicare program pays Springfield as a short term acute care hospital under IPPS which uses prospectively established rates that are not dependent upon Springfield's actual costs. As a result, the allocation of SGOH's home office costs to Springfield has little impact on Springfield's overall Medicare reimbursement. In contrast, the Medicare program pays Gravette as a CAH and, as a result, Gravette is paid 101 percent of its Medicare costs (which includes Gravette's share of SGOH's home office cost). As a result, the SGOH's home office cost allocation has significant impact on Gravette's overall Medicare reimbursement and, as such, the accuracy of that allocation is extremely important to ensure accurate Medicare reimbursement.

In addition to being different provider types, Springfield has six outpatient clinics and attributed 38 percent of its costs directly to those outpatient cost centers while, in contrast, Gravette had two outpatient clinics and only attributed 25 percent of its costs to its outpatient cost centers.[43] Also, the relative volume of inpatient versus outpatient services provided at the two facilities differs, as approximately 75 percent of Springfield's net revenue for FY 2010 came from its

[40] *See* Balanced Budget Act of 1997, Pub. L. 105-33, § 4201, 111 Stat. 251, 369 (1997). *See also* 42 C.F.R. § 485.618(d); 42 C.F.R. § 413.70(b)(4).
[41] 62 Fed. Reg. 45966, 45970, 46008 (Aug. 29, 1997).
[42] 42 C.F.R § 413.70(a)-(b)
[43] *See* Medicare Contractor's Final Position Paper at 11; Tr. at 125.

outpatient/clinic areas while just over 50 percent of Gravette's net revenue in FY 2010 came from its outpatient/clinic areas.[44] Similar revenue differences existed for FY 2011.[45]

In summary, the Board finds that Gravette and Springfield are materially different types of providers of services, are paid by Medicare under two materially different reimbursement systems, and have materially different levels of outpatient/clinic services. As such, the Board concludes that SGOH's chain does not "consist[] solely of *comparable* inpatient health care facilities"[46] and, therefore, that the Medicare Contractor properly adopted WPS' allocation of SGOH's pooled home office costs based on total costs as directed by PRM 15-1 § 2150.3(D)(2)(b) and PRM 15-2 § 3917.

With respect to SGOH's business office and transcription costs, PRM 15-2 § 3902(C) states that, if home office costs cannot be directly assigned, "where practical and the amounts are material, allocate these costs on a functional basis." Neither PRM 15-1 or 15-2 require a specific statistic for these allocations since the costs and/or services are variable. However, PRM 15-1 states the functional allocation should be "designed to equitably allocate the costs over the chain components . . . receiving the benefits of the costs. This allocation must be made in a manner reasonably related to the services received by the entities in the chain."[47]

The Board notes that business offices typically do billing and collection activities for both inpatient and outpatient areas of the provider. SGOH's business department description states that it is engaged in centralized charge entry, collection services, and account receivable maintenance for all of its facilities.[48] The description of SGOH's transcription services explains that transcription services are for both inpatient and outpatient services provided at *all* of its facilities.[49] Thus, the Board finds that the SGOH's inclusion of business office and transcription costs as part of pooled costs, and allocated based on patient days is incorrect, as it ignores how these activities also benefit the outpatient/clinic areas.[50] Given the material disparity in the percent of each facility's inpatient and outpatient/clinic volumes, using a statistic that excludes outpatient/clinic services simply does not result in an equitable allocation of SGOH's business office and transcription costs.

The Board also finds errors in the methodology that WPS used and the Medicare Contractor adopted. Specifically, the Board finds that WPS' use of gross revenue to functionally allocate SGOH's business office and transcription costs does not result in an accurate allocation of these costs to each chain facility because the charge masters of the two hospital were very different. In this regard, Gravette's witness testified that "the charge master was dramatically different

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[44] *See* Provider's August 10, 2018 letter to the Board at 2. Gravette's net revenue for FY 2010 for its outpatient and clinic services was $6,213,516 ($2,193,344 + $4,020,172) which is 53 percent of net FY 2010 revenue of 11,743,731. Springfield's net revenue for its outpatient and clinic services was $38,454,902 (8,567,185 + 29,887,717) which is 76 percent of net revenue of $50,576,724. The FY 2011 revenue reflected similar percentages.
[45] *Id.*
[46] (Emphasis added.)
[47] PRM 15-1 at § 2150.3(C).
[48] Exhibit I-6, SGOH Department Descriptions.
[49] *Id.*
[50] Outpatient and clinic areas have no patient days.

between [the] two hospitals. So the same service in Springfield would have been charged at twice the amount that it was charged in Gravette" and that an allocation based on revenue would "heavily weight [the costs] to Springfield simply because the charge master is so different."[51] At the conclusion of the hearing, the Board requested that Gravette submit on a post-hearing basis, the net revenue amounts for Springfield and Gravette for FYs 2010 and 2011 (broken out and identified by inpatient, the psychiatric unit and the outpatient clinics) in order to allow the Board to evaluate whether net revenue is a proper option to functionally allocate SGOH's business office and transcription costs. However, when the Board reviewed the submitted net revenue information, it determined that net revenue could not be used to accurately allocate the business office and transcription costs because the reliability of the underlying net revenue amounts is questionable and uncertain.[52]

As a result of the inaccuracies related to allocating SGOH's business office and transcription costs through patient days, gross revenue, and net revenue, the Board does not have a reliable functional statistic to allocate SGOH's business office and transcription costs. As such, the Board concludes that, for FYs 2010 and 2011, these costs should remain in the pooled home office costs,[53] and allocated between Gravette and Springfield based on total costs.

DECISION AND ORDER:

After considering the Medicare law and regulations, the parties' contentions, and the evidence admitted, the Board makes the following findings for FYs 2010 and 2011:

1. The Medicare Contractor properly used total costs, rather than patient days, as a statistic to allocate pooled home office costs to the components of the chain.

2. The Medicare Contractor improperly used gross revenues as a statistic to functionally allocate both business office costs and transcription costs to the components of the chain.

Accordingly, the Board directs that, for FYs 2010 and 2011, the Medicare Contractor include both business office costs and transcription costs in pooled home office costs and then allocate pooled home office costs to components of the chain based on total costs pursuant to the PRM 15-1 § 2150.3(D)(2)(b) (*i.e.*, "all chain components will share in the pooled home office costs in the same proportion that the total costs of each component (excluding home office costs) bear to the total costs of all components in the chain").

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[51] *See* Tr. at 74-75.

[52] The Board questions the reliability of the net revenue information because the Board's review of the record revealed that the net revenue amounts were not consistent and that Gravette had a *negative* net revenue amount for outpatient services for FY 2011.

[53] *See* PRM 15-2 § 3902(C) (confirming that a cost which cannot be allocated functionally may be appropriately included in the pooled costs and allocated as described in subsection D).

BOARD MEMBERS PARTICIPATING:

Charlotte F. Benson, C.P.A.
Gregory H. Ziegler, C.P.A.
Robert Evarts, Esq.

FOR THE BOARD:

8/12/2020

X Charlotte F. Benson

Charlotte F. Benson, C.P.A.
Board Member
Signed by: Charlotte Benson -A