PROVIDER REIMBURSEMENT REVIEW BOARD HEARING DECISION

99-D48

PROVIDER -
Community Health and Counseling Services
Bangor, Maine

Provider No. 20-7026

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/ Associated Hospital Services of Maine

DATE OF HEARING-
October 27, 1998

Cost Reporting Period Ended -
June 30, 1991
June 30, 1992
June 30, 1993

CASE NO. 95-0492E
97-0952E
97-2389E

INDEX

ISSUES:

1. Were the Intermediary's adjustments to building costs by the creation of separate cost centers and the elimination of common area costs proper?

2. Was the Intermediary's adjustment reclassifying supervisor salaries and benefits proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Community Health and Counseling Services ("Provider") is a not-for-profit home health agency ("HHA") located in Bangor, Maine. From several branch offices it provides home health services, mental health services and children's residential services. On the Provider's fiscal year ended ("FYE") June 30, 1991, 1992 and 1993 Medicare cost reports, the Associated Hospital Service of Maine ("Intermediary") determined that the Provider's utilization of the step-down method for allocating building costs resulted in inappropriate allocation of costs to the Medicare program. On the Provider's FYE 1992 and 1993 cost reports, the Intermediary determined that the Provider's methodology for allocating supervisory salary and benefit costs also resulted in an inappropriate allocation of costs to the Medicare program. On June 23, 1994, August 23, 1996 and February 28, 1997 the Intermediary issued separate Notices of Program Reimbursement ("NPRs") for fiscal years 1991, 1992 and 1993, respectively.[1] Those NPRs reflected Intermediary reallocations/adjustments to eliminate alleged improper cost shifting by the Provider. The Provider filed timely appeals with the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835.-1841 and has met the jurisdictional requirements of those regulations. The total reimbursement effect of the amounts in controversy is approximately $414,434. The Provider is represented by Mr. Bernard J. Kubetz, Esq., of Eaton, Peabody, Bradford, & Veague, P.A. The Intermediary is represented by Mr. Michael F. Berkey, Esq., CPA, and Mr. Bernard M. Talbert, Esq., of the Blue Cross and Blue Shield Association.

Issue No. 1- Capital Costs (Common Areas and Building Cost Centers)

Facts

The Provider accumulated its common area square footage and included its common area statistical basis in the A&G cost center. The A&G cost center was then allocated based on accumulated cost. Secondly, the Provider lumped all of the building costs in one capital cost center (separate from the S&G cost center), and accumulated that statistical base. It then allocated all the building costs based upon the square feet statistic.

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[1] Provider Exhibits P-13, P-36, and P-37.

Upon audit, the Intermediary determined that the Provider's methodology for allocating building costs resulted in an improper allocation of costs to the Medicare program. In its audits, the Intermediary adjusted the Provider's cost finding mechanism in two ways. First, the Intermediary addressed the common space issue by removing the common space from the statistical basis. The result is that the cost finding process now allocates the cost related to the eliminated square footage, proportionately, over the various services. Secondly, the Intermediary created several cost centers for various buildings, grouping those with exclusively mental health or other non-reimbursable activites into one cost center, and leaving those with partially or exclusively certified home health activites in separate cost centers.

PROVIDER'S CONTENTIONS:

The Provider asserts that with respect to the allocation of capital-related costs, the Medicare reimbursement regulations require all "free-standing" home health agencies to use the "step-down" method of cost accounting:

> [e]ffective for cost reporting periods beginning on or after October 1, 1980, HHAs not based in hospitals or SNFs must use the step-down method described in paragraph (d)(1) of this section.

42 CFR § 413.24(d) This rule is restated in the HCFA Manual provisions regarding allocation of overhead costs. See HCFA Pub. 15-1 § 2308 which states " [e]ffective for cost reporting periods beginning on or after October 1, 1980, free-standing home health agencies are required to use the step-down method of cost finding . . . ." The Manual further instructs providers on how to use the step-down method for these overhead costs. It directs providers to collect all capital-related costs in one general service cost center and then allocate these costs based on square footage:

> Column I - Capital Related Costs-Buildings and Fixtures -- Depreciation on buildings and fixtures and expenses pertaining to buildings and fixtures such as insurance, interest, rent and real estate taxes are combined in this cost center to facilitate cost allocation. All expenses should be allocated to the cost centers on the basis of square feet of area occupied.

HCFA Pub. 15-2 § 1709 (emphasis added).

HCFA Pub. 15-1 § 2307 then instructs that the general service cost center is allocated to specific services on a statistical basis, which in this case is square footage of building space:

> The costs of a general service cost center need to be allocated to the cost centers receiving service from that cost center. This

> allocation process is usually Medicare cost reporting purposes, through cost finding using a statistical basis that measures the benefit received by each cost center.

Id.

That section also allows an exception to the general rule of using the step-down method if three conditions are met:

(a) The provider makes a written request to the FI for direct assignment of costs at least 90 days prior to the beginning of the cost period to which the direct assignment will apply;

(b) The FI approves the direct assignment of costs in writing prior to the beginning of the relevant cost period; and

(c) The direct assignment of costs is made as part of the provider's own accounting system, with costs recorded as part of the ongoing accounting process, rather than as period-ending adjustments to the entries.

The Provider contends that none of these prerequisites has occurred in this case in that it did not seek or receive approval from the Intermediary to use a different accounting method. Indeed, as explained more fully below, both parties actually agreed that the Provider would follow the step down method. Therefore, the Provider contends that the general rule, requiring the aggregation of overhead costs into a single general service cost center and the statistical allocation of these costs, applies to the cost reports in this case.

The Provider further contends that the Intermediary's application of the rules in this case are improper. Instead of collecting all the building costs into the one general service cost center, the Intermediary put these costs into separate cost centers which it created for each building that the Provider occupies. HCFA Pub. 15-1 § 1709 permits, but does not obligate, the Provider to establish separate cost centers when it occupies more than one building. In the instant case, the Provider did not make such an election and therefore reported all building related costs in a single cost center. The Provider contends that because the language of § 1709 is permissive, at the election of the Provider, it cannot be retroactively mandated by the Intermediary.

The Provider also contends that the legal precedent cited by the Intermediary, Oklahoma Medical Center v. Blue Cross and Blue Shield of Oklahoma, HCFA Administrator Decision, October 26, 1992, Medicare & Medicaid Guide (CCH) ¶ 41,014, is without merit. That case is not applicable to this proceeding for two very important reasons:

1. The case now under consideration by this Board involves a Home Health Agency to which the provisions of section 2308 are mandatorily applied. Unlike Oklahoma Medical Center, this case has nothing to do with a hospital or a skilled nursing facility to which other provisions of the regulations and manual are specifically applicable.

2. The case now under consideration by this Board involves cost finding, unlike Oklahoma Medical Center, which was a cost apportionment case.

The Provider contends that the issues before the Board in this case concern only the cost finding process contained on Worksheets A and B of the cost report (HCFA - 1728), not cost apportionment.

The Provider also contends that the Intermediary's decision to exclude the common space from the square footage statistical base is not supported by the law or regulations. Common spaces in buildings have real costs (e.g., depreciation, fixtures, heating, maintenance) that are shared by many functions in the organization. As discussed above, the general rule in the manual for allocating these costs requires providers to gather these costs into one A&G cost center and then allocate the costs by the stepdown method. As a home health agency, the Provider is obligated by HCFA Pub. 15-1 § 2308 to apply the step-down method. At the hearing, the Intermediary provided no evidence to suggest that the Provider was ever informed of the Intermediary's interpretation of how square footage should be developed. Instead, the Provider has consistently, and in good faith, placed common area space in A&G for purposes of allocation since the early 1980s. If the Intermediary believes it is inappropriate to allocate common area costs to A&G, the Provider should have been so informed and instructed to implement the determination prospectively. It should be emphasized, however, that the Intermediary does not have the right to change the Provider's method for determining square footage from gross to net. That may only be done by the Provider's election.

The Provider contends that the Intermediary's creation of separate cost centers for each building and excluding the common space costs constitute a "more sophisticated method" of cost finding, because it directly allocates overhead costs to certain services instead of aggregating these costs into one general service cost center. While the Intermediary argues that its cost finding method is more accurate, this method of direct cost allocation is prohibited under these circumstances. As noted above, the Medicare regulations only allow a method other than the step-down method if the provider requests and receives approval from the intermediary. 42 CFR § 413.24(d)(ii). The Provider has neither requested nor received approval from the Intermediary for a different cost finding method, and the Provider contends that the Intermediary is not free to impose this method. In support of this position, the Provider cites The Sheppard & Enoch Pratt Hospital v. Blue Cross & Blue Shield of

Maryland, HCFA Admin. Dec., March 8, 1984, Medicare and Medicaid Guide (CCH) ¶ 33,905. In that case, the HCFA Administrator stated, in part, that the fiscal intermediary did not have regulatory authority to impose a more sophisticated method of cost finding on the provider.

INTERMEDIARY'S CONTENTIONS:

The Intermediary submits that five general contentions apply to both issues.

1. The cost-shifting prohibition is the most fundamental principle of the Medicare program; other regulations and manual instructions must yield where there is perceived conflict.

The Intermediary points to Medicare law at 42 USC § 1395x(v)(1)(A), which states that the Secretary, in promulgating regulations to define and determine reasonable cost, must ensure that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs.

The Intermediary contends this is the cost-shifting prohibition, and may also be found in various forms in the Medicare regulations at 42 CFR §§ 413.5(a) and 413.9(b)(1), manual instructions at HCFA Pub. 15-1 § 2200.1, and numerous administrative and court decisions.[2] The Intermediary avers that this principle is so fundamental that regulations and manual instructions have often been struck down in its wake, or interpreted or re-written to be consistent with its goal, accuracy of reimbursement. See Humana of South Carolina, Inc. v. Mathews, 419 F. Supp. 253 (D.D.C. 1976),[3] (striking 42 C.F.R. § 405.429(a)); Howard University v. Bowen, U.S.D.C., D.C., No. 85-3342, April 4, 1988, Medicare and Medicaid Guide (CCH) ¶ 37,057[4] (interpreting 42 C.F.R. §405.425(c)); Providence Hospital of Toppenish, et al. v. Shalala, 52 F. 3d 213 (9th Cir. 1995)[5] (interpreting HCFA Pub. 15-1 §§ 202.2 and 2150.3(B)); Fairview Hospital and Healthcare Services v. Bowen, U.S.D.C., D. Minn., Civil Action No. 4-87-316, March 21, 1988, Medicare and Medicaid Guide (CCH) ¶

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[2] Intermediary Exhibits I-12, I-2, and I-4.

[3] Exhibit I-13.

[4] Exhibt I-16.

[5] Exhibit I-14.

37,063[6] (interpreting HCFA Pub. 15-1 §§ 2150.3(B) and 2338); Druid Hills Nursing Home, Inc. v. Aetna Life and Casualty Company, PRRB Hearing Dec. No. 83-D34, February 18, 1983, Medicare and Medicaid Guide (CCH) ¶ 32,440,[7] affd, HCFA Admin. Dec., April 7, 1983, Medicare and Medicaid Guide (CCH) ¶ 32,839[8] (interpreting HCFA Pub. 15-1 § 2126.2, which was later re-written, as a result of the decision, to eliminate the cost-shifting).

The Intermediary points to a prior case involving this Provider, Community Health & Counseling Services v. Bowen, U.S.D.C., D. Maine, No. 86-0155-B, June 8, 1987, wherein the court affirmed the PRRB's quest for accuracy over strict interpretations of the manual. The court said,

> [f]inally, although the Secretary's instructions can be read to direct the calculations used by the plaintiff, the instructions are not inflexible. In the official instructions for the completion of Worksheet B (the worksheet on which overhead expenses are allocated to each of the reimbursable and nonreimbursable cost centers) the following language appears:
>
> NOTE: An HHA wishing to change its allocation basis for a particular cost center . . . must make a written request to its intermediary for approval of the change prior to the beginning of the cost reporting period for which the change is to apply.... In applying the agency must establish that the alternate basis . . . is more accurate than that indicated on the official form.

HCFA Pub. 15-2 § 420.

This language suggests that the instructions are not engraved in stone and that, under appropriate circumstances, changes will be allowed to achieve a more equitable allocation.

2. The cost-shifting prohibition is the most fundamental principle of the Medicare program; there are no exceptions or extensions to its enforcement.

The Intermediary contends that the cost-shifting prohibition principle does not allow for exceptions or extensions, whether for longstanding past practice or even prior explicit permission. Consistency is no bar to correction of cost-shifting. Although the Provider has pointed to Glenwood Regional Medical Center v. Blue Cross and Blue Shield Association et

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[6] Exhibit I-15.

[7] Exhibit I-23.

[8] Exhibit I-24.

al., PRRB Hearing Dec. No. 96-D18, March 7, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,066 to support its position, the Board in that case noted that it was more interested in accuracy than in the longstanding actions of the parties.

Moreover, none of the decisions noted above that show how strongly the cost-shifting prohibition principle has been enforced give any hint of any exceptions or extensions to the application of the principle for any reason.

3. There was no prior agreement between the parties to allow cost-shifting.

The Intermediary witness testified that he did not believe there was any agreement to allow the Provider to report in any particular way the three types of costs in dispute, that is, the common space, the-buildings, or the supervisors.[9]

The Intermediary further contends there is strong evidence to suggest that there was little if any reimbursement difference between the Provider's present method and the Intermediary's present method in the early 1980s through the turn of the decade. See Exhibit I-11 at Chart I (indicating the major increase in reimbursement effect on these issues in 1993), at Chart 2 (noting the dramatic increase in Medicare costs between 1984 and 1991 compared to increases in other costs at the enterprise), and at Chart 4 (noting the large decrease in certified home health space between 1983 and 1991 while the rest of the enterprise grew by leaps and bounds); see also Intermediary Hearing Chart 2 (comparing labor and supervision percentages between 1992 and 1993).. Moreover, the Intermediary employs an "audit by exception" process which did not show any significant cost-shifting prior to 1991.[10]

4. The cost-shifting prohibition is the most fundamental principle of the Medicare program; the Intermediary has no power to overturn it and the Provider has no power to estop the Intermediary from enforcing it.

The Intermediary contends that even if there were a rock solid agreement between the Intermediary and the Provider, the Intermediary has no power to agree to violate the cost-shifting prohibition and the Provider is not entitled to rely on any such illegal agreement. According to Heckler v.Community Health Services of Crawford County, 104 S.Ct. 2218 (1984), it does not matter what the Intermediary agrees to do. What matters is what the law and regulations require.

5. Neither party in this case desires to deviate from step-down cost-finding; there is no "more sophisticated method" being offered.

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[9] Tr. at 185, 297.

[10] Tr. at 172, 308.

The Intermediary disagrees with the Provider's argument that the Intermediary deviated from step-down cost-finding.[11] The Intermediary contends this is not a case of whether one party or the other should be permitted to use step-down cost-finding as both parties use that.[12] Instead, the Intermediary views this as a case of where (in which cost center) to collect the costs that are then subjected to step-down. Specifically, this is a case of whether to collect common areas and supervisors in A.& G. or in more specific cost centers, and whether to collect building costs in one cost center or in several more specific cost centers. Additionally, the Intermediary points out that while the Provider cites the case of The Sheppard and Enoch Pratt Hospital , to support its view that separate building cost centers can not be forced upon the Provider, the Administrator was careful to say in that case that the question of authority was being reserved, because the intermediary had not shown that its methodology was more accurate. As such, the Intermediary contends the proper questions are accuracy and cost-shifting, not strict adherence to manual sections.

The Intermediary offers three additional arguments relating to the specific costs involved in this issue.

1. Only the Intermediary's methodology prevents cost-shifting.

The Intermediary witness testified that in overseeing the audit of the Provider, his goal was to follow the cost-shifting prohibition and the requirement for accuracy found in 42 CFR §§ 413.5(a) and 413.9(b)(1) .[13] The Intermediary contends it has met that goal as evidenced by Intermediary Hearing Charts I & 2 which show how the Provider's allocation of common space to A&G, through the largely labor-based statistic), resulted in an inappropriate cost shift of common space to the Medicare program. Similarly, the difference between the parties' positions on whether separate building cost centers should be required is graphically illustrated in Intermediary Hearing Chart 3.[14]

The Intermediary contends that the Provider does not dispute these outcomes, only the theory behind it. That is, the Provider disputes the Intermediary's right to use the cost-shifting prohibition principle to make the adjustments, not the fact that they lead to a more accurate result.

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[11] Tr. at 19.

[12] Tr. at 91, 207, 299.

[13] Tr. at 168-169, 172.

[14] Tr. at 91-92, 105-106.

2. The specific authority on point supports the Intermediary.

The Intermediary contends that the only specific authority that exists on this issue supports the Intermediary's adjustments. Initially, the parties agree that there is no specific regulatory or manual reference dealing with common areas.[15] Nevertheless, the American Hospital Association ("AHA") publication Cost-Finding and Rate-Setting for Hospitals describes both the gross[16] and net methods[17] as acceptable. The Intermediary witness characterized them as equivalent methods and utilized the net method as its basis for adjustment.[18] The AHA does not, however, make any reference to the Provider's method, which is neither the gross nor the net method.

The Intermediary further contends that the only decision on point supports the Intermediary's treatment of the common areas. In Our Lady of Victory Hospital v. Blue Cross Association et al., PRRB Hearing Dec. No. 78-D44, June 16, 1978, Medicare and Medicaid Guide (CCH) ¶ 29,216, the Board refused to allow common space to be allocated to the A&G cost center where it could be identified with a particular activity. Here, using Provider records, most of the common areas could be identified with either the reimbursable or non-reimbursable activities, and the lion's share would be assignable to the non-reimbursable activities. The Intermediary contends that its adjustment, which uses the equivalent net method, effectively puts the common space where it is being used.

As to the building cost centers, the Intermediary contends that the Provider raised HCFA Pub. 15-2 § 1709 for the first time at the hearing to justify its cost report filing using a single cost center for all buildings. The Intermediary believes that the Provider is taking its quoted language from § 1709 out of context. The Provider now ignores significant introductory language in the section that it previously had emphasized. In its position paper, at page 7, the Provider noted that the manual section states, "[a]ll expenses should be allocated to the cost centers on the basis of square feet of the area occupied." The Intermediary contends that its adjustment to establish several building cost centers accomplishes that requirement. Thus, to the extent that § 1709 is specific authority on point, it supports the Intermediary.

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[15] Tr. at 52, 92-93, 179.

[16] Tr. at 93, 166, 179-180.

[17] Tr. at 94, 166, 180.

[18] Tr. at 167-168.

3. The Provider has not denied that its method results in cost-shifting.

The Intermediary contends that the Provider does not find the cost-shifting principle relevant to the cost reporting process, based on testimony at the hearing.[19] The Intermediary points out there is no indication that the Provider has denied that its methodology results in cost-shifting, or that the Intermediary's method corrects the cost shift. The Intermediary concludes that the Provider has instead chosen to base its case on the technical argument that it followed the manual and the Intermediary did not.

Issue No. 2. - Reclassification of Supervisory Salaries and Benefits

Facts

The Provider's Medicare cost report aggregated the salaries and fringe benefits for all supervisors who oversee two or more functions, including reimbursable and non-reimbursable services, into one A&G cost center. The A&G costs were then allocated to the services using the step-down method. Upon audit, the Intermediary adjusted the Provider's allocation of supervisory salaries and benefits costs to the cost centers where the supervisors worked. The effect of this adjustment was to move these costs to non-reimbursable services, as opposed to allocating these costs among all the services in the organization through use of the step-down method.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's decision to retroactively change the method of cost allocation is without legal basis and a fundamental deviation from its own previously required methodology.

The HCFA Pub. 15-2 § 1704 reflects the following with respect to the proper method for accounting for the supervisors:

> SUPERVISORS (Column 4)
>
> Employees in this classification are primarily involved in the direction, supervision and coordination of HHA activities.
>
> When a supervisor performs two or more functions, e.g., supervision of nurses and home health aides, the salaries and wages must be split in proportion with the percent of the supervisor's time spent in each cost center providing the HHA maintains the proper records (continuous time records) to

[19] Tr. at 85.

> support the split. If continuous time records are not maintained by the HHA, the entire salary of the supervisor will be entered on line 5 (A & G) and allocated to all cost centers through step-down. However, if the supervisor's salary is all lumped in one cost center, e.g., skilled nursing care and the supervisor's title coincides with this cost center, e.g., Nursing Supervisor, no adjustment will be required.

HCFA Pub. 15-2 § 1704 (emphasis added).

In this case, the Provider's supervisors who are the subject of the Intermediary's adjustments are all responsible for two or more functions. The Provider does not maintain continuous time records for these employees to allocate their time among their functions because maintaining these records would be too complicated and time consuming. Instead, the Provider reports the time of these individuals in its overhead costs.

The Provider contends it is adhering to the manual by collecting all supervisor salaries into the
A & G cost-center, and then allocating these costs to all its service cost centers. This method is expressly required by the Manual, and is the only cost finding method which may be used by a free-standing home health agency. See HCFA Pub. 15-1 § 2308 which states, "[e]ffective for cost reporting periods beginning on or after October 1, 1980, free-standing home health agencies are required to use the step-down method of cost finding."

The Provider points out that the more general sections of the manual support this procedure. HCFA Pub. 15-1 § 2302.9 defines "General Service Cost Centers" as "[t]hose organizational units which are operated for the benefit of the institution as a whole." Section 2302.10 defines "Special Service Cost Centers" as those units that "provide direct identifiable services to individual patients, and [which] include departments such as the operating room, radiology, laboratory, etc." Because the supervisors in this case serve two or more cost centers and do not provide direct patient services, the costs for the services belong in the general service cost center.

HCFA Pub. 15-1 § 2307 deals with the allocation of costs from general service cost centers. Regarding direct assignment of supervision costs, § 2307 provides:

> [i]ndirectly allocable supervision costs, other indirectly allocable costs (hereinafter, residual costs) and costs allocated from previously allocated general service cost centers (hereinafter, overhead costs) must not be directly assigned to the using cost centers, but must be allocated through cost finding.

HCFA Pub. 15-1, § 2307 (emphasis added).

The manual only allows direct allocation of these costs if the provider requests and receives approval from the fiscal intermediary in advance of the year for which the cost report will be made, which in this case was not done. See HCFA Pub. 15-1 §2313.2(E).

The Provider indicates the Board upheld this interpretation of the manual in the case of Golden Rain Home Health Agency v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 96-D44, August 1, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,540, declined HCFA Admin. September 16, 1996. The Board determined that the regulations and the manual required the use of the step-down method for allocating A&G costs, and that the provider had not requested permission from the intermediary to deviate from these rules and directly allocate the costs.

The Provider also contends that the adjustments by the Intermediary violate three fundamental principles which underlie issues 1. and 2.

1. The retroactive adjustments are not justified by the Medicare regulations.

The Provider disagrees with the Intermediary argument that the general regulatory language of
42 C.F.R. §§ 413.5 et seq. justifies the Intermediary's deviation from the manual. The Provider argues that the regulation merely sets forth basic principles of reimbursement, such as that costs must be reasonable, necessary, and proper, and that the Medicare program must bear its share of the indirect costs of delivering services to Medicare patients. The Provider points out that while the regulation does not provide specific technical guidance, the manual does. Therefore, the Provider cites the case of Fairview Hospital v. Bowen, CIV. No. 4-87-316 (aff'd. PRRB Dec. No. 87-D43), which holds that where the Manual specifically addresses an issue contained in the federal regulations, its interpretation is "determinative." The Provider also points to HCFA Program Memorandum A-93-5, which instructs the intermediaries to follow the policies and procedure in the manual:

> [I]n carrying out your audit responsibilities, apply program policies to specific situations to assure compliance with these policies. Your purview does not extend to determining whether program policies and procedures are appropriate or should be applied in a given circumstance.

HCFA Program Memorandum A-93-5 (emphasis added).

2. The Intermediary adjustments are contrary to the public policy behind the Medicare regulations.

The Provider contends that the Medicare manuals establish national standards that apply to many different types of health care providers. As such, the results of the accounting

procedure required by the manual will vary in individual cases. The consistent application of this policy, however, balances the cases when Medicare may pay more than its fair share, and other cases when Medicare may pay less than its fair share. The balancing of these payments results in Medicare paying an appropriate share of the overall costs for patient services. This concept has been referred to as the "averaging principle" See Doctors Hospital, Inc. v. Blue Cross and Blue Shield Assoc./Blue Cross of Louisiana, PRRB Dec. No. 85-D9.

The Provider therefore contends that although the accounting method it used, as required by the Medicare manual, resulted in Medicare paying for some portion of the cost of non-Medicare services it does not constitute "inappropriate cost shifting." The Provider further contends that the testimony of the Intermediary's own witness indicates that the Intermediary adjustments were subjectively made, without specific regulatory authority.[20]

3. The Intermediary's retroactive adjustments deviate from an existing agreement with the Provider.

The Provider's witness testified that an agreement was reached with the Intermediary pertaining to the fiscal year 1982, 1983, and 1984 whereby the Provider would allocate all indirect costs using the step-down method, as required by the manual.[21] The witness further testified that since the settlement of the 1982 cost report, all subsequent cost reports have been filed using the step-down.[22] The Provider also references a significant number of exhibits which purport to show prior interaction with the Intermediary relative to the Provider's use of the step-down method for cost allocation.[23]

The Provider cites Glenwood Regional Medical Center v. Blue Cross and Blue Shield Assoc./Blue Cross of Mississippi, PRRB Dec. No. 96-D18, March 7, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,066, decl'd. rev. HCFA Admin, April 25, 1996 as a case where the Board recognized that the intermediary may not unilaterally abandon an agreement arrived at by mutual consent and honored by the provider. Accordingly, the Provider contends the Intermediary should not be allowed to disregard an agreement which complies with the manual, and retroactively impose a different accounting procedure which does not comply with the manual.

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[20] Tr. at 196-197.

[21] Tr. at 60-61, and 68-69.

[22] Tr. at 69.

[23] Exhibits 3, 7, 23, 23A, 22B, 24, 25, 26, 26A, and 26B.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that this issue is the same in theory as Issue 1. As such, the Intermediary believes that its first five general contentions from Issue 1 are also applicable to this issue.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - 42 U.S.C.:

§ 1395x(v)(1)(A)	-	Reasonable Cost

2. Regulations -42 C.F.R.

§ 405.425(c)(10-01-85) redisig. §413.98	-	Purchase Discounts and Allowances
§ 405.429(a) redisig. §413.157	-	Return on Equity Capital of Proprietary Providers
§ 405.1835-.1841	-	Board Jurisdiction
§ 413.5(a)	-	Cost Reimbursement: General
§ 413.9(b)(1)Definition	-	(1)Reasonable cost
§ 413.24(d)	-	Cost finding methods
§ 413.24(d)(ii)	-	More sophisticated methods

3. Program Instructions - Provider Reimbursement Manual, Part 1 (HCFA Pub. 15-1):

§ 202.2	-	Necessary
§ 2126.2	-	Utilization Review in Skilled Nursing Facilities
§ 2150.3(B)	-	Allocation of Home Office Costs
§ 2200.1	-	Principle of Cost Apportionment

§ 2302.9	-	General Service Cost Center
§ 2302.10	-	Special Service Cost Center
§ 2307	-	Direct Assignment of General Service Costs
§ 2308	-	Cost Finding Methods
§ 2313.2(E)	-	Periodic Time Studies
§ 2338	-	Allocation of Interest and Other Expenses Related to Assets

Program Instructions - Provider Reimbursement Manual, Part 2 (HCFA Pub. 15-2):

§ 420 Worksheet B	-	Cost Allocation
§ 1704 Worksheet A 1	-	Compensation Analysis-Salaries & Wages
§ 1709 Worksheet B 1	-	Cost Allocation-Statistical Basis

Case Law:

Oklahoma Medical Center v. Blue Cross and Blue Shield of Oklahoma, HCFA Admin. Dec., October 26, 1992, Medicare & Medicaid Guide (CCH) ¶ 41,014.

Sheppard & Enoch Pratt Hospital v. Blue Cross and Blue Shield of Maryland, HCFA Admin. Dec., March 8, 1984, Medicare & Medicaid Guide (CCH) ¶ 33,905.

Humana of South Carolina Inc. v. Mathews, 419 F. Supp. 253(D.D.C. 1976).

Howard University v. Bowen, U.S.D.C. D.C., No. 85-3342, April 4, 1988, Medicare & Medicaid Guide (CCH) ¶ 37,057.

Providence Hospital of Toppenish, et al v. Shalala, 52 F. 3d 213 (9th Cir. 1995).

Fairview Hospital and Healthcare Services v. Bowen, U.S.D.C., D. Minn., Civil Action No. 4-87-316, March 21, 1988, Medicare & Medicaid Guide (CCH) ¶ 37,063.

Druid Hills Nursing Home Inc. v. Aetna Life and Casualty Company, PRRB Dec. No. 83-D34, February 18, 1983, Medicare & Medicaid Guide (CCH) ¶ 32,440. aff'd. HCFA Admin. Dec., April 7, 1983, Medicare & Medicaid Guide (CCH) ¶ 32,839.

Community Health & Counseling Services v. Bowen, U.S.D.C., D. Maine, No. 86-0155-B, June 8, 1987.

Glenwood Regional Medical Center v. Blue Cross & Blue Shield Association, PRRB Dec. No. 96-D18, March 7, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,066, decl'd. rev. HCFA Admin., April 25, 1996.

Heckler v. Community Health Services of Crawford County, 104 S. Ct. 2218 (1984).

Our Lady of Victory Hospital v. Blue Cross & Blue Shield Association/Blue Cross & Blue Shield of Western New York, PRRB Dec. No. 78-D44, May 19, 1978, Medicare & Medicaid Guide (CCH) ¶ 29,216, decl'd. rev. HCFA Admin., July 27, 1978.

Golden Rain HHA v. Blue Cross & Blue Shield Association/Blue Cross of California, PRRB Dec. No. 96-D44, August 1, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,540, decl'd rev. HCFA Admin., September 16, 1996.

Doctor's Hospital Inc. v. Blue Cross & Blue Shield Association/Blue Cross of Louisiana, PRRB Dec. No. 85-D9, October 17, 1984, Medicare & Medicaid Guide (CCH) ¶ 34,416, decl'd rev. HCFA Admin., November 19, 1984.

Alacare Home Health Services, Inc. v. Sullivan, 891 F. 2d. 850 (11th Cir. 1990).

4. Other:

HCFA 1728 (HHA Cost Report)

HCFA Program Memorandum A-93-5

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, and evidence presented, finds and concludes as follows:

Issue 1-Capital Costs (Common Area and Building Cost Centers):

The Board finds that the regulation at 42 C.F. R. § 413.24 requires non-hospital based or skilled nursing facility based home health agencies to use the step-down method of cost-finding to prepare the Medicare cost report. The Board notes that the Provider prepared and filed its Medicare cost report for the fiscal years in question using the step-down method.

The Board also notes that upon audit the Intermediary reviewed the Provider's cost-finding methodology and reclassified common space areas out of the cost report. The Intermediary also created a number of separate cost centers, to which the Provider's building costs were allocated. This was in contrast to the Provider's methodology of directly assigning all common area space to the Administrative and General (A&G) cost center.

The Board finds that, with respect to the accounting for common space areas, the Provider could have, but did not use either the "gross" or the "net" methods. However, that is really not the crux of the issue. Instead, the Board finds that accuracy in the cost finding process is the key element of concern. The Board finds, in the instant case, that the Provider used what amounts to a hybrid methodology of cost finding. First, common space costs were assigned directly into the A&G cost center, and then allocated to the Medicare program using Accumulated Costs. The Board also finds that the Intermediary was able to demonstrate that this practice resulted in the Provider receiving reimbursement for common space areas within buildings that housed no Medicare reimbursable activities.

The Board notes that the Medicare law at 42 U.S.C. § 1395x(v)(1)(A) states that the Secretary, in promulgating regulations to define and determine reasonable cost, must ensure that, under the method of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs. With this principle in mind, the Board finds that the Intermediary's cost finding methodology produces a more accurate reimbursement result.

The Board is not persuaded by the Provider's argument that if it uses the step-down methodology any reimbursement outcome must always be recognized. The Board cites the case of Our Lady of Victory, wherein the Board refused to allow common space to be allocated to the A&G cost center where it could be identified with a particular area. Secondly, the Board also notes the decisions in the Glenwood Regional Medical Center, and Oklahoma Medical Center cases wherein accuracy was cited as the desired outcome.

The Board does not find merit in the Provider's argument that since the Intermediary did not propose similar audit adjustments in prior years that it was thereby endorsing the Provider's's cost finding methodology. There was no written evidence in the record to support the Provider's contention that the Intermediary had agreed to accept the Provider's method for

handling common space. The Board notes that intermediaries audit on an exception basis. This concept is supported by the Alacare Home Health Services, Inc. v. Sullivan, 891 F. 2d 850 (11th Cir. 1990) case wherein the court stated that a number of factors are involved in an intermediary's evaluation of a Provider's cost, therefore each fiscal year must stand on its own.

Issue No. 2 - Reclassification of Supervisory Salaries and Benefits

The Board finds that the evidence and testimony indicates that the Provider did not maintain continuous time records, and collected the costs of all supervisors who oversee more than one function into one A&G cost center. The resulting costs were then allocated to all cost centers through step-down. This was done in accordance with HCFA Pub. 15-2, ¶1704, which states: "[i]f continuous time records are not maintained by the HHA, the entire salary of the supervisor will be entered on line 5 (A&G) and allocated to all cost centers through step-down." The Board also finds that since the supervisors serve two or more cost centers and do not provide direct patient services, the costs were properly reflected in the General Service Cost Center. This is supported by HCFA Pub. 15-1 § 2302.9 which defines a General Service Cost Center as "[t]hose organizational units which are operated for the benefit of the institution as a whole."

The Board notes that the Intermediary asserts that it may directly allocate certain of the supervisory salaries/benefits to non-reimbursable activities. However, the evidence does not indicate on what basis the Intermediary determined that the costs were not includable in the General Service Cost Center. Nor is there enough documentation in evidence to support the Intermediary's methodology for reclassification.

DECISION AND ORDER:

Issue 1 - Capital Costs (Common Areas and Building Cost Centers)

The Board finds that the Intermediary's cost finding methodology, with respect to these costs, produces the more accurate Medicare program reimbursement. The Intermediary's adjustments are affirmed.

Issue 2 - Reclassification of Supervisory Salaries and Benefits

The Provider's allocation of supervisory costs was in accordance with the direction provided by the Provider Reimbursement Manual. Complete documentation to support the Intermediary's
proposed reclassification of costs was not in evidence. Therefore, the Provider's cost finding approach is determined to be the most appropriate. The Intermediary's adjustments are reversed.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esq.
Martin W. Hoover, Jr., Esq.
Charles R. Barker[24]
James G. Sleep[25]

Date of Decision: May 06, 1999

For The Board:

Irvin W. Kues
Chairman

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[24] Withdrawn from any participation in this case in accordance with 42 C.F.R. §405.1847.

[25] Withdrawn from any participation in this case in accordance with 42 C.F.R. §405.1847.