PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
2000-D88

PROVIDER -
Extendicare 1996 Insurance Allocation Group

Provider No. Various

vs.

INTERMEDIARY –
Blue Cross and Blue Shield Association
United Government Services

DATE OF HEARING-
April 7, 2000

Cost Reporting Period Ended -
December 31, 1996

CASE NO. 99-3515G

INDEX

ISSUE:

Were the Intermediary□s adjustments reclassifying workers□ compensation and unemployment insurance expenses from the administrative and general cost center to the varying cost centers where employees were assigned proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Extendicare Health Services, Inc. (□Providers□) owned and operated the 153 Medicare-certified skilled nursing facilities (□SNFs□) comprising the group in this appeal. United Government Services (□Intermediary□) served as the fiscal intermediary during this period. In its cost reports for fiscal year ended (□FYE□) December 31, 1996, the Providers classified its workers□ compensation (□WC□) and unemployment insurance (□UI□) costs in the administrative and general (□A & G□) cost center. The Intermediary reclassified the WC and UI costs from the A & G cost center and directly assigned these costs to the using department at each SNF. The Providers appealed the Intermediary□s adjustments to the Provider Reimbursement Review Board (□Board□) and have met the jurisdictional requirements of 42 C.F.R. 405.1835-.1841. The amount of Medicare reimbursement in controversy is approximately $2.8 million.

Prior to the fiscal year at issue, the Providers assigned the WC and UI costs directly to the using departments on the trial balance of each SNF. The Providers requested that the Intermediary reopen and amend their cost reports for FYEs 1992, 1993 and 1994. The Intermediary denied the Providers□ request to reopen or amend prior cost reports. The Providers and Intermediary held a meeting on November 6, 1995, at which the WC and UI classification issue was discussed. The Providers sent a letter to the Intermediary on November 8, 1995.□ This letter indicated that the Intermediary had allowed these costs as either A & G or as departmental costs and that the Intermediary stated that the Providers could elect reporting them as A & G on its cost reports for FYE 1995 and subsequent periods.□ The Intermediary responded with a letter dated December 1, 1995 in which it stated the following concerning the WC and UI issue.□

To reiterate our position, it will be acceptable to UGS [Intermediary] for United Health [Providers] to report worker□s [sic] compensation and unemployment as A & G for FYE 1995 cost reports and subsequent periods as you will have elected to do so upon submission of these

cost reports. Contrastly, we will not accept amended cost reports for FYE 1992, 1993 and 1994 nor reopen cost reports for FYE 1992 and 1993 as elections have been made upon submission of the cost reports to include worker□s [sic] compensation and unemployment directly into the □user□ cost centers. Per HIM 15, Section 2931.2, □Once a cost report is filed, the provider may not file an amended cost report to avail itself of an option it did not originally elect.□

Intermediary Letter, December 1, 1995.

In a subsequent letter to the Provider, dated July 31, 1998, the Intermediary made the following statement concerning the reporting of WC and UI.□

In response to our July 16, 1998, meeting, I am providing this letter as a statement on UGC□s [Intermediary□s] current position regarding the proper cost reporting of worker□s compensation and unemployment expenses. Extendicare□s [Providers□] reclassification of worker□s compensation and unemployment expenses from the cost center incurring the expense to A & G is not acceptable as these costs represent employee health and welfare expenses that are derived from employee salaries and wages from which that are derived. Please note that your internal accounting system classifies these expenses as such.

To reiterate our discussion from the July 16 meeting, the letter dated December 1, 1995, to Walter Levenowich from Steve Holubowicz, did not properly convey that after the provider elects to file their costs repots in the described manner, the reporting methods remain subject to audit. The audit finding indicates that reclassifying these expenses to A & G distorts the cost finding mechanism of the cost report. Section 3524 of PRM2 states □The statistical basis shown at the top of each column on Worksheet B-1 is the recommended basis of allocation of the cost center initiated.□ In reference to the cost reporting form, HCFA 2540-96, indicates gross salaries as the recommended allocation basis for employee benefits. Classifying these benefits as A & G results in accumulated costs as the allocation basis. Alternative methods can only be approved for use if they provide a more accurate allocation result. For this reason, we find the reclassification of these costs of A & G unacceptable.

Intermediary Letter, July 31, 1998.

The reclassification of the WC and UI costs results in additional costs being allocated to the Medicare program. An example of how costs are shifted for a single SNF under the two allocation methods was presented by the Intermediary at the hearing for WC costs.

Total WC Reclassed to A & G

Routine/Nursing	Therapies	Other General Services

$75,325	$2,513	$24,112	

Effect on Routine and Therapies

Routine	Therapies	Total	
Salaries (98.7%)	$1,425,483 (1.3%)	$19,456	1,444,939
Accumulated Costs, Salaries, Other	$1,876,817 (42.9%)	$2,499,221 (57.1%)	$4,376,038

Cost Assignment Results for WC

Routine	Therapies
Per Intermediary	$75,325	$2,513
Per Providers	$33,393	$44,445
Medicare Utilization	21.9%	89.2%

The chart shows the amount of direct labor, through salaried employees, used to provide routine and therapy services. Associated with these costs, the Providers incur related payroll expenses such as health insurance, WC, UI and other expenses. The Providers principally use a contract to provide physical, occupational and speech therapy services and therefore incur minimal direct labor costs. It should be noted that the contract with the therapy company requires that they cover the worker compensation risk for their employees. The Providers internal allocation of costs for workers compensation costs is based on salaries in each department. Thus, before the reclassification, 96.8 percent of WC expense was allocated to the routine cost center. By reclassifying the costs as an A & G cost, the Providers then use the accumulated cost statistic for each department, thus some $41,932 are shifted to the therapy department. Finally, it is noted that the Medicare utilization of the therapy department is markedly higher and thus, the

high percentage rate is applied to the shifted costs so Medicare ends up covering a higher total percentage of the WC costs.

The Providers were represented by Eugene Tillman, Esquire, and Kevin R. Barry, Esquire, of Reed, Smith, Shaw and McClay, L.L.P. The Intermediary was represented by Bernard M. Talbert, Esquire, Associate Counsel, Blue Cross Blue Shield Association.

PROVIDERS CONTENTIONS:

The Providers contend that HCFA Pub. 15-1 2161.A.2 specifically defines both WC and UI as two forms of liability insurance. As such, and in contrast to fringe benefits that primarily benefit the employee, these costs may be included in its A & G cost center with their other liability insurance costs, a conclusion fully consistent with the Board's recent decision in Longwood Management Corporation 94-94/Workers Compensation Group v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 99-D34, April 6, 1999, Medicare and Medicaid Guide 80,177, declined rev., HCFA Administrator, June 4, 1999 (Longwood).

The Providers maintain that the Intermediary explicitly approved, in advance, both verbally and in writing in 1995 and on a number of occasions over a two and a half year period, its allocation of WC and UI costs as A & G costs for FYE 1995 and subsequent periods. The Providers reasonably relied on both the existing law and the Intermediary s written and repeated approvals, including the November 1995 meeting approvals, the confirmation of that position in the letters denying its proposed amended cost reports for FYEs 1992, 1993 and 1994, and the Intermediary's initial audit and approval of its FYE 1995 cost reports until their reopening in the year 2000. It is clear from the testimony of Intermediary s representative that the primary reason for the reversal of its approval was a new Intermediary auditor s mistaken conclusion that WC and UI are employee fringe benefits rather than insurance, notwithstanding the fact that the Intermediary has conceded that WC and UI are not in fact fringe benefits. The Intermediary s reclassification of these costs was therefore improper and must be reversed.

The Providers maintain that it correctly classified their WC and UI expenses as insurance costs in their A & G cost centers. The relevant Medicare reimbursement regulation provides that all payments to providers must be based on the reasonable cost of providing Medicare-covered services to beneficiaries and that such reasonable costs take into account both direct and indirect costs of providers of services. 42 C.F.R. 413.9(a) and (b). HCFA Pub. 15-1 2161 addresses the application of Medicare reimbursement principles to insurance costs. HCFA Pub. 15-1

2161.A.2 specifically defines both WC and UI as two forms of liability insurance that providers purchase to protect themselves from potential liabilities that could be incurred in the course of delivering patient care. The PRRB in Longwood recognized this fact and considered it to be of significant importance in determining that the providers had properly included their WC insurance costs in their A & G expense pool and allocated them over all allowable costs. The Providers followed both the explicit directions of HCFA Pub. 15-1¸ 2161.A.2 and the written approval and subsequent confirmations of this approval by the Intermediary over a two and one half year period when they classified these insurance expenses in the A & G cost center.

While the Longwood case addressed only workers compensation costs, we would note that unemployment compensation and workers compensation insurance costs are listed side-by-side as types of liability insurance in HCFA Pub 15-1¸ 2161.A.2. At the hearing, the Intermediary acknowledged that these two expenses are similar and should be addressed the same way.

The Providers further contend that WC and UI expenses are insurance expenses and clearly not fringe benefits, as addressed in HCFA Pub. 15-1¸ 2144. The case law set forth in the Longwood, including but not limited to the Court of Appeals decision in In Re HLM Corp., 62 F.3d 224, 226 (8th Cir. 1995), supports the Providers position that WC primarily benefits employers, not employees, in contrast to a fringe benefit. These expenses therefore are properly classified as an insurance expense in the A & G cost center. The Intermediary concedes that WC and UI expenses are not fringe benefits, which undermines its rationale in its July 1998 letter which bases its reversal of its prior approval on the assertion that WC and UI are employee benefits. The Intermediary witness also conceded that if the WC expense is considered by Medicare rules to be a type of liability insurance, that WC expense should be classified as an A & G cost center expense.

The Providers also assert that cost reporting instructions relied upon by fiscal intermediaries in the past to reclassify WC insurance as a wage-related cost do not reflect HCFAs reimbursement policy and, thus, are not controlling in any way in this appeal. In National Medical Centers et al v. Bowen, 851 F.2d 291, 295 (9th Cir. 1988) (National Medical Centers), the Court of Appeals determined that Part II of the Provider Reimbursement Manual (PRM) does not establish Medicare policy; rather, it contains instructions only to help fiscal intermediaries complete various Medicare reimbursement forms. Accordingly, the cost reporting

instructions for Form HCFA-339 are not to be accorded any particular deference. The Intermediary's witness on the cost reporting process conceded that these instructions have no controlling effect.

Finally, additional provisions of the PRM strongly support the Provider's position that WC and UI costs are properly categorized as liability insurance rather than as employee benefits and, thus, are appropriately recorded in the A & G cost center. HCFA Pub 15-1 2162.2 addresses insurance purchased from a limited purpose (or "captive") insurance company, including WC and UI. This section states that any funds returned to the provider/insured by the insurer (e.g., rebates, distributions) must be offset against the costs in the year the provider receives the returned funds. It further states that employee health care funds must be offset against costs in the Employee Health and Welfare cost center, while other costs (including, by direct implication, WC and UI costs) must be offset against the costs of the A & G cost center. Id. Accordingly, if refunds of these two types of insurance costs are credited to the A & G cost center, it follows that HCFA policy authorizes a provider to charge these costs to the A & G cost center in the first instance.

The Providers contend that they reasonably relied upon the Intermediary's prior oral and written approval of the classification of WC and UI in the A & G cost center commencing with their FYE 1995 cost reports and therefore including the FYE 1996 cost reports at issue in this appeal. The correspondence in evidence between the Intermediary and Providers on this point fully and unequivocally supports their position. Further, the Intermediary audited its 1995 cost reports without making any adjustments to the classification of these expenses in the A & G cost center which is another de facto approval of the allocation by the Intermediary. Similarly, the Intermediary's three letters in 1995 and 1996 in connection with the proposed amended cost reports for FYE 1992, 1993 and 1994 continue to reflect a position that the WC and UI classification approval given at the November 1995 meeting remained acceptable on a going-forward basis.

Neither the Intermediary's "after-the-fact" explanation in its Position Paper of its actual "intent" to require a "carve out" of certain ancillary costs with respect to the approval, nor the testimony of the Intermediary's witness with respect to the purported "real purpose" of the approval (i.e., pertaining to a routine cost limit ("RCL") exception requirement), are supported by the evidence. In fact, both explanations are totally devoid of any credibility. The hearing testimony made clear that the Intermediary prepared its Position Papers to the Board in this appeal, which purported to explain the "real intent" behind the December 1, 1995 approval

letter, without ever discussing that topic with the author of the approval letter, Mr. Holubowicz. The November 6, 1995 meeting agenda makes no reference whatsoever to the RCL topic that Mr. Holubowicz asserts was the primary subject of the meeting. Neither explanation was referenced in any manner in the Intermediary's December 1, 1995 approval letter, in the subsequent audit of the FY 1995 cost reports, in the July 1998 withdrawal of approval letter, or in its position papers. Thus, these explanations should not be accorded any weight whatsoever.

Under the Medicare program, fiscal intermediaries, as agents of HCFA, are charged with the duty of communicating HCFA's instructions to providers and making reimbursement decisions. See Mississippi Baptist Med. Health Ctr. v. Shalala, No. 3:92-CV-0821(L)(C)(S.D. Miss. 1994), Medicare & Medicaid Guide (CCH) 42,174 and 42 C.F.R. 421.100. More specifically, fiscal intermediaries "serve as a center for, and communicate to providers, any information or instruction furnished to it by the Secretary, and serve as a channel of communication from providers to the Secretary." 42 U.S.C. 1395h(a). Fiscal intermediaries therefore have a duty to advise providers with respect to policy issues, and an accompanying obligation to understand and consider the impact of their advice and approvals as received, and acted upon, by a provider. See Id. Moreover, fiscal intermediaries are required to execute these duties in full compliance with all applicable laws and HCFA PRM provisions. 42 C.F.R. 421.100, See also HCFA Agreement No. 87-001-1 (Part A contract). Accordingly, it is expected that providers will abide by official fiscal intermediary statements. An underlying assumption of this conclusion, of course, is that providers will not be penalized for such compliance and can rely on the counsel of the fiscal intermediary as an agent of HCFA.

In Chicago Lakeside Hosp. v. Aetna Life Insurance Company, PRRB Case No. 89-D66, September 27, 1989, Medicare & Medicaid Guide (CCH) 38,208, aff'd with modifications, HCFA Administrator, November 20, 1989, Medicare & Medicaid Guide (CCH) 38,260, the Board found that a provider's reliance on its fiscal intermediary's written instructions should be protected despite the fact that the fiscal intermediary subsequently changed its position.

In sum, the Providers contend that the Medicare program protects reasonable reliance on the directives of fiscal intermediaries. In the instant case, the Intermediary instructed the Provider, correctly and in writing, that it approved its assignment of WC and UI costs to the A & G cost center. That approval was essentially reiterated, in the subsequent FY 1995 cost report audits and other correspondence, for a period of two and a half years. The Intermediary's subsequent decision to renege on that approval, based on a wide range of rationales that shifted numerous

times up to, and including, the day of the hearing, is unjustified and, in these circumstances, disingenuous.

The Providers assert that the Intermediary□s attempt to disallow WC and UI insurance liability expenses as an A & G cost and require their direct assignment to other cost centers is violative of established Medicare cost-finding principles in the same way as was HCFA□s ill-fated and illegal attempt to directly apportion hospitals□ malpractice insurance costs (□Malpractice Rule□) to the Medicare program in the late 1970s.

In St. James Hosp. v. Heckler, 760 F.2d 1460 (7th Cir.), cert. denied, 474 U.S. 902 (1985), the court held that the Malpractice Rule was illegal because, among other things, the rule violated certain provisions of the Medicare Act. In discussing Medicare□s reasonable cost principles, the court noted that A & G costs include a variety of overhead expenses, □including . . . all types of insurance premiums□ Id. at 1463 (emphasis added). The proposed Malpractice Rule removed malpractice insurance premiums from the A & G pool of indirect costs and apportioned them directly based on malpractice loss experience because the Secretary believed that Medicare was paying a disproportionate amount of these costs. The court disagreed with the Secretary□s approach, noting that:

[t]he first provision of the Act at issue is the prohibition against shifting Medicare costs to non-Medicare patients and vice versa. 42 U.S.C. 1395x(v)(1)(A) (1982); see also Northwest Hospital. Inc. v. Hospital Service Corp. 687 F.2d 985, 989 (7th Cir. 1982). As mentioned previously, the Secretary□s mechanism for reimbursing providers□ indirect costs has consistently been to pool them together as G & A costs and then to reimburse a percentage of those costs on the basis of the provider's Medicare patient utilization ratio. This regulatory scheme was not premised on a belief that all G & A costs applied to all of a hospital□s patients equally, but rather on the assumption that some costs would be disproportionately allocated in favor of Medicare patients while others would be disproportionately allocated in favor of non-Medicare patients. Pooling all of the various costs together was believed to be the fairest and most administratively feasible way of allocating indirect costs among Medicare and non-Medicare patients. In addition, although there may have been cost-shifting with respect to a certain item (i.e., billing expenses associated predominately with the Medicare program), the G & A pool as a whole was thought to fairly allocate indirect costs among Medicare and non-Medicare populations such that neither sector impermissibly paid the costs of the other.

Even assuming that Medicare paid a disproportionate amount of malpractice insurance costs when they were included in the G & A pool, the Secretary seems to have forgotten that the G & A pool was designed to accommodate such imbalances. What is missing in the Secretary□s promulgation of the Malpractice Rule is the necessary starting premise: that the G & A pool including malpractice insurance costs, taken as a whole, impermissibly shifted costs attributable to non-Medicare patients to the Medicare program. See Boswell v. Heckler, 749 F.2d at 795. If the starting point was otherwise, the removal of a specific cost that was disproportionately attributable to non-Medicare patients would inevitably result in an imbalanced pool, in violation

of the Act. Id. The Secretary did not explicitly make this essential preliminary finding.

The Secretary□s action in removing malpractice insurance costs from the G & A pool is particularly suspect in light of the agency□s long-standing resistance to providers□ attempts to isolate other costs disproportionately attributable to Medicare and thus under-reimbursed under the pooling system. See PRRB Decision No. 79-D53, 1979-2 Medicare & Medicaid Guide (CCH) 30,086, at 9707 (□Program policy has consistently maintained that it is impractical to isolate discrete items of [G & A] cost between Medicare and non-Medicare beneficiaries and has posited that all such discrete items making up total [G & A] costs will □average out.□□) . . .

Id. at 1470.

Finally, the court quoted from the following HCFA policy that:

[t]he agency has long believed that the requirement in the law that our costs are not to be borne by others is construed to refer to total costs, not to any one cost. In our cost finding procedures.., it is presumed that where a particular cost might be allocated disproportionately to or from the program, there will be other costs disproportionately allocated in the other direction which will compensate for the first cost. In this manner, the program is presumed to bear its proper share of the total allowable costs.

Id. at 1472 (citing Intermediary Letter No. 234 (June 2, 1967)) (emphasis added).

In sum, the cases involving the Malpractice Rule support the Providers□ position that the Intermediary cannot do what the courts, the Health Care Financing Administration (□HCFA□), and the Board have said is improper; that is, to selectively identify costs for reclassification. The impropriety of such a reclassification is especially clear when, as here, direct authority exists in the Medicare instructions authorizing the Providers to classify their WC and UI costs in the manner in which they did.

The Intermediary□s contention that allocating WC and UI inappropriately shifts costs demonstrates its unwillingness to acknowledge a fundamental tenet of the Medicare program: the overall fairness that results from general principles of cost finding will not be compromised or sacrificed by isolated inconsistencies.□ In the instant case, just as with the Malpractice Rule, the Intermediary is attempting to tinker inappropriately with a well-settled system already designed to ensure that Medicare bears its proper share of total allowable costs. This type of selective manipulation is improper and must not be permitted.

The Intermediary□s own witness acknowledged that 99 percent of adjustments of a fiscal intermediary to a provider□s cost report result in □cost-shifting□ in one way or the other.□ In addition, the Intermediary□s cost reimbursement witness similarly admitted that it does not have the prerogative to select costs classified in the A & G cost center and □start slicing and dicing□ the costs in that cost center.□

The Providers point out that intermediaries, under contract with the federal government, are obligated to implement Medicare program policies. See 42 U.S.C. 1395h(a); 42 C.F.R. 421.100. They are required to follow PRM provisions promulgated by HCFA. See HCFA Agreement No. 87-001-1. In fact, an Intermediary witness acknowledged that it must follow Medicare policies and instructions, even if it believes that doing so would disadvantage the Medicare program in a particular case.□ Unilateral decisions by fiscal intermediaries deviating from Medicare policy would clearly exceed the authority delegated to fiscal intermediaries by HCFA and the Secretary of Health and Human Services (□HHS□), and would compromise the integrity, and uniform administration, of the Medicare program.

This type of ultra vires policy-making by fiscal intermediaries has long been prohibited. In program memoranda, HCFA has instructed fiscal intermediaries that:

[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.

Program Memorandum (□PM□), Intermediaries, Trans. No. A-92-5, August 1992, extended by PM-Trans. No. A-93-5, November 1993 (emphasis added),Medicare & Medicaid Guide (CCH) 7984.04.

These instructions clearly demonstrate that the Intermediary is bound to apply the PRM provisions. The Intermediary does not retain the discretion to implement a unilateral change in Medicare policy and therefore cannot deviate from the directions of HCFA□s PRM provisions. Given that HCFA Pub. 15-1 2161.A categorizes WC and UI as insurance, and HCFA Pub. 15-1 2144.2 excludes these expenses from employee fringe benefits, the Intermediary is required to apply these provisions uniformly, to all providers, and lacks the authority to develop its own contrary policy. Therefore, it must apply these provisions to the Providers.

The Providers contend that the Medicare reasonable cost regulation controlling the cost finding process, 42 C.F.R. 413.24, directs providers using the step-down method to assign costs to cost centers which they serve. 42 C.F.R. 413.24(d)(1). To effectuate this requirement, the Providers properly elected to follow Medicare policy by reporting WC and UI in the A & G cost center, along with other liability insurance expenses and stepping down these costs consistent with PRM provisions and authorization from the Intermediary.

Contrary to the Intermediary s contentions, this step-down method of accounting was used by all the Providers and there is no legal basis for the fiscal intermediary to impose a more sophisticated method. Under the regulations, a provider is only permitted to use a more sophisticated method of cost finding if it submits a request, in writing, to the fiscal intermediary before the end of the fourth month of the cost reporting period to which the request would apply. 42 C.F.R. 413.24(d)(2)(ii). Moreover, such a request would pertain to a provider's overall system of cost finding; it would not apply to individual instances of cost allocation as was the case here. The Providers did not make such a request. Consequently, they were required by law to use the step-down method.

The Providers contend that it is inaccurate for the Intermediary to conclude that direct costing of WC and UI expenses result in a more sophisticated or accurate cost reporting result. The WC premium is an actuarial estimate based on a complicated set of multiple criteria and takes into account industry statistics. Only one component of this computation involves a worker s salary, and that does not serve as an accurate proxy in setting the premium or determining ultimate WC costs. It is just an estimate. So the Intermediary s assertion that the broad, unsophisticated allocation set forth in the Providers general ledger is equivalent to direct costing and is more accurate than the method established in Medicare s standards for use of the step-down method is altogether without merit.

The Providers further contend that there is absolutely no legal authority to bind them to the cost categorizations they have made on their internal general ledger when they prepare their Medicare cost reports. A provider s general ledger, or trial balance, is used as a starting point, but only a starting point, for Medicare cost finding and allocations. A condition precedent for receipt of Medicare funds, however, is accurate completion of the Medicare cost report. The cost report must be completed in strict compliance with a myriad of rules and the fiscal intermediaries are appointed by HCFA to shepherd providers through this process. See 42 U.S.C. 1395x(v); 42 C.F.R. 413.9, 413.24 and 412.100; and HCFA Pub. 15-1. 2300, 2313 and 2312. While the rules are complex and detailed, not a single rule requires, or even suggests, that

a provider□s general ledger categorizations are fixed and binding and, therefore, control Medicare reimbursement. See Id.

Although this premise is so fundamental that it is not explicitly detailed in the PRM provisions, the Supreme Court has commented on this principle in Shalala v. Guernsey, 514 U.S. 87 (1995) (□Guernsey□). In Guernsey, the Court articulated the fact that, according to HCFA, □a provider□s cost accounting systems are only the first step in the ultimate determination of reimbursable costs.□ Id. at 93. In short, the Intermediary□s contention that the Providers□ general ledger categorizations impact completion of the Medicare cost report, and thus reimbursement, is without merit.

Next, the Intermediary suggests that the American Hospital Association□s (□AHA□s□) Chart of Accounts has some relevance to the instant case. At the outset, the Providers note that they are SNFs, not hospitals. The Providers further note that their internal bookkeeping and general ledger categorizations are different from hospitals. Therefore, assuming the AHA Chart of Accounts is a guiding resource, it would function as such only for hospitals, not SNFs, as testified to by the Providers□ cost reimbursement expert.□ Moreover, it has no legal applicability whatsoever to SNF Medicare cost reports. SNFs are governed by the Social Security Act, its implementing regulations, and HCFA□s PRM provisions, none of which refer, even tangentially, to the AHA Chart of Accounts in this context. In fact, the Intermediary□s own witness acknowledged that the AHA Chart of Accounts would never override an applicable Medicare instruction in the PRM.□

The Providers contend that the Longwood case was correctly decided, is nearly identical to the instant matter, and therefore should control the outcome in this case. The Intermediary acknowledges that the Longwood case does support the Provider□s position, but indicates that there are differences between the two cases, which upon careful examination, are both inaccurate and unpersuasive.

The Intermediary also noted that it will not □accept□ Longwood as precedent because the HCFA Administrator did not affirm the Board□s decision. The Providers recognize that prior Board decisions do not □control□ later cases under the formal doctrine of stare decisis. Nevertheless, the Board cases represent a final agency decision, once the HCFA Administrator decides not to review the case, as was the case here. 42 U.S.C. 1395oo(f)(1). Moreover, as final, published, agency rulings, Board decisions reflect agency policy, and guide providers□ actions. Therefore, consistency and legal soundness are required, and as a general matter, legal tribunals do not disturb a settled point. Consequently, the principles articulated by the Board in Longwood are fully applicable here.

In seeking to distinguish Longwood, the Intermediary argues that the Providers were able to identify and directly assign WC on its internal books, that is, the trial balance. This distinction is flawed for two reasons. First, it implies that the providers in Longwood were not able, and, in fact, did not directly assign such costs on their trial balance. There is no evidence in the record to support this assumption. Second, the Providers have already explained, and the Supreme Court in Guernsey agreed, that the manner in which costs are categorized on a general ledger or trial balance does not dictate Medicare reimbursement or trump Medicare cost reporting rules. Moreover, the direct costing of WC expenses is not nearly as accurate or predictive of ultimate WC experience as the Intermediary would suggest. Therefore, it is not relevant how the providers in Longwood, or these Providers, internally categorized the subject costs.

The second material difference presented by the Intermediary was that the Providers received prior intermediary approval for the subject allocation, while the providers in Longwood did not. The Providers agree that this is a material difference. As explained above, it was reasonable for the Providers to rely on the Intermediary s written approval and subsequent confirmations authorizing the Providers to allocate the subject costs to the A & G cost center. This reliance should be protected. The Intermediary s attempt to re-interpret the meaning of this approval is transparent and truly disingenuous.

Finally, the Intermediary seeks to distinguish the Longwood case on the grounds that the financial impact of any cost reporting inconsistency in Longwood was very limited, while the impact in the instant case is $2.8 million a year. The Intermediary s reasoning is flawed for several reasons. First, it is based on a misinterpretation of the legal principle, articulated in Longwood, that certain inconsistencies are inherent in any system built on general principles, but that this is greatly outweighed by the importance of maintaining uniformity. Application of this principle reveals that the financial impact in this case, or any particular case, is irrelevant. In other words, any modification in financial impact is not a sound or valid basis to disregard HCFA policy. Selective reclassification of A & G costs is a clear violation of these rules.

That said, the Intermediary s allegation that the financial impact in this case is more significant than Longwood is factually incorrect. In Longwood, the impact of utilizing the allocation method approved by the PRM and the December 1995 approval letter was approximately $23,500 per facility; in this case, the impact is approximately $18,500 per facility. The financial impact in this case is actually less than Longwood. Therefore, given that the Intermediary believed the impact in Longwood to be very limited, it would likely characterize the impact in this case as minute.

INTERMEDIARY S CONTENTIONS:

The Intermediary contends there are sufficient authorities throughout the Medicare Program s hierarchy of rules that supports the rejection of the Providers effort to allocate a payroll related expense to departments with no employees. See 42 C.F.R., 413.9. The Providers have pointed to no unequivocal authoritative support for the position and the result it is advocating.

The Intermediary refers to 42 C.F.R. 413.20 which has been in place since the start of the Medicare Program. It references the use of standardized definitions and accounting practices. As a standard practice, the Intermediary notes that the AHA's Chart of Accounts has been a source of information regarding cost classification questions. The relevant section includes WC as appropriately assigned to employee s functional reporting center along with other types of costs that are attributed to the presence of employees. While the Providers tried to argue that this provision would not cover SNFs, there is no logical explanation of what would be different.

The Intermediary also cited the relevant cost report instruction that includes WC in the same general service cost center as other payroll related expenses including the ones listed in the above reference AHA Chart of Accounts. The Intermediary contends that including WC expense in an employee benefits cost center and allocating based on salaries, accomplishes the result described by the Chart of Accounts as evidence of historical practices.

The Intermediary also cites 42 C.F.R. 413.20 which calls for the use of data from a provider s own accounts to arrive at a proper identification of the cost of services provided to Medicare beneficiaries. In reversing the A & G classification and reinstating the results flowing from the facilities internal accounting, the Intermediary acted consistent with 42 C.F.R. 413.20(a).

The Providers primary affirmative support for its position that its WC expense belongs in its A & G cost center comes from HCFA Pub. 15-1 2161. It is correct that HCFA Pub. 15-1 2161.A.2. includes WC insurance under a category called liability which also includes malpractice protection and comprehensive general liability costs. Within that section, employee health care is categorized separately. As a starting point, HCFA Pub. 15-1 2161 and later sections dealing with insurance are in the PRM to define what costs are allowable. Later subparts review the very technical conditions for allowability of the insurance program. The purpose of these sections was not to deal with proper cost reporting. Further, the insurance sections do not contemplate, support the Providers theory that it is appropriate to allocate an expense like WC to a cost center with no employees.

When a facility substantially staffs all of its direct patient care departments with salaried employees, the outcome of whether the cost is included in a broader pool such as A & G costs or a more special pool that is the employee benefit cost center, the difference in outcome is minimal. If the non-labor cost included in the accumulated statistic is in a different proportion than the labor cost, then a larger share of the WC expense will go to the department with the larger share of non-salaried costs. That type of distortion is inherent in any cost accounting system.

In this appeal, the Providers conscious decision to finance labor resources in two radically different modes requires further analysis. The distortion is compounded when the accumulated cost statistic in the therapy departments already contains an element of WC protection expense for the therapy department workers. In summary, nothing in HCFA Pub. 15-1 2161 is sufficiently on point to support the Providers position.

As a final point on authority, the Intermediary does not consider the decision in Longwood, supra, to be controlling. This was an issue of first impression, and the HCFA Administrator s decision to declination to review in Longwood cannot be considered as an automatic ratification of the Board s position.

A subsequent Board decision in the appeal of Bryn Mawr Terrace v. Blue Cross and Blue Shield Association, PRRB Case No. 99-D59, August 19, 1999, Medicare and Medicaid Guide (CCH) 80,323, declined rev., HCFA Administrator, October 4, 1999, dealt with a similarly argued issue but the subject matter was FICA. In that decision, the Board agreed with the Intermediary s use of gross salaries because it better matched the nature of the expense to the cost that generated that expense. The Intermediary indicates that similar reasoning should apply to WC expense.

One aspect of Longwood that should be revisited is its lack of a clear factual foundation to support the argument of cost shifting. In the instant appeal, the Intermediary has presented a very graphic and clear example of the distortion produced by attempting to allocate WC expense to departments that are staffed with contracted workers in which the protection is financed differently. In the face of the clear cost shifting, the argument that there is some greater good to be recognized fades away.

With all respect to the Board s analysis in Longwood, it is clear that the reasoning got tangled in a very esoteric debate over whether WC is a fringe benefit or something different. In the instant appeal, the Intermediary choose to stay out of that debate. Independent of Longwood, the Intermediary s analysis supports the contested reclassification.

The Providers are also trying to get mileage out of an argument that the Intermediary fully agreed with the Providers position on the substantive issue and later recanted its approval. If in fact clear approval was given, yet the Intermediary s current substantive analysis is correct, the prior approval issue is irrelevant. If the Providers are using the prior approval argument to buttress its own substantive argument to show that the Intermediary at one time agreed with its position, then the clouded circumstances under which the approval letter was written, is worthy of only minimal consideration. The ultimate question is still the substantive one.

The Providers have not come up with any argument or issues that it would have taken different action had the Intermediary said no to the reclassification in 1995. The most likely outcome of the Intermediary s not granting approval would have been a shorter hearing on April 7, 2000.

The Providers rely on the following in the Intermediary letter.

To reinstate our position, it will be acceptable to UGS for United Health to report worker's [sic] compensation and unemployment as A&G for PIE 1995 cost reports and subsequent periods as you will have elected to do so upon submission of these cost reports. Contrastly, we will not accept amended cost reports for FYE 1992, 1993, and 1994 nor reopen cost reports for FYE 1992 and 1993 as elections have been made upon submission of the cost reports to include worker's [sic] compensation and unemployment directly in the □user□ cost centers. Per HIM 15, Section 2931.2, □Once a cost report is filed, the provider may not file an amended cost report to avail itself of an option it did not originally elect.□

Intermediary Letter, December 1, 1995.□

What is missing from this element of the argument is a precise statement of the question. The actual question the Providers want matched to the answer it liked was, □We want to put all of our workers□ compensation expense in our A & G cost center and allocate a significant portion to our therapy departments which generate minimal workers□ compensation expense because they have minimal employees, are you okay with doing that because no matter how we choose to supply labor to our direct patient care departments, including the workers□ compensation expense for just our employees in the A & G cost center is correct?□ If the question was that pinpointed, the Providers might score a few points with their prior approval argument.

The Providers□ witness, who was present at the meeting that produced the approval letter,□ had no recollection of what was presented to the Intermediary prior to the meeting.□ The Intermediary witness did not recall any written input for the meeting.□

The Intermediary witness□ recollection of the underlying problem caused by classification of WC expenses was credible. The Board has enough experience with SNF RCL disputes to understand the importance of isolating direct labor salary expense from non-salary payroll expense, both discretionary fringes and mandated coverage like WC.

As a general rule, SNF□s follow the cost report instructions that identify the routine salary expense in the routine cost center and all other payroll related expenses in a discrete employee

benefit cost center. That is how RCL exceptions were processed. The Providers more sophisticated method of directly identifying its payroll expenses and including them in prior periods in the routine cost center was making processing their RCL exception problematical, even if acceptable as a cost reporting technique. The Intermediary indicates that this was the problem the Intermediary witness was addressing. Even if the Intermediary witness s perception was incorrect at the time of the November 5, 1995 meeting, nothing has been identified which makes crystal clear what the Providers agenda really was. If the Intermediary witness had clearly accepted the Providers argument that the manual mandated including all WC expense in A & G regardless of the circumstances, then his reference to a provider election in the December 1st letter does not fit. The Intermediary agrees with the general thrust of the Providers discussion of prior approval. Problems can be averted when a provider wants to make a change in its traditional cost report presentation and first seeks Intermediary counsel. When a provider does that in an uncertain area, the intermediary s advice should be fairly considered. Under the specific facts of the case under appeal, the general model outlined by the Providers breaks down. While the Providers seem to like the answer they received they have failed to identify the question that solicited the answer. Therefore, the verbiage in the approval letter, is meaningless and irrelevant to the outcome of this case.

The Intermediary contends it has convincingly established the illogical cost shifting which results from allocating WC expense to departments that have no employees. The Intermediary has identified adequate tools and authorities to match the allocation of WC expense to the source of the cost, that is, salaries. The adjustments should be affirmed.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

. 1395h et seq. - Use of Public Agencies or Private Organizations to Facilitate Payments to Providers of Service

. 1395oo et seq. - Provider Reimbursement Review Board

. 1395x(v) - Reasonable Costs

2. Regulations - 42 C.F.R.:

. 405.1835-.1841 - Board Jurisdiction

. 413.9 et seq. - Costs Related to Patient Care

. 413.20 et seq. - Financial Data and Reports

. 413.24 et seq. - Adequate Cost data and Cost Finding

. 421.100 - Intermediary Functions

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

. 2144 et seq. - Fringe Benefits

. 2161 et seq. - Insurance Costs

. 2162 et seq. - Provider Costs for Malpractice and Comprehensive General Liability Protection, Unemployment Compensation, Workers Compensation, and Employee Health Care Insurance

. 2300 - Adequate Cost Data and Cost Finding; Principle

. 2312 - Changing Cost Finding Methods

. 2313 - Changing Bases for Allocating Cost Centers or Order in Which Cost Centers are Allocated

4. Cases:

Bryn Mawr Terrace v. Blue Cross and Blue Shield Association, PRRB Case No. 99-D59, August 19, 1991, Medicare and Medicaid Guide (CCH) ¶ 80,323, declined rev., HCFA Administrator, October 4, 1999.

Chicago Lakeside Hosp. v. Aetna Life Insurance Company, PRRB Case No. 89-D66, September 27, 1989, Medicare & Medicaid Guide (CCH) ¶ 38,208, aff'd with modifications, HCFA Administrator, November 20, 1989, Medicare & Medicaid Guide (CCH) ¶ 38,260

In Re HLM Corp., 62 F.3d 224, 226 (8th Cir. 1995)

Longwood Management Corporation 94-95 Workers Compensation Group v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 99-D34, April 6, 1999, Medicare and Medicaid Guide ¶ 80,177, declined rev., HCFA Administrator, June 4, 1999

Mississippi Baptist Med. Health Ctr. v. Shalala, No. 3:92-CV-0821(L)(C)(S.D. Miss. 1994), Medicare & Medicaid Guide (CCH) ¶ 42,174

St. James Hosp. v. Heckler, 760 F.2d 1460 (7th Cir.), cert. denied, 474 U.S. 902 (1985)

Shalala v. Guernsey, 514 U.S. 87 (1995)

National Medical Centers et al v. Bowen, 851 F.2d 291 (9th Cir. 1988)

5. Other:

Provider Reimbursement Manual Part II

Form HCFA - 339

HCFA Agreement No. 87-001-1 (Part A Contract).

American Hospital Association Chart of Accounts

Program Memorandum, Intermediaries, Trans. No. A-92-5, August 1992, extended by PM-Trans. No. A-93-5, November 1993, Medicare & Medicaid Guide (CCH) ¶ 7984.04.

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, evidence presented, testimony elicited at the hearing, and post-hearing submissions, finds and concludes as follows:

The Board finds there are two aspects to the subject issue. The first aspect is whether the cost of WC and UI should be classified as an A & G expense or whether it is an employee benefit. The second aspect is whether or not that classification results in an improper allocation of costs; that is, allocating WC and UI costs on the basis of accumulated cost as an A & G expense or on the basis of salaries as an employee benefit. In addition, the Board notes that the Providers argue that they received advanced approval for the allocation.

Respectively, the Board finds that WC and UI are types of liability coverage whose costs are appropriately classified as an A & G expense. The Board finds that WC and UI are primarily purchased to protect an employer, in this case the Providers, from potential losses due to workers' injuries or unemployment, as compared to a fringe benefit that would inure primarily to an employee. In addition, the Board finds that the Intermediary approved the Providers' request for the allocation method used.

The Board finds that program instructions at HCFA Pub. 15-1 ¶ 2161.A.2 supports its position. In part, the manual states:

Liability.-- This insurance includes professional liability (malpractice, error in rendering treatment, etc.), unemployment compensation, worker□s compensation, automobile liability, etc.

HCFA Pub. 15-1¸ 2161.A.2 (emphasis added).

Also regarding this matter, the Board finds that the amount of WC and UI costs incurred by any given employer is not based solely upon salaries as argued by the Intermediary. Rather, the cost of such coverage for WC is determined to a large extent by the amount of risk involved with employee activities, i.e., the potential for employee injuries and the severity of such injuries should they occur, and the cost of coverage for unemployment compensation is determined based upon an employer□s previous unemployment claims.

Moreover, the Board finds no authoritative basis within Medicare regulations, program policies, or the generally accepted accounting principles (□GAAP□) supporting the classification of WC or UI costs as an employee benefit. The Board acknowledges the Intermediary□s reference to Medicare□s cost reporting instructions classifying WC and UI costs as a fringe benefit. However, the Board is not compelled by this argument. Essentially, the Board finds that Medicare reimbursement policy is reflected in Part I of the PRM, as is HCFA Pub. 15-1¸ 2161.A.2, quoted above. Cost reporting instructions, which are separately maintained in Part II of the PRM, may provide some guidance towards reimbursement policy but only if no other more authoritative source is available. The Board notes the Providers□ reference to National Medical Centers, supra, finding that Part II of HCFA Pub. 15 does not establish Medicare policy and, therefore, requires no particular deference.

In all, with respect to the classification of WC and UI costs as an A & G expense, the Board reaches the same findings and conclusions as it did in Longwood, supra.

With respect to the allocation of WC and UI costs, the Board finds that Medicare□s cost finding process dictates the basis upon which any cost will be divided among the other cost centers. Since WC and UI costs are appropriately charged to the A & G cost center, they are appropriately allocated on the basis of accumulated cost. Importantly, the Board also finds no impropriety with this process.

As noted by the Intermediary, allocating WC and UI costs on the basis of accumulated cost results, in some instances, in greater program payments than if it were allocated on the basis of direct salaries. However, this effect does not warrant a change in a cost□s classification since restricting program payments is not the intent of Medicare□s cost finding process.

The Board finds that Medicare□s cost finding process is designed to be fair and equitable to both the program and providers. It is not, however, designed to be a perfect process, meaning that every type of cost would be apportioned to Medicare with absolute precision. Clearly, there are far too many variations of provider costs and potential allocation bases to reach such result. Instead, the process recognizes that some A & G costs may be disproportionately allocated in

favor of Medicare while others would be disproportionally allocated in favor of other payors. For example, the cost of malpractice insurance is attributable far more greatly to non-Medicare patients than to covered patients, yet this cost is apportioned through the A & G cost center. Conversely, the cost incurred by providers to produce their Medicare cost report is also dispersed as an A & G expense, although its purpose is almost exclusively for the benefit of the program.

The Board rejects the Intermediary's argument regarding In re HLM Corp., supra. Specifically, the Intermediary contends that the court's findings in that case fail to support the classification of WC costs as an A & G expense. The Intermediary bases this argument on the fact that the issue in that case was employer debt rather than Medicare cost finding. The Board finds, however, that the nature of the case is not the relevant factor--it is what the court says that is most important. In this regard, the Board notes the court's language, as follows:

[w]hile workers' compensation programs are certainly designed to benefit employees, the institution of a workers' compensation insurance program helps 'employers safeguard their statutory obligations' by insuring the employer from its liability to provide workers' compensation benefits. Additionally, because the employee would still be entitled to such benefits even if the employer were illegally uninsured, the employer's participation in a workers' compensation insurance fund cannot be understood as a true 'benefit.' A true 'benefit' would be one more commonly associated with, for example, employee life insurance benefits, where unless an employer offered a life insurance benefit plan the employee would not necessarily have coverage.

Id. at 226.

The Board also rejects the Intermediary's reliance upon the findings and conclusions in Bryn Mawr, supra. The issue in that case involved employment taxes which are characteristically different from worker's compensation insurance. Clearly, the arguments in Bryn Mawr are not on point.

The Board also rejects the Intermediary's reliance upon the AHA's Chart of Accounts to support its argument that the cost of WC should be classified as an employee benefit. The Board agrees that the Chart of Accounts may be a useful source of information regarding cost classifications in some instances. However, it has no applicability in situations where Medicare policy has been established, as in the instant case, at HCFA Pub. 15-1. 2161.A.2.

In addition, the Board disagrees with the Intermediary's rebuttal of its findings and conclusions in Longwood because the Administrator of HCFA did not formally affirm that decision. The Board believes the Administrator's decision not to review that case is indicative of her general agreement with the resolution of the issue.

Finally, the Board finds that the Intermediary was aware of the intentions of the Providers to classify these costs in the A & G cost center and indicated it was acceptable. The Board does not find any evidence to support the Intermediary s argument that it was dealing with an RCL issue. The Board notes that previous decisions have found that where an Intermediary, representing HCFA, gives written advise to a provider, the provider should be permitted to rely on it, even if the intermediary changes its mind. See Chicago, supra.

DECISION AND ORDER:

The Board finds that the Providers properly classified WC and UI costs as an A & G expense. The Intermediary adjustment reclassifying these costs is reversed.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esquire
Martin W. Hoover, Jr., Esquire
Charles R. Barker
Stanley J. Sokolove

Date of Decision: September 26, 2000

FOR THE BOARD:

Irvin W. Kues
Chairman