PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2003-D48

PROVIDER –
Mercy Home Health
Springfield, PA

Provider No. 39-7015

vs.

INTERMEDIARY –
Cahaba Government Benefit Administrators/ Blue Cross Blue Shield Association

DATE OF HEARING -
November 6, 2002

Cost Reporting Periods Ended -
12-31-95, 12-31-96, 12-31-97
12-31-98, 12-31-99

CASE Nos. 99-2780, 99-2781,
01-1334, 01-1335, 02-0450

INDEX

ISSUE:

Was the Intermediary's adjustment to home office costs proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Mercy Home Health ("Provider") is a non-profit corporation located in Springfield, Pennsylvania. The Provider is a subsidiary of Mercy Home Health Services ("Home Office"). Home Office has three other components: a private duty nursing agency, a home care staffing agency, and a durable medical equipment supplier.

In all of the fiscal years at issue, the Home Office incurred various costs on behalf of its subsidiaries. These costs were allocated in two different ways. For fiscal years 1995 and 1996, the Home Office allocated costs to the Provider and its affiliates in accordance with a methodology that used the cost related to salaries/wages, employee benefits and professional contracted services as a statistic for the pooled cost allocation. Independence Blue Cross ("IBC"), the former Intermediary, approved the methodology for the fiscal years ("FY") 1993, 1994, 1995 and 1996.[1] However, in June 1996, IBC advised the Provider that, that approach would no longer be accepted. Instead, operating costs were to be used as the allocation statistic effective with the December 31, 1997 Medicare cost report. The Provider testified that IBC advised that it would not disturb or retroactively adjust the methodology used for the 1995 and 1996 cost report years.[2]

For the years 1997 through 1999, in the absence of an Intermediary approved alternative methodology, the Provider used a methodology to develop a statistic to allocate home office costs.[3] The Provider used the ratio of costs of each home office component, minus the cost of supplies, to the total costs of all home office components minus cost of supplies. Upon audit, for all cost periods under appeal, the current Intermediary, Cahaba Government Benefit Administrator, reallocated home office costs using the cost-to-total cost methodology prescribed in CMS Pub. 15-1 § 2150.3.D.

The Provider appealed the Intermediary's determination to the Provider Reimbursement Review Board ("Board") and has met the jurisdictional requirements of 42 C.F.R. § 405.1835-405.1841. The estimated Medicare reimbursement impact is approximately $1,673,000. Representing the Provider were Frances B. McGinley, Esq. and Kimberly A. Bane, Esq. of Cozen O'Connor, Attorneys. Eileen Bradley, Esq. of the Blue Cross Blue Shield Association represented the Intermediary.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's retroactive application of the cost-to-total cost methodology for the 1995 and 1996 cost report years was contrary to CMS Pub. 15-1

[1] Exhibits P-3, P-4 & P-5.
[2] Tr. at 75-78.
[3] Provider Post Hearing Brief at 6, footnote 4.

§ 2150.3.D, as well as case law. Its home office complied with the approval process by submitting a timely request in writing and setting forth the rationale for its allocation methodology.[4] IBC, the prior Intermediary, had approved the methodology for 1993 and 1994.[5] IBC's subsequent withdrawal was effective only prospectively for the next full cost reporting period after the Intermediary's reversal, i.e., beginning January 1, 1997.[6]
The Provider argues that the successor Intermediary to IBC, retroactively and improperly rescinded the IBC approval. First, the Provider contends it was not only entitled, but required, under CMS Pub. 15-1 § 2150.3.D to use its approved methodology until such time as a timely request for change was approved or it was prospectively notified by its intermediary that the approval was to be withdrawn. In that an IBC representative verbally affirmed that no change would be made for 1995 and 1996, the Provider argues it was entitled to rely in good faith on the IBC approval. In support of its position, the Provider cites the Board's decision in Extendicare 96 Insurance Allocation Group v. Blue Cross and Blue Shield Association/United Government Services, PRRB Dec. No. 2000-D88, September 26, 2000, Medicare & Medicaid Guide ("Extendicare 96") (CCH) ¶ 80,573, decl'd. rev. HCFA Admin., November 21, 2000. In that case, the Board opined that where an Intermediary representing HCFA gives written advice to a provider, the provider should be entitled to rely on it, even if the intermediary changes its mind.

Additionally, the Provider argues that its methodologies for all years provided a more precise allocation of home office costs to the chain components. Specifically, for 1995 and 1996, the home office costs were more equitably allocated based upon the pro-rata cost of personnel, as the home office oversight did not extend to the costs of the acquisition, warehousing and delivery of durable medical equipment ("DME").

For 1997 through 1999, the Provider developed and used an alternative methodology based on the exclusion of the cost of supplies from the cost of all components and from total costs. The Provider asserts that the DME component was basically a supplier of tangible healthcare products, whereas the other healthcare providers in the chain are providers of labor intensive services. The costs associated with acquisition, storage, maintenance and distribution were incurred directly by the DME at the subsidiary level and were not supported in any manner by the home office.[7] The Provider argues that since the home office did not support the functions of the DME subsidiary in an amount commensurate with the supply cost, the inclusion of supplies in the Intermediary's cost-to-total cost methodology results in the allocation of a disproportionate share of home office cost to the DME subsidiary. Wellmark and the current Intermediary's adjustments are flawed because they do not recognize the atypical nature of supply costs. Accordingly, a disproportionate share of costs flows to a component for which there is no Medicare reimbursement.

The Provider also points out that the facts in this case differ from the case cited by the Intermediary. Home Health Corporation of America - Home Office Group Appeals v.

---

[4] Exhibit P-1.
[5] Exhibit P- 4.
[6] Exhibits P-5 & P-6.
[7] Exhibits P-36-P-41.

Independence Blue Cross and Aetna Life Insurance Company, PRRB Dec. No. 2000 - D24, March 3, 2000, Medicare & Medicaid Guide (CCH) ¶ 80,400, decl'd. rev. HCFA Admin. April 28, 2000 ("Home Health Corporation of America").[8] Unlike the providers in Home Health Corporation of America, the Provider and its related DME subsidiary treated supplies in a consistent manner, excluding them from the allocation methodology.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its inclusion of total costs and the cost of goods sold/supplies in the pooled allocation statistic was appropriate and in accordance with the principles of reimbursement for home offices found in CMS Pub. 15-1 § 2150. In particular, § 2150.3D.2.b states in part:

> Under this basis, all chain components will share in the pooled home office costs in the same proportion that the total costs of each component (excluding home office costs) bear to the total costs of all components in the chain.[9]

The Intermediary points to the Board decision in Home Health Corporation of America, supra, wherein the Board found that the intermediary properly applied the provisions of CMS Pub. 15-1 § 2150, which establishes the allocation methodology for the distribution of home office costs to components in a chain. The Intermediary further contends that its decision is supported by a CMS letter dated February 4, 1999 to the Provider.[10] That letter advises:

> Cost of goods sold is part of the operating cost of the DME entity just as surely as salaries and wages are part of the operating cost of the HHA. Moreover, DME Medicare fee schedule reimbursement is calculated to include reasonable and necessary administrative cost. To apply pooled home office cost to the DME business using an incomplete basis of allocation would understate the cost allocated to the DME business and overstate the cost allocated to the HHA business.

The letter goes on to say:

> Whether or not the former Regional Home Health Intermediary ensured that each component administered by the home office was allocated the appropriate share of pooled home office cost in settlements for periods before 1995, Wellmark (the Intermediary) is required to apply the requirements as stated in the PRM.

---

[8] Exhibit I-5.
[9] Exhibit I-2.
[10] Exhibit I-6.

Id.

The Provider argues that since the former Intermediary granted approval for the alternative allocation method, the current Intermediary should not make this adjustment. The Intermediary would like to point out that the letter also states, "all methodologies that we (Independence Blue Cross) approve are subject to verification during audit." Id. Upon audit, the Intermediary does not agree that the submitted allocation methodology is appropriate, nor does it follow Medicare guidelines, as outlined above. Therefore, the Intermediary has adjusted the statistic to what it contends is the proper allocation methodology.

The Intermediary concludes that the Provider has not proved that its alternative methodology is more equitable or accurate, in that the Provider has not offered a distinction between "cost of goods sold" and "cost of services provided." The Intermediary contends that its inclusion of total costs in the pooled allocation statistic is the most appropriate methodology. In the instant case, the cost of labor is equated by the Intermediary to the cost of goods sold.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

During the cost years in dispute, the Provider's Home Office allocated its pooled costs (i.e., those remaining after direct and functional allocations were made) to the Provider and its affiliates in two different ways. Therefore, the Board must address this issue for two distinct periods, the first covering fiscal years 1995 and 1996.

Medicare guidelines at CMS Pub. 15-1 § 2150.3 require a provider, absent prior approval from its intermediary, to allocate costs using a cost-to-cost methodology. CMS Pub. 15-1 § 2150.3.D also states that a home office may use an allocation basis that provides for a more precise allocation of pooled home office costs if it obtains prior intermediary approval. The Board finds that in July 1993, the Provider sought Intermediary approval of a more sophisticated allocation methodology and, after responding to Intermediary concerns, received the Intermediary's permission to employ the new methodology effective July 1, 1993. The Board also finds that the Provider used the Intermediary-approved method of allocation for the fiscal years 1993 through 1996.

CMS Pub. 15-1 § 2150.3.D(2)(b) states in part:

> Where the Intermediary approves the home office request, the change must be applied to the accounting period for which the request was made, and to all subsequent home office accounting periods, unless the intermediary approves a subsequent request for change by the home office.

The Board concludes that the CMS guidance cited above reflects an intent of finality unless a change is requested by the Provider. There is no evidence in the record that the Provider failed to follow the approved methodology or that it made a request to change its methodology for the 1995 and 1996 years at issue. In addition, the Board is not convinced that the Intermediary's caveat "subject to verification at audit" leaves the door open for the current Intermediary to retroactively rescind the prior Intermediary's approval. The Board's position is supported by the language in Extendicare 96, supra[11] where the Board stated "provider's reliance on intermediary's written instruction should be protected even if intermediary subsequently changes position."

With respect to the fiscal years 1997, 1998, and 1999, a different set of facts apply. On July 26, 1996 the former Intermediary advised the Provider that the current statistic to allocate pooled costs (using salaries, benefits and contracted costs) would no longer be accepted. The Provider was advised that operating costs must be used as the allocation basis effective with the fiscal year 1997 Medicare cost report. For fiscal years 1997 through 1999, in the absence of an approved methodology, the Provider developed and used an alternative allocation methodology that was neither approved by the Intermediary nor consistent with CMS manual instructions.

The Board finds that the Provider had sufficient advance notice and the opportunity to collect data to show that its elected methodology was more sophisticated. The Provider testified in the hearing that the Provider's method resulted in a more accurate allocation of costs; however, these statements were not supported by any specific computations in the record to support the Provider's contention. Also, testimony revealed that some functions changed in 1996, in that a number of functions previously carried out in the DME component were now performed in the home office. The Board is persuaded by the Intermediary's argument that the cost of labor in the service-oriented affiliates could just as well be equated to the "cost of goods sold" in the DME affiliate. Thus, there is no valid rationale for excluding the cost of goods sold from the CMS-prescribed allocation methodology.

Based on these factors, the Board concludes that for the years 1997 through 1999 the total cost method set forth in CMS Pub. 15-1 § 2150.3.D.2(b) is the method to be used by the Provider. In the absence of supporting documentation as required by 42 C.F.R. §§ 413.20 and 413.24, the Board finds no justification for changing the Intermediary's application of the prescribed allocation statistic.

---

[11] Extendicare 96, (citing Chicago Lakeside Hospital v. Aetna Life Insurance Company, PRRB Dec. No. 89-D66, September 27, 1989, Medicare &Medicaid Guide CCH ¶ 38,208, aff'd with modifications CMS Admin., November 20, 1989, Medicare & Medicaid Guide (CCH) ¶ 38,260.)

DECISION AND ORDER:

FY 1995 and FY 1996

Provider's reasonable reliance on the approval of the original Intermediary should be protected. The subsequent decision by the new Intermediary to withdraw approval is contrary to CMS guidance and case law. The Intermediary's adjustments are reversed.

FY 1997, FY 1998, and FY 1999

The Intermediary's adjustments to the Provider's home office cost statements were proper and are affirmed.

Board Members Participating

Suzanne Cochran, Esquire
Dr. Gary Blodget
Martin W. Hoover Jr., Esquire
Elaine Crews Powell, CPA

DATE: August 22, 2003

FOR THE BOARD

Suzanne Cochran
Chairman