PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

ON THE RECORD
2004-D4

PROVIDER –
ProActive Home Care, Inc.
Wichita, Kansas

Provider No. 17-8012

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
Cahaba Government Benefit
Administrators

DATE OF HEARING -
August 21, 2003

Cost Reporting Periods Ended
December 31, 1997 and December 31, 1998

CASE NOS. 00-2255 and 01-2782

INDEX

ISSUE:

Whether the Intermediary's adjustment to include private duty nursing costs on the Medicare cost report was correct.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The Medicare program was established under Title XVIII of the Social Security Act (the "Act") to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS)[1] is the operating component of the Department of Health and Human Services charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under the Medicare law and under interpretative guidelines published by CMS. Id.

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurs during the fiscal year and the proportion of these costs to be allocated to Medicare. 42 C.F.R. § 413.20. The fiscal intermediary reviews the cost report and determines the total amount of Medicare reimbursement due the provider. It then issues a Notice of Program Reimbursement (NPR) setting forth a final determination of expenses allowed and disallowed by the intermediary. 42 C.F.R. § 405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board). 42 U.S.C. § 1395oo(a); 42 C.F.R. § 405.1835.

One of the principles of Medicare law is that the Medicare Program will not bear the costs of non-Medicare patients. Conversely, the costs of non-Medicare patients will not be borne by the Medicare program. 42 U.S.C. §1395(x)(v)(1)(A). The regulations at 42 C.F.R. §§413.9, 413.17, 413.20 and 413.24 provide Medicare's rules and requirements in order to ensure that Medicare pays its fair share of costs. At issue in this case is the correctness of the Provider's allocation of shared costs between two separate corporations that are located in the same building. One is the Provider and the other is a non-provider corporation owned and operated by one of the parties that owns the Provider. Some of the costs incurred by the corporations were shared and some were separately identifiable. The allocation of the shared costs is the foundation of this dispute.

ProActive Home Care, Inc. (Provider) is a home health agency located in Wichita, Kansas. Dr. Gerald Lessard and his wife, Dr. Betty Lessard, each own fifty percent of the shares of the Provider and are officers and directors of the corporation. Dr. Gerald Lessard is also the sole shareholder of a private duty nursing company, ProActive Associates, Inc. (Associates). Both Dr. Gerald Lessard and Dr. Betty Lessard are the officers and directors of this corporation. Dr. Gerald Lessard is the administrator of both organizations.

[1] Formerly the Health Care Financing Administration (HCFA).

When the Provider submitted the Medicare Cost Report (MCR), it identified specific costs as only related to the home health agency. The cost of Associates was not included on the cost report. The Provider identified shared costs and allocated them between the reimbursable (Provider) and non-reimbursable (Associates) companies prior to submission of the cost on the MCR. The following is a description of the costs the Provider allocated to Associates.

- The Provider allocated 15 percent of the salary of the human resources coordinator to Associates. This percentage was determined based on two time studies conducted in April and August of 1997. A portion of a scheduler's salary was also allocated to Associates beginning in December, 1997.

- Associates and the Provider occupy the same building. Each has a separate entrance and a dividing wall with a door to allow access to each area. The Provider allocated 11 percent of the cost for office rental, utilities, building insurance and building security costs to Associates based on square footage. The Provider also allocated 11 percent of the space for the reception area to Associates. [2]

- Telephone expense was allocated based on the number of phone lines Associates used.

The following costs were not separated between the two organizations but were determined by the Intermediary to have been shared:

- Associates and the Provider both advertised for staff openings in local publications. All of these costs were included in the Provider's advertising account.

- The Provider did not allocate any of Dr. Lessard's salary to Associates. The Provider states that he spent one hour a month at Associates' board meetings.

Many of the allocations described above were made based on estimates. The Intermediary determined that for proper allocation of costs, the costs related to Associates should be included on the MCR in a non-reimbursable cost center. This resulted in the shared administrative costs being allocated based on accumulated cost on Worksheet B of the MCR. Therefore, the Intermediary added the following costs to the MCR:

	1997	1998
Administrative and General	$123,492	$ 159,988
Private Duty Nursing	$404,222	$1,384,950

[2] See Intermediary's final position paper for case number 00-2255 (FYE 12/31/97); Intermediary Exhibit 1, Workpaper 3-6D

The Intermediary adjustments resulted in a reduction in Medicare reimbursement of approximately $111,000 in 1997 and $100,000 in 1998.

The Provider appealed the Intermediary's adjustments to the Board. The Provider's filings meet the jurisdictional requirements of 42 C.F.R. §§ 405.1835-405.1841. The Provider was represented by Martha Aaron Ross, Esquire, of Foulston and Siefkin, LLP. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's decision to ignore Associates' separate legal existence and combine its expenses on the Provider's cost report was justified solely on the Intermediary's criticism of the manner in which the Provider allocated costs to Associates. The Provider asserts that the Intermediary has not challenged the accuracy of the estimates or the reliability of the records used by the Provider to allocate costs for administrative staff, office space, and computer equipment to Associates. Relying solely on HCFA Pub. 15-1 §2307(a), the Intermediary has taken the position that the Provider could allocate costs directly to Associates (as opposed to treating Associates as a non-reimbursable cost center and allocating its costs pursuant to the step-down method) only if such allocation is based on actual usage. Absent such a basis for allocating costs, the Intermediary reasons, HCFA Pub. 15-1 §2307(a) requires that all of Associates' expenses be combined on the Provider's cost report in the manner set forth in the audit workpapers.

The Provider argues that nothing in HCFA Pub. 15-1 §2307(a), however, supports the Intermediary's adjustments. The section of the manual in which this provision is found, Chapter 23, Adequate Cost Data and Cost Finding, sets forth the manner in which a provider's costs are to be allocated among its departments for cost reporting purposes. According to HCFA Pub. 15-1 §2302.9, general service cost centers are those organizational units which are operated for the benefit of the institution as a whole. The Provider contends that these manual provisions do not govern the manner in which a provider is to allocate costs to a separate corporation with which it shares certain expenses.

The Provider relies on the Board's decision in Personalized Home Health Agency, Inc., v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of California, PRRB Decision 87-D60, March 30, 1987, aff'd HCFA Administrator, June 3, 1987, Medicare and Medicaid Guide (CCH) ¶36,240, (Personalized) in which a home health agency shared office space and administrative costs with two other agencies. The three entities were legally separate and maintained separate financial records. The home health agency did not report the costs allocated to the other agencies on its cost report. In challenging the intermediary's decision to treat the two agencies as nonreimbursable cost centers in the home health agency's cost report, the agency argued that while a home health agency must use step-down cost finding to determine its costs, the regulations do not preclude discrete costing prior to step-down cost finding. The Board agreed with this point, but found that the home health agency's discrete costing allocations of the shared

costs were based on unsupported estimates that were neither auditable nor verifiable in accordance with 42 C.F.R. §413.24.

The Provider acknowledges that the Board in Personalized upheld the intermediary's decision that the home health agency had not properly allocated costs to the separate corporations but emphasizes that the Board, nevertheless, found that a home health agency may engage in discrete costing. Discrete costing utilizes statistical surrogates to allocate costs to a separate legal entity prior to engaging in step-down cost finding to allocate costs among a Provider's revenue-producing and non-revenue-producing departments. In light of this ruling, the Provider argues that it acted appropriately when it utilized statistical surrogates in allocating expenses to Associates and the Intermediary's decision to disregard this allocation based solely on the Provider's utilization of statistical surrogates cannot be upheld.

The Provider further observes that, unlike the intermediary in Personalized, the Intermediary in the present case has not challenged the estimates on which the Provider allocated costs to Associates as "neither auditable nor verifiable." With respect to office rental, utilities, building insurance, and building security, these costs were allocated based on the percentage of the total square footage of the building occupied solely by Associates, i.e., 11 percent. The rental rate for Associates' use of the building's common areas, including the restroom, reception area, and the skills lab, also was based on this percentage. One utility, telephone service, was not allocated on this basis. Proactive allocated to Associates the cost of the phone line utilized by the private duty company. The Provider made the records relating to this allocation available to the on-site auditor. It argues that this method for allocating these costs ensures that costs of the Medicare Program will not be borne by individuals not so covered and the costs with respect to the individual not so covered will not be borne by the Medicare program. See, 42 U.S.C. §1395(x)(v)(1)(A). By contrast, the Provider claims that the Intermediary's cost allocation method forces Associates, which is not a Medicare provider, to bear a significant percentage of the costs related to services provided to Medicare beneficiaries by the Provider.

Finally, the Provider acknowledges that it allocated costs associated with computer equipment based on Associates' estimated usage of this equipment, but it points out that the Intermediary identifies no shortcoming in this estimate and offers no reason to believe the use of the estimate would result in an improper allocation of costs.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its audit adjustment was made in accordance with Medicare regulations at 42 C.F.R. §§413.9, 413.17, 413.20 and 413.24 and HCFA Pub. 15-1 §§2200, 2304, 2307, 2313 and 2328, and that the Provider has not met the requirements of HCFA Pub. 15-1 §2307 or §2313. The general service costs have been allocated based on statistical surrogates before the cost was claimed on the MCR. The Intermediary considers the costs of the human resource coordinator and scheduler to be administrative; therefore, these costs should be allocated through the step-down process

on the MCR. However, even if these salaries could be considered as direct costs, the Provider has not met the time study requirements of HCFA Pub. 15-1 §2313 in that it failed to submit a written plan and conduct a sufficient number of time studies as required by HCFA Pub. 15-1 §2313.

The Provider argues that Chapter 23 of HCFA Pub. 15-1 does not apply since the manual provisions do not address the manner in which a provider allocates costs to a separate corporation with which it shares certain expenses. The Intermediary responds that the regulations and instructions address adequacy of cost finding; they do not exclude allocation of cost to a separately incorporated organization. Further, HCFA Pub. 15-1 §2307 states that the costs of a general service cost center need to be allocated to the cost centers receiving service from that cost center. The Intermediary alleges that Associates receives benefits from the general service cost centers of the Provider; therefore, the general service costs must be allocated to Associates.

The Intermediary offers that Medicare will only reimburse the actual costs of the services to a provider. See, 42 C.F.R. §413.17. The general service costs must, therefore, be adequately distributed between the Provider and Associates. The Intermediary has adjusted the MCR to include all of the general service and direct costs not included by the Provider on the MCR so that the general service costs can be distributed through the step-down process. This will ensure that total allowable costs are correctly apportioned between program beneficiaries and other patients based on the actual costs of services furnished to each class of patients as required by 42 C.F.R. §413.9.

The Intermediary alleges that, as in Personalized, supra, the Provider in this case did not establish through documentary evidence, such as written contemporaneous records, that the bases used for its discrete costing allocation of shared costs yielded more accurate results. Telephone costs did not reflect any long distance calls incurred by Associates. The Provider did not provide invoices to support office supply costs. Computers purchased by the Provider were found to be in Associates' work area. Finally, Dr. Lessard's time spent on Associates, i.e., one hour per month at a board of directors' meeting, is questionable in light of Associates growth from 1997 to 1998.

The Intermediary also relies on California Health Professionals v. Blue Cross and Blue Shield Association/Wellmark Blue Cross and Blue Shield, PRRB Dec. No. 2000 D-16, February 7, 2000, Medicare & Medicaid Guide (CCH) ¶ 80,392, in which the intermediary adjusted the provider's direct costing by establishing a home office for allocation of shared services. The Board found there was no evidence to support the provider's request for a functional allocation, nor was there evidence to support a more sophisticated allocation methodology. This is similar to the Provider's case where the Provider has attempted to utilize direct costing, and the Intermediary has adjusted to establish a non-reimbursable cost center for allocating general service costs.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law and Program instructions, evidence and parties' contentions, finds and concludes that the Intermediary properly applied step-down cost finding to Associates' direct costs and eliminated the Provider's claimed discrete costing of shared costs before cost finding.

Section 1861(v)(1)(A) of the Social Security Act, as amended (42 U.S.C. §1395x), and the regulations at 42 C.F.R. § 413.9 require that the Medicare program reimburse the reasonable costs of furnishing care to program beneficiaries. This law and regulation specifically state that reasonable costs should be determined in such a fashion that none of the costs incurred in furnishing care to non-Medicare patients be borne by the Medicare program and vice-versa. Implicit in this prohibition on cross-subsidization of costs is the expectation that cost finding for Medicare reimbursement purposes be as accurate as possible.

Further, under 42 C.F.R. § 413.24, the object of cost finding is to allocate a provider's costs as accurately as possible. Under this regulation, a provider is required to furnish adequate cost data in support of its allocation. This must be based on statistical and financial information which is subject to verification. Under 42 C.F.R § 413.24(d)(2)(ii), a provider may use a more sophisticated method of cost finding such as direct costing, but it must first obtain intermediary approval and show that it yields a more accurate allocation of costs.

In this case the Provider shared its offices and administrative services with Associates, a legally separate private duty nursing corporation. It was undisputed that the indirect as well as the direct costs related to Associates were not allowable. The dispute in this case concerns the amount of indirect costs to be assigned to the nonallowable entity in the Medicare cost finding process.

The Board finds that the discrete costing allocations of the shared costs were based on unsupported estimates that were neither auditable nor verifiable in accordance with 42 C.F.R. § 413.24(a). The Provider did not establish through documentary evidence such as written, contemporaneous records, that the bases used for its discrete costing allocation of shared costs yielded more accurate results. For example, there were no contemporaneous time records or other documentation of Dr. Lessard's or the human resource person's time spent performing duties related to the Provider or Associates. The time studies that were provided were inadequate and did not meet the requirements of HCFA Pub. 15-1 §2313.2E which require a minimally acceptable time study to encompass at least one full week per month of the cost report period. The weeks selected must be equally distributed among the months of the cost reporting period.

The Board observes that the Provider did not allocate any owner's compensation to Associates as part of its discrete costing activity. It is illogical to accept the premise that Dr. Lessard, the owner and administrator for both corporations, spent only one hour per month performing duties for Associates. The latter corporation grew extensively in volume from 1997 to 1998. However, according to the Medicare cost report submitted

by the Provider, Associates had no leadership cost assigned to it. Obviously, Dr. Lessard's time and effort on behalf of Associates should have been recognized and the related cost removed from the Provider's cost report.

In the final analysis, the Board concludes that the Provider's direct assignment of overhead costs before step-down cost finding did not result in a more accurate allocation of costs.

DECISION AND ORDER:

The elimination of the Provider's discrete cost finding of overhead costs and the Intermediary's use of full step-down cost finding is proper. The Intermediary's adjustment is sustained.

BOARD MEMBERS PARTICIPATING

Suzanne Cochran, Esquire
Martin W. Hoover, Jr., Esquire
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, C.P.A.

FOR THE BOARD

DATE: November 25, 2003

Suzanne Cochran
Chairman