

CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:

Mercy Home Health

Provider

vs.

**Blue Cross /Blue Shield Association
Cahaba Government Benefit
Administrators**

Intermediary

Claim for:

**Provider Cost Reimbursement
Determination for Cost Reporting
Periods Ending: 12/31/95,
12/31/96, 12/31/97, 12/31/98 and
12/31/99**

**Review of:
PRRB Dec. No. 2003-D48
Dated: August 22, 2003**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in § 1878(f)(1) of the Social Security Act (Act), as amended (42 USC 1395oo(f)). The Intermediary submitted comments, requesting reversal of the Board's decision with respect to fiscal years (FYs) 1995 and 1996. Accordingly, the parties were notified of the Administrator's intention to review the Board's decision. Comments were also received from the Provider requesting that the Administrator affirm the Board's decision with respect to FYs 1995 and 1996 and reverse the Board's decision with respect to FYs 1997 through 1999. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue is whether the Intermediary's adjustment to home office cost statements was proper.

The Board held that for Fiscal Years (FY) 1995 and 1996, the new Intermediary improperly rescinded the prior Intermediary's approved allocation method. The Board determined that the Provider Reimbursement Manual (PRM) at § 2150.3.D, allowed a home office to use an alternative allocation method "if it obtains prior

intermediary approval.” The Board found that the Provider received written approval, and properly integrated the method for FYs 1993 through 1996. Thus, the Board found that the Provider reasonably relied on the salaries/wages/employee benefits cost allocation method approved by the original Intermediary. The Board also held that “a provider’s reliance on an intermediary’s written instruction should be protected even if intermediary subsequently changes position.”¹ Therefore, the Board reversed the Intermediary’s adjustments for FY’s 1995 and 1996.

For FYs 1997 through 1999, the Board held that the Intermediary’s adjustments to the Provider’s home office costs statements were proper. The Board found that the Intermediary informed the Provider in writing that, effective with FY 1997, operating costs should be used as the basis for allocating home office cost. However, despite proper notification, and without an approved methodology, the Provider developed and used an alternative allocation methodology. Thus, the Board concluded that the Provider was duly notified that the “salaries benefits and contracted costs” allocation basis would no longer be accepted by the Intermediary.

Moreover, the Board found that the Provider’s statements that its methodology resulted in a more accurate allocation of costs were not supported by any specific computation in the record to support the Provider’s conclusion. The Board was 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, the Board found that there was no valid rationale for excluding the cost of goods sold from the CMS-prescribed allocation methodology. Therefore, the Board held that the Intermediary’s adjustments were proper.

SUMMARY OF COMMENTS

The Intermediary commented requesting that the Administrator review and reverse the Board’s decision as to the Intermediary’s cost adjustments for FY’s 1995 and 1996. The Intermediary argued that its predecessor, in contravention of CMS policy, failed to employ the prescribed “cost to total cost” methodology in settling the Provider’s cost reports for 1993 through 1996. The Intermediary adds that while its predecessor provided written assurances that it would not disturb the

¹ Extencicare 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.)

methodology application as to FYs 1995 and 1996, the assurances did not conform to the mandates of the PRM, therefore, the assurances provided by the prior intermediary are not binding upon the present Intermediary. Specifically, the Intermediary argued that the Board's decision impermissibly binds, and compels payment by the Intermediary for the mistaken representations of its agent and successor, in an amount in excess of Medicare's financial obligation to the Provider, without the Provider's requisite showing of a bonafide adverse harm. Furthermore, the Intermediary argued that the Board impermissibly applied equitable estoppel in resolution of this issue, and that the misapplication of such equity powers exceeds the authority conferred on the Board by statute and the Secretary's regulation.

The Provider commented requesting that the Administrator affirm the Board's decision with respect to FYs 1995 and 1996 and reverse the Board's decision with respect to FYs 1997 through 1999. With respect to FYs 1995 and 1996, the Provider argued that the Intermediary acted arbitrary and capricious when it disallowed the alternative methodology, which had been previously approved by the predecessor Intermediary.

The Provider argued that, with respect to FYs 1997 through 1999, the Intermediary's adjustments were flawed because they did not recognize the atypical nature of supply costs. Specifically, the Provider argued that for FYs 1997 through 1999, a disproportionate share of costs flowed to the DME component for which there was no Medicare reimbursement. Therefore, since the home office did not support the functions of the DME component in an amount commensurate with the supply cost, the inclusion of supplies in the Intermediary's cost-to-total cost methodology resulted in the allocation of a disproportionate share of home office cost to the DME component. Finally, the Provider argued that while equitable estoppel is inapplicable in this case, in the interest of public policy, a Provider's should be able to reasonably rely on formal advice from the Government and its agents acting within the scope of their authority.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

Pursuant to § 1861(v)(1)(a) of the Act, providers are to be reimbursed the reasonable cost of providing services to Medicare beneficiaries. Section

1861(v)(1)(a) of the Act, defines “reasonable cost” as “the cost actually incurred, excluding from any part of the incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included....” In addition, § 1861(v)(1)(A) of the Act, sets forth the requirement that Medicare shall not pay for costs incurred by non-Medicare beneficiaries, and vice-versa, i.e., Medicare prohibits cross-subsidization of costs.

Consistent with the Act, the regulation at 42 C.F.R. § 413.9 establishes the principle that reimbursement to providers must be based on the reasonable costs of covered services, which are related to beneficiary care. This includes “all necessary and proper cost incurred in furnishing the services.” Necessary and proper costs are costs, which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities.

Finally, with respect to the conditions for payment, § 1815(a) of the Act states that Medicare payments will not be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider for the particular cost period at issue. The Secretary has implemented this provision in the regulations at 42 C.F.R. §§ 413.20 and 413.24, which require providers to maintain financial and statistical records sufficient for an accurate determination of program costs.

Consistent with the law, CMS set forth a method for allocating home office costs to components in chain organizations. These directions are found in § 2150.3 of the PRM which explains that, to the extent the home office furnishes services related to patient care to a provider, the reasonable costs of such services are includable in the provider’s cost report and are reimbursable as part of the provider’s costs. Section 2150.3 generally require three steps in order for providers within chain organizations to receive Medicare reimbursement. First, prior to the allocation process, the home office must delete all costs which are not allowable. Then, the first allocation step is to "directly assign" costs to the chain components where allowable costs were incurred for the benefit of, or directly attributable to, a specific provider or non-provider activity.

Second, for those costs that cannot be directly assigned costs but which can be allocated on a "functional basis" must be allocated among the providers on a basis designed to equitably allocate the costs over the chain components or activities receiving the benefits of the costs. These costs are to be allocated on a basis designed to equitably allocate the costs over the chain components or activities receiving the benefits of the costs. This allocation must be made in a manner reasonably related to the services received by the entities in the chain. Chain

home offices may provide certain centralized services, such as central payroll, or central purchasing, to the chain components. Where practical and the amounts are material, these costs must be allocated to the chain components based on the number of checks issued. The costs of a central purchasing function could be allocated based on purchases made or requisitions handled. Any residual allowable home office costs remaining after the functional costs allocation has been completed must be included as pooled costs and allocated as described in subsection D.

Relevant to this case, the third step involves the allocation of the residual home office costs. In each home office there will be a residual amount of costs, which must be "pooled" for general management or administrative service costs, which cannot be allocated on a functional basis. For home office accounting periods beginning on or after January 1, 1983, the PRM at § 2150.3 states in part that:

Pooled home office costs must be allocated to chain components on the basis of total costs if the chain is composed of either unlike health care facilities...or a combination of health care facilities and nonhealth care facilities.... 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 bear to the total costs of all components in the chain. (Emphasis added).

The PRM at § 2150.3(D)(2)(b) also provides that:

If evidence indicates that the use of a more sophisticated allocation basis would provide a more precise allocation of pooled home office costs to the chain components, such basis can be used in lieu of allocating on the basis of total costs. However, intermediary approval must be obtained before any substitute basis can be used.

The Provider is one of several components or lines of business operated under the aegis of Mercy Home Health Services, the Home Office.² For the FYs in dispute, the Home Office incurred various costs on behalf of its subsidiaries. For FYs 1995 and 1996, the Provider filed a written application with its Intermediary,³ to

² Other subsidiaries include a private duty nursing agency, a home care staffing agency and a durable medical equipment (DME) supplier. Only Mercy Home Health is a Medicare-certified provider.

³ Wellmark succeeded IBC as the fiscal intermediary on August 4, 1997, when IBC voluntarily terminated its intermediary appointment and left the Medicare Part A Program. Cahaba in turn succeeded Wellmark on June 1, 2000.

put in place an allocation methodology to use only the costs related to salaries/wages, employee benefits and professional contracted services as a statistic for the pooled cost allocation. This meant that the “costs of goods” or supplies were not included in the components costs for purposes of the “cost to total costs” allocation for those years. The Intermediary approved the Provider’s proposed pooled cost allocation methodology for the FYs 1993, 1994, 1995 and 1996.⁴ However, in June of 1996, the Intermediary advised the Provider that, for the years after 1996, the approved methodology would no longer be accepted and that the Provider would have to use the methodology set forth in the regulations and PRM. The Intermediary also advised the Provider that it would hold harmless or not retroactively adjust the methodology used for 1995 and 1996 cost report years.

For the FYs 1997 through 1999, in the absence of an approved alternative, the Provider developed and used an alternative allocation methodology. This methodology was similar to the first method in that it basically included salary-related costs and eliminated the “costs of goods” or supplies for each component entity in determining the “costs to total costs” ratio for allocating pooled costs. The Provider’s new Intermediary conducted an audit of the FYs 1995 through 1999 in dispute and reallocated home office costs using the cost-to-total cost methodology prescribed in the Provider Reimbursement Manual (PRM) at § 2150.3.D.

For FYs 1995 and 1996, the Provider argued that the Intermediary acted arbitrary and capricious when it disallowed the alternative methodology for allocating pooled home office cost, which had been previously approved by the predecessor Intermediary. The Board agreed, holding that, for FYs 1995 and 1996, the new Intermediary improperly rescinded the prior approved allocation method. The Board concluded that the Provider’s reliance on the prior approval should be protected even if the Intermediary subsequently changed its position

The Administrator does not agree that the methodology for the FYs 1995 and 1996 can be allowed only on the basis that it was approved by the prior intermediary. This basis for such an allowance ignores the dictates of the Medicare program set forth in § 1861(v)(1)(A) of the Act and elevates the PRM prior approval provisions above the requirements of the statute. A general principle under Medicare set forth at § 1861(v)(1)(A) of the Act is that to be reimbursable, the cost must be related to patient care and that Medicare shall not

⁴ FYs 1993 and 1994 are not at issue since the three-year period permitted for the Intermediary to reopen the cost reports on its own initiative had lapsed and no fraud or similar fault existed. See 42 C.F.R. § 405.1885(a) & (d).

pay for costs incurred by non-Medicare beneficiaries, and vice-versa, that is, the Medicare prohibits cross-subsidization of costs. Moreover, the documentation requirements of the statute and the regulation places the burden of demonstrating that costs are to be paid by Medicare on the provider.

In evaluating the costs at issue under §1861(v)(1)(A) of the Act for the FYs 1995 and 1996, the Administrator finds that the Provider failed to demonstrate that the prior approved methodology for allocating home office cost is, in fact, a more accurate and sophisticated method. As noted by the Board, the costs of goods sold are part of the operating costs of the DME entity just as salaries and wages are part of the operating cost of the Provider. The Provider has failed to articulate a valid rationale as to why the cost of labor in the service oriented affiliates is not equated with the costs of goods in the product oriented DME affiliate. Consequently, based on these failures on the part of the Provider and regardless of the prior approval (which was subject to audit), the Administrator finds that the Intermediary properly disallowed the Provider's methodology and allocated the pooled costs under the required "costs to total costs" methodology of 2150.3(D)(2)(b) of the PRM for the FYs 1995 and 1996.

In addition, the Administrator disagrees with the Provider's statement that intermediaries arbitrarily rely on PRM 2150.3D to support their position when it favors the government, but dismisses the very same PRM provision when it disfavors the government. The Administrator notes that CMS has accepted a particular cost allocation alternative, notwithstanding the lack of prior approval, when that method can be demonstrated to result in a more appropriate and accurate allocation of costs, and is supported by adequate and auditable documentation. (See Sunbelt Health Care Centers Group Appeal v. Aetna Life Insurance Co., PRRB Dec., No. 97-D13 (December 3, 1996) decline review, HCFA Adm. Dec. January 21, 1997.) In those instances, CMS has ruled that the lack of prior approval is secondary to the Medicare cost principle prohibiting costs shifting and the accurate payment of costs. Similarly, the existence of prior approval in this case, does not negate those same Medicare principles and permit the payment of costs not otherwise allowable.⁵

With respect to FYs 1997 through 1999, the Administrator agrees with the Board's determination that the Intermediary's adjustments to the Provider's home office cost statements were proper. As the Provider set forth, its rationale for the methodology used for the FYs 1995 and 1996 period is also its rationale for the

⁵ This case is distinguished from the Board's decision in Extendi-Care 96 Insurance Allocation Group, PRRB Dec. No. 2003-D88. The Board determined in that case that the provider's method was in fact more accurate.

FYs 1997 through 1999 period methodology.⁶ The record shows that the Provider failed to collect data or provide any specific computations or reasonable justification to support their contention that the alternative method in fact resulted in more equitable and accurate allocation of costs. The record also shows, as the Board agreed, that the Provider did not offer a valid rationale for excluding the cost of goods sold from the CMS-prescribed allocation method.⁷

Under 42 C.F.R. §§ 413.20 and 413.24, a provider has the burden of maintaining adequate documentation to support its claimed costs and enable the Intermediary to determine the amount payable. Therefore, the Board was proper in its conclusion that the adjustments to the Provider's home office costs statements were proper with respect to FYs 1997 through 1999.

⁶ See Provider's Consolidated Post-Hearing Brief, n.9.

⁷ While the Board stated that, certain functions performed by the Home Office changed for these later FYs 1997 through 1999 cost years (hence suggesting that these later years are distinguished from the earlier years), such is not dispositive of this case. The Provider sets forth this same unsupportable rationale for the very similar methodology used for FYs 1995 through 1999.

