PROVIDER REIMBURSEMENT REVIEW BOARD HEARING DECISION

ON-THE- RECORD
2000-D2

PROVIDER -
Methodist Hospital of Lexington

Provider No. 44-0008

vs.

INTERMEDIARY - Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Tennessee

DATE OF HEARING-
September 1, 1999

Cost Reporting Period Ended -
December 31, 1992

CASE NO. 96-1218

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ISSUE:

Was the Intermediary's reclassification of home health agency costs proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Methodist Hospital of Lexington ("Provider") is a 48 bed facility located in Lexington, Tennessee. The Provider is one of several hospitals and other health care facilities which are members of the Methodist Health System, headquartered in Memphis, Tennessee.[1]

During the reporting period ended December 31, 1992, the Provider operated a home health agency ("HHA") whose costs were included in its Medicare Hospital Cost Report. During this period the HHA employed one full-time individual and engaged the services of two other part-time individuals to perform certain administrative and clerical functions (Billing/Data Entry Clerk).[2] The Provider charged the salary and related costs of these individuals directly to the HHA cost center within the hospital cost report, as administrative and general ("A&G") expenses. Blue Cross and Blue Shield of Tennessee ("Intermediary") audited the Provider's cost report and reclassified the costs of the three individuals from the HHA cost center to the Provider's or hospital's A&G cost center.[3]

On September 18, 1995, the Intermediary issued a Notice of Program Reimbursement reflecting its adjustments to the Provider's cost report. On March 8, 1996, the Provider appealed the reclassification of the subject A&G costs to the Provider Reimbursement Review Board pursuant to 42 C.F.R. §§ 405.1835-.1841, and met the jurisdictional requirements of those regulations. The amount of Medicare reimbursement in controversy is approximately $25,000.[4]

The Provider was represented by Mary Susan Philp, Esq., of Powers, Pyles, Sutter & Verville, P.C. The Intermediary was represented by Bernard M. Talbert, Esq., Associate Counsel, Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that it properly charged the costs of the three billing/data entry clerks directly to the HHA cost center. These individuals were either employed by, or contracted with, the hospital's

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[1] Provider's Position Paper at 1. Intermediary's Position Paper at 1.

[2] See Exhibit P-1.

[3] Provider's Position Paper at 2-4. Intermediary's Position Paper at 3.

[4] Provider's Position Paper at 1. Intermediary's Position Paper at 1-2.

HHA, and performed duties exclusively for the HHA. Accordingly, there is no reason for the costs to be reported in the Hospital A&G cost center because they would be allocated through the cost finding process to hospital cost centers that received no benefit from the individuals' services.[5]

The Provider believes that Medicare's regulations and manual instructions regarding the direct allocation of costs are inapplicable to this case because the costs for the billing/data entry clerks are, in fact, the costs of the HHA and not the hospital. Therefore, there is no need to directly assign these expenses.[6] However, the Provider also contends that Medicare's provisions regarding the direct allocation of general service costs nevertheless support its position.[7]

The Provider asserts that the first requirement for direct costing requires the direct assignment to result in a "more accurate" allocation of costs. 42 C.F.R. § 413.24(d)(2)(ii), Provider Reimbursement Manual, Part I ("HCFA Pub. 15-1") § 2310. In this regard, the Provider argues that its methodology clearly results in more accurate cost finding than the Intermediary's methodology. As noted above, the Intermediary's methodology results in an allocation of the billing/data entry clerks' costs to hospital cost centers which receive no benefit from their services; the billing/data entry clerks performed duties exclusively for the HHA.

For example, one of the cost centers which received an allocation of the costs for the billing/data entry clerks on the Hospital Cost Report is the Provider's operating room cost center. The billing/data entry clerks, however, had no involvement with operating room services or the administrative tasks generated from operating room services. Accordingly, an allocation of their costs to this cost center violates HCFA Pub. 15-1 § 2302.9, which explains that general service costs are to be allocated on the basis of services rendered.

In addition, the Intermediary's methodology results in the HHA receiving only a small allocation of the total cost for its billing/data entry clerks, despite the fact that the individuals' time was exclusively devoted to HHA matters. This is because the allocation is based upon total direct costs, and the total direct costs of the HHA cost centers are relatively small in comparison to the direct costs of the hospital's cost centers. Therefore, under the Intermediary's methodology, the HHA received only a small percentage of the billing/data entry clerks costs in comparison to the amounts received by the hospital's cost centers.

The Provider disagrees with the Intermediary's argument that the reclassification is necessary to avoid a duplicate allocation of A&G costs to the HHA, i.e., because the HHA also receives an allocation of

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[5] Provider's Position Paper at 5.

[6] Provider's Position Paper at Footnote 1..

[7] Provider's Position Paper at 6.

A&G costs incurred by the hospital.[8] The Provider believes this reasoning is illogical because hospital-based HHAs routinely receive an allocation of costs from the hospital A&G cost center since they benefit from the management and supervision furnished by the hospital. If the Intermediary's methodology was taken to its logical end, there would be no hospital-based HHA A&G costs, rather, all HHA A&G costs would be reclassified to the hospital's A&G cost center. For example, the HHA has an Administrator, and the hospital also has an Administrator. Similarly, an HHA may have a receptionist or someone who is responsible for answering the telephone, while the hospital will have a switchboard. Virtually every category of administrative function or cost which is included in the HHA A&G cost center will have a counterpart in the hospital A&G cost center. Clearly, the Intermediary's approach is inconsistent with established Medicare cost reporting requirements which require the establishment of a separate A&G cost center for an HHA. See Form HCFA-2552-92, Hospital and Hospital Health Care Complex Cost Report, Supplemental Worksheet H-4, Line 1 (Administrative and General-HHA Cost Center) (Exhibit P-12); HCFA Pub. 15-11 §§ 2845, 2845.1 (Allocation of HHA Administrative and General Costs) (Exhibit P-13).

The Provider contends that the facts in this case are analogous to the facts in Upjohn Health Care Services, Inc. v. Blue Cross and Blue Shield United of Wisconsin, PRRB Dec. No. 96-D52, August 19, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,558, rev'd. HCFA Admin., October 17, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,960 ("Upjohn") in which the Board upheld the provider's allocation method.[9] The Provider explains that in Upjohn home office billing costs were allocated to Medicare certified HHAs and to non-Medicare private duty agencies. The home office had two billing units, one for the Medicare-certified agencies and one for the private duty agencies. The provider directly allocated the costs of the Medicare billing unit to its Medicare-certified HHAs and allocated the costs of the non-Medicare billing unit on a pooled basis.

The Board determined that the intermediary's adjustment in Upjohn was improper and reversed it. The Board stated that the allocation of the Medicare billing unit to the Medicare-certified agencies properly reflected utilization of services. Likewise, in this case, the allocation of costs for the billing/data entry clerks to the HHA properly reflects the utilization of the services of these individuals. The Provider notes that the Administrator reversed the Board's decision in Upjohn because she found that the costs of the non-Medicare billing unit were nonallowable, however, not on the basis of the allocation methodology which is the issue in this case. See also Upjohn Health Care Services, Inc. v. Blue Cross and Blue Shield United of Wisconsin, PRRB Dec. No. 96-D47, August 9, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,548, modf'd. HCFA Admin., October 10, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,981.

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8 Provider's Position Paper at 8. See also Provider's Supplemental Position Paper at 3.

9 Provider's Position Paper at 8.

The Provider also cites Medical Center of Garden Grove v. Blue Cross of California, PRRB Dec. No. 95-Dl, October 13, 1994, Medicare & Medicaid Guide (CCH) ¶ 42,913, decl'd. rev. HCFA Admin., November 11, 1994 ("Medical Center of Garden Grove") where the provider allocated costs for maintenance and repair services purchased from outside vendors to the cost centers which benefitted from the services.[10] The intermediary reclassified these costs to the Maintenance and Repairs cost center and allocated all costs through the step-down process. The Board reversed the intermediary's adjustment. The Board determined that the provider's cost allocation resulted in a more accurate allocation of costs than the intermediary's method because the outside vendor costs were allocated to the cost centers which benefitted from them. Similarly, the hospital in this case allocated the costs of the HHA billing/data entry clerks only to the cost centers which benefitted from their services. See also Western Medical Center v. Blue Cross of California, PRRB Dec. No. 97-D2, October 12, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,744, decl'd. rev. HCFA Admin. December 4, 1996 ("Western Medical Center"); Sierra Vista Regional Medical Center v. Blue Cross of California, PRRB Dec. No. 95-D11, December 8, 1994, Medicare & Medicaid Guide (CCH) ¶ 42,969, decl'd. rev. HCFA Admin., January 16, 1995; Circle City Hospital v. Blue Cross of California, PRRB Dec. No. 95-D4, October 14, 1994, Medicare & Medicaid Guide (CCH) ¶ 42,916, decl'd. rev. HCFA Admin., November 21, 1994; Arroyo Grande Community Hospital v. Blue Cross of California, PRRB Dec. No. 95-D3, October 14, 1994, Medicare & Medicaid Guide (CCH) ¶ 42,915, decl'd. rev. HCFA Admin., November 21, 1994.

The Provider asserts that the discussion above demonstrates that its method of recording and allocating the costs of the billing/data entry clerks results in a more accurate allocation of costs than the reclassification and allocation of the Intermediary.

The Provider asserts that the second requirement for the direct assignment of costs is that the assignment be made as part of a provider's "accounting system with costs recorded in the ongoing normal accounting process."[11] HCFA Pub. 15-1 § 2307. As discusses above, the billing/data entry clerks were either employed by, or under contract with the HHA. Therefore, the costs for these individuals were recorded in the HHA's financial records as part of its routine accounting process, and this second requirement is clearly met.

The third requirement for the direct assignment of costs is that a provider's request to use such an allocation methodology be approved by its intermediary prior to the beginning of the applicable cost reporting period. HCFA Pub. 15-1 § 2307.[12] The Provider argues that in recent cases the Board has adopted a "no harm, no foul" approach to this requirement and allowed providers to use a more sophisticated cost allocation methodology without prior approval if the methodology resulted in a more

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[10] Provider's Position Paper at 10.

[11] Provider's Position Paper at 11.

[12] Id.

accurate allocation of costs than the intermediary's methodology. Pinnacle Care Drug Gross-Up Group Appeal v. Aetna Life Insurance Company, PRRB Dec. No. 97-D41, March 26, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,167, decl'd. rev. HCFA Admin., May 7, 1997; Sunbelt Health Care Centers Group Appeal v. Aetna Life Insurance Company, PRRB Dec. No. 97-Dl3, December 3, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,923, decl'd. rev. HCFA Admin., January 14, 1997. With respect to the instant case, the Provider's method of cost reporting results in a more accurate allocation of costs than that of the Intermediary, as discussed above. Therefore, prior approval is not necessary.

Moreover, the Board has held that an intermediary may indicate its approval of a provider's cost finding methodology if it audited the provider's prior year cost reports and did not make any adjustments to the methodology. Glenwood Regional Medical Center v. Blue Cross and Blue Shield of Mississippi, PRRB Dec. No. 96-Dl8, March 7, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,066, decl'd. rev. HCFA Admin., April 25, 1996. Respectively, worksheet A-6 of the Provider's 1991 audited cost report shows that the Intermediary did not reclassify any costs for home health employees to the hospital's A&G cost center. (Exhibit P-4). Accordingly, the Intermediary has indicated its approval of the Provider's cost finding methodology and cannot now argue that the Provider should have formally requested approval to direct cost the billing/data entry clerk expenses.

In summary, the Provider maintains that it met all of the program's requirements to charge the costs of the subject billing/data entry clerks directly to the HHA cost center.

The Provider also contends that the Intermediary has not disputed the fact that the billing/data entry clerks at issue provided services only for the HHA, and that they performed no services for the hospital itself.[13] Moreover, the reclassification of these individuals' costs to the hospital's A&G cost center means that they will be allocated to various hospital cost centers which derived no benefit from these individuals' services. Thus, the reclassification of the salaries and related costs for these positions to the hospital's A&G cost center violates a fundamental principle of Medicare cost allocation, i.e., general service costs must be allocated to other cost centers on the basis of services rendered. HCFA Pub. 15-1 § 2302.9.

Also, the Board has frequently held that certain costs should not be assigned to the A&G cost center but should be assigned to the specific cost center which benefited from the applicable services. For example, in St. Elizabeth Hospital v. Blue Cross and Blue Shield Association, PRRB Dec. No.81-D69, August 5, 1981, Medicare & Medicaid Guide (CCH) ¶ 31,475, the Board held that utilization review costs should not be assigned to a provider's A&G cost center because the costs related solely to inpatient services. Thus, allocation of the costs to outpatient cost centers as part of the provider's A&G costs was improper.

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[13] Provider's Supplemental Position Paper at 1.

The courts have reached similar conclusions.[14] For example, in Chicago College of Osteopathic Medicine v. Heckler, Medicare & Medicaid Guide (CCH) ¶ 34,044 (No.826 N.D. Ill. 1984) (Exhibit P-9), the district court held that the cost of a medical director's office should not have been classified as A&G because the medical director's activities related only to patient care services. The court concluded that the medical director expense could not be classified as A&G because A&G expenses are allocated to all components of the provider, including nonreimbursable cost centers which were not benefited by the medical director costs.

Similarly, the Board has ruled that the assignment of costs for services furnished by outside contractors to individual departments which benefit from those services is more accurate than assigning such costs to a general service cost center. St. Mary's Hospital and Medical Center v. Blue Cross and Blue Shield Association, PRRB Dec. No. 90-D34, June 18, 1990, Medicare & Medicaid Guide (CCH) ¶ 38,627, decl'd. rev. HCFA Admin., August 3, 1990; St. John's Hospital & Health Center v. Blue Cross and Blue Shield Association, PRRB Dec. No. 84-D131, June 11, 1984, Medicare & Medicaid Guide (CCH) 34,163, decl'd. rev. HCFA Admin., July 23, 1984.
Clearly, the assignment of the subject billing/data entry clerks' costs directly to the HHA results in a more accurate allocation of costs than the Intermediary's methodology, whereby, these costs are allocated to various hospital cost centers which derive absolutely no benefit from them.

The Provider disagrees with the Intermediary's argument that its adjustment is proper since the Provider did not directly assign all of the costs in its general service cost center.[15] Essentially, the Intermediary asserts that if any general service costs are to be directly assigned that all costs in a general service cost center must be directly assigned pursuant to HCFA Pub. 15-1 § 2307. However, the Provider does not find any such requirement in the manual. The Provider surmises that the Intermediary is referring to the language in HCFA Pub. 15-1 § 2307 which states that "[a]ll costs within the general service cost center which can be directly allocated must be assigned to the benefiting cost centers. . . . ." Id. However, the Provider asserts that this instruction refers only to the direct assignment of those costs "which can be directly allocated," and does not require all costs in a general service cost center to be directly assigned. Id.

Also, the Provider finds this argument contradictory to numerous Board rulings which have upheld the direct assignment of certain costs even though there is a general service cost center for that category of cost. See, e.g., Medical Center of Garden Grove upholding the direct assignment of maintenance and repair costs to the individual departments benefitting from them rather than the maintenance and repair cost center (Exhibit P-14); Western Medical Center (same) (Exhibit P-15).

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[14] Provider's Supplemental Position Paper at Footnote 2.

[15] Provider's Supplemental Position Paper at 3.

The Provider reiterates that the subject billing/data entry clerks' costs were recorded in the HHA A&G cost center in the first place, and were never recorded in the Hospital A&G cost center until the Intermediary reclassified them. As noted, it is clearly arguable that the Medicare provisions relating to direct assignment, such as HCFA Pub. 15-1 § 2307, are not even applicable to the instant case because the costs in question are those of the HHA and not the hospital. Nevertheless, the underlying Medicare principles relating to direct assignment of costs (e.g., direct assignment must result in a more accurate allocation of costs) support the Provider's position that the billing/data entry clerks' costs should be included in the HHA A&G cost center.

Finally, the Provider asserts that the Intermediary's reliance upon Children's Hospital of San Francisco, a California nonprofit corporation, et al. v. Bowen, Civ. No. S-85-0092-MLS , U.S. District Court for the Eastern District of California ("Children's Hospital"), which involved Medicare's malpractice insurance rule, is not relevant to the instant case.[16] That case, as well as many others which held that the "malpractice rule" was invalid, involved an attempt by the Health Care Financing Administration to establish a separate apportionment methodology for malpractice insurance costs, i.e., a methodology for determining Medicare's share of a particular cost. This case does not involve cost apportionment, but rather involves cost allocation and the process of assigning costs to different cost centers. Thus, Children's Hospital and the other malpractice rule cases lend no support to the Intermediary's position.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its adjustment is proper. The Provider reported billing costs and other administrative costs of the hospital in the Hospital A&G cost center. Therefore, the direct assignment of these same types of costs to the HHA would result in a duplicate allocation of overhead to the HHA through the cost finding process.[17]

The Intermediary asserts that a vital element of "cost finding," or determining Medicare's share of a provider's total cost, is that overhead expenses be consistently charged to the overhead cost centers and then allocated to the revenue producing departments using statistical bases. Provisions at 42 C.F.R. § 413.24(d)(1) describe the "step-down method" of cost finding, the method used by the Provider, as follows:[18]

> (l)Step-down method. This method recognizes that services rendered by certain nonrevenue producing departments or centers are utilized by certain other nonrevenue-producing centers as well as by the revenue-producing centers. All costs of nonrevenue-producing centers are

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[16] Provider's Supplemental Position Paper at 5.

[17] Intermediary's Position Paper at 3.

[18] Intermediary's Position Paper at 5.

> allocated to all centers which they serve, regardless of whether or not these centers produce revenue.

42 C.F.R. § 413.24(d)(1).

With respect to the instant case, the step-down methodology allocates the hospital's A&G cost center to all departments including the HHA's cost centers on the basis of accumulated cost. Therefore, the Provider's direct assignment of certain A&G costs would improperly result in the HHA receiving a share of billing and other administrative costs incurred by the hospital as well as 100 percent of its own, directly assigned, A&G costs.

The Intermediary contends that HCFA Pub. 15-1 § 2307 does provide for the direct assignment of costs. However, the Provider did not meet the program's requirements for using this method of cost finding.[19]

The Intermediary asserts that the primary requirement a provider must meet in order to directly assign costs is that "all direct costs be identified and assigned to the revenue-producing cost centers." HCFA Pub. 15-1 § 2307 (emphasis added). This requirement does not allow a provider to select only certain costs to be directly assigned, which could resulting in an inappropriate duplication or loading of costs to a particular cost center.

Respectively, however, the Provider did not identify all billing costs and other administrative costs at issue, and directly assign them. Rather, the Provider only identified and directly assigned these certain HHA costs.

The Intermediary contends that the Medicare cost report does reflect a cost center entitled "Home Health Agency Administrative and General."[20] The Intermediary asserts, however, that this cost center is designed to contain costs which would apply to all of an HHA's other departments. The purpose of this cost center is to capture these departmental costs and allocate them to the various disciplines of the HHA. The HHA A&G cost center is not designed to contain directly assigned costs when costs of the same type are not directly assigned to any other cost centers.

Finally, the Intermediary contends that the Provider's direct assignment of the subject A&G costs violates Medicare's prohibition against "cost-shifting" at 42 U.S.C. § 1395x(v)(1)(A).[21] Specifically, the duplication of the billing and other administrative costs in the HHA cost center inappropriately benefits the Provider by shifting more of its costs to the Medicare Program.

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[19] Intermediary's Position Paper at 6.

[20] Intermediary's Position Paper at 8.

[21] Intermediary's Position Paper at 9.

The Intermediary asserts that cost-shifting was previously addressed in Children's Hospital where Medicare was found to be erroneously shifting provider malpractice insurance costs. Prior to 1979, malpractice insurance costs were treated the same as any other A&G cost, i.e., they were allocated to the ancillary cost centers through the cost allocation process, and reimbursed to a provider based upon the facility's Medicare utilization rate. Then, in 1979, a new rule was promulgated which removed malpractice costs from the allocation process and reimbursed the cost under a totally different methodology which, in many instances, shifted costs away from the Medicare Program. In Childrens Hospital the court stated that it "agrees with the decisions of the many circuit courts that have considered the validity of the rule that was previously in force. . . . and finds that the 1979 malpractice insurance rule is invalid because it violates the statuary prohibition against cost-shifting." Id. The Intermediary concludes that the prohibition against cost-shifting applies to the issue at hand regarding billing and other administrative costs.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§ 1395x (v)(1)(A)	-	Reasonable Cost

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

§§ 405.1835-.1841	-	Board Jurisdiction
§ 413.24 et. Seq.	-	Adequate Cost Data and Cost Finding

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

§ 2302.9	-	General Service Cost Centers
§ 2307	-	Direct Assignment of General Service Costs
§ 2310	-	More Sophisticated Methods

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

§ 2845	-	Allocation of HHA Administrative and General Costs
§ 2845.1	-	Administrative and General-HHA Cost Center

5. Case Law:

Children's Hospital of San Francisco, a California nonprofit corporation, et al. v. Bowen, Civ. No. S-85-0092-MLS , U.S. District Court for the Eastern District of California.

St. Mary's Hospital and Medical Center v. Blue Cross and Blue Shield Association, PRRB Dec. No. 90-D34, June 18, 1990, Medicare & Medicaid Guide (CCH) ¶ 38,627, decl'd. rev. HCFA Admin., August 3, 1990.

St. John's Hospital & Health Center v. Blue Cross and Blue Shield Association, PRRB Dec. No. 84-D131, June 11, 1984, Medicare & Medicaid Guide (CCH) 34,163, decl'd. rev. HCFA Admin., July 23, 1984.

Chicago College of Osteopathic Medicine v. Heckler, No. 82 C (N.D. Ill. 1984).

St. Elizabeth Hospital v. Blue Cross and Blue Shield Association, PRRB Dec. No. 81-D69, August 5, 1981, Medicare & Medicaid Guide (CCH) ¶ 31,475.

Glenwood Regional Medical Center v. Blue Cross and Blue Shield of Mississippi, PRRB Dec. No. 96-Dl8, March 7, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,066, decl'd. rev. HCFA Admin., April 25, 1996.

Pinnacle Care Drug Gross-Up Group Appeal v. Aetna Life Insurance Company, PRRB Dec. No. 97-D41, March 26, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,167, decl'd. rev. HCFA Admin., May 7, 1997.

Sunbelt Health Care Centers Group Appeal v. Aetna Life Insurance Company, PRRB Dec. No. 97-Dl3, December 3, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,923, decl'd. rev'd. HCFA Admin., January 14, 1997.

Upjohn Health Care Services, Inc. v. Blue Cross and Blue Shield United of Wisconsin, PRRB Dec. No. 96-D47, August 9, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,548, modf'd. HCFA Admin., October 10, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,981.

Upjohn Health Care Services, Inc. v. Blue Cross and Blue Shield United of Wisconsin, PRRB Dec. No. 96-D52, August 19, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,558, rev'd. HCFA Admin., October 17, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,960.

Medical Center of Garden Grove v. Blue Cross of California, PRRB Dec. No. 95-Dl, October 13, 1994, Medicare & Medicaid Guide (CCH) ¶ 42,913, decl'd. rev. HCFA Admin., November 11, 1994.

Western Medical Center v. Blue Cross of California, PRRB Dec. No. 97-D2, October 12, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,744, decl'd. rev. HCFA Admin. December 4, 1996.

Sierra Vista Regional Medical Center v. Blue Cross of California, PRRB Dec. No. 95-D11, December 8, 1994, Medicare & Medicaid Guide (CCH) ¶ 42,969, decl'd. rev. HCFA Admin., January 16, 1995.

Circle City Hospital v. Blue Cross of California, PRRB Dec. No. 95-D4, October 14, 1994, Medicare & Medicaid Guide (CCH) ¶ 42,916, decl'd. rev. HCFA Admin., November 21, 1994.

Arroyo Grande Community Hospital v. Blue Cross of California, PRRB Dec. No. 95-D3, October 14, 1994, Medicare & Medicaid Guide (CCH) ¶ 42,915, decl'd. rev. HCFA Admin., November 21, 1994.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The Provider is a 48-bed hospital that operated a HHA during the subject cost reporting period. The HHA, during this period, employed one full-time individual and engaged the services of two part-time individuals to perform certain administrative and clerical functions. The Provider charged the salary and related costs of these individuals to the HHA cost center within the hospital cost report. The Intermediary, however, reclassified these costs to the Provider's A&G cost center to be allocated to all revenue producing cost centers.

The Intermediary argues that the reclassification is necessary according to Medicare's "direct assignment" rules. In particular, the Intermediary asserts that the reclassification avoids an inappropriate allocation of overhead to the HHA, i.e., 100 percent of the subject clerks' costs plus a portion of the Provider's costs for the same types of services that would be allocated to the HHA through the cost report process.

The Provider asserts that Medicare's rules regarding direct assignment do not apply to the instant case because the individuals in question were employees of the HHA and not the Provider, and because these individuals performed services exclusively for the HHA. Notwithstanding, the Provider also maintains that charging the individuals' costs to the HHA cost center results in a more accurate method of cost finding than allocating them through the Provider's A&G cost center, which is the primary objective of Medicare's cost finding process.

The Board finds that the HHA, although hospital-based is, itself, a Medicare provider. It was certified by the Medicare program on December 1, 1991, separately from the Provider's certification, and operates under its own Medicare provider number. These circumstances, coupled with the fact that the subject individuals were employed by the HHA and worked solely for the HHA, affirms the propriety of the Provider's position. The Board finds that the Provider's practice of recording the costs of these particular employees in the HHA cost center reflects a sound and proper accounting policy.

The Board notes that the applicable Medicare cost reporting forms support the Provider's accounting of the clerks' costs. Specifically, the "H" series of the Form HCFA 2552, <u>Medicare Cost Reporting Forms for Hospitals and Hospital Health Care Complexes</u>, provide a mechanism for a hospital-based HHA to record and allocate its own A&G costs. While the instructions for these forms do not address the exact circumstances at issue, the Board finds no basis in the instructions to distinguish the administrative and general nature of the subject clerks' costs from any other A&G costs that may be charged to the HHA cost center.

The Board also notes that there are no disputes in this case regarding the Provider's assertion that the subject clerks were employed by the HHA and not by the Provider, or the contention that they worked only for the HHA. Evidence of the individuals' responsibilities and commitment to HHA matters is provided at Exhibit P-1.

The Board also finds that assigning the clerks' costs to the HHA cost center results in a more accurate method of cost finding than charging these expenses to the Provider's A&G cost center. As noted, the subject individuals worked solely for the benefit of the HHA. Yet, if their costs were allocated through the Provider's A&G cost center, many hospital departments that received absolutely no benefit from the clerks' efforts would receive a part of their costs. Also, since the allocation of the Provider's A&G cost center is based upon accumulated cost, and since the hospital's costs are far greater than those of the HHA, the HHA would receive only a small portion of its own employee expenses.

In this same context, the Board rejects the Intermediary's argument that charging the clerks' costs to the HHA cost center results in an improper allocation of the Provider's or hospital's overhead. The Board's analysis of this argument is based upon materiality. That is, recording the clerks' costs in the HHA cost center does result in some additional hospital overhead being allocated to the HHA because, as previously mentioned, the allocation is based upon accumulated cost. However, because the hospital's costs are understood to be so much greater than those of the HHA, the actual affect of the clerks' costs on the allocation is considered insignificant. In all, the Provider's practice of recording the clerk's costs in the HHA cost center may not be a perfect cost finding methodology. However, it results in far more accurate methodology than that which results from the Intermediary's reclassification. Significantly, the Board agrees with the Provider, in that, "accuracy" is the primary objective of the Medicare cost finding process. 42 C.F.R. 413.24(d)(2)(ii).

The Board also rejects the Intermediary's argument that the HHA A&G cost center, within the Medicare hospital cost report, is not designed to contain costs such as those of the subject clerks.

As discussed immediately above, the Board finds that the instructions for the pertinent cost reporting forms do not provide sufficient detail to distinguish the administrative and general nature of the clerks' costs from any other A&G costs that would be charged to the HHA cost center. The Board believes the Intermediary's position regarding this matter is speculative.

Finally, the Board rejects the Intermediary's reliance upon HCFA Pub. 15-1 § 2307. Essentially, the Intermediary argues that in order for a provider to directly assign any given costs, it must identify and directly assign all like costs to avoid a duplicate allocation of overhead. On this basis, the Intermediary maintains that its adjustment is proper because the Provider identified and directly assigned the billing and administrative costs associated with the subject clerks but failed to identify and directly assign all other like billing and administrative costs. The Board, however, finds no evidence in the record to substantiate this claim. Clearly, the Intermediary has not demonstrated the Provider's failure to directly assign like costs, or the extent to which the Provider may have directly assigned any other costs.

DECISION AND ORDER:

The Intermediary's reclassification of certain salary and related costs from the HHA cost center to the hospital's A&G cost center is improper. The Intermediary's adjustment is reversed.

Board Members Participating:

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

Date of Decision: October 14, 1999

FOR THE BOARD:

Irvin W. Kues
Chairman