PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2001-D25

PROVIDER -
CareMed of Chicago
Chicago, Illinois

Provider No. 14-7017

vs.

INTERMEDIARY -
Blue Cross Blue Shield Association/
Palmetto Government Benefits
Administrators

DATE OF HEARING-
August 11, 2000

Cost Reporting Period Ended -
June 30, 1997

CASE NO. 99-3163

INDEX

ISSUES:[1]

1. Was the Intermediary=s adjustment to the Provider=s Administrative and General (AA&G@) cost center proper?

2. Was the Intermediary=s reclassification adjustment of delivery expenses claimed by the Provider proper?

3. Was the Intermediary=s reclassification adjustment of courier costs claimed by the Provider proper?

4. Was the Intermediary=s adjustment to home office Business Development and Managed Care salaries proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

CareMed of Chicago (AProvider@) is a Medicare-certified home health agency (AHHA@) located in Chicago, Illinois. The Provider is an operating division of QV, Inc., which is also a wholly owned affiliate of the University of Chicago Hospital and Health System. QV, Inc. operates and manages other health care-related activities and serves as the home office for these operating entities. In September of 1995, QV, Inc. acquired the operating assets of the Visiting Nurse Association of Chicago (AVNA@), and subsequently consolidated VNA=s operations with CareMed=s existing health care operations. The VNA=s operations acquired by QV, Inc. included a Medicare-certified HHA, a private duty nursing program, and a business located in Elmhurst that provided intravenous (AIV@) therapy, respiratory equipment and durable medical equipment (ADME@).

Upon completion of its audit of the Provider=s Medicare cost report for the fiscal year ended June 30, 1997, Blue Cross and Blue Shield Association/Palmetto Government Benefits Administrators (AIntermediary@) issued a Notice of Program Reimbursement on November 25, 1998 which included adjustments relating to the above stated issues. The Provider appealed the Intermediary=s determinations to the Board pursuant to 42 C.F.R. '' 405.1835-.1841 and has met the jurisdictional

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[1] The Provider also appealed two additional issues concerning the disallowance of interest expense which were identified as Issue Nos. 4 and 5 at the hearing before the Provider Reimbursement Review Board (ABoard@) (See Tr. at 5). The Provider has requested a separate expedited judicial review determination for these issues to be rendered at the same time that the Board issues its decision for this case (See Tr. at 6-8). All other issues appealed by the Provider have been administratively resolved or withdrawn from this appeal.

requirements of those regulations. The Provider was represented by Eugene Tillman, Esquire, and Daniel A. Cody, Esquire, of Reed Smith Shaw & McClay, LLP. The Intermediary=s representative was Bernard M. Talbert , Esquire, of the Blue Cross and Blue Shield Association.

Issue 1- A&G Cost Center:

In its Medicare cost report for the fiscal year in contention, the Provider utilized three separate cost centers to report its administrative and general (AA&G@) costs. The three cost centers established by the Provider consisted of A&G Shared Expenses, A&G HHA Only and A&G HHA and Hospice. After audit, the Intermediary determined that the Provider=s methodology for reporting A&G costs did not comply with the cost finding principles set forth in 42 C.F.R. '413.24 and sections 2307 and 2313 of the Provider Reimbursement Manual (AHCFA Pub.15-1@). Accordingly, the Intermediary collapsed the three unique cost centers into one A&G cost center, and established the cost allocation statistics on the basis of accumulated costs. The reimbursement effect of this adjustment is approximately $900,000.

PROVIDER=S CONTENTIONS:

The Provider contends that its use of the three A&G cost centers was appropriate and that the collapsing of the cost centers by the Intermediary was unnecessary and resulted in inaccurate cost finding. The Intermediary=s determination was based on the erroneous conclusions that: (1) the Provider did not attempt to properly segregate general service costs related to its nonreimbursable components; and (2) the Provider shifted an inequitable amount of general services costs related to nonreimbursable activities to the home health program. The Provider argues that its use of unique cost centers was based upon a methodology previously approved by the Intermediary. The Provider points out that its predecessor, VNA, requested and was granted approval from the Intermediary to amend its methodology for allocating the general service cost center for the fiscal year beginning on July 1, 1989, and all subsequent fiscal years. This approval allowed for the use of expanded cost centers for shared overhead costs, including A&G Shared Expenses and A&G HHA Only. The cost reports for fiscal years 1989 through 1995 were audited by the Intermediary, and the cost finding methodology was found to be appropriate for each of those years. Following the acquisition of VNA, the Provider notified the Intermediary that it would create an additional A&G cost center called A&G HHA and Hospice. The Provider requested this change to reflect its additional operations which was fully consistent with the Intermediary=s prior (and unrevoked) approval.

The Provider believes that it properly relied on the Intermediary=s prior approval of VNA=s expanded cost centers and, accordingly, filed its 1996 and 1997 Medicare cost reports using the three unique cost centers. Since the cost centers utilized by the Provider were merely a further expansion of the cost centers previously approved for VNA, the Provider contends that the Intermediary=s prior approval was equally applicable to its cost finding methodology in accordance with 42 C.F.R. ' 413.24 and HCFA Pub. 15-1 '' 2307 and 2313. The Provider notes that the Intermediary never objected to its

expansion of the general service cost centers, and that this change was necessary to reflect the Provider=s additional operations. Importantly, the Intermediary=s witness at the hearing before the Board acknowledged that, from a conceptual standpoint, there was nothing inappropriate or inequitable with the cost allocation methodology utilized by the Provider.[2]

The Provider maintains that the Intermediary=s adjustment is based on the erroneous conclusion that the Provider did not attempt to properly segregate nonreimbursable general service costs. While a separate nonreimbursable A&G cost center was not included on the cost report, the Provider argues that its accounting system includes specific cost centers that only contain expenses associated with the nonreimbursable components (i.e. IV/DME, Private Duty and Hospice). The Provider asserts that, except for certain supervisory services, all of the personnel expenses and other costs associated with these cost centers were listed as nonreimbursable costs. With respect to the Elmhurst location, the Intermediary inappropriately determined that general service costs related to nonreimbursable components were placed in the shared general service cost centers. Contrary to the Intermediary=s findings, the Provider believes it has demonstrated that a significant percentage of the activities at the Elmhurst location were attributable to the reimbursable home health program, and that these costs were accurately allocated to the A&G Shared cost center. The Provider cites the following examples to support its contention:

- 38% of Elmhurst personnel are related to the home health program, including a nurse manager, reimbursement personnel, a coordinator, and security escorts;

- 39% of all deliveries coordinated and completed related to the home health program;

- 35% of delivery personnel salaries are home health related (the duties of two delivery personnel were 100% home health related);

- 34% of the salaries for reimbursement personnel were related directly to home health activities (the duties of two reimbursement personnel were 100% home health related);

- 100% of the home health medical supplies materials management process is coordinated from the Elmhurst location;

- 100% of the Provider=s purchasing activities are managed through the Elmhurst site.

The Provider argues that the Intermediary collapsed the A&G cost centers based upon an inadequate understanding of the Provider=s operation. Specifically, the Intermediary highlighted the areas of private duty managers, schedulers, data processing staff, client relations, and patient accounting/billing to

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[2] Tr. at 114, 125 and 145.

demonstrate the improper segregation of costs. Rather than collapsing the A&G cost centers based upon fundamental misunderstandings, the Provider believes the Intermediary should have taken the more obvious and equitable approach of correcting simple allocation errors. The Provider acknowledges that the private duty managers allocated to the A&G HHA Only cost center should have been allocated to the A&G Shared Expenses cost center. However, this inadvertent and fully explainable error should have been corrected by the Intermediary through a mere reclassification adjustment. The Provider states that its misallocation of private duty managers was due to an inadvertent failure to transfer salary costs upon changes in the job responsibilities of certain managers who were previously assigned to the A&G HHA Only cost center.[3]

With respect to the schedulers, the Provider argues that the Intermediary misperceived that these personnel also performed hospice duties. During interviews of Provider personnel, the Provider contends that the Intermediary confused its ABridge Program@ with its Hospice Program. The Provider points out that, before home health patients make a hospice election, the Bridge Program transitions these patients from home health to the Hospice Program. The Provider believes the Intermediary=s misunderstanding could have been avoided if its audit had been performed in a reasonable and careful manner, and had sought and considered explanations from the Provider=s management.[4] Further, the Intermediary=s witness conceded that terminally ill patients who have not yet made a hospice election are still home health patients.[5]

The Provider contends that the Intermediary also misunderstood the functions performed by the Provider=s data processing personnel. In particular, the Provider points out that the Intermediary relied on an interview with an employee who was not present during the entire fiscal year, and who did not completely understand the full scope of the Provider=s data processing functions for the time period in contention. The employee=s explanation of the Provider=s operations pertained to the time of the audit in May of 1998, and not during the fiscal year in contention. The Provider asserts that it properly allocated the costs in question to the A&G HHA and Hospice cost center, whereas the Intermediary mistakenly believed that an A&G Shared Expenses allocation was more appropriate.[6]

Further evidence of the Intermediary=s inability to perform a reasonable and careful audit concerns the Provider=s client relations function. The Provider argues that it properly classified these personnel in the A&G HHA and Hospice cost center because they perform intake functions for both home health and hospice patients. Consistent with the Medicare guidelines at HCFA Pub. 15-1 ' 2113, these intake

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[3] Tr. at 43-44

[4] Tr. at 45-47.

[5] Tr. at 127.

[6] Tr. at 47-48.

personnel identified the full range of a patient=s care needs and made any necessary referrals to satisfy these needs. Accordingly, the Intermediary inappropriately classified the client relations function in the A&G Share Expenses cost center.[7] Similarly, the Intermediary misunderstood the function of the Provider=s patient accounting/billing personnel claiming that these costs were nonreimbursable. The Provider asserts that these personnel performed multiple functions, including many reimbursable functions, and that its allocation in the A&G Shared Expenses cost center was correct.[8]

The Provider contends that, through the development of objective alternative statistics,[9] it has demonstrated that its use of unique cost centers did not shift an inequitable amount of costs related to nonreimbursable activities to the reimbursable home health program. The alternative statistics were utilized to determine the reasonableness of the Provider=s allocation methodology as compared to the Intermediary=s collapsing of the A&G cost centers. The Provider states that it examined various activity-based statistics that reflected the volume of activities in several cost centers and chose statistics giving a broad overview of each cost center. Specifically, an examination was made of each one of the A&G cost centers highlighting general administrative functions benefiting all of the Provider=s activities. These functions included: general administration; controller accounting; human resources; and payroll. Each of these activities was applied to the respective cost center in order to compute an aggregate amount of A&G to be identified with home health care. The Provider believes that the results of its alternative analysis demonstrate that, overall, its use of unique cost centers resulted in more accurate cost finding than the Intermediary=s collapsing of the A&G cost center. The following are comparisons of the total percentage of general service costs allocated to reimbursable cost centers:

Provider=s As-Filed Cost Report Before Modification For Acknowledged Minor Errors	79%	
Provider=s As-Filed Cost Report Including Modification	74%	
Alternative Activity-Based Statistics Analysis		73%
Intermediary=s Audited Cost Report After Collapsing of A&G Cost Centers		59%

[7] Tr. at 50-52.

[8] Tr. at 52-53.

[9] See Provider Exhibit P-14.

Based on the above comparisons, the Provider contends that its cost allocations are supportable and fully consistent with its actual costs, and that the Intermediary=s accumulation of all general service costs into one A&G cost center was inappropriate, and substantially distorts the actual costs of the Provider=s reimbursable home health operations.

In response to the Board=s request that the parties address the issue of whether the revised manual provisions (HCFA Pub.15-2 ' 3214) regarding cost allocation and establishment of unique cost centers were applicable to the fiscal year in contention (FYE June 30, 1997),[10] the Provider advises that the revised manual provisions allowed for the creation of alternative unique cost centers. In March of 1997, the Health Care Financing Administration (AHCFA@) issued the new manual provisions at ' 3214 establishing two possible A&G service cost methodologies which were available to HHAs effective for cost reporting periods ending on or after March 31, 1997. Option one allowed HHAs to elect a three component A&G with the following allocation sequence: (1) A&G Shared Costs; (2) A&G Reimbursable Costs; and (3) A&G Nonreimbursable Costs. The second alternative allowed for the creation of unique A&G cost centers to further refine the allocation process. Under the second option, the statistical basis upon which to allocate fragmented A&G costs must represent, as accurately as possible, the consumption or usage of A&G services by the benefitting cost centers. The Provider points out that, while it was subject to the new manual provisions, the provisions recognized the creation of alternative unique cost centers beyond the three component model (i.e. A&G Shared Costs, A&G Reimbursable Costs and A&G Nonreimbursable Costs). Accordingly, the Provider concludes that its use of an alternative cost allocation methodology consisting of A&G Shared Expenses, A&G HHA Only and A&G HHA and Hospice was appropriate where the cost centers refine the allocation process and result in more accurate cost finding. Further, the Intermediary never contested the legal authority for its use of unique cost centers for the year in contention.

INTERMEDIARY=S CONTENTIONS:

The Intermediary contends that it properly collapsed the Provider=s three unique A&G cost centers into one A&G cost center based on its factual audit findings and the appropriate application of relevant regulatory and manual provisions. Contrary to the Provider=s belief, the prior intermediary=s approval of VNA=s request to utilize unique cost centers and direct costing does not mean that this approval continues in perpetuity. The conditional approval previously granted is still subject to audit verification, and does not automatically carry over to the Provider=s new owners. While the Provider claims that it requested approval from the Intermediary to use direct costing under the new ownership in its letter of May 17, 1996,[11] the Intermediary contends that this letter was not a request, but was merely a

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[10] Tr. at 148-149.

[11] See Intermediary Exhibit I-1.

notification that the Provider was expanding the general service cost centers on its cost report. Accordingly, the Intermediary did not respond to the Provider=s request because it planned to review the Provider=s use of direct costing during its yearly audit, as was done on an annual basis under the previous ownership by the prior intermediary.

The Intermediary contends that the Provider=s treatment of the concept of unique cost centers is incorrect. Pursuant to requirements set forth in HCFA Pub. 15-1 ' 2302.4, ' 2307 and ' 2313, the intent of the concept of unique cost centers is to have the Medicare program share in its proper portion of costs that are truly shared types of costs. Where the establishment of separate A&G cost centers is adopted to further refine the allocation process, the methodology must accommodate an allocation process that componentizes A&G related costs into (1) A&G Shared Costs; (2) A&G Reimbursable Costs; and (3) A&G Nonreimbursable Costs. The Provider=s attempt to utilize direct costing and unique cost centers fails to comply with the manual requirements in that: (1) there was no identification of A&G costs related solely to nonreimbursable services, and (2) certain nonreimbursable activities with incidental benefits to the home health activity were classified as shared costs. The Intermediary argues that the failure to apply the proper methodology results in an over-allocation of nonreimbursable costs to the Medicare program contrary to the basic reimbursement principles set forth in 42 U.S.C. ' 1395x(v)(1)(A) and 42 C.F.R. ' 413.50.

In support of its adjustment the Intermediary cites the following manual provisions:

In defining allocable costs, HCFA Pub. 15-1 ' 2302.4 states the following:

> Any item or group of items of cost chargeable to one or more objects, processes, or operations in accordance with cost responsibilities, benefits received, or other identifiable measure of application or consumption (also known as general service costs).
>
> A. Directly Allocable Costs. -Directly allocable costs are chargeable based on actual usage (e.g., metered electricity) rather than a statistical surrogate.
>
> B. Indirectly Allocable Costs. -Indirectly allocable costs are not chargeable based on actual usage, and thus, must be allocated on the basis of a statistical surrogate (e.g., square feet).

HCFA Pub. 15-1 ' 2302.4

With respect to the direct assignment of general service costs, the provisions of 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. This allocation process is usually made, for Medicare cost reporting purposes, through cost finding using a statistical basis that measures the benefit received by each cost center. Alternatives to cost finding... may be used where appropriate after obtaining intermediary approval. The Provider must make a written request to its intermediary and submit reasonable justification for approval of the change no later than 90 days prior to the beginning of the cost reporting period for which the change is to apply. The Intermediary must respond in writing to the provider=s request, whether approving or denying the request, prior to the beginning of the cost reporting period to which the change is to apply.
>
> When the request is approved, the change must be applied to the cost reporting period for which the request was made, and to all subsequent cost reporting periods unless the intermediary approves a subsequent request for a change by the provider. The effective date of the change will be the beginning of the cost reporting period for which the request has been made.

HCFA Pub. 15-1 ' 2307 (emphasis added).

The manual provisions at HCFA Pub. 15-1 ' 2313.1 discusses the use of unique cost centers stating the following:

> Based on the provider=s individual accounting system, a provider may elect to use its unique cost centers in lieu of the recommended cost centers on the cost reporting forms for cost finding purposes, subject to the following provisions.
>
> A. Each cost center must meet the definition of a cost center as expressed in '2302.8.
>
> B. Each cost center to be established must:
>
> 1. Be separately identified in the provider=s accounting system with any direct costs recorded on a regular ongoing basis throughout the accounting period, not only period ending adjusting entries;

2. For general service cost center, be placed in the allocation sequence in an order such that the cost center servicing the most other cost centers, while receiving benefits from the least number of cost centers, is allocated earliest in the sequence; and

3. For general service cost centers, use a single statistical basis of allocation which accurately measures the amount of service rendered by that cost center to the other cost centers.

C. The Intermediary must be satisfied that the provider=s use of its unique cost centers will result in a more accurate cost finding.

D. A written request must be submitted to the intermediary 90 days prior to the end of the cost reporting period for which it applies and must be approved by the intermediary within 60 days from the date of receipt. The intermediary=s approval, which applies to both the cost centers and the proposed basis of allocation, must be furnished in writing and is binding for the initially approved and all subsequent cost reporting periods until a subsequent request is approved.

HCFA Pub. 15-1 ' 2313.1 (emphasis added).

Pursuant to the above referenced manual provisions, the Intermediary argues that the requirement for obtaining prior intermediary approval for changes in cost reporting procedures is not a new concept, and that these instructions are explicit as to the responsibilities of the provider and intermediary. The Intermediary asserts that it did not grant nor did the Provider request prior approval for the direct assignment of costs.

The Intermediary advises that the Provider=s failure to obtain prior approval is not the main reason that it collapsed the Provider=s three unique A&G cost centers into one A&G cost center. Based on its audit findings , the Intermediary determined that the Provider: (1) was unable to properly maintain its records to reflect the use of unique cost centers; (2) consistently misclassified costs to reimbursable areas when these costs mainly benefitted nonallowable cost centers; and (3) misclassified direct costs. The Intermediary cites the following as examples of its findings:

Private Duty Managers:

The Provider classified the management staff of its Private Duty Nursing Program to the A&G HHA Only cost center. The Provider established a nonreimbursable Private Duty cost center for the Private Duty direct-nursing services, but classified the Private Duty management staff as A&G HHA Only. As a result of this classification, 100 percent of the nonreimbursable costs were being allocated to the HHA reimbursable cost center, while the Private Duty cost center received no allocation of these overhead costs that are directly attributable to the Private Duty cost center. The Intermediary contends that the Provider should have complied with the provisions of HCFA Pub.15-1 ' 2307 and directly assigned these costs to the nonreimbursable cost center through its accounting system instead of utilizing the step down method of allocation.

Schedulers:

Schedulers who were classified as both Hospice and Home Health were classified to the A&G HHA Only cost center. Since the salaries and benefits of the schedulers appear to be a shared type of cost, this misclassification allocated all of these costs to the HHA reimbursable cost center and none to the Hospice cost center.

Data Processing:

The Provider classified its data processing staff as A&G HHA & Hospice. The Intermediary determined that these staff personnel also furnished services to other nonreimbursable components, such as the DME, Respiratory, Infusion, and Private Duty areas. Since the Provider classified these particular costs as A&G HHA & Hospice, the other nonreimbursable cost centers did not receive any allocation of the data processing costs. This misclassification shifted a majority of the costs to the HHA reimbursable cost centers and a minimal amount to the Hospice cost centers. During discussions with Provider personnel, the Intermediary was advised that the other nonreimbursable areas received little benefit from the Data Processing department as the services provided were from outside vendors. Upon verification, the Intermediary determined that minimal outside vendor costs were incurred, and that the outside vendor costs were also charged to the A&G HHA & Hospice cost center.

Client Relations:

The costs associated with these individuals were classified to the A&G HHA & Hospice cost center. The other nonreimbursable cost centers, such as Private Duty, DME, etc., also had this activity but classified the costs to the A&G Shared Expenses cost center, thus allocating additional unnecessary costs to the HHA reimbursable cost center.

Patient Accounting/Billing:

While the Provider properly classified the Home Health and Hospice billers to the A&G HHA and Hospice cost center, it misclassified the IV/DME billers to the A&G Shared Expenses cost center. The costs associated with the IV/DME billers should have been directly charged to the nonreimbursable cost centers.

Based on its audit findings, the Intermediary concludes that the Provider=s method of direct assignment of general service costs is not a more accurate allocation of costs to all of the Provider=s health care programs. Since the Provider=s use of the three unique A&G cost centers does not fairly or accurately capture costs or equitably apportion costs, the Intermediary believes that it was appropriate and reasonable to collapse the unique cost centers into one A&G cost center. In accordance with the regulatory requirements of 42 C.F.R. ' 413.9, ' 413.20 and ' 413.24, and the manual provisions at HCFA Pub. 15-1 ' 2304, it is the Provider=s responsibility to furnish adequate documentation to support the allowability of costs and apportionment methods used in determining reimbursable costs under the Medicare program. Since the Provider failed to comply with these requirements, the Intermediary believes it utilized the best available information from the Provider=s books and records to determine the proper amount of Medicare reimbursement.

Issue 2-Delivery Expenses:

The Provider claimed certain delivery expenses on its Medicare cost report, which were classified in the A&G Shared Expenses cost center. Upon audit, the Intermediary reclassified the delivery expenses consisting of transportation costs, leased vehicle and salary costs to a non- reimbursable cost center identified for IV and DME costs. The estimated reimbursement effect of this reclassification adjustment is $128,000.

PROVIDER=S CONTENTIONS:

The Provider contends that it correctly classified the delivery expenses as shared costs between IV/DME and Home Health, and has produced adequate documentation to support this allocation. The Provider argues that the Intermediary based its reclassification adjustment on a misinterpretation of the job descriptions and actual duties performed by certain delivery personnel. Although job descriptions were furnished to the Intermediary,[12] the Intermediary failed to take the time needed to develop an accurate understanding of how the Provider actually operated.

[12] See Provider Exhibit P-16.

The Provider argues that the delivery expenses were attributable to both reimbursable and nonreimbursable activities. The Provider=s Chief Financial Officer testified that the delivery personnel delivered various products to a patient=s home, including medical supplies and pharmacy-related products used by the Provider=s intermittent home health nurses. Since the Provider did not attempt to quantify the specific amount of the activity attributable to reimbursable and nonreimbursable components, it properly allocated these costs to the A&G Shared Expenses cost center.[13] The Provider notes that part of the purpose for using shared unique cost centers is to eliminate the need of making such fine grade distinctions. The cost finding process recognizes that some A&G costs may be disproportionately allocated in favor of the Medicare program, while other costs may be disproportionately allocated in favor of other payors.

The Provider further argues that the Intermediary=s methodology changed the cost allocation method for these costs, and selectively subjected a portion to discrete costing contrary to cost reporting instructions. Accordingly the Intermediary=s reclassification of delivery expenses was incorrect, and its effort to engage in such selective and one-sided reclassifications should be rejected.

INTERMEDIARY=S CONTENTIONS:

The Intermediary contends that its audit of delivery expenses revealed that the Provider used a leased vehicle solely for the delivery of DME and, thus, the associated costs should have been directly charged to the nonreimbusable DME cost center as outlined under HCFA Pub. 15-1 ' 2307. The Intermediary further determined that non-routine supplies (i.e., chargeable medical supplies) were delivered directly to the patient=s home by an outside vendor. While the Provider=s delivery personnel did deliver incidental routine supplies to the branch offices, the Provider=s internal records (i.e., job descriptions, performance evaluations, interviews) show that the primary jobs of delivery and warehouse personnel centered around filling, delivering and billing of DME, respiratory, infusion and pharmacy products and equipment.

The Intermediary argues that the Provider did not furnish any evidence that its delivery and warehouse personnel provided allowable administrative support services, direct or indirect, that were necessary and related to the rendering of home health visits. Incidental deliveries of routine supplies to branch offices do not justify the classification of the job functions of these personnel to a shared service cost center. The Intermediary states that the regulations at 42 C.F.R. '' 413.20 and 413.24, and the manual provisions under HCFA Pub. 15-1 '' 2300 and 2304ff explicitly require a provider to maintain sufficient financial records and statistical data for the proper determination of costs under the Medicare program. Such data must be consistent with the provider=s financial records, accurate and in sufficient detail to accomplish the intended purpose. The Provider

[13] Tr. at 155-157.

failed to meet the requirements of the regulations and manual instructions, and did not demonstrate with any evidence that the adjustment made during the Intermediary=s audit was inaccurate, erroneous or unacceptable for cost reporting purposes.

Issue 3-Courier Costs:

The Provider classified its courier costs as shared costs in the A&G Shared Expenses cost center. The Intermediary reclassified these costs to the skilled nursing (AHHA@) and pharmacy (Anonreimbursable@) cost centers based on its audit of the Provider=s accounting records. The Intermediary=s reclassification adjustment reduced Medicare reimbursement by approximately $75,000.

PROVIDER=S CONTENTIONS:

The Provider contends that it appropriately allocated the courier costs as a shared cost in the A&G Shared Expenses cost center, and that the Intermediary=s reclassification was incorrect. The Provider asserts that the courier costs incurred related to both blood sample pick-ups for home health patients and pharmacy services deliveries and, accordingly, were placed in one cost center as courier expenses. The Provider believes that the Intermediary engaged in its own effort at discrete costing by reclassifying these costs into both reimbursable and nonreimbursable cost centers. Based on the services of the couriers, a portion of their costs was attributable to the home health operations, and the provider properly allocated these expenses to the A&G Shared Expenses cost center. Again, the Provider insists that part of the purpose of utilizing shared unique cost centers is to eliminate the necessity of making such distinctions.

Finally, the Provider contends that the Intermediary improperly changed the allocation method and selectively subjected a portion of the costs to discrete costing, contrary to Medicare cost reporting instructions. Therefore, the Intermediary=s reclassification of these costs should be reversed.

INTERMEDIARY=S CONTENTIONS:

The Intermediary contends that its reclassification adjustment of courier costs was properly based on the documentation and information obtained during its audit of the Provider=s Medicare cost report. The Intermediary states that it reviewed invoice samples and patient files pertaining to the courier activities of outside courier companies to document the necessity of the delivery charge. Based on the data reviewed for one particular company, the Intermediary determined that an amount of $72,760 should have been directly allocated to the skilled nursing (AHHA@) cost center. With respect to the review of invoices and route slips for two other companies that provided courier services, the Intermediary determined that deliveries made pertained primarily to nonallowable activities. In addition ,

the Intermediary ascertained that the type of delivery charges incurred were not common costs for providers that render home health services. Based on the information furnished, the Intermediary concluded that an amount of $108,778 should have been directly allocated to the pharmacy cost center. An additional courier cost amount of $3,087 was disallowed because the Provider did not have any documentation to support this expenditure.

The Intermediary again cites the documentation requirements set forth in 42 C.F.R. '' 413.20 and 413.24 and the manual instructions at HCFA Pub.15-1 '' 2300 and 2304ff. Since the Provider failed to maintain sufficient financial records and statistical data for the proper determination of cost payable under the Medicare program, the Intermediary believes the Board should uphold its determination regarding courier costs.

Issue 4 - Home Office Costs:

The Provider claimed certain costs reported in the home office cost statement of QV, Inc., which were audited and adjusted by the Intermediary in determining Medicare reimbursable cost. The sole home office cost adjustment remaining in this appeal concerns the reclassification of costs related to Business Development and Managed Care from the Provider component to a non-provider component within the home office. The Intermediary=s home office adjustment reclassified approximately $840,000 to non-reimbursable departments, which reduced Medicare reimbursement by about $260,000.

PROVIDER=S CONTENTIONS:

The Provider contends that the Intermediary incorrectly disallowed the Business Development and Managed Care costs claimed on the home office cost statement based upon a misunderstanding of the duties performed by employees in these areas. Despite the detailed job descriptions provided for these employees,[14] the Intermediary considers these employees to be primarily salespersons. The Provider argues that the employees in question provided general services such as finance, budgeting, legal services, strategic planning, and payroll administration to the Provider and other divisions of QV, Inc.. Their duties also included such reimbursable responsibilities as coordinating efforts internally to service patients, and providing information to the managed care personnel regarding patient utilization and outcomes. The Managed Care personnel were also responsible for contracting activities.[15] Accordingly, the Intermediary was incorrect in disallowing these clearly reimbursable activities.

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[14] See Provider Exhibit P-18.

[15] Tr. at 182-184.

INTERMEDIARY=S CONTENTIONS:

The Intermediary contends that the entity AQV, Inc.@ does not meet the usual definition of a home office, which customarily exists to provide its entities and components with centralized administrative support. In the instant case, QV, Inc. only provides a minimal amount of centralized administrative support, and the majority of its existence is to be a referral source for physician services, DME supplies, and to acquire physician practices to provide additional referral sources to all of its entities. The Intermediary asserts that these components and activities of QV, Inc. are nonallowable activities and the associated costs are nonreimbursable under the Medicare program. The Intermediary believes that, by establishing these activities and allocating such nonallowable costs through the home office cost statement without the establishment of nonprovider components, the Provider has shifted the majority of these costs to the Provider component resulting in the improper reimbursement of these costs by the Medicare program.

With respect to the Managed Care activity, the Intermediary states that this function manages, negotiates and analyses existing and future agreements between the various entities and health insurers within the entire health system. The documentation furnished by the Provider (Provider Exhibit P-18) lists the various affected providers of the University of Chicago Hospital and Health System as follows:

> University of Chicago Practice Plan (faculty physicians) QV, Inc (University of Chicago Physicians Group) Chicago Partners (a management services organization) Care Med of Chicago (home health agency) Midwest Medical Center (an ambulatory surgical center) University of Chicago Hospitals LaRabida Hospital

In addition, the documentation also states that the employees involved in this function work with various health plans to include the Provider as an A... authorized provider of home health services.@

The documentation regarding the Business Development activity states that this function is responsible A... for developing and implementing the Primary Service Area strategy and for the Secondary Service Area plan. These initiatives are designed to increase the business activities of QV entities within these geographic areas.@

The efforts of the Business Development activity are concentrated on three main functions:

1. Expanding links between community based providers and networks to the home office (QV, Inc.);

2. Recruiting physicians to QV businesses as practitioners and administrators; and

3. Developing strategic and business plans for QV entities.

The Intermediary explains that its intent in describing the associated employees as Asalespersons@ is to state that the activities themselves are to be considered as patient solicitation. Through the Managed Care and Business Development activities, the home office is able to develop outside networks of provider contacts to increase patient utilization in its own health system. Even though some services are being furnished to the Provider, the Intermediary maintains that these home office activities are nonreimbursable functions under the Medicare program as set forth under HCFA Pub. 15-1 ' 2113.2. The Intermediary concludes that its adjustment which established a nonprovider component on the home office cost statement was correct, and that the costs of the Business Development and Managed Care activities are nonreimbursable and should not be allocated to the Provider=s Medicare cost report through the home office cost statement.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

' 1395x(v)(1)(A)	-	Reasonable Costs

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

'' 405.1835-.1841	-	Board Jurisdiction
' 413.9	-	Cost Related to Patient Care
' 413.20	-	Financial Data and Reports
' 413.24	-	Adequate Cost Data and Cost Finding
' 413.50	-	Apportionment of Allowable Costs

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

' 2113 et seq.	-	Patient Solicitation Activities
' 2300	-	Adequate Cost Data and Cost Finding - Principle
' 2302.4	-	Allocable Costs
' 2304ff	-	Adequacy of Cost Information

' 2307	-	Direct Assignment of General Service Costs
' 2313	-	Changing Bases for Allocating Cost Center or Order in Which Cost Centers are Allocated
' 2313.1	-	Alternate Method of Allocating Administrative and General Expenses

4. Program Instructions - Provider Reimbursement Manual, Part II (HCFA Pub. 15-11):

' 3214	-	Worksheet B-Cost allocation - General Service Costs and Worksheet B-1 - Cost Allocation - Statistical Basis

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 briefs, finds and concludes as follows:

Issue 1-A&G Cost Center:

The Board finds that the Intermediary properly denied the Provider=s alternative cost allocation methodology, and that the collapsing of the three unique cost centers into one A&G Cost center was an appropriate determination given the Provider=s failure to present adequate and reliable documentation to support its use of the unique cost centers. The record shows that the Intermediary performed an in-depth audit of the Provider=s Medicare cost report for the FYE June 30, 1997. Based on its comprehensive review of the Provider=s cost finding procedures, the Intermediary identified extensive reporting deficiencies and misclassifications of A&G costs which distorted the accuracy of the alternative cost finding methodology applied by the Provider in determining Medicare reimbursement. While the Board finds that the Provider had an acceptable cost finding methodology, the admissibility of such an alternative allocation process hinges on the Provider=s ability to support the accuracy and proper application of the methodology in determining allowable costs under the Medicare program.

Under the principles of cost reimbursement set forth in 42 C.F.R. '' 413.20 and 413.24, providers of services are required to maintain sufficient financial records and statistical data for the proper determination of costs payable under the Medicare program. Such data and documentation must be based on the financial and statistical records of the provider and furnished to the intermediary for the

purpose of ascertaining whether the information is accurate and pertinent to the determination of the proper amount of program payments. While the Provider has presented extensive testimony and generalized information in support of the validity and accuracy of its cost finding methodology, the Board finds that the Provider has failed to provide the necessary documentation (i.e. time records, logs, job descriptions) which would support the accuracy and admissibility of its unique cost finding methodology. The Board believes the Provider had ample opportunity to provide the necessary documentation in response to the Intermediary audit findings, but has declined to present auditable records to support its contentions. In the absence of adequate documentation, the Board is not persuaded by the Provider=s summarial rebuttal to the specific findings identified by the Intermediary.

The burden of maintaining adequate records and documentation rests with the Provider to support the proper payment of costs to be borne by the Medicare program. Since the Provider has not met its obligation with respect to the proper application of its alternative cost allocation methodology for the A&G cost center, the Board finds the Intermediary=s determination to be in compliance with the documentation criteria set forth under 42 C.F.R. '' 413.20 and 413.24.

Issues 2 and 3 - Delivery Expenses/Courier Costs:

With respect to the issues concerning Delivery Expenses and Courier Costs, the Board finds the Intermediary=s reclassification adjustments to be supportable determinations based on its specific audit findings in the Provider=s accounting records. As set forth in the Board=s findings for Issue 1 above, the Provider has again failed to refute the Intermediary=s specific audit adjustments with adequate and supportable documentation. Since the Provider has not furnished any documentary evidence to dispute the Intermediary=s findings, the Board holds that the Provider has not met the requirements of 42 C.F.R. '' 413.20 and 413.24 which establish basic cost reimbursement principles for the maintenance of adequate documentation capable of being audited.

Issue 4 - Home Office Costs:

The adjustments before the Board for this issue concerns the Intermediary=s reclassification of home office costs for the activities associated with Business Development and Managed Care to a nonprovider component on the home office cost statement. With respect to the Business Development component, the Board concurs with the Intermediary=s determination that this activity is a nonreimbursable function as set forth under HCFA Pub. 15-1 ' 2113.2. Based on the functional statement presented by the Provider,[16] it is the Board=s conclusion that the primary purpose of the

[16] See Provider Exhibit P-18.

Business Development activity is to expand the business activities of the health care-related activities served by QV, Inc. In as much as the principal objective of this home office activity is to increase patient utilization within QV, Inc.=s health system, the costs associated with such activities are not related to the provision of patient care services as required under 42 C.F.R. ' 413.9.

Regarding the home office=s Managed Care activity, the Board does not concur with the Intermediary=s reclassification of the costs associated with this function to a nonprovider component on the home office cost statement. The Board believes that managed care contracting is an integral function in the existing health care industry, and that expenditures incurred for this activity are necessary and allowable costs which should be included in the determination of Medicare reimbursement. Accordingly, the Board finds that the costs incurred by QV, Inc. for its Managed Care activity should be included in the pooled costs of the home office cost statement, and proportionately allocated to the Provider based on the benefits received from this necessary function.

DECISION AND ORDER:

Issue 1 - A&G Cost Center:

The Intermediary=s adjustment to the Provider=s A&G cost center was proper. The Intermediary=s determination is affirmed.

Issue 2- Delivery Expenses:

The Intermediary=s reclassification adjustment of delivery expenses claimed by the Provider was proper. The Intermediary=s reclassification adjustment is affirmed.

Issue 3 - Courier Costs:

The Intermediary=s reclassification adjustment of courier costs claimed by the Provider was proper. The Intermediary=s reclassification adjustment is affirmed.

Issue 4 - Home Office Costs:

The Intermediary=s adjustment to home office Business Development and Managed Care costs is modified as follows: The Intermediary=s adjustment to home office Business Development costs was proper and is affirmed. The Intermediary=s adjustment to home office Managed Care costs was not proper and is reversed.

BOARD MEMBERS PARTICIPATING:

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

Date of Decision: May 4, 2001

FOR THE BOARD

Irvin W. Kues
Chairman