PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2004-D33

PROVIDER –
Genesis 96, 97 Proper Cost Category Group
Genesis 98 Payroll Tax/Workers Compensation Cost

Provider Nos. Various

vs.

INTERMEDIARY –
Blue Cross Blue Shield Association/
Veritus Medicare Services

DATE OF HEARING -
September 12, 2003

Cost Reporting Periods Ended
Various

CASE NO. 99-3663G
00-2170G

INDEX

ISSUE:

Should the Providers' Federal Insurance Contributions Act (FICA) payroll costs be classified to the administrative and general cost center?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

This is a dispute over the amount of Medicare payments to a health care provider.

Medicare's payment and audit functions are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under the Medicare law and under interpretative guidelines published by the Centers for Medicare and Medicaid Services (CMS). Id.

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it occurred during the fiscal year and what proportion of those costs are to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary audits the cost reports and determines the total amount of Medicare reimbursement due the provider, which it publishes in a notice of program reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

The Providers in these two group appeals are skilled nursing facilities (SNFs) owned or operated by Genesis Health Ventures, Inc. Prior to the 1998 fiscal year at issue, the Providers assigned FICA, workers' compensation costs and Federal Unemployment Tax Act (FUTA) and State Unemployment Taxes Act (SUTA) taxes to departments with salary expenses on the trial balance of each SNF. In 1998, a number of the Providers in the group reported their workers' compensation costs and employee related taxes including FICA, in the administrative and general (A&G) cost center on their Medicare cost reports. These costs were reclassified by the Veritus Medicare Services (Intermediary) to the employee benefits cost center for allocation purposes.

In 1999, the Providers learned that CMS had issued letters to the Intermediary addressing the manner in which skilled nursing facilities were to classify FUTA, SUTA, and workers' compensation payroll costs.[1] The Providers subsequently contacted the Intermediary seeking to reopen or amend their fiscal year 1996 and 1997 Medicare cost reports and to get an extension of time to complete their 1998 cost reports to be consistent with the CMS letters. This would have allowed the Providers to have included the payroll costs at issue in the A&G cost center and would have yielded higher Medicare payments. The Intermediary denied the Providers' request to reopen or amend the 1996 and 1997 cost reports and also its request for an extension to file the 1998 cost reports. The classification of all payroll-related expenses was originally at issue in this case;

[1] Exhibits P-2, P-3, and P-4 for case number 00-2170G.

however, the Intermediary withdrew its opposition to the classification of FUTA, SUTA and workers' compensation insurance costs as A&G expenses.[2]

The Intermediary maintained its opposition to classifying FICA taxes as A&G, however, based on a subsequent CMS official's letter clarifying the earlier positions.[3]

The Providers appealed all 1996 and 1997 cost reports still subject to review by the Provider Reimbursement Review Board (Board) requesting that the cost reports be adjusted to be consistent with what the provider asserted were CMS authoritative letters allowing FICA and other taxes to be classified as administrative and general costs. The Providers' also appealed the Intermediary's 1998 cost report adjustments which they claimed were not consistent with the CMS letters.

On February 20, 2002, the Board issued its opinion that it lacked jurisdiction over the 1996 and 1997 cases, and on April 19, 2002, the CMS Administrator declined to review the Board's decision. The Provider then sought judicial review in the U.S. District Court for the District of Columbia. Pursuant to a Stipulation of the parties entered before the court, this matter was remanded to the Board with instructions to accept jurisdiction.[4] By order dated April 7, 2003, the CMS Administrator remanded the case to the Board and directed it to issue a decision on the merits of the Providers' claims.[5]

The estimated Medicare reimbursement impact for all the cases is approximately ten million dollars.

The Provider was represented by Joseph Brooks, Esq., and Donna K. Thiel, Esq., of Morgan, Lewis & Bockius, LLP. The Intermediary's representative was Bernard M. Talbert, Esq., of the Blue Cross Blue Shield Association.

PROVIDERS' CONTENTIONS:

The Providers contend that they should be permitted to include FICA taxes in the administrative and general cost center on their Medicare cost reports, in accordance with instructional letters issued by CMS. The Providers further assert that the Intermediary disregarded the CMS instructions and did not properly advise the Providers of the instructions as required by 42 C.F.R. §421.100.

The Providers also contend that a number of CMS precedents have held that employment based taxes are not "fringe benefits" for purposes of HCFA Pub.15-1 §2144.1. In addition, there is no basis to distinguish FICA taxes from FUTA, SUTA, and worker's compensation, which CMS has recognized, and the Intermediary has conceded, are not fringe benefits. See Whitley County Memorial Hospital v. Blue Cross and Blue Shield

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[2] Intermediary Supplemental Position Paper; Tr. p 34.
[3] Intermediary Exhibit 18.
[4] Exhibit P-22.
[5] Exhibit P-23.

Association/Blue Cross and Blue Shield of Indiana , CMS Administrator's Decision, October 24, 1986, Medicare and Medicaid Guide (CCH) ¶ 36,059, Longwood Management Corporation v. Blue Cross and Blue Shield Association/Blue Cross of California PRRB Dec. No. 99-D34, April 6, 1999, decl'd. rev. CMS Administrator, Medicare and Medicaid Guide (CCH) ¶80,177 and Extendicare 1996 Insurance Allocation Group v. Blue Cross and Blue Shield Association/United Government Services, PRRB Dec. No. 2000-D88, September 26, 2000, Medicare and Medicaid Guide (CCH) ¶80,573.

The Providers further contend that the Intermediary's argument that improper cost shifting would result if the Board were to find in the Providers' favor is without merit. A cost shift does not occur simply because Medicare incurs higher costs in an individual instance. It occurs when the cost reporting process fails to properly apportion costs between Medicare and non-Medicare payers. While the Providers do not dispute that the change in classification of FICA expenses to A&G increased their Medicare reimbursement, they claim that it is the Medicare step-down cost reporting methodology that ultimately affects Medicare reimbursement here, because it dictates whether costs are reimbursed based on ancillary or routine utilization.

The Providers point out that the Intermediary's witness at the hearing testified that no effort had been made to determine the impact of classifying the employer's share of FICA to the A&G cost center would have on overall allocation of costs between the Providers and the Medicare program, or whether it would have resulted in any cost shifting.[6] The Providers maintain that no disproportionate allocation of total costs or total A&G costs has been shown to result from the classification of FICA costs to A&G, and the employer's share of the FICA tax should be classified to the A&G cost center on all of the cost reports at issue.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Providers' primary argument is that in certain policy based letters, CMS unequivocally agreed with the position that FICA costs should be allocated as A&G expenses. However, a subsequent CMS letter issued on August 23, 1999 negated the concept that FICA is an A&G expense that must be allocated based upon accumulated costs and without regard to the fact that most ancillary departments have few or no employees and are staffed through contracts in which the fee recognized in " other" costs covers any payroll expense.[7]

The Intermediary views the underlying problem as one of cost shifting to the Medicare program resulting from improper cost classification. FICA taxes are incurred as a percentage of salaries. Therefore, the Intermediary contends that salaries are the most appropriate method of allocating these costs. Allocating FICA taxes based on the A&G cost center's accumulated cost statistic, as the Providers advocate, would result in an

[6] Tr. at p. 192-193.
[7] I-18 in PRRB case No. 00-2170G & I-19 in case PRRB case No. 99.

allocation of these costs to cost centers that do not contain any direct salary expenses, thus failing to match the expenses to the cost centers where they were incurred. More specifically, the Providers' approach over-allocates costs to the ancillary departments which carry a higher Medicare utilization rate than the routine cost centers.[8]

The Intermediary also points to the Board's decision in Bryn Mawr Terrace Convalescent Center v. Blue Cross Blue Shield Association/Veritus Medicare Service, PRRB Dec. No. 99-D59, August 19, 1999, Medicare and Medicaid Guide (CCH) ¶80,323, decl'd rev. HCFA Admin. Ocotber 4, 1999, Rem'd. HCFA Admin., March 26, 2000, Medicare and Medicaid Guide (CCH) ¶80,549, that FICA tax is a salary-generated cost that is most appropriately allocated via gross salaries[9] by classifying the FICA tax as an employee benefit. After seeking review by the CMS Administrator, which was denied, the Provider sought judicial review. The case was remanded to the Board for further consideration. The Board found again that "employment related taxes such as FICA and federal and state unemployment taxes are 'wage related costs' and should be allocated as part of the employee benefit cost center."[10]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

First, the Board finds that the employer's share of FICA taxes is an employee fringe benefit that serves to secure a right to a future benefit, i.e., social security at retirement, disability or survivor's benefits. As such, FICA taxes meet the definition of fringe benefits set forth in HCFA Pub. 15-1 § 2144.1, which states:

> Fringe benefits are amounts paid to, or on behalf of, an employee, in addition to direct salary or wages, and from which the employee, his/her dependent (as defined by IRS), or his/her beneficiary derives a personal benefit before or after the employee's retirement or death. In order to be allowable, such amounts must be properly classified on the Medicare cost report, i.e., included in the costs of the cost center(s) in which the employee renders services to which the fringe benefit relates and, when applicable, have been reported to the IRS for tax purposes. . . . .

Second, the Board finds that as a fringe benefit, FICA costs should be classified to the employee benefits cost center. Since these costs are salary-generated costs, the use of gross salaries as the allocation basis properly matches these expenses to the activities which benefited from the services rendered by the employees. Using the allocation method advocated by the Providers would result in the allocation of costs to cost centers

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[8] I-17 & I-18 in Intermediary's post hearing brief; Also, p. 6-7 of Intermediary's post hearing brief.

[9] I-9

[10] I-10

that do not even contain any employees or direct salary expense. Further, the Intermediary has demonstrated that the Providers' allocation approach over-allocates costs to ancillary departments that are reimbursed at a higher Medicare utilization rate.[11]

The Board also closely reviewed Provider Exhibits P-1 through P-4 which contained CMS letters stating that various types of payroll expenses should be allocated as A&G expenses. The Providers view these letters as authoritative guidance for their position. However, a subsequent CMS letter dated August 23, 1999[12] serves to clarify the earlier correspondence. It states that, in terms of the various options for allocating payroll-related tax costs, the A&G allocation methodology would not be the most appropriate or accurate. While CMS letters can be accorded "great weight" by the Board, the letters in the instant case reflect inconsistent points of view by the same writer. Accordingly, the Board finds the CMS letters cited by the Providers are unpersuasive, and as such are entitled to no particular deference.[13]

Finally, the Board concludes that the primary consideration in this case is the payment of reasonable costs consistent with the regulation at 42 C.F.R. §413.24, which seeks the development and application of methodologies which yield the most accurate determination of actual costs incurred in the provision of health care services under the Medicare program. The Board finds that the Intermediary's methodology for allocating FICA costs is the most accurate and appropriate.

DECISION AND ORDER:

The Intermediary's methodology for allocating FICA taxes is proper and is affirmed.

BOARD MEMBERS PARTICIPATING

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Martin W. Hoover, Jr., Esquire
Elaine Crews Powell, CPA
Anjali Mulchandani

DATE: August 13, 2004

FOR THE BOARD:

Suzanne Cochran
Chairman

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[11] Pages 6 and 7 of Intermediary's Supplemental Position Paper and Exhibit I-17 in PRRB Case No. 00-2170G and Exhibit I-18 in PRRB Case No. 99-3663G.

[12] I-18 in PRRB Case No. 99-3663G and I-19 in PRRB Case No. 00-2170G.

[13] See, Christensen v. Harris County, 529 U.S. 576, 587 (2000).