PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2002-D17

PROVIDER -
Sun Home Health Services, Inc.
Northumberland, PA

Provider No. 39-7095

vs.

INTERMEDIARY -
Blue Cross and
Blue Shield Association/ Cahaba
Government Benefit Administrators

DATE OF HEARING-
June 29, 2001

Cost Reporting Periods Ended -
March 31, 1998

CASE NO. 00-1736

INDEX

ISSUE:

Was the Intermediary's reclassification of the salaries and benefits attributable to the unallowable activities from the administrative and general ("A & G") cost center to a non-reimbursable cost center proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Sun Home Health Services, Inc. (the "Provider") is a freestanding not-for-profit home health agency located in Northumberland, Pennsylvania. Wellmark (the "Intermediary")[1] conducted the field audit and settled the cost report for the Provider's fiscal year ended ("FYE") March 31, 1998 cost report. The Intermediary disallowed costs associated with certain positions because they involved non-allowable activities of marketing and expanding the Provider's business. The Provider filed a timely appeal and has met the jurisdictional requirements set forth in 42 C.F.R. § 405.1835-.1841. The Medicare reimbursement in controversy is approximately $323,000.

During the fiscal year at issue, the Provider employed a Director of Development, a Community Service Coordinator and four Community Service Associates. Initially, the Intermediary made the following disallowances. Because the duties of the Director of Development related to outreach, grant writing and funding activities, the Intermediary disallowed all of the salary for this position and reclassified the entire amount to a non-reimbursable cost center. Because the duties of the Community Service Coordinator related to managing the Community Service Associates and maintaining and expanding the Provider's presence in the market place, the Intermediary disallowed all of the salary for this position and reclassified the entire amount to a non-reimbursable cost center. Because the duties of the Community Service Associates included educational activities and activities similar to the Community Service Coordinator, the Intermediary determined that some of their activities were allowable and others were unallowable; however, due to poor documentation, all costs were disallowed and reclassified to a non-reimbursable cost center.

[1] Cahaba Government Benefits Administrators became the successor intermediary to Wellmark. See Tr. at 23-25.

Between the time when the Intermediary settled the Provider's cost report and the date of hearing, the Provider submitted additional materials to support its claims that not all of the Community Service Associates' salaries and benefits should be placed in a non-reimbursable cost center.[2] After conducting an analysis of the materials, the Intermediary divided the Community Service Associates' activities into four different areas: (1) undocumented days; (2) reimbursable activities; (3) non-reimbursable activities; and (4) partially reimbursable activities (that is, a day consisting of the performance of allowable and unallowable activities).[3] The Intermediary proposed a revised adjustment related to the Community Service Associates but maintained its original position with regard to the Director of Development and the Community Service Coordinator.[4]

Before the hearing, the Intermediary took a further step to arrive at an alternative way to allocate the costs in question and developed Methodology I.[5] Under Methodology I, salaries and benefits for fully allowable activity days were included in the A & G Cost Center.[6] Salaries and benefits associated with fully non-allowable activity days were placed in the non-reimbursable cost center.[7] Costs associated with mixed activity days were distributed between the A & G cost center and the non-reimbursable cost center based on a formula devised by the Intermediary.[8] Days with no documentation were not presumed to be allowable or unallowable or mixed.[9] The Intermediary simply offset the pertinent salaries and benefits on Worksheet A-5 under authority of the Medicare documentation rules.[10]

Methodology II differs from Methodology I in its treatment of the undocumented days. Under this scenario, the Intermediary allocated costs between the A & G cost center and the non-reimbursable cost center based on the percentage of undocumented days.[11] In all other respects,

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2 Intermediary Supplemental Position Paper ("ISPP") at 4.

3 Id.

4 Id.

5 Methodologies I and II are exhibits 1 through 5 in the Intermediary's Post Hearing Brief ("IPHB").

6 Tr. at 122-23.

7 Id.

8 Tr. at 124.

9 Tr. at 127.

10 Tr. at 122-27; IPHB, Exhibit 1.

11 Tr. at 127-29; see, also ISPP at 4-5.

it follows the summary depicting Methodology I.[12]

[12] IPHB, Ex. 1-3.

Prior to the hearing, the Provider accepted the Intermediary's calculation on allowability and disputed only the Intermediary's reclassification of costs it determined to be non-allowable from the A & G to a non-reimbursable cost center.[13]

The Provider was represented by Tom Ward, Esquire, and Jim Hamilton, CPA, of American Express Tax and Business Services, Inc. The Intermediary was represented by Eileen Bradley, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider asserts that the sole issue in this case is where the costs belong on the Medicare cost report. The Provider does not dispute the Intermediary's calculations on what costs are allowable, as set forth in the Intermediary's supplemental position paper. The basis of the Intermediary's reclassification appears to be an assumption that the costs at issue received services from other parts of the A & G cost center.

The Provider believes that under Medicare reimbursement principles there can be little dispute that the types of costs in question are A & G (overhead) costs. This is demonstrated by the fact that in splitting the costs between allowable and non-allowable, the Intermediary only reclassified non-allowable costs to a nonreimbursable cost center but left allowable costs in administrative and general. The result of this reclassification is that overhead costs are allocated to the non-allowable costs, increasing the amount disallowed. The Intermediary's justification is that Medicare reimbursement is overstated if non-allowable costs are left in the A & G cost center. According to the Intermediary, the non-allowable duties of these positions should receive allocated overhead because they receive services from other positions that are included in A & G costs. The Intermediary also claims that an unallowable Medicare activity cannot benefit another cost center, but has cited no Medicare rule or precedent.[14] In fact, no provision exists in Medicare law that authorizes the Intermediary to reclassify a non-allowable cost from A & G costs to direct care costs.

The Provider bases its opinion on the plain language of the cost reporting instructions for the Medicare home health cost report used in this fiscal period (Form HCFA-1728-94) and the structure of the cost report itself. See Chapter 32, CMS Pub. 15-2.

Home health agencies are required to use the step-down method of cost reporting. See 42 C.F.R.

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[13] See Provider Post Hearing Brief at 3.

[14] Tr. at 135.

§ 413.24(d). The regulation defines the step-down method as follows:

> 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 allocated to all centers which they serve, regardless of whether or not these centers produce revenue. The cost of the nonrevenue-producing center serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first. Following the apportionment of the cost of the nonrevenue-producing center, that center will be considered "closed" and no further costs are apportioned to that center. This applies even though it may have received some service from a center whose cost is apportioned later. Generally when two centers render service to an equal number of centers while receiving benefits from an equal number, that center which has the greatest amount of expense should be allocated first.

See 42 C.F.R. § 413.24(d)(l); See also CMS Pub. 15-1 § 2306.1.

In designing the home health agency cost report, CMS incorporated the step-down method. The cost report instructions state:

> These forms include the step-down method of cost finding which provides for the allocation of the cost of services rendered by each general service cost center to other cost centers which utilize such services.

See CMS Pub. 15-2 § 3200.

In other words, CMS has built the step-down method into the cost report.

Worksheet A of the cost report is entitled "Reclassification and Adjustment of Trial Balance of Expenses." See CMS Pub. 15-2 § 3206. Lines 1-5 of Worksheet A list the A & G cost centers:

> Lines 1-2: Depreciation, Leases, Rentals
> Line 3: Direct Operation and Maintenance Expenses
> Line 4: Transportation Costs
> Line 5: Administrative and General Costs

CMS' instructions for Line 5 state: "Use this cost center to record the expenses of several costs which benefit the entire facility. Examples include fiscal services, legal services, accounting, data processing, taxes, and malpractice costs."

Lines 6 and below refer to cost centers that are providing direct care:

Line 6: Skilled Nursing
Line 7: Physical Therapy
Line 8: Occupational Therapy
Line 9: Speech Therapy
Line 10: Social Services
Line 11: Home Health Aides
Line 12: Medical Supplies
Line 13: Costs of Vaccines
Line 14: Durable Medical Equipment
Line 15: Home Dialysis Aide Services
Line 16: Cardiopulmonary Treatments
Line 24: HHA-Based CORF
Line 25: HHA-Based Hospice
Line 26: HHA-Based CMHC
Line 27: HHA-Based RUG
Line 28: HHA-Based FQHC

The cost report thus determines overhead costs on Lines 1-6 of Worksheet A. These costs are then allocated to the direct care cost centers below Line 6.

To adjust the trial balance of expenses to properly reflect Medicare costs, the cost report instructions provide for "reclassifications" and "adjustments" of expenses that are listed on Worksheet A. Worksheet A-4 provides for reclassifications, which are simply the reassignment of a cost from one cost center to another, usually from A & G to a direct care cost center or from a direct care cost center to A & G. The cost report instructions provide several examples of reclassifications. See CMS Pub. 15-2 § 3210. For example, under the instructions, leases applicable to buildings or movable equipment must be reclassified into the capital-related account.

Worksheet A-5 is entitled "Adjustments to Expenses." See CMS Pub. 15-2 § 3201. According to the Intermediary's witness, an adjustment "[o]ffsets the expense entirely."[15] The effect of making an "A-5 adjustment" is to make the expense non-allowable under Medicare.

In preparing the adjustments at issue, the Intermediary failed to follow the instructions for Worksheets A-4 and A-5. Rather it reclassified the coordinator expenses on Worksheet A-5 in clear violation of the cost report instructions. However, Worksheet A-5 permits only the adjustment, or offset, of expenses. Reclassification of expenses is to occur on Worksheet A-4. While this may seem to be a technical argument, these are the instructions written by CMS and

[15] See Tr. at 133.

which intermediaries and providers must follow. The Provider questioned the legal basis on which the Intermediary bifurcated these expenses and reclassified from A & G costs only the portion that it deemed to be non-allowable.

The cost report and its instructions have been approved by the Office of Management and Budget, as required by the Paperwork Reduction Act of I 995, 44 U.S.C. §§ 3501-3520 and associated regulations, 5 C.F.R. part 1320. The OMB approval number is OMB No. 0938-002 and is in effect until May 31, 2004. Having had the instructions approved, it would be impermissible to alter them without appropriate OMB approval. See 5 C.F.R. § 1320.5(a).

The Intermediary has no basis to argue that the non-allowable costs do not belong in the A & G cost center. At the hearing the Intermediary appeared to argue that any non-allowable cost could not be considered an administrative and general cost. It has provided no legal authority for this position nor could there be any.

CMS Pub. 15-1 defines general service costs as:

> [t]hose organizational units which are operated for the benefit of the institution as a whole. Each of these may render services to other general service areas as well as to special or patient care departments. Examples of these are: housekeeping, laundry, dietary, operation of plant and maintenance of plant. Costs incurred for these cost centers are allocated to other cost centers on the basis of services rendered.

See CMS Pub. 15-1 § 2302.9.

At the hearing the Provider's witness testified that the costs did benefit the entire institution.[16] The Intermediary offered no evidence to contradict his testimony.

CMS Pub. 15-1 § 2302.8 also defines a cost center as an "organizational unit, generally a unit or subunit, having a common functional purpose for which direct and indirect costs are accumulated, allocated and apportioned." The cost centers that CMS has created are on Lines 1-28 of Worksheet A of the cost report. The only two places on the cost report where the coordinator costs could possibly go are on Line 6, the A & G cost center, or in a cost center created by the Intermediary somewhere below Line 6. The Intermediary, through its adjustment, has improperly fragmented a unified cost center by splitting it between A & G costs, and a non-reimbursable cost center.

The Intermediary also raises the argument that its adjustment/reclassification must be done this way in order to avoid an overstatement of Medicare reimbursement. There is no evidence in the

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[16] Tr. at 30-38.

record, however, that the costs in question receive services from other parts of the A & G cost center.

In implementing the step-down method for this cost report, CMS did not define multiple cost centers for A & G costs; it created only one. It did not create a cost report where one starts with the salary of the Chief Executive Officer and allocates that salary to all directly subordinate positions, and then to the next level, and so on. Rather, implicit in CMS' design of the cost report is that these costs are to be considered together, since to try to delineate the various reporting arrangements would create a cumbersome and unworkable cost report. Clearly, under the cost report instructions and cost report structure, CMS did not intend or provide for the type of adjustment that the Intermediary made here.

For the reasons set forth in its position paper, the Provider requests that the Intermediary's reclassification be reversed.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its reclassification of salaries and benefits associated with unallowable marketing, patient solicitation, and other activities intended to maintain and expand the Provider's market share to a non-reimbursable cost center complies with applicable provisions of the Medicare statute, implementing regulations, CMS Pub 15-1, and is supported by various decisions reached by both the Board and the CMS Administrator.[17]

The Intermediary asserts that the establishment of a non-reimbursable cost center is not restricted to direct service costs, but may be created to ensure that all direct and indirect costs associated with unallowable/non-reimbursable activities that can be effectively distinguished from other parts of a provider's operation are properly accounted for and that Medicare does not pay for overhead costs related to non-allowable activities. The Intermediary maintains that the marketing personnel and community service associates used direct and indirect services from the Provider's general service cost centers while performing non-allowable activities.[18] The Intermediary contends that if the costs associated with the unallowable activities were

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[17] See IPP at 7, 10-12; ISSP at 5.

[18] See IPP, Exhibits 1-14.

maintained in the A & G cost center, they would also be allocated to the ancillary cost centers and overstate the Provider's proper Medicare reimbursement.[19]

[19] See Tr. at 126 and 130.

According to the Intermediary, the Provider has offered only rhetorical statements, but no documentary evidence, to substantiate its assertion that the non-allowable activities benefitted all of the direct care operations of the Provider. However, even if the Provider's statements are true, the Provider failed to maintain adequate documentation that would have enabled direct assignment of costs to the non-reimbursable parts of the Provider's operation. Moreover, from a Medicare reimbursement perspective, it is immaterial whether an unallowable activity "benefitted" a reimbursable activity. Indeed, the stance taken by the Provider on this point is a tautological challenge. Thus the Intermediary appropriately treated the costs in question when it established the Non-Reimbursable Cost Center.[20]

The Intermediary argues that an offset on the "Adjustment to Expenses" Worksheet A-5 is not the appropriate vehicle for treating the costs at issue. Worksheet A-5 adjustments involve non-allowable costs to which general service costs are non-applicable. The nature, scope and extent of the Provider's unallowable activities were substantial and clearly drew a material amount of overhead from the general service cost center.[21]

The Intermediary asserts that it has offered a fair and reasonable resolution to resolve the dispute in this case, especially in view of the substandard state of the Provider's documentation.[22] The Intermediary requests that the Board find that its proposed resolution, with its use of a non-reimbursable cost center for unallowable costs, be found proper.

CITATIONS OF LAWS, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§ 405.1835 -.1841	-	Board Jurisdiction
§ 413.24(d) et seq.	-	Cost Finding Methods

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

§ 2302.8	-	Cost Center
§ 2302.9	-	General Services Cost Centers
§ 2306.1	-	Step-Down Method
§ 2328	-	Distribution of General Service

[20] See Tr. at 131-32.

[21] See Tr. at 50, 63, 66, and 125.

[22] See ISSP at 4-5; Tr. at 122-29.

Costs to Non-allowable Cost Areas

3. Program Instructions - Provider Reimbursement Manual, Part I (CMS Pub. 15-2):

§ 3200 et seq. - Home Health Agency Cost Reporting Instructions

4. Other:

Paperwork Reduction Act of 1995, 44 U.S.C. §§ 3501-3520 and associated regulations at 5 C.F.R. Part 1320.

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:

The Board notes that the Intermediary initially denied all costs associated with the Director of Development, the Community Service Coordinator and the Community Service Associates because their activities included unallowable activities and there was insufficient documentation to determine the amount of any allowable activities. Prior to the hearing, the Provider provided additional documentation. The Intermediary reviewed the documentation and agreed to modify its adjustment to reimburse a portion of the time for the Community Service Associates related to their allowable educational activities. Even with the modification, the Intermediary adjustment still disallows the entire costs of the Director of Development and the Community Service Coordinator and a majority of the costs of the Community Service Associates. In all, the Intermediary disallowed approximately 70 percent of the total costs for the activities of these employees. The Board notes that the Provider accepted the Intermediary's determination concerning allowability of costs and only argued that it was not appropriate to create a non-reimbursable cost center for the non-allowable costs.

The Board finds that it is appropriate to create a non-reimbursable cost center when there is a measurable amount of employee time and/or physical space dedicated to a specific non-reimbursable activity or function. The Board notes that CMS Pub. 15-1 § 2302.8 defines a cost center as "an organizational unit, generally a department or its subunit, having a common functional purpose for which direct and indirect costs are accumulated, allocated and apportioned." The Board finds that the non-reimbursable activities of marketing, fundraising and grant writing properly fit within the definition of a separate cost center. The Board also notes that CMS Pub. 15-1 § 2328 provides that "[n]on-allowable cost centers to which general services costs apply should be entered on the cost allocation worksheets after all the General Services Cost Centers. General service costs would then be distributed to non-allowable cost centers in the routine 'step-down' process." The Board notes that this cost distribution helps ensure that all direct and indirect costs are accounted for in each cost center and that the Medicare program pays only its share of these costs.

The Provider argues that the non-allowable activites in this case are A & G costs that benefit the entire organization. The Provider asserts that it is inappropriate to assign these costs to a non-allowable cost center and then step-down A & G costs to them. Rather the costs should be disallowed by a Worksheet A-5 adjustment without the assignment of overhead from the general service cost center. The Board disagrees. The Board not only finds that the direct costs of employees engaged in marketing, fundraising and grant writing are unallowable but that these activities consumed direct and indirect services from the Provider's general cost center. CMS Pub. 15-1 § 2328 provides for creation of non-allowable cost centers and the assignment of overhead to them.

DECISION AND ORDER:

The Intermediary's adjustment reclassifying salaries and benefits attributable to the unallowable activities from the A & G cost center to a non-reimbursable cost center was proper. The Intermediary's adjustments are affirmed.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esquire
Stanley J. Sokolove
Dr. Gary Blodgett
Suzanne Cochran, Esquire

Date of Decision: April 17, 2002

FOR THE BOARD:

Irvin W. Kues
Chairman