PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

98-D7

PROVIDER -Girling Health Care, Inc. -
New York Subunit
New York, New York

Provider No. 33-7243

vs.

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

DATE OF HEARING-
September 18, 1996

Cost Reporting Period Ended -
July 31, 1990

CASE NO. 94-3386

INDEX

ISSUE:

Was the Intermediary's adjustment reversing the direct assignment of the New York sub-unit costs proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Girling Health Care Inc. ("GHC") is the home office of a chain organization which operates thirteen home health agencies ("HHAs") located in five states. GHC is located in Austin, Texas. GHC's New York Subunit ("Provider") is a freestanding HHA located in New York, New York, and is operated by GHC. The Provider is owned by Girling Health Care Affiliates which is comprised of GHC, Girling Health Care Services, Inc., Girling Health Systems, Inc. and Girling Medical Equipment and Supply, Inc. These entities are controlled by common stockholders and share common management. All of GHC's providers are Medicare-certified and provide intermittent care to patients. Many of the HHAs also provide non-reimbursable services, including primary home care, private pay, family care (Texas HHAs), expedited hospital discharge ("Bridge Program"-New York Provider), and respite care. Since the state of Texas requires that a primary home care program be part of a Medicare-certified HHA, a provider cannot operate as a separate administrative body. The Bridge Program is a city of New York Medicaid program that provides skilled nursing and home maker services to Medicaid beneficiaries.[1]

Since 1983, Blue Cross and Blue Shield of Iowa ("Intermediary") has served as the Medicare fiscal intermediary for GHC and its thirteen providers. It issued a Notice of Program Reimbursement ("NPR") for the fiscal year ended July 31, 1990 ("FY 90") for GHC providers on March 31, 1994.[2] As a result of administrative resolutions between GHC, the Intermediary, and Blue Cross and Blue Shield Association, the Intermediary reopened the FY 90 cost reports to reflect those resolutions and issued a revised NPRs on July 21, 1995.[3] The Intermediary disallowed GHC's direct cost distribution to the New York Provider. This resulted in a reduction in Medicare reimbursement of approximately $270,000. GHC is represented by George H. David, Esquire. The Intermediary is represented by James R. Grimes, Esquire, of Blue Cross and Blue Shield Association.

GHC has two nonreimbursable programs at the New York agency - the Bridge Program and Private Pay. In its as-filed Medicare cost report, GHC excluded the costs of these non-reimbursable programs. It directly assigned administrative costs for these programs off of the Medicare cost report through the general ledger and through a Worksheet A-5 adjustment of

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1 See Intermediary Exhibit No. 13 for a detailed description.

2 See Intermediary Exhibit No. 2.

3 See Intermediary Exhibit No. 3.

the Medicare cost reporting forms. It directly assigned 100 percent of administrative and general ("A&G") costs between the reimbursable and non-reimbursable programs. Thus, the as-filed Medicare cost report contained only A&G cost directly assigned to the Provider.

The Intermediary reviewed the allocations of cost directly assigned to reimbursable and non-reimbursable activities at the New York agency level and determined that some of the allocations did not comply with the Medicare program instructions and regulations. It reclassified the following costs to the residual A&G expense pool to be allocated under Medicare's standard cost finding process:

	Reclassification to Residual
Miscellaneous adjustment	($ 21,323)
Direct allocations of reimbursable activity	826,522
Direct allocations of nonreimbursable activity:	
Bridge Program	209,946
Private Pay	66,164
Total reclassified to residual	$1,081,309[4]

In April 1987, GHC requested approval from Blue Cross and Blue Shield of Iowa to use the direct assignment of cost methodology as an alternative to cost finding.[5] GHC's first request for direct assignment was denied in a June 5, 1987 letter from the Intermediary.[6] The letter outlined elements of GHC's proposed direct assignment methodology that would have to be modified in order to approve the request.

In a June 30, 1987 letter to the Intermediary,[7] GHC offered revisions to the proposed direct assignment methodology based on the recommendations made in the Intermediary's June 5, 1987 letter. On July 16, 1987, the Intermediary granted tentative approval (subject to audit) of the direct assignment of cost applicable to the July 31, 1988 fiscal year end. The approval was tentative since GHC's cost assignment methodology was based on unaudited theoretical information provided by GHC. The direct assignment request/approval did not specifically address the New York agency as it was not Medicare-certified until January 7, 1988. GHC did not consult with the Intermediary for guidance with direct assignment when GHC started the Bridge Program in New York.

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4 See Provider Exhibit No. 63.

5 See Intermediary No. Exhibit 4.

6 See Intermediary No. Exhibit 5.

7 See Intermediary No. Exhibit 6.

Prior to the FY 90 audit, GHC had presented information indicating that the Medicare operations and other business operations of GHC were separate and distinct in regard not only to patient care, but also to related support activities (administrative and general services, space costs, etc.). In an August 29, 1986 letter to Blue Cross and Blue Shield of Iowa,[8] GHC indicated that the business operations of the company operated as distinct, separate entities and that employees and facilities were not shared among operations. This assertion continued during 1988 and subsequent audits. The Intermediary relied upon the representations of GHC management that the application of direct assignment methodologies would result in an immaterial allocation of residual administrative and general costs.

In July 1990, during the review of GHC's Medicare home office cost statement for the 12 months ending July 31, 1989 ("FY 89"), the Intermediary discovered that separation of administrative staff between GHC's Medicare operations and its other business operations was not at the level GHC had represented. Until this audit of the FY 89 Medicare home office cost statement, the application of GHC's direct assignment methodology was not challenged because GHC senior management led the Intermediary to believe that their Medicare and other business operations were staffed separately, and that separate administrative and supervisory staff positions existed for each business operation. The Intermediary examined information that led them to believe that a significant amount of commingling staff and resources did occur among all operating divisions within the GHC organization.

The examination of GHC's continuous time reports ("CTRs") and other supporting documentation indicated that there were inconsistencies, i.e., certain costs related to all of the programs rather than just the home health program. Examination of this information suggested that GHC was not applying direct assignment methodologies consistent with those approved by the Intermediary effective August 1, 1987. GHC submitted a worksheet A-5 offset on the Provider's cost report to directly assign shared non-salary costs to the Bridge Program. During the audit of the New York FY 90 Medicare cost report, the Provider indicated that the Provider agency had problems with direct assignment, and that it would be necessary to collapse non-salary costs.

PROVIDER'S CONTENTIONS:

The Provider contends that, just as in the case of the Provider's home office salary and non-salary cost, and as in the case of the Provider's agency salary cost, the Intermediary has no basis to disallow $270,279 of the Provider's reimbursable cost by reclassifying legitimately directly assigned agency level administrative salary expense to the residual expense pool. The Intermediary audited the FY 89 and FY 90 cost reports as one combined two year audit. To be consistent with the ultimate results of this audit, since the Intermediary reversed its reclassification of home office and agency provider salary level expense (except for New York), the Intermediary should have reversed its reclassification of New York agency

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[8] See Intermediary No. Exhibit 9.

Provider administrative salary expense to residual for FY 90.[9] The Provider's direct assignment methodology at the agency provider level was applied to all agency providers, including New York, as one contiguous direct assignment system. Since almost all component agency provider portions of the system were considered acceptable, the New York agency provider direct assignment should also have been considered acceptable because New York is an integral part of the Provider's direct assignment system.

The Provider contends that it has complied fully with the requirements of Provider Reimbursement Manual, HCFA Pub. 15-1 ("HCFA Pub. 15-1") § 2307.[10] This Manual requirement does not require 100 percent accuracy and perfection in the assignment of costs, but rather that all costs that can be directly allocated must be assigned.[11] The Provider followed the approved direct assignment methodology for salary expense at its New York agency provider by directly assigning salary cost based on time spent, as documented by CTRs.[12] Once the Intermediary approved the Provider's direct assignment methodology, the Provider was required to continue doing direct assignment until the Intermediary's approval was either withdrawn or modified.[13]

The Provider contends that implementation of its approved direct assignment methodology for the New York agency Provider under HCFA Pub. 15-1, § 2307 was far more accurate than the Intermediary's reclassification of expenses to residual with resultant step-down allocation under HCFA Pub. 15-1, § 2308.[14] Thus, application of the Provider's direct assignment methodology at the New York agency Provider complies with the Medicare statute and with 42 C.F.R. §§ 413.5, 413.9, 413.20 and 413.24 regulatory provisions which advocate accuracy and proper costing.

The Provider contends that it had effective systems in place to insure that the New York agency Provider administrative salary expense would be properly directly assigned.[15] The Intermediary did not examine the Provider's internal control system, and consequently, did

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9 Transcript ("Tr.") at 16, 95-96.

10 Tr. at 189-190.

11 Id.

12 Tr. at 117-119.

13 Tr. pg. 97-98.

14 Tr. at 114.

15 Tr. at 115-116, 117-119.

not know the extent of the direct assignment safeguards employed by the Provider.[16] Further, the Provider's general ledger, supporting CTRs, and other documentation requested by the Intermediary were available and provided to the Intermediary. They were in sufficient detail to be auditable and verifiable, and accordingly, complied with the requirements of 42 C.F.R. § 413.20 and § 413.24.

The Provider contends that the Intermediary approached the audit incorrectly from the beginning because an on-site audit of the New York agency Provider location was not conducted.[17] The Intermediary's witness stated that it conducted the audit in Austin, Texas since all of the Provider's records were in Austin.[18] Nevertheless, the Intermediary's numerous misunderstandings may have been easily explained by an on-site visit to the New York agency Provider location. An on-site visit is a standard part of generally accepted auditing practices, especially when such a large adjustment ($1,081,309) is being considered. Specifically, the Intermediary did not understand that the supervisory visits for the custodial Bridge Program patients were treated as Medicaid visits on Worksheet C of the Medicare cost report, and accordingly, were paid for by Medicaid, not Medicare.[19]

The Provider notes that based on the Intermediary's senior auditor's testimony, the Intermediary did not examine even a single FY 90 CTR as a basis for the reclassification of all administrative salaries to residual.[20] It used only FY 89 audit data and results. Governmental Auditing Standards as well as the Medicare Part A Intermediary Manual require separate audit evidence each year per provider in order to adequately support Intermediary adjustments. The Intermediary admitted that it was customary to do separate audits of home offices and agency provider level cost reports but decided not to do so in this case.[21]

The Provider argues that even though the clinical distinctions between intermittent home health and the Bridge Program were explained to the Intermediary auditors, the Intermediary did not understand the differences between the programs in New York. Because of this lack of understanding, the Intermediary expected the ratios of administrative expense to total expense in all programs to be approximately the same. When that did not occur, it decided to

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16 Tr. pg. 159.

17 Tr. at 152.

18 Tr. at 205.

19 Tr. at 160-161.

20 Tr. at 179-180, 181, 182.

21 Tr. at 181-182.

reclassify all New York agency Provider administrative salary expense to residual. The Intermediary did not take into consideration the small number of Bridge Program custodial care patients (ranged from 5 to 17 patients) when evaluating the reasonableness of that program's administrative cost as compared to the home health intermittent care administrative cost (ranged from 60 to 65 patients).[22]

The Provider argues that as a result of the Intermediary's lack of understanding of the duties of the various administrative personnel who ran the Bridge Program custodial care program, the Intermediary considered the CTR designated salary classifications to be erroneous when, in fact, these New York agency administrative salary costs were properly classified. A significant part of the Intermediary's misunderstanding was that it considered Medicaid supervisory nursing visits on the Bridge Program custodial patients to be residual administrative cost.[23] In fact, supervisory nursing visits on the Bridge Program custodial patients are considered by Medicaid as part of direct costs, separately billable to Medicaid, and included in the total visit count on Worksheet C of the Medicare cost report.[24] The Medicaid supervisory nursing visits to the Bridge Program custodial patients were apportioned away from the Medicare program based on the ratio of Medicaid visits to total visits on Worksheet C. Thus, Medicare did not pay for the cost of Medicaid supervisory nursing visits on the Bridge Program custodial patients.[25]

The Provider notes that the Intermediary also erroneously found large gaps of time without scheduling, coordination and clerical support for the Bridge Program custodial care program.[26] Uncontroverted testimony at the hearing established that scheduling, coordination, and clerical support were provided consistently throughout FY 90.[27] The Intermediary mistakenly concluded that administrative overhead time for the Bridge Program patients was charged to the Medicare program on the Medicare cost report. Uncontroverted testimony at the hearing established that overhead costs such as training for the Bridge Program custodial care providers were treated as home health costs and were apportioned away from the Medicare program on Worksheet C of the Medicare cost report based on the ratio of Medicaid visits to total visits.

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22 Tr. at 47-48.

23 Tr. at 165.

24 Tr. at 240-241.

25 Tr. at 165-167, 240-241.

26 Tr. at 95.

27 Tr. at 48-56, 184-186.

The Provider contends that the Intermediary performed such an inadequate audit that the Intermediary's audit results do not support its 100 percent reclassification of New York agency provider administrative salary expense to residual.[28] Mr. Lance Loria, an Ernst & Young partner and an acknowledged expert by the Board,[29] reviewed the Intermediary's audit workpapers in detail and considered them insufficient to support the Intermediary's $1,081,309 New York administrative salary expense reclassification to residual.[30] He examined the 16 CTRs for FY 89 which were part of the Intermediary's 516 CTR "acceptance" sample and concluded that the New York FY 89 CTRs did not contain any "actual" errors and only 12 potential errors based on misunderstandings by the Intermediary. The "actual"error rate in the New York "acceptance" sample was 0. The "potential" error rate in the New York "acceptance" sample was 4.0%, (12 "potential" error time dots out of a universe of 301 time dots on 16 CTRs for FY 89). This was well within the "tolerable error rate" of 4.38%. Accordingly, the New York acceptance sample was appropriate, and a New York administrative salary expense reclassification adjustment could not be based on the "acceptance" sample results.[31]

The Provider notes that the financial statement effect of these adjustments for the New York provider was devastating to the Bridge Program as follows:

	EHD FINANCIAL (AS SUBMITTED)	EHD FINANCIAL (PER NPR)
Revenues	$961,502	$961,502
Total Expenses	(747,054)	(1,219,268)
Net Profit/(Loss)	$214,448	$ (257,766)

The Provider clearly depicts the punitive impact of the Intermediary's arbitrary collapse of administrative salary, benefits and occupance costs to residual. The Provider cannot continue in business with losses of this magnitude if not reversed by the Board. Further, it notes that the effects of the Intermediary's adjustments resulted in a 27% loss in the EHD program, which cannot be recouped from the State of New York. GHC would not have entered into the Bridge Program contract if it had known that the Intermediary intended to collapse all New York agency Provider administrative salary, benefits, and occupancy costs to residual.

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28 Tr. at 115, 123.

29 Tr. at 219-221.

30 Tr. at 230-240.

31 Tr. at 225-228.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that providers participating in the Program are to be reimbursed the reasonable costs actually incurred in the provision of patient care services to Medicare beneficiaries per 42 C.F.R. § 413.9. Costs actually incurred are determined under 42 C.F.R. § 413.24 which sets out the requirements of adequate cost finding and establishes the step-down method of cost finding. Finally, HCFA Pub. 15-1 § 2307 permits an alternative method of direct assignment of general service cost centers based upon actual usage. The Provider did not meet the requirements of the above regulations and Manual section in that it could not demonstrate that its method of direct costing was based on actual usage.

The Intermediary contends that the Provider had never adequately established a system by which it could direct cost the Bridge Program. The Provider did not disclose the existence of the Bridge Program until after filing its cost report for FY 88. It then requested the Intermediary to adjust that cost report to include cost and to allocate it by the step-down method. The Provider then filed its FY 89 cost report, including the Bridge Program, and again allocated costs through normal step-down cost finding. Later the Provider resubmitted its cost report with a direct assignment of administrative salary cost, allocating the non-salary administrative costs through step-down. In the Intermediary's view, the Provider was clearly having trouble direct costing the Bridge Program and merely tried to recast its cost records after the fact. The Intermediary's auditor testified that the FY 89 audit first uncovered the problem because the Provider had originally classified administrative salary costs to the Bridge Program in its books. It later reclassified the costs to the home health agency in order to reverse the payroll allocations to the Bridge Program for all the non-direct personnel because this program was considered non-reimbursable.[32]

The Intermediary observes that the evidence clearly established that the Provider had never captured the actual cost of the Bridge Program. For example, supervision of the Bridge Program home health aids was billed out of the home health agency as a skilled service.[33] While they were billed to Medicaid, they were not included in the Bridge Program but in the home health program. Further, the Provider claimed that the administrative or supervision cost of the Bridge Program was included in the supervisory visit cost. That cost, however, was not shown in the Bridge Program costs, thus resulting in a mismatching of costs to the program. Further, there was additional supervision on the part of the program director of the agency as well as other administrative personnel that would not be included in the supervisory visit charge to Medicaid. The costs of administrative personnel should have been allocated to the Bridge Program since it received a benefit. However, under the Provider's direct costing, no such allocation was made.

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[32] Tr. at 195.

[33] Tr. at 41-42.

The Intermediary notes that the Director of Patient Care was director of all programs at the New York agency. The director supervised registered nurses ("RNs") who would charge time to both programs. Yet, the Director of Patient Care did not charge time to the Bridge Program.[34] While RNs were shared between programs, all orientation time or training for them was assumed to be home health, and therefore, no allocation for such training was made to the Bridge Program. Certainly, the RNs were benefitting from the training in that their understanding of new techniques and new business practices in the field would enhance their abilities and benefit all patients in any program. Further, during the start up period of the program and during the period when patients were in the Bridge Program from July 1 to December 31, 1989, there were no administrative salaries assigned to that program.[35]

The Intermediary believes the findings of the CTR analysis are seriously flawed. The analysis assumed that employees were 100% home health employees. If that assumption was wrong, then many conclusions drawn from the review of the employees' time entries might also be incorrect. An example was review of the time entries in connection with Linda Blank.[36] Ms. Blank was Patient Director, a position responsible for both home health and the Bridge Program. The study assumed that Ms. Blank's time was 100% home health. Time entries relating to general administration of the office, including her own workplans and employee matters, were assigned 100% to home health. As Director of the Bridge Program during the initial stages of implementation, it would seem unlikely that the Director's workplans and administration of the office would not include time spent on the Bridge Program or benefit that program. The fact that no time was assigned to the Bridge Program clearly indicates a failure in the timekeeping system. Further, during periods when the Bridge Program was in operation, the CTRs did not include a place to record time to the Bridge Program. As a result, an administrative employee might not have realized that general administrative duties should be assigned in such a way that the cost would be allocated to multiple programs. While the Provider contended the Bridge Program was not in operation during FY 88, it was generating revenue which would indicate patients were receiving benefits during the time period.

The Intermediary contends that there were multiple examples of shared employees who did not allocate time to residual when it would seem more than obvious that some time would benefit all programs. In other cases, no time was allocated to the Bridge Program under the Provider's CTR method. These facts indicate that the Provider's direct costing method was not adequate under HCFA Pub. 15-1 § 2307 because it did not allocate costs based on actual usage. Therefore, the Intermediary was correct in reclassifying the Provider directly assigned costs to residual and to allocate all administrative salary cost through the normal step-down cost finding method.

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34 Tr. at 202.

35 Tr. at 199.

36 See Provider Exhibit No. 78.

The Intermediary notes that an analysis of elements of GHC's administrative costs suggests that an inordinate amount of costs were being allocated to the company's Medicare operations. GHC is applying a strategy intended to fund fixed administrative overhead costs through reimbursement from the Medicare program. The schedule below shows the ratio of administrative costs to direct patient care costs to be equally excessive within GHC's own home health care operations. It shows that the ratio of administrative costs to direct patient care costs for GHC's non-Medicare operations at New York averages 49 percent, compared to 117 percent for the Medicare operations.

Girling Health Care, Inc. - New York
Analysis of Costs by Line of Business
12 Months Ending July 31, 1990

Line of Business	Direct Patient Care Costs	Adminstrative Costs	Administrative Costs as a Percentage of Direct Costs
Medicare Home Health	$ 570,628	$668,745	117%
Bridge Program	513,272	209,947	41%
Private Pay	45,554	66,164	145%
Total Per Internal Profit and Loss Statements	$1,129,454	$944,856	84%

Source: Girling Health Care, Inc., Internal Profit and Loss Statements

The Intermediary recognizes that participation in the Medicare program imposes a greater administrative burden than participation in other third party payor programs. However, it appears unreasonable that GHC's Medicare operation at New York accounts for 54 percent of total revenues while 71 percent of total administrative and general expenses are assigned to the division. The New York nonreimbursable entities (Bridge Program and Private Pay), which represent 46 percent of total revenues, account for only 29 percent of total administrative and general expenses. An analysis of sources of revenue for GHC's business operations compared to the allocation of administrative and general expenses to its business operations is illustrated below.

Girling Health Care, Inc. - New York
12 Months Ending July 31, 1990
Analysis of Revenues and Administrative and General Expenses

Operating Division	Revenues	Percent	Expenses	Percent
Home Health Division	$1,206,253	54%	$668,745	71%
Bridge Program	961,502	43%	209,947	22%
Private Pay Division	69,840	3%	66,164	7%
Total	$2,237,595	100%	$944,856	100%

Source: Girling Health Care, Inc., General Ledger Reports

CITATIONS OF LAWS, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§ 1395x(v)(1)(A)	-	Reasonable Cost

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

§ 413.5	-	Cost Reimbursement: General
§ 413.9	-	Costs Related to Patient Care
§ 413.20	-	Financial Data and Records
§ 413.24	-	Adequate Cost Data and Cost Finding

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

§ 2307	-	Direct Assignment of General Service Costs
§ 2308	-	Cost Finding Methods - Home Health Agencies

4. Cases:

Girling Health Care, Inc. v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Iowa, PRRB Dec. No. 97-D96, September 10, 1997.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the facts, parties' contentions, documentary evidence, and post-hearing briefs, finds and concludes that the Intermediary improperly reclassified the directly assigned GHC/Provider overhead costs to a residual cost pool. The Board's review of the record disclosed that the Intermediary made its adjustments on superficial grounds which resulted in its arbitrary decision to reclassify the Provider's directly assigned costs. In fact, the record shows that no audit was actually made at the New York Provider even though over $1 million in adjustments were made by the Intermediary, and that information regarding all aspects of the New York operation were available for review. Further, the Board notes that the Intermediary had originally granted approval of the GHC organizations' direct costing method for twelve of thirteen providers in the chain. That decision was changed in part due to the Intermediary's reopening of the Providers' home office cost report. The Board has reviewed that decision in Girling Health Care, Inc. v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Iowa, PRRB Dec. No. 97-D96, September 10, 1997, and has affirmed the Providers' cost finding method.

The Board finds that the CTRs used by the Provider to directly assign overhead costs at the Provider were acceptable. The Board found the independent CPA's audit of the CTRs, including recognized sampling techniques to be persuasive. That audit disclosed an actual error rate of 0% and the potential error rate of the "acceptable" sample of 4%. The Board finds these error rates reasonable, and thus, strong supports accepting the CTRs as the basis for directly assigning the Provider's overhead costs. Moreover, several audit concerns, such as the allocation of certain individual's times, were adequately responded to in testimony offered at the hearing. In summary, the Board finds the Intermediary's reallocation of overhead costs to a residual cost pool unreasonable and not supported by the facts in this case and statistical records available at the Provider.

DECISION AND ORDER:

The Intermediary improperly reclassified the Provider's directly assigned overhead costs to a residual cost pool. The Intermediary's adjustment is reversed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Teresa B. Devine
Henry C. Wessman, Esquire

FOR THE BOARD:

Irvin W. Kues
Chairman