This Provider disputes the audit adjustment removing the statistics from the Organ Acquisition cost centers on Worksheet B-1. The overarching principle that governs reimbursement for organ acquisition costs is set forth at 42 U.S.C. 1395x(v)(1)(a), which states that hospitals are to be reimbursed under a reasonable cost methodology that “take[s] into account both direct and indirect costs of providers of services . . . in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs.” Although plant, property, and equipment indisputably qualify as indirect, but necessary, costs for the delivery of care, the MAC’s adjustments result in a lack of any allocation of these costs to the organ acquisition cost centers. Medicare thus is not bearing its fair share of the Provider’s organ acquisition costs, in violation of the statute.

The MAC’s workpapers cite as the basis for the adjustment that the direct costing provisions of Section 2307 of the Provider Reimbursement Manual, Part I have not been followed. However, the requirements pertaining to direct assignment of costs are inapplicable to the costs at issue. That same Manual section also states: “Indirectly allocable supervision costs, other indirectly allocable costs (hereinafter, residual costs) and costs allocated from previously allocated general service cost centers (hereinafter, overhead costs) must not be directly assigned to the using cost centers, but must be allocated through cost finding.” The Provider did not improperly attempt to use a direct cost assignment. Rather it properly used a cost finding methodology, as required by the Manual. This involved the use of square feet as a statistical surrogate, as required by Section 2302.4 of the Manual. The Provider thus followed the correct process for allocating costs that, by statute, it was entitled to claim. The MAC’s adjustments, which remove these costs in their entirety, must be reversed.

Did the MAC properly determine the Provider’s organ acquisition costs? Section 1861(v)(1)(A) of the Social Security Act, 42 C.F.R. § 413.24(d)(1) (adjustment 3)

1. **Facts**

The Provider is a tertiary-care, academic medical center in Nashville, Tennessee. In 2015, the Provider states they excised and transplanted 680 organs, comprised of kidney, heart, liver, lung and pancreas transplants. This Provider is a Medicare Certified Transplant Center which allows them to file for costs to be covered by Medicare for providing these services. In the Provider’s paper, the Provider explains in detail its methodology to “create” statistics to allocate certain overhead costs for services to pre-transplant patients. These costs include Building and Fixtures, Major Moveable Equipment and Maintenance and Repair costs related to the organ acquisition cost centers reported on the cost report. Since the organ acquisition cost centers have no dedicated space or equipment to allocate these costs through the normal statistical allocation on Worksheet B-1, the Provider used employee surveys to estimate the percentage of time spent on pre-transplant activities versus post-transplant activities and applied the pre-transplant percentage to the total square footage of identified areas involved in services to pre-transplant patients. The calculated pre-transplant square footage was then allocated to each organ acquisition cost center based on the ratio of usable organs to total usable organs for all organ acquisition cost centers. The calculated square footage for each organ acquisition cost center was included in B-1 statistics for the allocation of Buildings and Fixtures, Major Movable Equipment, and Maintenance and Repair costs. The Provider’s appeal is based on the claim that the MAC erroneously disallowed these costs the Provider determined as appropriate overhead costs related to pre-transplant care of transplant candidates for the cost report period ending June 30, 2015.

1. **Argument**
2. **The MAC Properly Adjusted General Service Costs Allocated by the Provider for Pre-Transplant Care.**

During the audit and reopening of the cost report ending June 30, 2015, the MAC determined that the Provider “created” a statistical basis of square footage to allocate Buildings and Fixtures, Major Movable Equipment, and Maintenance and Repair costs to organ acquisition cost centers (heart, liver and lung) scoped for review. Since the organ acquisition cost centers do not hold dedicated space and equipment to support a statistical basis for allocation of these costs, the MAC proposed an adjustment to remove the “created” statistic. (*See* **Exhibit C-3**.) The Provider applied the same methodology to kidney and pancreas organ acquisition cost centers for the same cost report period, though these were not scoped for review. The Provider describes in its preliminary paper, the methodology for “creating” the statistic.

The methodology was comprised of several steps. The first step was to identify the areas of the Provider that are involved in services to pre-transplant patients. These areas include the “Transplant/General Surgery Unit,” the “Transplant Center Admin,” and the “Transplant Center.” The total square footage of these areas was then compiled. To ensure that only pre-transplant activities are included in the Organ Acquisition Cost cost centers, employee surveys were used to determine the percentage of time spent on pre-transplant activities, versus post-transplant activities. The percentage of time dedicated to pre-transplant activities was then multiplied by the total square footage to develop a total square footage allocable to pre-transplant activities. Finally, the square footage was allocated to each of the respective organ acquisition cost, based on the ratio of each such Organ Acquisition Cost cost center’s usable organs, to total usable organs across all such cost centers. The resulting square footage statistics were included with each of the Organ Acquisition Cost cost center lines on Worksheet B-1 for the allocation of Building & Fixtures, Major Moveable Equipment, and Maintenance & Repair costs.

CMS provides instruction to Providers to properly complete the Medicare Cost Report through The Provider Reimbursement Manuals (PRMs). MACs are bound to follow the instructions and guidance in these manuals while reviewing, auditing and settling the cost reports.

CMS Publication 15-1, The PRM-Part 1 (**Exhibit C-4**), includes the following definitions and principles for Providers (emphasis added):

2302.4 Allocable Costs.--An 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)*.

2302.7 Cost Finding.--A determination of the cost of services by the use of informal procedures, i.e., without employing the regular processes of cost accounting on a continuous or formal basis. It is the *determination of the cost of an operation by the assignment of direct costs and the allocation of indirect costs*.

2302.9 General Service Cost Centers.--Those 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.*

2304. ADEQUACY OF COST INFORMATION

Cost information as developed by the provider must be current, accurate, and in sufficient detail to support payments made for services rendered to beneficiaries. This includes all ledgers, books, records and original evidences of cost (purchase requisitions, purchase orders, vouchers, requisitions for materials, inventories, labor time cards, payrolls, bases for apportioning costs, etc.), which pertain to the determination of reasonable cost, *capable of being audited*.

Financial and statistical records should be maintained in a consistent manner from one period to another. However, a proper regard for consistency need not preclude a desirable change in accounting procedures, provided that full disclosure of significant change is made to the intermediary.

2306. COST FINDING METHODS

Departments within a provider are usually divided into two types:

1) Those that produce patient care revenue (e.g., routine services, radiology), and 2) Those that do not directly generate patient care revenue but are utilized as a service by other departments (e.g., laundry and linen, dietary). The two types of departments are commonly referred to as "revenue-producing cost centers" and "nonrevenue-producing cost centers," respectively.

Although nonrevenue-producing cost centers do not directly produce patient care revenue, they contribute indirectly to patient care revenue generated by "serving" as a service to the revenue producing centers and also to other nonrevenue-producing centers. Therefore, for the purpose of proper matching of revenue and expenses, the cost of the revenue-producing centers should include both its direct expenses and its proportionate share of the costs of each nonrevenue-producing center (indirect costs) based on the amount of services received. *The process of allocating the cost of a particular nonrevenue-producing center to other nonrevenue-producing centers and revenue producing centers is performed by utilizing a set of statistics* (e.g., pounds of laundry for allocating "laundry and linen" costs, square feet for allocating "depreciation building" costs).

Every nonrevenue-producing cost center has the potential of being allocated to every other nonrevenue-producing cost center in addition to the revenue-producing cost centers. This precludes a simple allocation of the direct expense of the nonrevenue-producing cost center because *the indirect costs derived from allocation of other nonrevenue-producing cost centers must be computed in determining the "full cost" (direct and indirect costs) of the nonrevenue-producing cost center being allocated.* All cost finding methods employ this computation in determining the full costs of departments.

2306.1 Step-Down Method.--This method recognizes that services rendered by certain nonrevenue-producing departments or centers are utilized by certain other nonrevenue-producing centers, as well as by the revenue-producing centers. *All costs of nonrevenue-producing centers are allocated to all centers which they serve, regardless of whether these centers produce revenue.* The cost of the nonrevenue-producing center serving the greatest number of other centers is allocated first. Following the allocation of the cost of the nonrevenue-producing center, that center will be considered "closed" and no further costs are allocated to that center. This applies even though it may have received some services from a center whose cost is allocated 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.

Section 2306 describes additional cost finding methods which are generally more complicated than the Step-Down Method.

2307. DIRECT ASSIGNMENT OF GENERAL SERVICE COSTS

The costs of a general service cost center need to be allocated to the cost centers receiving services 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 as described below 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.

A. Direct Assignment of Cost.—Direct assignment of cost is the process of assigning directly allocable costs of a general service cost center (see §2302.9) to all cost centers receiving service from that cost center *based upon actual auditable usage*. Hours worked by hourly wage or metered utility consumption are examples of measures of actual usage. *Estimates, including a statistical surrogate such as square feet, are not acceptable. Time studies are considered statistical surrogates and, thus, may not be used as a basis for direct assignments of costs.* Indirectly allocable supervision costs, other indirectly allocable costs (hereinafter, residual costs) and costs allocated from previously allocated general service cost centers (hereinafter, overhead costs) must not be directly assigned to the using cost centers, but must be allocated through cost finding…

*The direct assignment of costs must be made as part of the provider’s accounting system with costs recorded in the ongoing normal accounting process.* This means costs are to be recorded on a regular basis throughout the accounting period, not only as period ending adjusting entries. For example, if the costs being directly assigned are an element of payroll costs, the direct assignment should be recorded as often as all payroll costs are recorded (usually each pay period). If a provider fails to maintain the records as specified in its request and as a basis for the intermediary’s approval, no direct assignment of cost is allowed for the cost reporting period and a new request must be initiated for any future direct assignment of cost.

Examples of acceptable direct assignment of cost to benefiting cost centers are salaries paid to housekeeping staff directly assigned, based on time records of housekeeping maintained throughout the cost reporting period; purchased laundry and linen costs directly assigned, based on invoices which identify the cost for each benefiting cost center; and *depreciation on moveable equipment physically present or used in each of the cost centers*.

2312. CHANGING COST FINDING METHODS

Should a provider (other than a free-standing home health agency) desire to change cost finding methods (regardless of whether the desired change is to be a more or less sophisticated method), the *request to change must be made to the intermediary in writing and must be submitted to the intermediary 90 days prior to the end of the cost reporting period to which the request for change applies*. (**Exhibit C-4**)

CMS Publication 15-2, The PRM-Part 2 (**Exhibit C-5**), includes specific instructions for preparing a hospital cost report and allocating costs for general service areas which cannot be directly assigned as part of the Provider’s accounting system (emphasis added):

4020. WORKSHEET B, PART I - COST ALLOCATION - GENERAL SERVICE COSTS AND WORKSHEET B-1 - COST ALLOCATION - STATISTICAL BASIS

Base cost data on an approved method of cost finding and on the accrual basis of accounting except where government institutions operate on a cash basis of accounting. (See 42 CFR 413.24(a).) Cost data based on such basis of accounting is acceptable subject to appropriate treatment of capital expenditures. Cost finding is the process of recasting the data derived from the accounts ordinarily kept by you to ascertain costs of the various types of services rendered. It is the determination of these costs by the allocation of direct costs and proration of indirect costs. The various cost finding methods recognized are outlined in 42 CFR 413.24. Worksheets B, Part I, and B-1 have been designed to accommodate the stepdown method of cost finding.

*The provider can elect to change the order of allocation and/or allocation statistics, as appropriate, for the current cost reporting period if a request is received by the contractor, in writing, 90 days prior to the end of that reporting period. The contractor has 60 days to make a decision and notify the provider of that decision or the change is automatically accepted. The change must be shown to more accurately allocate the overhead or should demonstrate simplification in maintaining the changed statistics.* If a change in statistics is requested, the provider must maintain both sets of statistics until an approval is made. If both sets are not maintained and the request is denied, the provider reverts back to the previously approved methodology. The provider must include with the request all supporting documentation and a thorough explanation of why the alternative approach should be used. (See CMS Pub. 15-1, chapter 23, §2313.)

Simplified Cost Allocation Methodology

As an alternative approach to the cost finding methods identified in CMS Pub. 15-1, chapter 23, §2306, *the provider may request a simplified cost allocation methodology. This methodology reduces the number of statistical bases a provider maintains.* It may result in reducing Medicare reimbursement. A comparison is recommended if the possible loss reimbursement is surpassed by the reduced costs of maintaining voluminous statistics. *The following statistical bases must be used for purposes of allocating overhead cost centers. There can be no deviation of the prescribed statistics and it must be utilized for all the following cost centers.*

Cost Center Statistical Basis

**Buildings and Fixtures Square Footage**

**Movable Equipment Square Footage**

**Maintenance and Repairs Square Footage**

Operation of Plant Square Footage

Housekeeping Square Footage

Employee Benefits Salaries

Cafeteria\* Salaries

Administrative and General Accumulated Costs

Laundry and Linen Patient Days

Dietary\*\* Patient Days

Social Service Patient Days

Maintenance of Personnel Eliminated and moved to A&G for simplified cost finding

Nursing Administration Nursing Salaries

Central Services and Supply Costed Requisitions

Pharmacy Costed Requisitions

Medical Records and Library Gross Patient Revenue

Nursing Program\* Assigned Time

Interns and Residents Assigned Time

Paramedical Education Assigned Time

Nonphysician Anesthetists 100 percent to Anesthesiology

(**Exhibit C-5**)

As described above from PRM-Part 1 Section 2302, general service costs (i.e. cost centers that benefit or serve other cost centers, which may include other nonrevenue- producing and revenue-producing centers) are either directly assigned based on a measure of actual usage or allocated using a statistical basis which has been prescribed or approved by the MAC in advance.

Specific to the organ acquisition cost centers, the Provider states that the pre-transplant services are occurring virtually across every area of the hospital, as patients who are the transplant donors or recipients are undergoing very comprehensive testing and treatments before their transplant. The purpose of Worksheet B series of the cost report is to step down cost to the user cost centers based on established or “approved” statistical basis (per Manual). Based on the Provider’s documentation, there is no equipment that is solely designated for the examination and treatment of pre-transplant patients, nor are there designated areas in which transplant procedures or testing are performed.

The general service costs allocated by the Provider to the organ acquisition cost centers (i.e. Buildings and Fixtures, Movable Equipment and Maintenance and Repairs) based on its “created” statistic are prescribed to be allocated based on square footage according to the Simplified Cost Allocation Methodology described in PRM-Part 2 Section 4020. The Simplified Cost Allocation Methodology is the methodology used by the Provider in prior years’ cost reports with the exception of Movable Equipment which was allocated based on Depreciation Expense where each cost center received an allocation of depreciation based on equipment assigned to it.

The Provider’s attempt to allocate Building and Fixtures, Major Moveable Equipment and Maintenance and Repair using a “created” statistic of square footage based on employee surveys when the organ acquisition cost centers have no designated space, equipment or related maintenance and repairs is contrary to all manual instructions and cost finding principles. 42 CFR §413.24 Adequate cost data and cost finding states, “…must be based on their financial and statistical records which must be capable of verification by qualified auditors. The cost data must be based on an approved method of cost finding…” (**Exhibit C-6**). The Provider’s “created” statistic is not an approved method of cost finding. Cost report instructions state that statistics for a given overhead cost center must be allocated on the same basis; therefore, an attempt by the provider to “create” square footage and moveable equipment statistics does not adhere to Medicare regulations or Program instructions.

Additionally, Worksheet D-4 of the cost report, Computation of Organ Acquisition Costs and Charges for a Transplant Hospital with A Medicare-Certified Transplant Program (see **Exhibit C-7**), applies cost to charge ratios to charges for each cost center utilized by organ acquisition patients to develop full cost of organ acquisition cost centers. The costs computed based on cost to charge ratios include full costs for each cost center (i.e., direct and indirect costs derived on Worksheet B through the step-down process); and therefore, have received an allocation of Buildings and Fixtures, Movable Equipment and Maintenance and Repair costs from each cost center accessed by the organ acquisition patients.

1. **Conclusion**

The Provider has failed to demonstrate that the MAC erroneously disallowed overhead costs allocated to organ procurement. The MAC respectfully requests that the Board affirm the adjustments to the Medicare cost report ending June 30, 2015 as the MAC has followed Medicare regulations and Program instructions.

**IV. LAWS, REGULATIONS, AND PROGRAM INSTRUCTIONS**

Other Sources:

**Agency Instructions:**

CMS Publication 15-I, Section 2307, 2312

CMS Publication 15-II, Section 4020

**Code of Federal Regulations:**

42 C.F.R. §413.24

**V. EXHIBITS**

**C-1** Audit Adjustment Report

**C-2** Estimated Reimbursement Impact Calculation

**C-3** MAC Auditor’s Workpaper

**C-4** CMS Publication 15-I, Section 2300-2312

**C-5** CMS Publication 15-2, Section 4020

**C-6** 42 CFR §413.24

**C-7** MAC Adjusted Cost Report 06302015 Worksheet D-4