PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

98-D45

PROVIDER -
St. Mary's Hospital and Medical Center
San Francisco, California

DATE OF HEARING-
December 5, 1996

Provider No. 05-0457

Cost Reporting Period Ended -
June 25, 1989

vs.

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

CASE NO. 92-0507

INDEX

Page No.

ISSUE:

Did the Intermediary properly adjust outpatient surgery, anesthesia and supply charges?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

St. Mary's Hospital and Medical Center ("Provider") is a short-term, general service, acute care hospital located in San Francisco, California. On its fiscal year ended ("FYE") June 25, 1989 cost report, the Provider grossed-up its charges for its Medicare outpatient surgery, anesthesia, and supplies and used the grossed-up figure for apportionment purposes. Blue Cross and Blue Shield of California ("Intermediary ") adjusted the Provider's charges to agree with the summary of paid claims report ("PS&R report"). The Provider filed a timely appeal with the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841. The Medicare reimbursement at issue is approximately $129,000.[1]

The Provider renders inpatient and outpatient surgery in the same surgical suites using the same staff, equipment, and supplies. Due to competition in the area, the Provider established charges for its outpatient surgical services, including those related to anesthesia and supplies, at a lower rate than the corresponding inpatient charges. Although the charges are less for outpatients, the costs for both inpatient and outpatients are the same. The surgical procedure charges are based upon time and staffing levels. The minimum staffing level is used for both inpatient and outpatient procedures. The Provider grossed-up its outpatient charges to the comparable level of its inpatient charges in order to provide for proper cost apportionment to outpatient services and the Medicare program.

The Intermediary adjusted the charges to agree with the PS&R report, which reflected the Provider's billed charges for outpatient services.

The Provider was represented by Thomas P. Knight, President of Toyon Associates, Inc. The Intermediary was represented by Bernard M. Talbert, Esquire, Associate General Counsel of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary is responsible for evaluating the Provider's charging practices to ascertain whether they may serve as an equitable basis for apportioning costs. In order for a Provider's charges to be acceptable for apportioning costs, the charge structure must be applied uniformly to each patient, whether inpatient or outpatient, and the charges must be reasonable and consistently related to the cost of the services. Since the Provider's charging practice for outpatient surgery is different from its charging practice for inpatient surgery, the Provider asserts that its surgery, anesthesia, and supply charges must be

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[1] See Intermediary Position Paper at 5.

adjusted in order to promote proper and equitable cost apportionment. The Provider contends that the regulations at 42 C.F.R. §§ 413.5, 413.50, 413.53 and manual provisions at HCFA Pub. 15-1 §§ 2204, 2203 and 2302.6 support its position that charges used for cost apportionment must be adjusted.

The Provider proposes that the charges for its outpatient surgical services be increased or grossed-up to the level of equivalent inpatient charges. This charge gross-up includes all surgical outpatients including Medicare patients. The proposed gross-up involves increasing the total charges reflected on Worksheet C of the cost report as well as increasing the Medicare outpatient charges.

The Provider contends that the gross-up principle is well established and has been the subject of a number of Board and court decisions. In general, these cases find that grossing-up of charges is required for proper apportionment. In Madison Avenue Hospital v. The Travelers Insurance Company, PRRB Dec. No. 79-D10, March 5, 1981, Medicare and Medicaid Guide (CCH) ¶ 29,654, declined rev. HCFA Administrator, December 9, 1981, a hospital charged a lower rate for use of the operating room for abortion patients than for other patients. The Board found that grossing-up abortion patient charges to the level of other patients was necessary under HCFA Pub. 15-1 § 2302.[2] In St. Mary's Hospital Medical Center v. Heckler, 753 F.2d 1362 (7th Cir. 1985), a hospital charged a lower rate for laboratory services to outside patients than it charged for its hospital patients. The court concluded that the outside patient laboratory services must be grossed-up because the hospital could not document that the cost of the outside laboratory services were any different than the cost of its other laboratory services.[3] In Tri-County Hospital v. Heckler, Civ. No. 83-2638, (D.D.C. April 18, 1985), Medicare and Medicaid Guide (CCH)
¶ 34,604, a hospital charged a lower rate for pharmacy services to its outpatients, nursing home residents, and over-the-counter patients, than it charged its inpatients. The court held that the lower rate for pharmacy services had to be grossed-up to the level charged to the hospital patients in order to establish a uniform charge structure for cost apportionment purposes, because the hospital could not document that the cost of the lower rate services were any different from the cost of the same services for inpatients.[4] In Glencoe Municiple Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Minnesota, PRRB Dec. No. 89-D4, November 22, 1988, Medicare and Medicaid Guide (CCH) ¶ 37,530, declined rev. HCFA Administrator, December 23, 1988, a hospital charged a lower rate for laboratory services to non-provider patients than what it charged its own patients. The Board concluded that the charges for laboratory services furnished to the non-provider patients had

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[2] See Provider Exhibit 5.

[3] See Provider Exhibit 6.

[4] See Provider Exhibit 7.

to be grossed-up to the same level as those of the provider's patients.[5]

In the instant case, the Provider established a lower charge for outpatients than inpatients and acknowledges that the costs for both were the same. Therefore, for proper apportionment of cost, the outpatient costs must be grossed-up to the level of inpatients. The Provider presented the method it used to gross-up.[6]

The Provider notes that the Intermediary suggested that if the Provider was permitted to gross-up its outpatient Medicare charges then there would also have to be a gross-up of the 20 percent coinsurance amount which applies to outpatient Part B services. The Provider indicates that the Part B coinsurance is to be reported based upon the actual amount billed to the patient and should not be changed. The Provider states that there is no rule directing the gross-up of the coinsurance amount, and the charge gross-up requested by the Provider was solely for the purpose of correcting the cost apportionment process and should have no impact on the coinsurance amount.

In addition, the Provider claims that the Intermediary has not challenged its facts about its charge structure or its gross-up calculation. If the Intermediary is claiming that it has used its discretion not to gross-up, it has not presented any evidence or rationale for not doing so in the instant case. The Provider claims that the Intermediary is responsible for evaluating the charging practices and should allow adjustments where it is shown that it would be equitable to do so.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that it used the charges from the PS&R report because they were the best available information during the audit. To gross-up Medicare charges in order to compensate for discounting ancillary services would be improper. The adjustments are made in accordance with 42 C.F.R. § 413.24 which states, in part, that "adequate cost information must be obtained from the Provider's records to support payments made for services rendered to beneficiaries. . . ." The Intermediary indicates that the Provider did not furnish any documentation indicating that its data is more accurate or adequate. Also, HCFA Pub. 15-1 § 2304 requires that "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 invoices of cost. . . which pertain to the determination of reasonable costs, capable of being audited." Id.

The Intermediary states that the Provider must demonstrate that services being performed for

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5 See Provider Exhibit 8.

6 See Provider Exhibit 10.

inpatients and outpatients are the same, that these services are not all inclusive charges, and that its proposed gross-up is accurate. The Intermediary has not accepted the factual basis that operating room services to inpatients are identical to outpatients. In addition, the Intermediary also claims that the 20 percent coinsurance payment would have to be recalculated from the grossed-up charge and billed to the Medicare beneficiaries.

The Intermediary cites HCFA Pub. 15-1 § 2203 which indicates that whether the Intermediary adjusts or lowers charges is clearly within the discretion of the Intermediary . The key word is "may" not "must." In this case, the Provider made the decision to lower its operating room charges for outpatients to attract business. The Intermediary contends that the HCFA Pub. 15-1 § 2203 does not license the Provider to have a dual charge system, one that maximizes business and the other that maximizes Medicare reimbursement.

Finally, the Intermediary notes that the Provider's gross-up calculation is overstated. The actual ratio is closer to 50, as opposed to the 29 cents on the dollar used by the Provider. The Final settlement, if the Provider prevails on the gross-up theory, has to take into account a gross-up of the 20 percent co-payment. In the Medicare outpatient settlement cost, payments are reduced by a 20 percent charge driven co-payment; the Provider should not have its costs determined at the full retail pricing but have its co-payment based on a substantial discount.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§ 1395x(v)(1)(A)	-	Reasonable Cost

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

§ 413.5	-	Cost Reimbursement: General
§ 413.13	-	Amount of Payment if Customary Charges for Services Furnished are Less Than Reasonable Costs
§ 413.24	-	Adequate Cost Data and Cost Finding
§ 413.50	-	Apportionment of Allowable Costs
§ 413.53	-	Determination of Cost of Services to Beneficiaries

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

§ 2202.4	-	Charges
§ 2203	-	Provider Charge Structure as a Basis for Apportionment
§ 2204	-	Medicare Charges
§ 2302	-	Definitions
§ 2302.6	-	Charges
§ 2304	-	Adequacy of Cost Information
§ 2604.3	-	Customary Charges

4. Program Instructions - Provider Reimbursement Manual, Part II (HCFA Pub. 15-21):

§ 2418.2	-	Medicare and Other Health Services

5. Cases:

Glencoe Municipal Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Minnesota, PRRB Dec. No. 89-D4, November 22, 1988, Medicare and Medicaid Guide (CCH) ¶ 37,530, declined rev. HCFA Administrator, December 23, 1988.

Madison Avenue Hospital v. The Travelers Insurance Company, PRRB Dec. No. 79-D10, March 5, 1981, Medicare and Medicaid Guide (CCH) ¶ 29,654, declined rev. HCFA Administrator, December 9, 1981.

Oregon 90 Coinsurance Group Appeal v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Oregon, PRRB Case No. 96-D29, April 26, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,168, rev'd HCFA Administrator, June 24, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,591.

St. Mary's Hospital Medical Center v. Heckler, 753 F.2d 1362 (7th Cir. 1985).

Tri-County Hospital v. Heckler, Civ. No. 83-2638, (D.D.C. April 18, 1985), Medicare and Medicaid Guide (CCH) ¶ 34,604.

5. Other:

§ 4521 of the Balanced Budget Act of 1997, P.L. 105-33

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board majority after considering the facts, parties' contentions and documentary evidence presented, testimony elicited at the hearing, and posthearing brief, finds and concludes that it was proper for the Provider to gross-up its outpatient surgery charges to match those of its inpatient surgery charges and utilize these grossed-up charges to apportion inpatient and outpatient costs. The Board majority finds that it would not be proper, as suggested by the Intermediary, to gross-up co-insurance amounts for purposes of determining the Medicare program's liability to the Provider.

The Board has previously noted that the amount the Medicare program will reimburse a provider is determined by a four step process. See Oregon 90 Coinsurance Group Appeal v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Oregon, PRRB Case No. 96-D29, April 26, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,168, rev'd HCFA Administrator, June 24, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,591 ("Oregon"). The first step is the identification of allowable costs. The second step is the allocation of overhead costs. The third step is the apportionment of allowable costs between Medicare and non-Medicare patients. The fourth step involves settlement of the Medicare program's liability by subtracting the applicable beneficiary coinsurance and deductibility amounts from the provider's Medicare allowable costs.

Medicare program regulations at 42 C.F.R. § 413.53(a) provide for the apportionment of reasonable costs and state that "[t]otal allowable costs of a provider shall be apportioned between program beneficiaries and other patients so that the share borne by the program is based on actual services received by program beneficiaries." The regulations further state that "[a]pportionment means an allocation or distribution of allowable cost between the beneficiaries of the health insurance program and other patients." 42 C.F.R. § 413.53(b). A provider's ancillary costs are apportioned based upon the charges incurred by Medicare beneficiaries to total charges incurred by all hospital patients for each ancillary department.

In the instant case, the Board majority finds that the Provider's inpatient and outpatient surgical patients utilized the same staff, equipment and supplies for a number of surgical procedures and incurred similar costs. The Board majority also finds that, due to competition, the Provider established a lower charge for its outpatients. The Board majority notes the manual instructions dealing with utilization of a provider's charge structure as a basis of apportionment provide, in part, that "[w]hile the Medicare program cannot dictate to a provider what its charges or charge structure may be, the program may determine whether or not charges are allowable in apportioning costs under the program." HCFA Pub. 15-1 § 2203. It is not appropriate to utilize the ratio of charges to cost used for apportionment purposes,

where charges have not been uniformly applied to all patients. When differences in charges exist, providers are required to record all charges used for apportionment at their gross value. HCFA Pub. 15-1 § 2202.4. The purpose of grossing-up charges is to insure proper apportionment of costs between Medicare and non-Medicare patients. The Board majority also notes that grossing-up of charges for apportionment is consistent with generally accepted accounting principles. Therefore, the Board majority finds that it was proper for the Provider to gross-up its outpatient surgery charges to match those of its inpatient surgery charges and utilize these grossed-up charges to apportion inpatient and outpatient costs.

The purpose of a uniform charge structure is to ensure proper apportionment between Medicare and non-Medicare beneficiaries. If charges are less for non-Medicare beneficiaries, less ancillary costs are assigned to them and there is an inappropriate shifting of costs to the Medicare program. In the instant case, all inpatients pay the same higher charge and all outpatients pay the same lower charge. There is no cost shifting from non-Medicare to Medicare patients. The grossing-up of charges allows the Provider to properly assign costs to all inpatients and outpatients. Although apportioning additional costs to the all outpatients effects reimbursement, it is not inappropriately shifting costs from non-Medicare to Medicare beneficiaries.

The Board majority finds that it would not be proper, as suggested by the Intermediary, to gross-up co-insurance amounts for purposes of determining the Medicare program's liability to the Provider. The Board majority notes that, as previously indicated in Oregon, supra, it is not appropriate to gross-up the 20 percent beneficiary co-payment. The beneficiary is responsible for paying 20 percent of the provider's reasonable costs not to exceed 20 percent of the amount customarily charged by the provider. The regulations at 42 C.F.R. §§ 413.13(b), (e), 413.53(b), define "customary charges" as the regular rates which are charged to Medicare beneficiaries and other paying patients. The program instructions further define "customary charges" to be: "those uniform charges in a provider's established charge schedule which is in effect and applied consistently to most patients and recognized for program reimbursement." HCFA Pub. 15-1
§ 2604.3. The Board majority disagrees with the Intermediary contention that if a provider has an established separate charge schedule for inpatient and outpatient services, and bills inpatients more than outpatients for similar services on these schedules, the provider has discounted the outpatient charges, and must record the coinsurance based on inpatient charge levels, rather than actual outpatient charges. Again, all inpatients pay the same higher charge and all outpatients pay the same lower charge. There is no cost shifting from non-Medicare to Medicare patients. These charges are the Provider's established charge schedule, and no individual or group of patients pays a different charge. The Board majority finds that there is no basis to determine that the higher inpatient charges are the customary charge or that a discount has been granted from the regular charge. The Board majority finds that it is inappropriate to apply HCFA Pub. 15-2
§ 2418.2, requiring that the coinsurance be reported at 20 percent of the established charge, because the Provider's lower outpatient charge is its customary charge and it has not offered

patients a discount from their regular charge.

The Board majority notes that the Provider has charged all of its outpatients the same lower charge and has calculated the co-insurance for Medicare beneficiaries based on these charges. If the co-insurance is grossed-up in the manner proposed by the Intermediary, there is a liability created to either the Medicare beneficiaries or the Provider. The Board majority believes that additional billing to Medicare beneficiaries is impractical and inappropriate and will likely result in a debt to the Provider. The Board majority suggests that the coinsurance payment should be established from the Medicare payment amount, which is allowed for outpatient surgery under
§ 4521 of the Balanced Budget Act of 1997, P.L. 105-33, versus 20 percent of an artificially grossed-up amount created for proper apportionment of costs.

DECISION AND ORDER:

The Intermediary adjustments disallowing the Provider's grossing up of its outpatient surgery charges for apportionment purposes was improper. The Intermediary's adjustment is reversed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire (Dissenting)

Date of Decision: April 24, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman

Dissenting Opinion of Henry C. Wessman

I dissent. My dissent is rooted in the concept of "reasonable cost" and "fair share" as codified at 42 U.S.C. 1395x(v)(1)(A). This statute is intended to assure comparability of payment for efficiently delivered health care services between Medicare and non-Medicare recipients. The question of "grossing up" charges to meet the comparability requirements of 42 U.S.C. 1395x(v)(1)(A), the issue in this case, presents a well-marked analytical trail.

Beginning in 1979, the PRRB upheld the Intermediary's "grossing up" of a Provider's non-uniform charges to effectuate comparability. Madison Avenue Hospital v. The Travelers

Insurance Company, PRRB Dec. No. 79-D10, March 5, 1979. In 1985, the U.S. Court of Appeals, Seventh Circuit (St. Mary's Hospital Medical Center v. Heckler, 753 F.2d 1362 (7th Cir. 1985)) and the U.S. District Court for the District of Columbia (Tri-County Hospital v. Heckler, Civ. No. 83-2638, (D.D.C. April 18, 1985)) both upheld Intermediary "grossing up" of Provider charges to equalize cost apportionment for Medicare payment calculation. In 1988, the PRRB reaffirmed the "grossing up" methodology implemented by the Intermediary. Glencoe Municipal Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Minnesota, PRRB Dec. No. 89-D4, November 28, 1988. To this point, then, the "gross up" analytical trail has been notched by the Intermediary, the PRRB, the HCFA Administrator (by declining review), and the Courts - all recognizing the necessity to "gross up" lower charges for comparability in determining the ratio for cost allocation between Medicare and non-Medicare recipients. The Provider pretty well stood alone in opposition.

Regulations promulgated by HCFA to address cost equitability are found primarily in HCFA Pub.
15-1 Section 2203 - - Provider Charge Structure as Basis for Apportionment. Basically, this Section requires that " . . each facility should have an established charge structure which is applied uniformly . . and . . consistently related to the cost . ." Further, in HCFA Pub. 15-1 Section 2314.B - - Limitation of Allocation of Indirect Costs Where Ancillary Services Are Furnished Under Arrangements, one method of equalizing charges is that of "grossing up" the charges of lower non-Medicare clients to meet Medicare. Ostensibly, the Manual states that such "grossing up" can be used "if the intermediary determines that a provider is able to"; but upon condition that " . . the provider must receive the intermediary's written approval within 90 days after the beginning of the cost reporting period." Id.

In the instant case, the Intermediary offers two basic contentions. One is that it is the Intermediary's call, not the Provider's, to employ the "grossing up" methodology of comparability. Referring to the third sentence of HCFA Pub. 15-1, Section 2203, the Intermediary notes that " . .whether to adjust the charges or lower the provider's actual charges is clearly within the Intermediary's discretion. The key word is "may", not "must"... ". Intermediary Response to Provider's Position Paper at 3. This contention does not fare well in light of at least four PRRB decisions. Florida Life Care, Inc. Group "Gross-Up" v. Ætna Life Insurance Co., PRRB Dec. No. 90-D25, May 9, 1990 ("Florida"); St. Mary's Hospital and Medical Center v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 90-D34, June 18, 1990 ("St. Mary's"); Sunbelt Health Care Centers Group Appeal v. Ætna Life Insurance Co., PRRB Dec. No. 97-D13, December 3, 1996 ("Sunbelt"); Pinnacle Care Drug "Gross Up" Group Appeal v. Ætna Life Insurance Co., PRRB Dec. No. 97-D41, March 26, 1997 (Pinnacle). In Florida, the PRRB stated:

> Clearly, the "gross-up" method results in a more accurate cost-finding approach. As such, it is consistent with the Medicare law and regulations. The Board does give great weight to, but is not bound by, the PRM. In this case, it finds that the 90-day PRM limit for granting permission to use the "gross-up"

> technique is unreasonable because missing the 90-day deadline results in less accurate cost findings. This results in an improper underpayment of the Providers' costs and conflicts with 42 U.S.C. Sec. 1395x(v) and 42 C.F.R. Sec. 405.402 . . . The Board finds that a PRM timing requirement should not prohibit the Providers from using a more accurate cost finding methodology. Moreover, an intermediary approval to "gross up" charges should not be necessary because this methodology is the correct, most accurate method of determining costs in such a situation.

Florida at 5.

Similarly, in St. Mary's, the Board noted that " . . the prior approval requirement . . . should not prohibit the provider from effecting a more accurate allocation of costs". St. Mary's at 5. At this point along the analytical trail, all effected parties appear to embrace the "gross up" methodology of equalizing cost allocation.

The second contention of the Intermediary, that all parts of the non-Medicare side of the apportionment formula, including the 20% co-insurance/co-pay, be "grossed up" in order to reflect true uniformity of charges, is, I believe, accurate. It is this final "notch" that pretty well takes the analytical trail out of the "comparability v. business opportunity/loss leader" woods. As noted by the Intermediary in the instant case, " . .PRM Sec. 2203 does not license a Provider to have a dual charge structure. (One to maximize its Medicare reimbursement and the other to
maximize its business opportunities.) In the Medicare outpatient settlement, cost payments are reduced by a 20% charge-driven co-payment factor. The Provider should not have its costs determined at full retail pricing, but have its co-payment based on a substantial discount." Intermediary's Response to Provider's Position Paper at 3.

Actually, while endorsing "gross up" for the 80% factor of outpatient charges to meet inpatient charges, the PRRB, in Oregon 90 Coinsurance Group Appeal (Ore.) v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Oregon, PRRB Dec. No. 96-D29, April 26, 1996, rev'd, HCFA Administrator, June 24, 1996 ("Oregon") denied the Intermediary's "gross up" adjustment of the 20% co-pay, because the Provider "did not offer patients discounts from their regular charges". Oregon at 9. The operant word is "discount"; while the Provider clearly recouped less on outpatient charges (the business "loss leader"), the Board could not bring itself to call it what it is - a lesser (discounted) price.

Oregon, in fact, is a study in semantics. The HCFA Administrator, in reversing the Board, relied on PRM - 1, Sections 2202.4 and 2604.3. Section 2202.4 provides that charges be related consistently to the cost of services and uniformly applied to all patients, whether inpatient or outpatient. "All patient charges used in the development of apportionment ratios should be recorded at the gross value." Administrator's Decision Letter, PRRB Dec. No. 96-D29, June 26, 1996, at 4. Section 2604.3 defines "customary" charges as those uniform

charges listed in a provider's established charge schedule ". . . applied consistently to most patients and recognized for program reimbursement." Administrator's Decision Letter, PRRB Dec. No. 96-D29, June 26, 1996, at 4. The Administrator further states,

> Accordingly, in order for charges to be "customary" for Medicare payment purposes, charges must be uniformly applied and recognized for program reimbursement. As customary charges are the proper charges upon which to base the determination of the Medicare payment, customary charges are the proper charges upon which to base the determination of the coinsurance amount for Part B outpatient services.

Id.

Applying the logic of the above to Medicare payment, the calculation of which is based on the apportionment ratio, one must include consideration of PRM - 2, Section 2418.2, which requires that Part B Medicare coinsurance be based on 20% of a providers' full charges, i.e. customary, not discounted charges.

It is at this point that I part company with my Board colleagues; they have a problem with the word "discounted". I do not. When a provider purports to offer identical services to two different customers, and bases the "charge" on cost of the service, but "charges" one customer more, and the other less - either there is an inflated charge to one, or a discounted charge to the other. Business logic tells me that, in the instant case, it is the latter. And that being the case, the 20% co-pay must be "grossed up" to make the apportionment ratio/formula equitable.
This point can be deduced from the Provider's Post Hearing Brief at 4:

> If the Provider had taken the approach of reducing inpatient charges to make them equivalent to the charging practice for outpatient surgery services rather than grossing-up outpatient charges, it is unlikely the Intermediary would insist on inpatient deductibles or coinsurance amounts to be reduced. Further, if inpatient charges were reduced, there would be no adjustment to Medicare outpatient charges and, therefore, no issue with respect to adjusting the outpatient coinsurance amount.

Id.

That is exactly the point. A "netting down" of the ratio/equation would place outpatient co-pay at its actual amount. But as long as "grossing up" is the method of choice for equalization of the apportionment ratio to business decision reality, both sides of the apportionment ratio must be based on the same "customary" ("full", "uniform") and, I might add, non-reduced ("discounted") charge; be equal; and be comparable.

In the instant case, I reject the Intermediary's contention that the Provider can not unilaterally

"gross up" lower outpatient charges to reach "uniformity" and "comparability". Of course it can, and someone must. But they must also "gross up" all factors making up the apportionment ratio, including a basing of the 20% co-pay on those same "uniform" charges purported to be based on cost, so that both sides of the equation are accurate.

Henry C. Wessman, Esquire
Board Member