PROVIDER REIMBURSEMENT REVIEW BOARD HEARING DECISION

98-D87

PROVIDER -
Minnesota '94 Occupational Therapy/ Speech Therapy Salary Equivalency Limits Group

Provider No. See Attachment I

vs.

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

DATE OF HEARING-
March 12, 1998

Cost Reporting Period Ended - See Attachment I

CASE NO. 97-0682G

INDEX

ISSUE:

Were the Intermediary's adjustments to occupational and speech therapy costs proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

This case is brought by 33 skilled nursing facilities ("SNFs") (the "Providers") located in the State of Minnesota. The Medicare cost reporting period at issue is each facility's fiscal year ending on or after June 30, 1993 and before March 1, 1995.[1] During this period, the Providers furnished occupational therapy ("OT") and speech therapy ("ST") services to Medicare beneficiaries through arrangements with outside contractors.[2]

During 1995, Blue Cross and Blue Shield of Minnesota ("Intermediary") conducted an analysis of OT and ST costs. Essentially, the Intermediary compared the costs incurred by 5 randomly selected SNFs that used outside contractors to furnish OT and ST services to the costs incurred by 5 randomly selected SNFs that employed their own therapists. The Intermediary concluded that SNFs using outside contractors incurred far greater costs rendering OT and ST care than did SNFs employing therapists.[3]

Based upon the results of its analysis, the Intermediary in 1996 initiated a "focused review"[4] initiative to determine the reasonableness of OT and ST costs claimed for program reimbursement. The Intermediary's review was limited to SNFs that used outside contractors and incurred $250,000 or more in OT and ST costs for the year, in aggregate.[5]

In order to assess the reasonableness of provider costs through the focused review effort, the Intermediary established a "benchmark" per hour for each therapy service. In general, costs found to be in excess of the benchmark would be considered unreasonable based upon Medicare's prudent buyer principle. The benchmark was derived from data the Intermediary

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1 The parties to this appeal stipulated that the issues in this case are the same as the issues in the appeal filed by the Providers for the subsequent cost reporting period. Therefore, as requested by the parties, this decision applies also to PRRB Case No. 98-0467G. See Transcript ("Tr.") at 6, and Provider Letter dated March 13, 1998.

2 Providers' Post Hearing Brief at 9.

3 Tr. at 152-154.

4 "Focused review" is a type of provider audit. It is used to maximize audit resources by examining a limited number of potentially high risk reimbursement issues at a target group of providers.

5 Id.

obtained from Rehab Providers of Minnesota and from an independent wage survey performed by the State of Minnesota, and from data the Intermediary obtained from an audit of a rehabilitation facility.

The Intermediary's application of the benchmark to the target group of providers[6] resulted in cost reductions that were reflected in Notices of Program Reimbursement ("NPRs") issued between July 23, 1996, and September 24, 1996. In response, 44 providers timely appealed the reductions to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841, and met the jurisdictional requirements of those regulations.

Subsequent to the Intermediary's issuance of the NPRs and the Providers' appeal to the Board, the Intermediary refined its benchmark.[7] In general, the Intermediary's calculations were modified to give consideration to Bureau of Labor Statistics ("BLS") salary data received from the Health Care Financing Administration ("HCFA"), and to recognize 2,080 hours as the minimum work year to reflect a perception that SNFs could not hire a therapist at less than full-time hours.

As a result of the Intermediary's refined calculations, the number of SNFs that maintained their appeal to the Board was reduced to the current provider group of 33 SNFs. The amount of Medicare reimbursement in controversy is approximately $2,277,000.[8]

The Provider was represented by Ronald N. Sutter, Esquire, and Christopher L. Keough, Esquire, of Powers, Pyles, Sutter & Verville, P.C. The Intermediary was represented by James R. Grimes, Esquire, Associate Counsel, Blue Cross and Blue Shield Association.

PROVIDERS' CONTENTIONS:

The Providers contend that the Intermediary's adjustments are improper. The costs they incurred to provide OT and ST services under arrangements with outside contractors are reasonable and necessary in accordance with Medicare rules and regulations.

The Providers contend that the majority of SNFs in Minnesota obtained OT and ST services under arrangements with outside contractors during fiscal year 1994. Therefore, their costs - are squarely in line with the costs incurred by the majority of all SNFs in Minnesota to provide OT and ST services. The Providers explain that most SNFs in Minnesota obtained OT and ST services through outside contractors because it is very difficult to recruit and

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6 Approximately 49 providers, in total, were included in the Intermediary's target group. Tr. at 181.

7 Intermediary's Position Paper at 10.

8 See Attachment I.

retain qualified therapists to work directly for SNFs.[9] Therapists are in high demand and short supply. Moreover, SNFs are disadvantaged in recruiting therapists in competition with other prospective employers including hospitals, therapy service contractors, home health agencies, and school systems. There are therapist preferences to patient populations that are perceived to be more technically challenging, perceptions of SNFs offering less potential for career advancement, desires to work under more flexible schedules than most SNFs can accommodate and, in some cases, less attractive physical plants and neighborhoods. As a consequence of the foregoing factors, it is expensive to recruit and retain qualified therapists to work in-house for a SNF.[10] The Providers add that it is also difficult and expensive to furnish therapy services through in-house staff even when a SNF is successful in recruiting qualified therapists. There is an annual turnover rate of 50 percent for therapists due to the abundant supply of attractive job opportunities which serves to further increase recruiting costs. In addition, a SNF's rehabilitation case load typically fluctuates substantially from month to month. These short-swing fluctuations in utilization increase the cost of furnishing therapy services in-house. That is because the SNF must incur fixed compensation costs for staff therapists even during periods of low utilization while employing a sufficient number of therapists to cover patient care needs during periods of peak utilization.

The Providers contend that limitations imposed upon SNFs under Minnesota law also discourage them from employing therapists. In general, the limitation restricts a SNF's therapy revenue to 108 percent of its costs. Revenues in excess of the 108 percent limitation are offset against the facility's Medicaid payment rate. This offset has the potential to create a financial loss for a facility.[11]

The Providers contend that they are entitled to be reimbursed the actual costs they incurred furnishing OT and ST services to beneficiaries based upon Medicare's statutory and regulatory principles of reimbursement.[12] Pursuant to 42 U.S.C. §§ 1395(f)(b) and 1395(a)(2)(b), the amount paid to a SNF for OT and ST services furnished to Medicare beneficiaries shall be the lesser of the SNF's customary charges or its reasonable cost "[a]s determined under section 1861(v) [42 U.S.C. § 1395x(v)]." (emphasis added.) Pursuant to 42 U.S.C. § 1395x(v)(1)(A), "reasonable cost" shall include "the cost actually incurred . . . in the efficient delivery of needed health services" and "shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included in determining such costs . . ."(emphasis

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9 Providers' Post Hearing Brief at 10.

10 Tr. at 98-99 and 131-133. See also Exhibit P-104 at 31 and 34-41, and Exhibits P-35 and P-36.

11 Providers' Post Hearing Brief at 12.

12 Providers' Post Hearing Brief at 23.

added.) The Providers cite the 1965 legislative history of the Social Security Act as stating the legislative intent of this provision, as follows:

> to meet the actual costs, however widely they may vary from one institution to another, except where a particular institution's costs are found to be substantially out of line with those of institutions similar in size, scope of services, utilization, and other relevant factors.

S. Rep. No. 404, 89th Cong., lst Sess. (1965), reprinted in 1965 U.S.C.C.A.N. 1943, 1976.[13]

The Providers contend there are only two potential exceptions to the provision in 42 U.S.C. § 1395x(v)(1) requiring reimbursement of their actual therapy costs, and the Intermediary has not complied with either one of them.[14]

As reflected in the 1965 legislative history of 42 U.S.C. § 1395x(v)(1)(A) quoted above, and implementing regulations at 42 C.F.R. § 413.9, the Intermediary may disallow costs that are shown to be substantially out of line with costs incurred by comparable providers in the same area for similar services. Under the plain words of 42 C.F.R. § 413.9(c)(2), the substantially out of line limitation may be applied only on the basis of a comparative peer group analysis of costs incurred for similar services by providers "in the same area that are similar in size, scope of services, utilization, and other relevant factors." 42 C.F.R. § 413.9(c)(2) The substantially out of line limitation is also applied retrospectively.

The Intermediary's disallowances, however, were not made in accordance with the substantially out of line rule. While the Intermediary's benchmarks or limits were applied retroactively, they were neither established nor applied on the basis of a case by case comparative analysis of actual costs incurred by comparable providers in the same area for similar services. The Intermediary admits that it did not compare the Providers' costs to the costs of any other SNFs in Minnesota in establishing or determining its adjustments. The Intermediary also admits that it made no finding that the actual costs incurred by any Provider in the group were substantially out of line with the costs incurred by any other SNF.[15]

The second exception to the reasonable cost provisions which the Intermediary also did not comply with is the salary equivalency limits authorized by 42 U.S.C. § 1395x(v)(5)(A).[16] Implementing regulations at 42 C.F.R. § 413.106 require that salary equivalency limits for

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13 Exhibit P-62.

14 Providers' Post Hearing Brief at 24.

15 Tr. at 213-217.

16 Providers' Post Hearing Brief at 27.

therapy services be applied only on a prospective basis and that providers be given advance notice of the limits through publication in the Federal Register. In addition, the regulations provide for "exceptions" to the limits in several circumstances including instances in which a provider demonstrates the existence of "unique circumstances or special labor market conditions in the area." Id.

With respect to the instant case, the subject disallowances were not imposed in accordance with the requirements of the salary equivalency regulations. Specifically, the limits used to disallow the Providers' OT and ST costs were established by the Intermediary not HCFA; they were not established or applied prospectively; they were not published in advance anywhere; and, they were not derived from statistically valid data. Moreover, the limits were applied only to a class of providers, i.e., those with aggregate OT/ST costs of $250,000 or more.

The Providers contend that the Intermediary's adjustments clearly reflect the application of illegal salary equivalency limits. Therefore, the adjustments are improper.[17] The Providers assert that the Intermediary's original calculations were derived directly from the application of HCFA's salary equivalency limits for physical therapy ("PT") determined on worksheet A-8-3 of the SNF cost reporting form. The Intermediary calculated its limits using a worksheet and instructions that are identical to the A-8-3 worksheet and instructions.[18] The only differences between the Intermediary's original disallowances and the application of HCFA's PT salary equivalency limits is that the Intermediary had to create its own salary equivalency amounts because HCFA had not published such limits for OT and ST services in 1994, and the Intermediary's limits were applied retroactively while HCFA's limits are applied only prospectively.

Moreover, the changes made in connection with the Intermediary's refined calculations do not transform the Intermediary's limits into something other than salary equivalency limits.[19] The salary equivalency regulation defines "adjusted hourly salary equivalency amount" to mean a "prevailing hourly salary rate" plus a "fringe benefit and expense factor." 42 C.F.R. § 413.106(b)(3) In this case, the undisputed evidence shows that the Intermediary's revised calculations reflect "salary, fringe benefit, and expense factor amounts"calculated by BLS based upon a 1989 survey of hospital industry wages for therapists.[20]

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17 Providers' Post Hearing Brief at 30.

18 Compare Exhibit P-4 at 20 with Exhibit P-47. Tr. at 35-40.

19 Providers' Post Hearing Brief at 34.

20 Exhibits I-13 and P-83.

The Providers also assert that the evidence in this case shows that the concept behind the Intermediary's limits is identical to the concept of salary equivalency limits. Salary equivalency limits reflect an estimate of the costs that would be incurred to furnish therapy services through an employment relationship plus a reasonable amount of additional overhead costs incurred by contractors furnishing services under arrangement. 42 C.F.R. § 413.106(b)(3) (definition of salary equivalency amount).[21] The concept underlying the Intermediary's limits is, by its own admission, exactly the same. The Intermediary's revised limits reflect the application of an estimate of the costs that would be incurred by providing therapy services in-house plus an allowance for additional overhead costs incurred by contractors furnishing services under arrangement.[22]

The Providers reject the Intermediary's argument that it allowed them an opportunity during the focused review initiative to explain how their decision to purchase therapy services was prudent, and that that opportunity supports the Intermediary's contention that its adjustments are, in fact, based on Medicare's prudent buyer principle.[23] The Providers argue that the Intermediary has not shown that this exception actually existed; even though many of the Providers furnished the requested explanation, the Intermediary admits that it granted no exceptions and proceeded to effectuate its adjustments.[24] For example, many of the Providers explained that the limitations imposed upon in-house therapy programs under Minnesota state law, as well as issues such as recruiting costs, training costs, and other expenses associated with in-house programs made it prudent for them to contract for therapy services.[25]

Furthermore, the Providers argue that the Intermediary's contention that its adjustments are not based upon salary equivalency limits because they are not "absolute," meaning that a provider could have qualified for an exception, is based upon the Intermediary's misunderstanding that HCFA's salary equivalency limits are absolute.[26] However, HCFA's salary equivalency regulation clearly provides for four discrete types of exceptions to salary equivalency amounts. 42 C.F.R.
§ 413.106(f)(2)

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21 Tr. at 188.

22 Tr. at 197-199.

23 Providers' Post Hearing Brief at 35.

24 Tr. at 164-165.

25 See Exhibits P-32 through P-37.

26 Tr. at 201.

Furthermore, the Providers assert that they are not required to provide therapy services in-house or to provide documentation such as that required by the Intermediary. Medicare regulations clearly provide that a SNF may furnish therapy services directly or under arrangements with outside contractors. 42 C.F.R. § 483.45 Moreover, HCFA's record keeping and reporting requirements for therapy services only require a SNF to keep "a daily log or similar daily records" that are sufficient "to support the statements submitted with its cost report." Provider Reimbursement Manual, Part I ("HCFA Pub. 15-1") § 1417.A.

The Providers contend that the reasonable cost reimbursement provisions of 42 U.S.C. § 1395x(v) and 42 C.F.R. § 413.9(c)(2) cannot be construed to permit the Intermediary to disallow costs in excess of unpublished and retroactively applied salary equivalency limits.[27] If the Intermediary were permitted such authority Congress would not have needed to amend the Medicare statutes in 1972 to permit the Secretary to establish prospective salary equivalency limits effective for cost reporting periods beginning after publication in the Federal Register. The Providers argue that it is a fundamental canon of construction that the provisions of each statute be construed to give effect, and not to render any provision superfluous. Washington Hospital Center v. Bowen, 795 F.2d 139, 145 (D.C. Cir. 1986).[28] The Providers maintain that Congress enacted 42 U.S.C. § 1395x(v)(5)(A) and, HCFA, pursuant to that authority, established prospective salary equivalency limits for PT and respiratory therapy ("RT") in accordance with the requirements of 42 C.F.R. § 413.106 because the Intermediary has no authority to impose salary equivalency limits. The Intermediary may only impose salary equivalency limits that have been adopted in accordance with the statute and implementing regulations Home Health Care, Inc., 717 F.2d at 592 (the Secretary and the Medicare intermediaries must obey regulations).

The Providers contend that the Board has historically reversed disallowances of therapy costs that were based upon the application of salary equivalency limits established by an intermediary.[29] In Hospital Sin Padres, Inc. v. Coopertiva de Seguros de Puerto Rico, PRRB Dec. No. 83-D93, June 15, 1983, Medicare & Medicaid Guide (CCH) ¶ 33,081, decl'd rev., HCFA Admin. July 19, 1983 ("Hospital Sin Padres"), the intermediary limited a home health agency's costs for RT services obtained from outside contractors to an amount reflecting the average salary and fringe benefit costs incurred by that home health agency for RT services furnished through its own salaried employees. The Board reversed those adjustments finding that:

> [t]he Intermediary failed to consider what other providers were paying for therapy services under arrangements. Therefore, there is no basis to determine

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27 Providers' Post Hearing Brief at 40.

28 Exhibit P-88.

29 Providers' Post Hearing Brief at 42.

> if the provider's costs were substantially out of line with other similar institutions in the same area.

Hospital Sin Padres, Medicare & Medicaid Guide ¶ 33,081 at 10,460.

The Providers contend that the use of fixed criteria to limit reasonable cost is also contrary to the substantially out of line limitation in 42 C.F.R. § 413.9(c)(2) regardless of its designation such as "benchmark"in the instant case.[30] The regulation recognizes that reasonable costs may vary widely from one provider to another and from time to time for the same provider as a result of differences in the scope and intensity of services provided. The Providers maintain that the courts, like the Board, have overturned the use of a benchmark or fixed criterion in the context of retrospective analysis of a provider's reasonable costs. The Providers cite Home Health Services of Greater Philadelphia v. Harris, 530 F. Supp. 1236, 1246-1248 (E.D. Pa. 1982) ("Home Health Services"),[31] and explain that the Board, in its analysis of that case, stated: "[t]he Board does not accept the Intermediary's position that the Provider's management fees are substantially out of line compared with other institutions in the same geographic area which are similar in size, scope of services, utilization, and relevant factors as defined in 42 C.F.R. § 405.451(c)(2)." Id.

Moreover, the Providers explain that the court agreed with the Board stating:

> [t]he record is devoid of any reference to the costs incurred by a single provider "in the same area," and "similar in size, scope of services, utilization, and other relevant factors" as required by 42 C.F.R. § 405.451(c)(2). While the record contains evidence that the intermediary attempted to collect estimates of what it would cost to obtain the various services provided by Unihealth from outside sources, there was no evidence that the various service corporations providing the estimates serviced providers in or around the Philadelphia area or that these estimates represented the prices comparable providers in the Philadelphia area were paying in 1975.

Home Health Services, 530 F. Supp. at 1247.

The Providers contend, therefore, that the Intermediary is legally obligated to reimburse their actual costs of furnishing OT and ST services because they were not substantially out of line with the costs incurred by like providers. Pursuant to 42 U.S.C. § 1395x(v)(1)(A) and 42 C.F.R.
§ 413.9, the Intermediary is required to reimburse the Providers' actual costs "however widely they may vary from one institution to another" subject only to the limitation on costs

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30 Providers' Post Hearing Brief at 43.

31 Exhibit P-74.

that are found to be substantially out of line. The Providers paid an average of $25 for each 15-minute unit of OT or ST service obtained from outside contractors.[32] Those costs were not out of line with costs incurred by other SNFs in Minnesota.[33] As previously noted, the great majority of all SNFs in Minnesota furnished OT and ST services under arrangements with outside contractors during the fiscal year at issue.[34] See Home Health Services of Dallas, Inc. v. Schweiker, (1983 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 33,009 at 9918-19 (N.D. Tex. 1983), where costs must be substantially in excess of the average in order to be found "substantially out of line."

Notwithstanding the Providers' argument that their costs are reasonable and in line with those of most other SNFs in Minnesota, they also argue that the Intermediary did not perform a comparative analysis to dispute that fact.[35] Moreover, the principle that a comparative analysis of a provider's costs with those of other like facilities must be performed in order to effectuate an adjustment pursuant to 42 C.F.R. § 413.9(c)(2) is supported by many prior Board and court decisions.[36] See also Vermillion Home Health Agency, [1990 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 38,377 at 22,125 (W.D. La. 1989), where each

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32 Tr. at 69.

33 Tr. at 179-180 and 215-217.

34 Exhibit P-101.

35 Providers' Post Hearing Brief at 48.

36 See e.g., Memorial Hospital/Adair County Health Center v. Bowen, 829 F.2d 111, 118 (D.C. Cir. 1987), Exhibit P-75; Home Health Care, Inc. v. Heckler, 717 F.2d 587, 591-93 (D.C. Cir. 1983), Exhibit P-76; Home Health Services of Greater Philadelphia, Inc. v. Harris, 530 F. Supp. 1236, 1246-1248 (E.D. Pa. 1982), Exhibit P-74; Saddleback Community Hospital v. Blue Cross and Blue Shield Association, PRRB Dec. No. 83-D15, Dec. 16, 1982, Medicare & Medicaid Guide (CCH) ¶ 32,352, decl'd rev. HCFA Admin., Jan 18, 1983, Exhibit P-78; Alma Nelson Manor v. Ætna Life Insurance Co., PRRB Dec. No. 90-D15, Feb. 26, 1990, Medicare & Medicaid Guide (CCH) ¶ 38,429, decl'd rev., HCFA Admin., March 28,1990, Exhibit P-79; Oxford Lane, Ltd. v. Ætna Life Insurance Co., PRRB Dec. No. 91-D36, April 3, 1991, Medicare & Medicaid Guide (CCH)
¶ 39,178, decl'd rev., HCFA Admin., May 20, 1991, Exhibit P-80; PRRB Hearing Dec. 75-Dl7, Medicare & Medicaid Guide (CCH) ¶ 27,582, Exhibit P-81; Part A Intermediary Letter 76-31 (July 1976), Exhibit P-82; Part A Intermediary Letter 78-16, Medicare & Medicaid Guide (CCH) ¶ 28,971 (Apr. 1978), Exhibit P-71; Memorandum from Deputy Director, Bureau of Policy Development, HCFA, to All Regional Administrators, June 21, 1995, Exhibit P-83.

of the factors contained in 42 C.F.R. § 413.9(c)(2) must be taken into account,[37] and Eagle Healthcare - 1993 Prudent Buyer Group Appeal v Ætna Life Insurance Co., PRRB Dec. No. 97-D83, July 17, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,504, rev'd, HCFA Admin., September 12, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,727, where each of the factors has "a notable bearing on the comparability of services and their associated costs." Id.

The Providers also contend that the Intermediary's limits are not comprised of the same basic elements as their OT and ST costs. Therefore, the Intermediary's limits and the Providers' costs are not comparable for the purpose of a substantially out of line analysis.[38] Initially, the Providers assert that they are not comparable to all hospitals included in the 1989 BLS hospital wage study or to all employers that responded to the 1994 Minnesota occupational wage survey. The Providers note there is a 20 percent differential in the wages paid to therapists working in hospitals and the wages paid to therapists working in SNFs.[39] Moreover, the studies relied upon by the Intermediary reflect that wage costs may vary substantially across different geographic areas in the state, and some of the Providers in the group are located in areas where it is extremely difficult to find qualified therapists who are willing to work in SNFs.[40] In addition, the Intermediary's salary equivalency limits for OT and ST services purportedly reflect the salary and benefits costs the Providers would have incurred, per paid hour, to furnish therapy services to patients through employees. Paid hours include all therapist time spent in a facility plus all paid time off for vacation, sick leave, etc. The Providers, however, paid only for therapy services furnished to patients and related patient record documentation. The Providers did not pay for travel time, nonproductive time that contract therapists spent in the facility, or therapists' paid time off. [41]

The Providers assert that consideration must also be given to productivity rates (therapy hours in proportion to paid hours) associated with therapy services furnished by SNFs through in-house employees. For example, in a situation where one SNF employs a full-time therapist at $25 an hour, and another SNF pays a contracted therapist at a rate of $25 per 15-minute unit of therapy service, it is not possible to determine the more prudent purchaser unless the volume of services is known.[42]

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37 Exhibit P-77.

38 Providers' Post Hearing Brief at 50.

39 Exhibit P-100.

40 Exhibits P-34, P-36, P-37 and P-39.

41 Tr. at 69 and 217.

42 Providers' Post Hearing Brief at 54. Tr. at 218.

The Providers also assert that the Intermediary's reliance on paid hours to apply its limits, and disregard for productivity, can actually provide for the payment of costs incurred in the inefficient delivery of therapy services. For example, to determine the reimbursement limit for a provider's OT costs the Intermediary multiplies its OT salary limit ($40.63 per hour) times the number of paid hours worked. So, in a situation where two SNFs provide the same units of service, yet one of them spends significantly more time rendering that service, that SNF's costs would be significantly greater than the efficient SNF's costs, yet its allowable cost limit under the Intermediary's methodology would also be far greater.[43]

The Providers contend that the Intermediary's reliance upon a 1974 court decision to support its position is misplaced.[44] The Intermediary suggests that the retroactive application of its salary equivalency limits for OT and ST costs is supported by the court's decision in New Jersey Chapter, Inc. of the American Physical Therapy Association, Inc. v. Prudential Life Insurance Co. of America, 502 F.2d 500 (D.C. Cir. 1974) ("New Jersey").[45] The Intermediary's limits, however, are quite different from the benchmarks at issue in that case. In New Jersey, a trade association brought suit to enjoin a Medicare intermediary from using salary benchmarks to review the reasonableness of provider PT costs. Significantly, Prudential's benchmarks, unlike the Intermediary's salary equivalency limits, were established prospectively with the approval of the Bureau of Health Insurance (HCFA's predecessor) and advance notice was given to the affected parties. Furthermore, Prudential avowed that its salary benchmarks would not be applied as limits but merely as a scoping tool to identify costs below the benchmark amounts which would be automatically reimbursed without further review. Id. at 10,054

The Providers contend that the Intermediary's reliance upon program instructions contained in HCFA Pub. 15-1 § 2103 and Medicare Part A Intermediary Manual, Part II ("HCFA Pub. 13-2") § 2130 to support its position is also misplaced.[46] The Intermediary believes its use of benchmarks to determine prudence is authorized under HCFA Pub. 15-1 § 2103.B, which states that intermediaries may "employ various means for detecting and investigating situations in which costs seem excessive." The Intermediary also relies on HCFA Pub. 13-2 § 2130.2, which states that an intermediary "should determine whether it would have been feasible for the provider to provide the [contract] services more economically by hiring additional personnel on a part-time or full-time basis."[47] Id.

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43 Tr. at 76-81 and 221-222.

44 Providers' Post Hearing Brief at 55.

45 Exhibit I-4.

46 Providers' Post Hearing Brief at 57.

47 Intermediary's Position Paper at 4.

The Providers assert, however, that HCFA Pub. 15-1 § 2100ff clearly acknowledges that reasonable cost, as defined in 42 C.F.R. § 413.9, encompasses the "actual costs of providing high quality care, regardless of how widely they may vary from provider to provider," subject only to the exception that applies when a provider's costs are shown to be substantially out of line. HCFA Pub. 15-1 § 2102.1 Further, HCFA Pub. 15-1 § 2103 clearly contemplates a comparison of prices paid by comparable providers for comparable services. Therefore, in accordance with the Medicare manual the Intermediary may "employ various means" to detect and investigate costs that "seem excessive." However, nothing in the manual supports the Intermediary's belief that it may use these investigational techniques to effect retroactive disallowances of a provider's actual costs.

The Providers assert that the Intermediary's reading of HCFA Pub. 13-2 § 2130 is also erroneous. This manual section clearly reflects that the Intermediary may not impose retroactive cost disallowances without following the substantially out of line limitation mandated by 42 C.F.R.
§ 413.9(c)(2). Specifically, the manual states:

> [t]he application of this [prudent buyer] concept . . . intends that intermediaries be alert, from their professional contact with providers and their cost report settlement process, to situations where a provider's costs of operations will become or in fact already are out of line (i.e. , appear unreasonable) with similar costs of comparable providers . . . If it is determined by this effort that the cost is out of line with what comparable providers incur . . . that portion of the costs which exceeds what comparable providers incurred constitutes unreasonable costs not reimbursable by Medicare.

HCFA Pub. 13-2 § 2130.1 (emphasis added).

The Providers reject the Intermediary's concern regarding indemnification provisions in the contracts they entered with their outside contractors. The Providers argue that demanding contractual guaranties that the contractors' services and charges are reasonable and allowable is directly in the course of the prudent buyer concept.[48]

The Providers contend that the Intermediary did not show that they were imprudent to furnish OT and ST services under arrangements with outside contractors at the per unit costs which they incurred in the subject cost reporting period. In applying its limits the Intermediary failed to consider or present any evidence concerning important aspects of the problem of furnishing therapy services in-house. The Intermediary instead relied upon assumptions that

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[48] Providers' Post Hearing Brief at Foot Note 13.

are clearly false, arbitrary and capricious, and not based upon substantial evidence, as follows:[49]

- The Intermediary's salary equivalency limits purportedly reflect the cost per paid hour that the Providers would have incurred to furnish OT or ST services in-house. However, the Intermediary failed to consider or present any evidence concerning the productivity of in-house therapists. Therefore, even if the Intermediary's limits were presumed to accurately reflect the costs per paid hour that the Providers would have incurred to furnish OT and ST services in-house, application of the Intermediary's limits is nonetheless invalid. In order to determine whether or not the Providers paid too much furnishing therapy services under arrangement with outside contractors the Intermediary would have to consider volume of services and the efficiency of in-house staff to contract services.[50]

- The Intermediary failed to consider significant disincentives under Minnesota state law that make it imprudent for most SNFs in that state to furnish therapy services through employees. Specifically, Minnesota legislation enacted in 1987[51]creates significant risks of loss for Minnesota SNFs that provide therapy services to patients through employees. Those risks arise from limitations on the revenues a SNF may keep when it employs therapists to furnish therapy services in-house.[52]

- The Intermediary failed to consider cost savings realized through the use of contract services. The Intermediary concluded that all but three of the Providers in the group would have incurred greater costs to provide ST services in-house than they incurred using outside contractors. Nevertheless, the Intermediary disallowed OT costs incurred in the same instances. For example, the Intermediary determined that Lake Haven Manor would have incurred an additional $49,634 to provide ST services in-house than it incurred to obtain ST services from an outside contractor. And, even though that savings was almost four times greater than the difference ($12,884) between Lake Haven's actual OT costs and the amount that the Intermediary determined the provider

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49 Providers' Post Hearing Brief at 62.

50 Providers' Post Hearing Brief at 62.

51 Exhibit P-41

52 Providers' Post Hearing Brief at 67. Exhibit P-103.

would have incurred to provide OT services in-house, the Intermediary disallowed the $12,884.[53]

- The Intermediary did not calculate the paid hours component of its salary equivalency limitations consistently. Recognizing that the Providers could not have hired part-time therapists during fiscal year 1994, the Intermediary rounded the number of paid hours worked by contract therapists up to 2,080 in those instances where the actual number of paid hours worked were less than one full-time equivalent ("FTE"). However, therapists' hours in excess of 2,080 were not rounded up to the next whole FTE number of hours, and assistants' paid hours were not increased to reflect a whole FTE number of hours in any instance.[54]

- The data used by the Intermediary to determine its salary equivalency limits is inaccurate and does not reflect the costs that would have been incurred by a SNF in Minnesota to provide therapy services in-house.[55] The BLS data used by the Intermediary does not take into account the significant costs that would be incurred by a SNF to recruit, train, and maintain qualified therapists on staff. The data is also outdated as it was based on surveys of OT and ST salaries paid in 1989. Moreover, the data included only hospital wage data. A survey of compensation paid to nearly 50,000 therapists employed by 194 hospitals and 517 nursing homes shows that SNFs pay occupational therapists 18 percent more than hospitals, and paid speech therapists 21 percent more than hospitals.[56]

The Minnesota occupational wage data reflected the salaries of only 40 occupational therapists employed by SNFs and no speech therapists. These numbers are so low that the results are unreliable and, as acknowledged by the authors of study, should only be used with an abundance of caution. The Minnesota wage data report clearly warned:

> CAUTIONARY NOTE!
>
> Wage rates may fluctuate a great deal from year to year depending on which employers responded to the survey. This is especially true for occupations with low reported employment.

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53 Providers' Post Hearing Brief at 69. Exhibit P-4 at 16 and 17. Tr. at 226.

54 Providers' Post Hearing Brief at 70.

55 Providers' Post Hearing Brief at 71.

56 Exhibit P-100. Tr. at 100-102.

Minnesota Salary Survey 1994.[57]

Moreover, the Intermediary made only selective use of the data obtained from Rehab Providers of Minnesota, admittedly using some elements, modifying some elements, and ignoring others to back into a 67 percent fringe benefit.[58] Also, the data compiled by Rehab Providers of Minnesota shows that the costs incurred by the Providers to furnish therapy services under arrangements with outside contractors were not out of line with costs that would have been incurred to provide therapy services in-house. Specifically, the data shows total costs for OT and ST of $48.59 and $49.26 per paid hour, respectively. Dividing those costs by the 40 percent productivity factor for in-house SNF therapy programs shows that the equivalent costs per treatment hour would have been $121.48 for OT and $123.15 for ST.

The Providers contend that the Intermediary's selective enforcement of its salary equivalency limits, i.e., applying them only to SNFs that incurred at least $250,000 in OT and ST costs, is arbitrary and capricious. In effect, the Intermediary applied its limits to a SNF because it furnished a high volume of therapy services not because the SNF's costs were necessarily out of line. This selective application is also contrary to mandates imposed under the Omnibus Budget Reconciliation Act of 1987 ("OBRA 1987").[59] Under the requirements enacted by OBRA 1987, a SNF "must provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." 51 Fed. Reg. 48,826 (1991)[60] Because of the added burden brought by the OBRA 1987 provisions, Congress clearly explained its intention that the Medicare program would reimburse SNFs for the costs incurred to comply with the new requirements. The legislative history of OBRA 1987 states:

> (e) Costs of Meeting Requirements.--SNFs, reimbursed on a reasonable-cost basis, would be allowed to include on their cost reports the costs the SNF incurred in complying with the new Medicare standards . . . .

H.R. Rep. No. 100-391, 100th Cong., lst Sess. 937, 1655 (1987), reprinted in 1987 U.S.C.C.A.N. 2313-554.[61]

The Providers contend that the Intermediary's selective enforcement of its salary equivalency limits is also arbitrary and capricious because administrative rules must be applied

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57 Exhibit P-49.

58 Providers' Post Hearing Brief at 74. Tr. at 159.

59 Providers' Post Hearing Brief at 77.

60 Exhibit P-51.

61 Exhibit P-56.

uniformly.[62] When an administrative agency allows exceptions to a rule "it must provide a rational explanation if it later refuses to allow exceptions in cases that appear similar." Hooper v. National Transportation Safety Board, 841 F.2d 1150, 1151 (D.C. Cir. 1988). Furthermore, the Intermediary's limits are arbitrary and capricious even as applied to the few SNFs subjected to the Intermediary's focused reviews. As noted above, SNFs that incur the exact same cost per unit of service are subject to wildly differing determinations of allowable cost under the Intermediary's limits. The D.C. Circuit recently noted in Transactive Corp. v. United States that:

> [a]long line of precedent has established that an agency action is arbitrary when the agency offered insufficient reasons for treating similar situations differently. See, e.g., Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mutual Auto. Ins. Co., 463 U.S. 29, 57, 103 S.Ct. 2856, 2874, 77 L.Ed. 2d 443 (1983) (citing Greater Boston Television Corp. v. FCC, 444 F.2d 841, 852 (D.C. Cir. 1970), cert. denied, 403 U.S. 923, 91 S. Ct. 2229, 2233, 29 L.Ed. 2d 701 (1971); Airmark Corp. v. FAA, 758 F.2d 685, 691-92 (D.C. Cir.1985); Local 777, Democratic Union Organizing Committee v. NLRB, 603 F.2d 862, 872 (D.C. Cir. 1978).

Transactive Corp. v. United States, 91 F.3d 232, 237 (D.C. Cir.1996).[63]

The Providers contend that the Intermediary's retroactive application of salary equivalency limits is a violation of due process. The Providers assert that they were not given fair warning of either the limits that would be applied to their OT and ST costs or the methodology by which the limits would be established and applied.[64] Although the Intermediary argues that the Providers were given advance notice in a bulletin issued December 1, 1993,[65] the Providers maintain that that bulletin merely stated: "an example of the prudent buyer principle is when employment of a therapist is less costly than contracted services." Id. The Providers assert that the December notice clearly did not put them on notice of the salary equivalency limits established by the Intermediary in 1996 to be applied retroactively to 1994. Furthermore, the Providers note that the December 1993 bulletin was issued after the beginning of most of the cost reporting periods at issue in this case.

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62 Providers' Post Hearing Brief at 79.

63 Exhibit P-86.

64 Providers' Post Hearing Brief at 81.

65 Exhibit I-5.

The Providers cite General Electric Company v. United States Environmental Protection Agency, 53 F.3d 1234, 1330 (D.C. Cir. 1995)[66] where the court held that a party may not be held liable under an agency's interpretation of a regulation that is (like the Intermediary's interpretation of 42 C.F.R. § 413.9(c)(2)) "so far from a reasonable person's understanding of the regulations that [it] could not have fairly informed [the regulated party] of the agency's perspective." Id. The court explained that its holding was based on traditional notions of due process and fair play. Respectively, in this case, the Providers were given no prior notice of the Intermediary's salary equivalency limits or the methodology that would be used to establish and apply those limits to the years at issue.

Finally, the Providers contend that HCFA specifically advised a Medicare intermediary in 1992 that it could not legally impose limits or benchmarks for OT and ST costs that were derived from the same 1989 BLS hospital wage data that the Intermediary used in this case.[67] At that time, HCFA stated:

> [t]he information provided shows that [the intermediary] developed a "salary equivalency guideline" by updating amounts published in the "Industry Wage Survey: Hospitals, March 1989" published in Bulletin 2364 by the Bureau of Labor Statistics in August 1990. [The intermediary] concluded from these salary equivalency guidelines ". . . that speech and occupational therapy rates . . . were unreasonable . . ." As I noted above, the application of "salary equivalency guidelines" may not be performed until after publication or prior approval by HCFA.

HCFA letter dated July 21, 1992.[68]

The Providers conclude that HCFA did not construe its own regulations in 1992 to permit fiscal intermediaries to apply salary equivalency guidelines for OT and ST costs derived from the 1989 BLS hospital wage data. Therefore, they can not reasonably be charged with advance warning that 42 C.F.R. § 413.9(c)(2) permitted the application of retroactive salary equivalency limits based upon that same data.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its adjustments to the Providers contracted OT and ST costs are proper. The adjustments are based upon an appropriate application of Medicare's prudent

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66 Exhibit P-87.

67 Providers' Post Hearing Brief at 83.

68 Exhibit P-93 at 2.

buyer principle.[69]

In accordance with 42 C.F.R. § 413.9(c)(2), program payments are intended to cover the actual reasonable costs incurred by a provider, however widely those costs may vary from one provider to another. However, the regulation makes an exception, or subjects program payments to a limit "if a particular institution's costs are found to be substantially out of line with other institutions in the same area that are similar in size, scope of services, utilization, and other relevant factors." 42 C.F.R. § 413.9(c)(2).

Manual instructions at HCFA Pub. 15-1 § 2103 clarify the concept of reasonable costs. In part, the manual states: "[t]he prudent and cost-conscious buyer not only refuses to pay more than the going price for an item or service, he also seeks to economize by minimizing cost." HCFA Pub. 15-1 § 2103. A. Moreover, the manual instructs intermediaries on the application of this principle by explaining, in part, that: [i]ntermediaries may employ various means for detecting and investigating situations in which costs seem excessive." HCFA Pub. 15-1 § 2103.B.

The Intermediary contends that in accordance with the provision of HCFA Pub. 15-1 § 2103.B allowing for the use of "various means" to detect imprudent situations, it took several steps to evaluate the reasonableness of provider therapy costs.[70]

First, the Intermediary recognized a significant increase in the volume and dollar amount of OT services being provided by SNFs throughout Minnesota. The Intermediary's Medical Review Department had communicated to the Audit Department that it had also recognized a change in the utilization of OT and ST services and that there had been a significant increase in charges.

Next, the Intermediary conducted an analysis of therapy costs by comparing the costs incurred by five SNFs that purchased therapy services from outside suppliers to the costs incurred by five SNFs that employed their own therapists. This analysis demonstrated that it was significantly less expensive to employ therapists than to provide therapy services under arrangements with outside contractors, as follows:

	Occupational Therapy Cost Per Hour		
	Purchased Services	Employed Therapists	Difference
HIGH	75.00	28.80	46.20
LOW	54.12	20.67	33.45

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69 Intermediary's Post Hearing Brief at 2.

70 Intermediary's Post Hearing Brief at 3-4. Intermediary's Position Paper at 6.

Based upon the results of the analysis, the Intermediary then decided to establish a salary rate benchmark for calculating the reasonableness of OT and ST costs charged to the Medicare program. An initial benchmark determination was made based upon data received from Rehab Providers of Minnesota and from an independent wage survey conducted by the State of Minnesota.[71] Subsequent to the development of the initial benchmark and issuance of the pertinent NPRs, the Intermediary applied a second salary rate benchmark. This refined amount included data from BLS, and was applied using a standard 2,080 "paid hours" work year in lieu of actual "on-site hours" spent by therapists.[72] Providers who incurred costs in excess of the reasonable salary benchmark were given an opportunity to document or justify the premium paid.[73] In those cases where no justification was established, an adjustment was made to disallow the amount over the reasonable rate. Application of the benchmark established that Providers, unable to justify the premium paid, had failed to comply with the prudent buyer rules in contracting for services.[74]

The Intermediary disagrees with the Providers' claim that its benchmark or rate determination was flawed since it did not consider productivity or the efficiency of the therapy services provided. In considering productivity, the Providers looked at total hours of therapy delivered under contract as well as the dispersion of the total hours over a twelve month period. The Providers argued that the hours of therapy service varied significantly from one period to the next. The Providers claimed that since the contractor could send therapists when needed, they could be more productive with less down time than in cases where therapists were employed. The Intermediary asserts, however, that if the Providers had hired a full-time therapist their salary cost would have been approximately $80,000 a year. The claimed contracted therapy costs grossly exceeded that annual salary amount. Even considering the efficiency of the contracted therapist, it is more cost effective to employ a full-time therapist and absorb the down time rather than to pay the excessive cost resulting from efficient therapist services.[75]

The Intermediary also disagrees with the Providers' arguments that they would need more than one full-time employee to cover peak times but could not contract services for short periods. The Intermediary asserts that no evidence was submitted to support this claim and,

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71 See Intermediary's Position Paper at 7 for a more detailed discussion of the benchmark determination including an adjustment factor for employee overhead and fringe benefits. Tr. at 155-161.

72 Intermediary's Post Hearing Brief at 4. Intermediary's Position Paper at 10. Tr. at 166-168.

73 Tr. at 161-164.

74 Id.

75 Intermediary's Post Hearing Brief at 4. Tr. at 235.

moreover, coverage of peak periods of medical need is exactly what contracted services are for.[76]

The Intermediary also rejects the Providers' contention that its adjustments are improper because they are the result of retroactive rule making or an application of costs limits. The Intermediary maintains that there is a fundamental difference between the application of the prudent buyer principle and the application of strict cost limits such as the reasonable cost limitations applicable to PT and RT. Application of the prudent buyer principle allows providers the opportunity to demonstrate that costs in excess of what appears reasonable were warranted; providers may show that they were acting as prudent buyers when incurring the costs. With respect to the instant case, the Providers were afforded such an opportunity during the audits of their cost reports.[77] The Providers, however, could not document attempts to hire therapists, or provide minutes of meetings or other discussions explaining the rationale initially used to contract therapy services. The Providers' contracts for OT and ST services are annually renewable which allows the Providers to reevaluate whether to hire therapists, renew the contracts, or enter into new contracts with other suppliers. Yet, the Providers have not submitted any documentation to support their decisions.

The Intermediary notes that one of the major reasons stated by the Providers for contracting therapy services was the lack of available therapists. However, there is no documentation as to why the Providers came to this conclusion. The Providers did not document that they tried to hire any therapists and assistants. Yet, it is evident that the various therapy suppliers hired therapists and assistants to work at the Providers' locations, thus disproving the Providers' contention that therapists were not available in the local market.

Also, the Providers stated they could not justify having full-time therapists on staff. The implication is that they could not afford to hire therapists. Yet, the Providers' payments to the rehabilitation services suppliers are in excess of the amounts that would have been paid to employed therapists. For example, in the case of Elim Home, the OTs and assistants worked a total of 3,596 on-site hours. For these hours of service, the Provider paid a total of $201,367 after inclusion of the gross-up of $47,339 per HCFA Pub. 15-1 § 2314.B, and reduction for rent received of $3,272 from the rehabilitation services supplier for space rental, for an average of almost $56.00 per hour. Speech therapists worked a total of 1,177 on-site hours. For these hours of service the Provider paid $68,080 after inclusion of the gross-up of $21,992 for an average of almost $57.84 per hour.[78] The Intermediary asserts that the State survey information shows that OTs cost about $33.40 per hour and assistants cost about $24.85 per hour including overhead. Speech therapists, per the State survey information, cost

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[76] Intermediary's Post Hearing Brief at 5. Tr. at 129.

[77] Id. Intermediary's Position Paper at 4 and 9.

[78] See Exhibits I-11 and I-12.

about $38.09 per hour.

The Intermediary also asserts that the Provider has the burden of proof when attempting to justify a purchasing decision that results in excessive costs. Program instructions at HCFA Pub. 15-1
§ 2103 state: "in the absence of clear justification for the premium [payment of higher costs], the intermediary excludes excess costs in determining allowable costs under Medicare."

The Intermediary also contends that its "benchmark" approach for applying Medicare's prudent buyer principle is supported by the court's decision in New Jersey.[79] In that case, the court held: "Prudential [the intermediary] is bound to apply the reasonable cost standard to claims submitted by providers." Id. The court also addressed the Providers' contention that the Intermediary, by applying the prudent buyer principle, had issued a regulation "without notice and comment," by stating: "we hold that Prudential's letter was not a regulation but was merely an explanation or interpretation of the reasonable cost limitation found in the Medicare Act." Id. The letter referred to above is a letter sent by Prudential to their providers notifying them of the possible application of the prudent buyer principle.

The Intermediary adds that it also sent the Providers a notice on December 1, 1993, explaining that the prudent buyer principle applied to purchased therapy services. The notice specifically stated: "[a]n example of the prudent buyer principle . . . is when employment of a therapist is less costly than contracted services, the level of allowable costs . . . cannot exceed the costs of an employed therapist."[80] Id.

The Intermediary contends that the Providers' have an approximate aggregate Medicare utilization of 67.7 percent for OT and 59.5 percent for ST, as compared to an overall average Medicare utilization of 6.8 percent.[81] Therefore, Medicare is bearing the majority of the costs related to these services. Program instructions at HIM 13-2 § 2130.2 specifically address this situation as follows:[82]

> [a]lso, when most or all of the recipients of a service are Medicare beneficiaries, costs should be examined with particular care to ensure that the providers are motivated to seek discounts or exercise prudence to the degree they otherwise would. Particular attention should be given to situations where a provider contracts with an outside supplier to render various services. The

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79 Intermediary's Position Paper at 4. Exhibit I-4.

80 Exhibit I-5.

81 Exhibit I-6.

82 Exhibit I-7.

> intermediary should determine whether it would have been feasible for the provider to provide the services more economically by hiring additional personnel on a part-time or full-time basis.

HIM 13-2 § 2130.2

Finally, the Intermediary contends that the Providers had no incentive to behave like prudent buyers since their contracts with the therapy services suppliers contained an indemnification clause.[83] Essentially, this clause contractually obligates the rehabilitation services suppliers to pay back (refund) to the Providers any disallowed OT and ST costs that may result from the audits of their cost reports performed by the Intermediary. Therefore, without any exposure to the risk of loss the Providers could contract for excessively high cost OT and ST services through the rehabilitation services suppliers and not be concerned with disallowances that may result. Moreover, because of the financial environment created by the indemnification clause, the Intermediary also believes there is no incentive for the Providers to be prudent in their decision making process in deciding to hire therapists or contract services, or in deciding between one contractor or another for the best cost.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§ 1395(f)(b)	-	Amount Paid to Providers
§ 1395(a) et seq.	-	Amount of Payment
§ 1395x(v) et seq.	-	Reasonable Cost

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

§§ 405.1835-.1841	-	Board Jurisdiction
§ 413.9 et seq. (Previously Designated 405.451)	-	Cost Related to Patient Care
§ 413.106 et seq.	-	Reasonable Cost of Physical and Other Therapy Services Furnished Under Arrangements
§ 483.45	-	Specialized Rehabilitative Services

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[83] Intermediary's Position Paper at 5. Exhibit I-8. Tr. at 171.

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

§ 1417.A	-	Data to be Maintained by Provider
§ 2102 et seq.	-	Reasonable Cost
§ 2103 et seq.	-	Prudent Buyer

4. Program Instructions-Part A Intermediary Manual, Part II (HCFA Pub. 13-2):

§ 2130 et seq.	-	Determination of Provider Costs-Prudent Buyer

5. Case Law:

Hospital Sin Padres, Inc. v. Coopertiva de Seguros de Puerto Rico, PRRB Dec. No. 83-D93, June 15, 1983, Medicare & Medicaid Guide (CCH) ¶ 33,081, decl'd rev., HCFA Admin. July 19, 1983.

Home Health Services of Dallas, Inc. v. Schweiker, (1983 Transfer Binder] Medicare & Medicaid Guide (CCH) § 33,009 at 9918-19 (N.D. Tex. 1983).

Vermillion Home Health Agency, [1990 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 38,377 at 22,125 (W.D. La. 1989).

Eagle Healthcare - 1993 Prudent Buyer Group Appeal v. Ætna Life Insurance Co., PRRB Dec. No. 97-D83, July 17, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,504, rev'd, HCFA Admin., September 12, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,727.

Memorial Hospital/Adair County Health Center v. Bowen, 829 F.2d 111 (D.C. Cir. 1987).

Home Health Care, Inc. v. Heckler, 717 F.2d 587 (D.C. Cir. 1983).

Home Health Services of Greater Philadelphia, Inc. v. Harris, 530 F. Supp. 1236, 1246, 1247-48 (E.D. Pa. 1982).

Saddleback Community Hospital v. Blue Cross and Blue Shield Association, PRRB Dec. No. 83-D15, Dec. 16, 1982, Medicare & Medicaid Guide (CCH) ¶ 32,352, decl'd rev. HCFA Admin., Jan. 18, 1983.

Alma Nelson Manor v. Ætna Life Insurance Co., PRRB Dec. No. 90-D15, Feb. 26,

1990, Medicare & Medicaid Guide (CCH) ¶ 38,429, decl'd rev., HCFA Admin., March 28,1990.

Oxford Lane, Ltd. v. Ætna Life Insurance Co., PRRB Dec. No. 91-D36, April 3, 1991, Medicare & Medicaid Guide (CCH) ¶ 39,178, decl'd rev., HCFA Admin., May 20, 1991.

PRRB Hearing Dec. 75-Dl7, Medicare & Medicaid Guide (CCH) ¶ 27,582.

New Jersey Chapter, Inc. of the American Physical Therapy Association, Inc. v. Prudential Life Insurance Co. of America, 502 F.2d 500 (D.C. Cir. 1974).

Mariner Health Care/Liberty Health Care - 1994 Occupational and Speech Therapy Group Appeal v. Mutual of Omaha Insurance Company, PRRB Dec. No. 98-D48, May 8, 1998, rev'd. HCFA Admin. July 7, 1998.

Hooper v. National Transportation Safety Board, 841 F.2d 1150 (D.C. Cir. 1988).

Transactive Corp. v. United States, 91 F.3d 232 (D.C. Cir.1996).

General Electric Company v. United States Environmental Protection Agency, 53 F.3d 1234 (D.C. Cir. 1995).

Washington Hospital Center v. Bowen, 795 F. 2d 139 (D.C. Cir. 1986).

6. Other:

S. Rep. No. 404, 89th Cong., lst Sess. (1965), reprinted in 1965 U.S.C.C.A.N. 1943, 1976.

H.R. Rep. No. 100-391, 100th Cong., lst Sess. 937, 1655 (1987), reprinted in 1987 U.S.C.C.A.N. 2313-554.

Part A Intermediary Letter 76-31 (July 1976).

Part A Intermediary Letter 78-16, Medicare & Medicaid Guide (CCH) ¶ 28,971 (Apr. 1978).

HCFA Memorandum, Bureau of Policy Development to All Regional Administrators dated June 21, 1995.

51 Fed. Reg. 48,826.

62 Fed. Reg. 14,869 (March 28, 1997).

Medicare Cost Reporting Form Worksheet A-8-3 and Instructions.

HCFA Letter, July 21, 1992.

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 that the adjustments made by the Intermediary to the Providers' OT and ST costs are proper. The Board finds that the Intermediary's adjustments are appropriately based upon Medicare's reasonable cost reimbursement rules and prudent buyer principle.

The Board finds that the Providers in this case furnished OT and ST services to Medicare beneficiaries under arrangements with outside contractors. Program payments for the costs of therapy services furnished under arrangements are limited to guidelines published by HCFA. Pursuant to 42 C.F.R. § 413.106(c)(5), however, if HCFA has not issued a guideline for a specific therapy or discipline "costs are evaluated so that such costs do not exceed what a prudent and cost conscious buyer would pay for the given service." Id.

With respect to the instant case, the Board finds that HCFA had not issued payment guidelines for OT and ST services effective for the subject cost reporting periods. Therefore, in accordance with the provision of 42 C.F.R. § 413.106(c)(5), quoted above, the Board turns to program rules and instructions governing Medicare's prudent buyer principle. Respectively, the Board finds that 42 C.F.R. § 413.9(c)(2) explains that program payments are intended to meet a provider's actual costs except where such costs "are found to be substantially out of line with other institutions in the same area that are similar in size, scope of services, utilization, and other relevant factors." Id. Moreover, the Board finds that HCFA Pub. 15-1 § 2102.1 explains the program's expectation:

> that the provider seeks to minimize costs and that its actual costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service (see § 2103). If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable under the program.

HCFA Pub. 15-1 § 2102.1 (emphasis added).

Also, with respect to the application of the prudent buyer principle, program instructions at HCFA Pub. 15-1 § 2103.B state:

> [i]ntermediaries may employ various means for detecting and investigating situations in which costs seem excessive. Included may be such techniques as comparing the prices paid by providers to the prices paid for similar items or services by comparable purchasers . . . In those cases where an intermediary notes that a provider pays more than the going price for a supply or service . . . in the absence of clear justification for the premium, the intermediary excludes excess costs in determining allowable costs under Medicare.

HCFA Pub. 15-1 § 2103.B.

Contrary to the Providers' arguments, the Board finds that the subject adjustments are based upon these prudent buyer rules properly applied by the Intermediary. The Board rejects the Providers' argument that the subject adjustments are founded upon an application of cost limits pursuant to 42 C.F.R. § 413.106, which would be illegal since such limits may only be established by HCFA.

In support of their position, the Providers explain that the concept behind the Intermediary's adjustments is the same as the concept behind HCFA's cost limits, i.e., the Intermediary's adjustments are based upon an estimate of the costs that would be incurred by a provider furnishing therapy services through an employment relationship plus a reasonable amount of additional overhead expenses. In addition, the Intermediary initially determined its adjustments using the exact same methodology that HCFA uses to apply PT cost limits.

The Board, however, finds these arguments irrelevant. In a situation where HCFA has not establish cost limits, as in the instant case, the Intermediary is responsible for determining the reasonableness of the Providers' therapy costs and, in accordance with HCFA Pub. 15-1 § 2103.B, may employ "various means" for this purpose. The fact that there are distinct similarities between techniques used by the Intermediary and relevant program rules and instructions governing any specific category of cost is logical and expected.

Nevertheless, the Board also distinguishes the Intermediary's application of Medicare's prudent buyer rules from an application of cost limits by the fact that the Intermediary allowed the Providers an opportunity to document why their decisions to use contracted therapists was prudent. If the Providers could furnish such documentation no adjustment would be made to their OT or ST costs. The record shows that the Intermediary was willing to accept a broad range of documentation the Providers may have had in this regard including attempts to hire therapists, minutes of board meetings, etc.

The Providers, however, failed to submit any evidence that they considered hiring therapists as a less expensive alternative to contractual arrangements, or that they even sought to find the least expensive contractor. One notable argument raised by the Providers that was supported with substantive documentation concerns a Minnesota state law which essentially limits a SNF's profits from therapy services provided by a related vendor (employee) to 108

percent of therapy costs; profits in excess of the 108 percent level are recovered through a reduction to the SNF's Medicaid payment rate. However, while the Board recognizes the Providers' need to be concerned with revenues and profits, the Board finds that a limitation placed on revenues by a State Medicaid Agency bares no relationship, nor justifies in any way, excessive and/or unnecessary Medicare program payments.

The Board acknowledges the Providers' argument that allowing them an opportunity to document why their decision to use contracted therapists was prudent before disallowing costs does not distinguish the Intermediary's actions from that of an application of cost limits; that is, because 42 C.F.R. § 413.106(f)(2) also provides for exceptions to Medicare's cost limits just as the exceptions extended to them by the Intermediary. The Board, however, disagrees. The Board finds that 42 C.F.R. § 413.106(f)(2) is a formal process requiring providers to demonstrate that Medicare's cost limits or guidelines are inappropriate. The actions taken by the Intermediary in the instant case, while requiring documentation, did not require such a denouncement; rather, all that was required was evidence of the Providers' attempts to be prudent.

The Board also rejects the Providers' arguments regarding the "substantially out of line" provision of 42 C.F.R. 413.9(c)(2). That is, the Providers' contend that even if the Intermediary's adjustments are found to be based upon Medicare's prudent buyer principle rather than an illegal application of cost limits, they are still improper because they were not determined in accordance with program rules. Specifically, the Providers argue that the Intermediary's adjustments are based upon data obtained from a state survey and from BLS; the adjustments are not based upon a comparison of each individual Provider's costs to the costs of other providers "in the same area that are similar in size, scope of services, utilization, and other relevant factors" as required by the regulation. Moreover, if such a comparison were performed it would show that the Provider's costs are not out of line with the costs of other providers in the area since the vast majority of all SNFs in the state of Minnesota contracted for OT and ST services.

In response, the Board finds that Medicare's substantially out of line criteria does not necessarily encompass the prudent buyer policy contained in HCFA Pub. 15-1 §§ 2102.1 and 2103.B. This means that an intermediary may use a case-by-case comparison of provider costs to determine reasonableness in accordance with the substantially out of line provision of 42 C.F.R.
§ 413.9(c)(2), or may employ other means to detect and disallow excessive costs in accordance with HCFA Pub. 15-1 § 2103.B. With respect to the instant case, the Board finds that the Intermediary did, in fact, employ other means to determine the reasonableness of the Providers' OT and ST costs, and that those means resulted in accurate cost disallowances.

As mentioned above, the Intermediary initially used salary data obtained from a state survey to determine the reasonableness of the Providers' OT and ST costs. Essentially, this data was compared to the Providers' costs using a methodology analogous to HCFA's methodology for

applying cost guidelines to PT. However, the Intermediary ultimately refined its determinations by developing a revised reasonable cost "benchmark". This benchmark, which was also compared to the Providers' costs to determine reasonableness, relied upon the higher of the salary amounts found in the state survey or a salary amount derived by BLS. Also, the Intermediary's methodology was revised to rely upon paid hours as opposed to the actual number of hours spent by a therapist on-site at a facility, and were recalculated to reflect a perception that a SNF could not hire a part-time therapist. That is, if a therapist's paid hours were less than 2,080, which is the number of hours the Intermediary equated to a full-time position, the Intermediary used 2,080 hours in its reasonable cost determination.

Respectively, the Board finds that the salary data and paid hours methodology used by the Intermediary establishes sound bases for the prudent buyer determinations and cost adjustments at issue in this case. The Board believes that the BLS data, which is based upon hospital industry wages in major metropolitan areas, reflects salary amounts equal to or greater than salary amounts that would be paid by SNFs to employ therapists. The BLS data had been updated for inflation to October 1, 1995, which is generally a year later than the cost reporting periods at issue. In addition, the fact that the Intermediary based its decisions on the state survey data in those instances where it was greater than the BLS wage data, shows that the Intermediary took a conservative approach to this matter.

Finally, the Board finds support for the propriety of the Intermediary's methodology through a comparison of the Intermediary's benchmark for OT services to the reasonable salary benchmark for OT services determined by another intermediary. Specifically, the hourly rate used by the Intermediary for OT services derived from BLS data is $40.63 per hour.[84] This rate, multiplied times the 2,080 minimum hour work year used by the Intermediary yields an annual reasonable salary of approximately $84,500. In Mariner Health Care/Liberty Health Care - 1994 Occupational and Speech Therapy Group Appeal v. Mutual of Omaha Insurance Company, PRRB Dec. No. 98-D48, May 8, 1998, rev'd. HCFA Admin. July 7, 1998, the intermediary determined from a survey of over 1,000 SNFs that the annual salary rate for OT in the Midwest region of the United States, based upon the 75th. percentile of the arrayed data, equated to $45,000. Applying a fringe benefit and expense factor of 71.86 percent[85] to this amount yields an annual reasonable salary of approximately $77,300.

DECISION AND ORDER:

The Intermediary's adjustments to the Providers' OT and ST costs are appropriately based upon Medicare's prudent buyer principle and are proper. The Intermediary's adjustments are affirmed.

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[84] Intermediary's Position Paper at 10.

[85] HCFA proposed a 71.86 percent overhead and fringe benefits expense factor in developing salary guidelines for OT. See 62 Fed. Reg. 14,869 (March 28, 1997).

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire
Martin W. Hoover, Jr., Esquire

Dateof Decision: September 02, 1997

FOR THE BOARD:

Irvin W. Kues
Chairman