PROVIDER REIMBURSEMENT REVIEW BOARD HEARING DECISION

2000-D1

PROVIDER -
Interim Health Care of New Haven

Provider No. 07-7133

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/Associated Hospital Services of Maine

DATE OF HEARING-
March 31, 1999

Cost Reporting Period Ended -
June 30, 1994

CASE NO. 97-0602

INDEX

ISSUE:

Was the Intermediary's adjustment to disallow franchise fees correct?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Interim HealthCare of New Haven, Inc. ("Provider") is a home health agency ("HHA") located in North Haven, Connecticut. On its fiscal year ended ("FYE") June 30, 1994 cost report, the Provider claimed weekly service fees for administrative support services under its contract with Interim, the franchise company. Associated Hospital Services of Maine ("Intermediary") disallowed a portion of these costs. The Provider filed a timely appeal with the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841 and has met the jurisdictional requirements of those regulations. The Medicare reimbursement effect is approximately $176,361.

The Provider, although independently owned and operated, has a contract with Interim dating back to 1973.[1] The contract provides that the Provider pay an up-front franchise fee for territorial franchise rights.[2] The contract also requires the Provider to pay a separate weekly service charge, based on a percentage of the Provider's gross revenues, in exchange for an unlimited package of administrative support services furnished on an ongoing basis.[3] The services include, telephone consultation and correspondence on daily administrative issues, the provision of policy and procedure manuals and updates, risk management services, legal services, operational bulletins and memoranda, specialist visits, training seminars, and quality assurance assistance.[4]

Prior to the FYE at issue these costs had been determined to be reasonable by earlier intermediaries using comparative analysis,[5] and later under the componentized analysis specified in HCFA Pub. 15-1 § 2135.1.[6] On July 1, 1987, the Provider was assigned to the Intermediary and was directed to submit the "lead schedule" of the componentized analysis.[7] The Intermediary indicated that it would "maintain

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1 See Tr. at 30 and Intermediary Exhibit 7.

2 See Id. § 19(a) and addendum dated June 8, 1991.

3 Id. § 19(b).

4 See Tr. at 43 and 59 through 95 and Provider Exhibits 8 and 40 through

5 See Provider Exhibit 25 at 2.

6 See Intermediary Exhibit 1.

7 See Provider Exhibit 4.

consistency and uniformity on this issue."[8] The Intermediary reviewed, audited and allowed the full amount claimed for weekly service fees paid to Interim for FYEs June 30, 1989, June 30, 1990, and June 30, 1993.[9]

For the FYE 1994, the Provider paid Interim $233,228 in weekly service fees.[10] Of that amount, the Provider claimed a total of $213,121, after offsetting the portion of the weekly services fees in excess of three percent of the gross revenues received from sources other than Medicare and Medicaid.[11] The weekly services fees were included in the Provider's Administrative and General ("A and G") cost center.[12]

The Provider presented data concerning its costs as compared with other HHAs in Connecticut.[13] The Provider also presented data comparing its cost to HCFA's cost limits.[14] The Provider also compared its cost per visit to those allowed in a recent Board case. See Maximum Home Health Care, Inc. v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of South Carolina, PRRB Case No.99-D12, November, 25, 1998, Medicare and Medicaid Guide (CCH) ¶ 80,143, rev'd,HCFA Administrator, January, 28, 1999, Medicare and Medicaid Guide (CCH) ¶ 80,171 ("Maximum"). The Provider also presented data concerning its fees, as a percentage of revenues, compared to other HHAs.[15] The Provider furnished the Intermediary with a componentized analysis.[16] The Provider also provided the Intermediary with supporting documentation showing the fair market value ("FMV") of the administrative support services.

The Intermediary disagreed with the Provider's valuation. The Intermediary carried out its componentized analysis and initially allowed a total of $36,860. The Intermediary specifically allowed the following amounts: Offsite Support, $26,000; Specialist Visits, $2,333; Workshops, $2,400; and

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8 Id.

9 Tr. at 40-42 and Provider Exhibit 6.

10 Tr. 42 and 43 and Provider Exhibit 9, 3rd page.

11 Tr. 44 and 97 and Provider Exhibit 9, 3rd page.

12 Tr. 45 and Provider Exhibit 9, 4th page.

13 Tr. 45 and 46.

14 Tr. 54 and 55 and Provider Exhibit 30, audited cost report, worksheet C Provider Exhibits 29 and 30.

15 Tr. 56 through 58 and Provider Exhibits 35, 36, 2nd page, and 37, 8th page.

16 See Provider Exhibit 8.

Intangibles, $6,127.[17] At the hearing, the Intermediary presented a revised componentized analysis which allowed a total of $137,250 and included the following specific amounts: Offsite Support, $91,000; Specialist Visits, $16,200; Training and Seminars, $2,400; and Risk Management, $27,650.

The Provider was represented by Christopher L. Keough, Esquire, of Powers, Pyles, Sutter and Verville. The Intermediary was represented by James R. Grimes, Esquire, of the Blue Cross and Blue Shield Association ("BCBSA").

PROVIDER'S CONTENTIONS:

The Provider contends that the Social Security Act ("Act"), §§ 1814(b) and 1833(a)(2)(B), 42 U.S.C. §§1395f(b) and 13951(a), provide for payment of the lesser of the HHA's customary charges or its reasonable costs of services, "as determined under section 1861(v)" of the Act. Section 1861(v)(1)(A) of the Act, 42 U.S.C. §1395x(w), defines "reasonable cost" as follows:

> [t]he reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary 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 . . . .

Id. (Emphasis added.)

Section 1861(v)(1)(A) of the Act, 42 U.S.C. §1395x(v) also mandates that the regulations take into account both the direct and indirect costs of services furnished to Medicare beneficiaries.

The regulations implementing the statutory provision for payment of reasonable cost are codified in 42 C.F.R. § 413.9. Section 413.9(a) provides that reasonable cost includes all "necessary and proper costs incurred" in furnishing "services covered under Medicare and related to the care of beneficiaries." The regulation defines "necessary and proper costs" to mean:

> costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. They are usually costs that are common and accepted occurrences in the field of the provider's activity.

42 C.F.R. § 413.9(b).

The regulations further provide that the statutory provision for payment of reasonable cost is intended to include the "actual costs" incurred for services that are appropriate and helpful in developing and

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[17] See Intermediary Exhibit 2.

maintaining patient care facilities and activities. 42 C.F.R. § 413.9(c)(2)-(3). This standard is subject to just one limitation that applies only "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). A long line of precedent construing the reasonable cost standard in 42 C.F.R. § 413.9 holds that the intermediary bears the burden of showing that a provider's actual costs are substantially out of line with comparable costs incurred by comparable providers in the same area for comparable services.[18]

Interpretative guidelines addressing the reasonableness of costs incurred for a package of administrative support services are set forth in HCFA Pub. 15-1 § 2135 and BCBSA Administrative Bulletin 1401, 80.01. HCFA Pub. 15-1 § 2135.3.1 states that an intermediary may perform a componentized analysis of a package of administrative support services in order "to provide the same assurance as can be provided in other situations by a comparison of services in the aggregate, that the total cost of the necessary services is not substantially out of line. Consistent with the substantially out of line standard established in 42 C.F.R. § 413.9(c)(2), the interpretative guidelines in BCBSA Administrative Bulletin 1401, 80.02 state that the intermediary bears the burden of establishing the FMV of a package of administrative support services based on statistically valid data reflecting current marketplace prices.[19] The BCBSA guidelines further provide the componentized analysis should be used only as a scoping tool to identify costs that might be substantially out of line and should be isolated for further review.[20]

The Provider asserts that the Intermediary's disallowance is inconsistent with the reasonable cost standard established in the statute and regulations. The Provider claims that there is no genuine dispute that the administrative support services furnished to the Provider were appropriate and helpful to the development and maintenance of the Provider's HHA and its patient care activities. Thus, the Provider is entitled to reimbursement for the actual service fees claimed for the FYE 1994, subject to just one exception, the extent that the Provider's costs are shown to be substantially out of line with comparable costs incurred by comparable providers in the same area for comparable services. 42 C.F.R. 413.9 (c)(2).

The Provider indicates that the Intermediary concedes that no objective evidence in the record shows that the weekly service fees claimed by the Provider were substantially out of line with costs incurred by comparable providers in the same area for comparable services.[21] Instead, the Intermediary attempts to employ wholly arbitrary and inconsistent criteria to redefine various components of service furnished

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[18] See Provider Post Hearing Brief at 17, n. 12.

[19] See Provider Exhibit 27, at 3-4.

[20] Id.

[21] Tr. 163-64 and 209-11.

to the Provider and seeks to declare the FMV of those components based solely on its own subjective opinion.

The Provider notes that BCBSA Administrative Bulletin 1401, 80.01 defines "offsite support services" to include routine telephone calls and correspondence to assist a provider in the resolution of daily administrative issues. [22] The prior intermediary assigned a FMV of $26,000 to that category of service, in 1980, based on a market rate of $50 per hour for consulting services.[23] The Intermediary now concedes that the market rate for consulting services during the FYE 1994 was $175 per hour, 3.5 times the 1980 market rate.[24] The Intermediary insists, however, that the updated FMV for offsite support, $91,000, should be applied not only to routine consultations in resolution of daily administrative issues, but to "everything that's provided to more than one more than one franchiser (sic)."[25]

Similarly, BCBSA Administrative Bulletin 1401, 80.01 allows a 20 percent add-on as the estimated FMV of intangible and standby services furnished or made available to a provider. The Intermediary included this component in its original determination for the Provider's FYE 1994, [26] but now insists that the add-on percentage should not be recognized in the FMV assigned to the services furnished to the Provider because that allowance only covered "profit factors and errors."[27]

The Provider asserts that the Intermediary cannot base its disallowance solely on these arbitrary evaluation criteria and its subjective judgment as to the value of the services furnished to the Provider by Interim. As noted above, the reasonable cost standard established under the Act and in the implementing regulations require the Intermediary to show that the weekly service fees claimed by the Provider are substantially out of line, based on objective evidence. Neither Section1861 (v) (1) (A) of the Act, nor the implementing regulations published in 42 C.F.R. § 413.9, authorizes the Intermediary to simply declare what is a reasonable cost for the administrative support services obtained from Interim or to disallow the Provider's costs based upon an alleged lack of documentation for the FMV of those services. The Provider cites St. Joseph's Hospital v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Case No.83-D104, July 5, 1983, Medicare and Medicaid Guide (CCH) ¶ 33,096, aff'd in part (concerning administrative fee issue), HCFA

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[22] Provider Exhibit 26, at 2.

[23] Id.

[24] Tr. 155-56, 189 and 192.

[25] Tr. at 155.

[26] Provider Exhibit 9, at 2-3.

[27] Tr. 154, 202-3 and 206-7.

Administrator, September 6, 1983, Medicare and Medicaid Guide (CCH) ¶ 33,424, where the intermediary attempted to compute a disallowance based upon its estimates of the value of services furnished to the provider was reversed by the Board and upheld by the HCFA Deputy Administrator. The Board ruled that the management fees were "reasonable and . . . fully allowable" under the substantially out of line limitation, noting that the intermediary had "failed to show that the management fees were unreasonable in comparison to those incurred by other comparable providers." Id. Medicare and Medicaid Guide (CCH) ¶ 33,096, at 10,510. Since the Intermediary concedes that it has not shown costs to be substantially out of line,[28] its disallowance must be reversed.

The Provider indicates that evidence in the record shows that the weekly service fees are allowable. The Provider points out that it has strong incentives to keep its costs as low as possible because it is operated for-profit and most of its patient care services are not cost reimbursed.[29] The Provider's AG cost per visit, including the weekly service fees claims by the Provider, is lower than AG costs per visit incurred by the vast majority of home health agencies in the Provider's area.[30] An analysis performed by an independent certified public accounting firm of cost report data obtained from a HCFA database for 21 HHAs in the Provider's area shows that those agencies incurred allowable AG costs per visit ranging from a low of $5.51 to a high of $45.90, with a median cost per visit of $11.39. [31]

The Provider's audited cost report for the FYE 1994,[32] shows that its allowable AG cost per visit is $8.68, including the total weekly service fees claimed by the Provider in 1994.[33] That figure represents only the 18th percentile of the range of allowable AG costs per visit for the other 21 HHAs in the Provider's area.[34] Thus, the Provider's costs are in-line with other providers and are thus reasonable. Furthermore, the Provider's total costs per visit are only 60 percent of HCFA's limits.[35]

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[28] Tr. at 163-64 and 209-11.

[29] Tr. 28-29 and 45.

[30] Tr. 49-52, 162 and 164-67; See Provider Exhibit 51.

[31] See Provider Exhibit 51.

[32] Provider Exhibit 30.

[33] Tr. 49-52.

[34] Tr. 52; Provider Exhibit 51.

[35] Tr. 54-55 and Provider Exhibits 29 and 30: as-filed cost report, worksheet C; audited cost report, worksheet C; and analysis of costs in comparison with HCFA cost limits.

The Provider asserts that the service fees are reasonable in comparison to the costs incurred by other HHAs for similar types of service. The portion of the weekly service fees claimed attributable to the home health services furnished to its patients is $1.50 per home health visit.[36] In comparison, another study reflects that the mean cost per visit incurred by HHAs for management services ranges from $7.25 to $17.27, with a mean cost per visit of $11.38 and a standard deviation of $2.93. See Maximum, supra. The Provider's total A and G cost per visit, including the disallowed portion of the service fees paid to Interim, is only $11.24. This cost per visit is lower than the mean cost per visit reflected in the study noted above solely for management services furnished to HHAs, which would necessarily incur additional administrative costs on top of the management fees.

Finally, the Provider asserts that its weekly fees are lower than the FMV of the services provided, as a percentage of its gross revenues, is generally lower than the percentage fees charged by other franchise operations in the home health field.[37]

The reasonableness of the weekly service fees claimed by the Provider is also demonstrated by a comparison of costs claimed to the FMV of the items and services furnished by Interim. The FMV of the administrative support services furnished to the Provider during the FYE 1994 is substantially greater than the weekly service fees claimed by the Provider for that year, $213,121. The Provider presented a detailed componentized analysis of the services furnished by Interim which reflects that the FMV of the items and services furnished by Interim falls within a range of $394,769.[38]

The Provider disagrees with the Intermediary's assertion that the weekly fees contain an amount for territorial franchise rights. The Provider notes that the contract provided separately for a franchise fee and that weekly service fees were not charged for a new territory acquired by the Provider until it conducted business in that area and used those services. The Provider also points out that this view is inconsistent with all prior treatment of these costs. The Provider asserts that such a marked change in treatment without any notice or change in circumstances is arbitrary and capricious and would violate administrative law principles and deny the Provider due process rights.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that it reviewed the claimed franchise fee payments under HCFA Pub. 15-1 § 2135 . That provision indicates that purchased services are to be reviewed for reasonableness. If a presumption of reasonableness can be drawn from the documentation, the Intermediary does not need

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[36] See Provider Exhibit 31 and Tr. at 51.

[37] Tr. 56-58; Provider Exhibits 35; 36, 2nd page; and 37, 8th page.

[38] See Provider's Post Hearing Brief, pp. 29 through 46 and Appendix A.

to look at individual services and costs.[39] HCFA Pub. 15-1 § 2135.3 states that purchased management and administrative support services are allowable costs if reasonable and necessary to patient care. However, HCFA Pub. 15-1 § 2135.4 states that rights to a logo, non-competition clauses, or exclusive franchise rights or a particular territory, or promotion of a franchise are not related to a provider's patient care activities, and are therefore, not allowable.

The Intermediary contends that a review of the franchise agreement between the Provider and Interim clearly demonstrates that the Provider was receiving both allowable and non-allowable services. The franchise agreement grants the Provider the right to "use Company's trademarks, service marks and trade names, and to utilize the Company's good will . . . ." Further, the agreement grants to the Provider the use of "trade secrets" owned by Interim. The agreement also grants to the Provider an exclusive territory.[40] In addition, Interim may, from time to time, develop advertising programs in which the Provider agrees to participate.[41] These types of services relate to the value of the franchise rights; its name and reputation. Such costs are not related to patient care, and as a result are non-allowable.

The franchise benefits received by the Provider have value. The Provider's witness testified that the right to use the Interim trademark and name, the logos and the exclusive territory were valuable benefits.[42] Yet, the Provider in attempting to value the services provided in return for the weekly service fee, assigned absolutely no value to these benefits.[43]

The Provider has argued that it paid a one-time $6,000.00 fee for all franchise rights; relying on the description in the agreement with Interim which referred to the payment as a "non-refundable franchise fee" for support.[44] The Provider then argues that the weekly service charge is a separate charge not related to the franchise rights. The Provider's witness admitted he was not an employee of the Provider at the time the agreement with the Provider was entered into, and did not participate in any negotiations in connection with that agreement. The Intermediary believes the Provider's reading of the agreement is self-serving and does not reflect the nature of the transaction. First, the $6,000 fee was to purchase the franchise in the stated counties in Connecticut, including all the services that went with that franchise. Nowhere in ¶ 19 of the agreement does it say the $6,000 accounts only for Medicare non-allowable

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39 Tr. at 146.

40 Tr. at 146-147.

41 See Intermediary Exhibit 7, at 5.

42 Tr. at lO5-106.

43 Tr. at 42.

44 Tr. at 31.

franchise services. The Intermediary suggests a more reasonable reading of the provision is that the $6,000 was the initial payment for the purchase of the entire contractual arrangement. The Intermediary asserts that the Provider's claim that it paid $6,000 in 1973 for unlimited trademark use and protection is not reasonable. The franchise agreement can be renewed at ten-year intervals with no required additional payments other than the weekly service fee. The Intermediary asserts that Interim expends funds each year for trademark promotion and protection.

The second component of the payment arrangement is the weekly service fee. Nowhere is that payment limited to services other than the franchise services.[45] It is merely described as a service charge based on gross sales. The Intermediary argues that this weekly service fee pays for all services provided by Interim to the Provider. As a result the cost related to the weekly service charge should be allocated between the allowable and non-allowable services.

In support of its franchise fee costs, the Provider submitted a componentized analysis of the value of services received from Interim. The componentized analysis utilized the system described in the Blue Cross Administrative Bulletin 1401, July 2, 1980.[46] The Provider valued the Medicare allowable services received from Interim at $490,845.60. Since that figure far exceeded the $233,000 paid to Interim during the cost reporting period, the Provider argues that the entire weekly franchise fees should be considered payment for allowable services.

The Intermediary disagreed with the Provider's valuation, and allowed only $36,860. The Intermediary also used the componentized analysis and valued services as follows:

Offsite support	$26,000.00
Specialist Visits	2,333.00
Workshops	2,400.00
Intangibles	6,127.00
Total	$36,860.00

In preparation for the hearing, the Provider submitted additional information to support its' valuation of the services received from Interim.[47] This time the total valuation came to $393,706. After review of Provider analysis and considering the nature of services provided, the Intermediary proposed a modification of its' adjustment. The modification seeks to recognize that the holder of an Interim franchise will receive a package of services developed for all Interim franchisees. In addition, the franchise holder will receive some services related only to that specific franchise. The analysis should seek to recognize the general package of services available to all franchise holders, as well as those

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[45] Tr. at 133.

[46] Intermediary Exhibit 2.

[47] See Provider Exhibit 50.

services performed for the franchise exclusively. The analysis must also include recognition of the non-allowable franchise benefits provided by Interim.

The Intermediary notes that services such as manuals and updates to manuals, newsletters, and memoranda are services prepared once by Interim and then provided to all of its franchise holders. The Provider, in its analysis, has attempted to value these newsletters and manuals as if they were written for this provider alone. So that if a newsletter takes two hours to draft, and salary and fringe benefits paid to the drafter is assumed to total $175 an hour, the value of the newsletter is then assumed to be $350. That approach produces a grossly inflated valuation, as can be seen from the total values computed by the Provider.[48]

The Intermediary approach will recognize an allowable franchise fee made up of two components. The first component is a flat fee covering all allowable services, which are provided to all of the franchise holders. The second component will represent the value of allowable services specific to this franchise holder. The Provider valued "offsite support" at $91,000.00. [49] The Intermediary notes that offsite support is defined in the BCBSA Administrative Bulletin, as day-to-day administrative advice, including phone conferences, letters, and other communications. The Intermediary believes this description covers the capacity to provide information of a general nature, back-up support, and advice.[50] The Intermediary agrees to use the Provider's valuation for offsite support in the amount of $91,000. That figure was computed by assuming 520 hours of service at $175.00 per hour. The offsite support would then cover Interim's manuals, newsletters, memoranda, human resources policies and job descriptions, and all general information distributed to franchise holders, as well as back-up support.

In addition, the Intermediary would recognize the tangible services related directly to this Provider. The Intermediary would accept the total hours claimed by the Provider related to these services, and value the services at a rate of $175 per hour. Therefore, the Intermediary would recognize the full cost of on-site operational specialist visits in the amount of $16,200.[51] The Intermediary would also recognize the value of the training seminar in the amount of $2,400.[52] Finally, the Intermediary would recognize the value of the risk management occurrence reporting services in the amount of $27,650 if the Provider can document that the services performed were specific to this Provider.[53]

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[48] See Provider Exhibits 8 and 50.

[49] See Provider Exhibit 50.

[50] Tr. at 156-57.

[51] Provider Exhibit 50, subsection B.

[52] Provider Exhibit 50, subsection C.

[53] Provider Exhibit 50, subsection E.

With these modifications, the allowable portion of the franchise fees paid by the Provider would be:

Offsite support	$91,000.00
Specialist Visits	16,200.00
Training & Seminars	2,400.00
Risk Management	27,650.00
Total	$137,250.00

The Intermediary believes that through this modification, it is recognizing the reality of the relationship between the Provider and Interim. The Intermediary is recognizing the fact that the franchise agreement provides for the right to use the trademark and logos, the right to an exclusive territory and the protection of the trademark and territory. The modification also recognizes allowable services, in the nature of information and technical advice. Finally, the modification recognizes that there are some services provided solely and specifically to an individual franchise. For this Provider, the valuation recognizes that of the $233,000.00 paid to Interim, $137,250 or 59 percent of the total relates to allowable cost. At the same time, $95,750 or 41 percent relates to franchise rights costs.

The Intermediary, providers, and HCFA have been grappling with how to value franchise cost for almost twenty years. The one conclusion everyone can agree on is that no scientific methodology has been developed to date. The Intermediary believes its valuation is a reasonable approach to allocating the franchise cost. The Intermediary has accepted the hourly rate and time proposed by the Provider related to agency specific services, and has adopted the hourly rate and total time assumption used by the Provider for offsite support. However, the Intermediary's approach recognizes that some important services delineated in the franchise agreement and unquestionably provided by Interim to the Provider relate to non-allowable franchise costs. These costs must also be identified and carved out when determining what portion of the total franchise fee should be reimbursed by the Medicare program.

CITATIONS OF LAWS, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§ 1395x(v)(1)(A)	-	Reasonable Cost
§ 1395f(b)	-	Amount Paid to Providers
§ 1395l(a)	-	Amount of Payment

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

§ 413.9ff	-	Reasonable Costs

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

§ 2135ff	-	Purchased Management and Administrative Support Services.

4. Cases:

Maximum Home Health Care, Inc. v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of South Carolina, PRRB Case No.99-D12, November, 25, 1998, Medicare and Medicaid Guide (CCH) ¶ 80,143, rev'd, HCFA Administrator, January, 28, 1999, Medicare and Medicaid Guide (CCH) ¶ 80,171

St. Joseph's Hospital v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Case No.83-D104, July 5, 1983, Medicare and Medicaid Guide (CCH) ¶ 33,096, aff'd in part (concerning administrative fee issue), HCFA Administrator, September 6, 1983, Medicare and Medicaid Guide (CCH) ¶ 33,424

5. Other:

BCBSA Administrative Bulletin No. 1401, 80.01 - Evaluating the Reasonableness of the Fee in Management Contract Arrangements, July 2, 1980

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 brief, finds and concludes as follows:

The Board finds that the Provider presented considerable evidence that its costs were reasonable in three different categories - overall, administrative and general and weekly service fees. The Board notes, however that the Intermediary raised two concerns with the Provider's cost. First, whether they included franchise fees or other services such as advertising costs which are unallowable. Second, whether the FMV claimed for those services was reasonable. The Board recognizes that costs such as franchise fees and advertising are not allowable. The Board, however, finds no evidence in the record to substantiate that any costs are attributable to either franchise fees or other unallowable costs. The Board also notes that the Intermediary did not carry out a persuasive analysis of the FMV of services rendered by the Provider and did not permit standby costs that should have been permitted under the program guidelines. Furthermore, the Board finds that, even if it reduced the amounts claimed by the Provider to what it felt were the conservative FMV for the services delivered, the value of the services still exceed the amount claimed by the Provider. Therefore, the Board finds that the costs claimed by the Provider were reasonable and supported by adequate documentation of their FMV.

The Board finds that the Provider presented evidence that its costs were reasonable. As noted above, the Provider presented evidence that its administrative and general costs were in general compared to other HHAs in Connecticut. The data indicates that the Provider's costs per visit were $7.43,[54] whereas the median administrative and general costs for other HHAs in Connecticut was $11.39.[55] The Provider also presented data showing that their costs were well below the cost limits established by HCFA by some $2 million and would still be below those limits if the adjustment concerning administrative costs were reversed.[56] The Board also notes that the Provider presented data showing that their fee for management services were lower, as a percentage of revenues, than other HHAs.[57] The Intermediary did not present specific data that questioned the reasonableness of the Provider claimed cost compared to other HHAs.

The Board notes that the Intermediary raised two concerns with the administrative and general costs that, if substantiated, would support its disallowance. The Intermediary indicated that the weekly fees represented a franchise fee that are prohibited pursuant to HCFA Pub. 15-1 § 2135.4 and that the FMV of the services received did not equal the costs claimed. The Board notes that the contract between the parties contains an initial $6,000 fee for franchise costs. The Intermediary does not believe the Provider's claim that this was the only franchise fee and assumes that some of the weekly fees must be attributable to costs associated with franchise fees such as advertising costs or promotion and protection of its trademark. The Board did not find any evidence in the record to support the Intermediary's contention that weekly fees were for non-allowable costs.

With regard to the FMV of the services received by the Provider, the Board notes that at the hearing the Intermediary modified its position to increase the amount it allowed from $36,760 to $137,250. The Board disagrees with the Intermediary's assessment of the FMV of the services and further notes that costs allowed do not include the 20 percent allowance permitted under BCBSA Administrative Bulletin 1401, 80.01. The Board notes that the provider presented a detailed analysis of all services included in the weekly fees.[58] The Board agrees with the Intermediary that offsite support should be valued at $91,000 and that at least $27,650 should be recognized for risk management. The Board also finds that at least the minimum amounts claimed by the Provider for the following other tangible services should be included in the allowable costs: sexual harassment training, home solutions meetings, specialist visits and review of operations, memoranda, group health, operational and clinical manuals,

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[54] See Tr. at 46 - 50.

[55] See Provider Exhibit 51, Cost Per Visit Chart - highest to lowest order, allowable administrative and general costs chart.

[56] See Tr. at 54 and 55 and Provider Exhibit 30.

[57] See Tr. at 56-58 and Provider Exhibits 35, 36 at 2, and 37 at 8.

[58] See Provider's Post Hearing Brief at 29-46 and Appendix A.

yellow pages, and legal assistance.[59] The Board also believes that at least some percentage of costs associated with meetings and assistance with "PHS" agreements, human resources, group purchasing and national payer agreements should be allowed. The Board observes that if one merely allowed the minimum cost claimed for tangible services, without assigning any costs for those areas where a percentage would be appropriate, the total amount of allowable costs with the usual 20 percent permitted for standby costs far exceeds the FMV of the costs claimed by the Provider. The Board finds that the Provider presented sufficient evidence that the FMV of the services it received exceeded the costs that were claimed on the cost reports, and thus, the costs claimed should be allowed.

In summary, the Board finds that the Intermediary failed to show any evidence that the fees claimed by the Provider contained any unallowable costs and that the Provider presented considerable evidence that the FMV of the services received exceeded the cost of those services claimed on the cost report. As a result, the Board finds that the Intermediary adjustment should be reversed.

DECISION AND ORDER:

The Intermediary's adjustment disallowing the costs of the Provider's weekly service fees was improper. The Intermediary's adjustment is reversed.

Board Members Participating:

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

Date of Decision: October 14, 1999

FOR THE BOARD:

Irvin W. Kues
Chairman

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[59] See Id.