PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2000-D63

PROVIDER -
All-Care Home Health Services
Rancho Cordova, CA

Provider No. 55-7253

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Iowa/ d/b/a Wellmark

DATE OF HEARING-
March 28, 2000

Cost Reporting Periods Ended -
March 31, 1995
March 31,1996
March 31,1997
March 31,1998

CASE NOS.
97-0643; 98-0770,
99-3555, 99-0613

INDEX

ISSUES:

1. Was the Intermediary's adjustment to Physical Therapy costs proper?

2. Was the Intermediary's adjustment to owners compensation proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

All-Care Home Health Services ("Provider") is a California corporation headquartered in Rancho Cordova, California. It operates its home health agency in Sacramento, Yolo, Placer, and El Dorado counties in California. The Provider is part of a chain organization and has filed a home office cost report. The Provider was serviced by Blue Cross and Blue Shield of Iowa d/b/a Wellmark ("Intermediary").

The Intermediary reviewed the Provider's cost reports, made certain adjustments and issued Notices of Program Reimbursement (NPR). The Provider disagreed with the adjustments and filed a timely appeal with the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R.''1835-.1841 and has met the Jurisdictional requirements of those regulations. The Medicare reimbursement is approximately $256,784.

The Provider is represented by James M. Ellis Esq. of Holleb & Coff. The Intermediary is represented by Bernard M.Talbert Esq. of the Blue Cross and Blue Shield Association, Chicago.

ISSUE 1 - Physical Therapy Costs:

FACTS:

Physical therapy services were provided by employee and contracted physical therapists. The Intermediary concluded that the compensation of all physical therapists is subject to the Physical Therapy Salary Equivalency Guidelines ("Guidelines"). The employee physical therapists did not maintain time records in support of their service. Consequently, the Intermediary was unable to calculate compensation per hour for these physical therapists.

PROVIDER'S CONTENTIONS:

The Provider contends that the Guidelines were not intended to apply to employee physical therapists. Section 1861 (v)(5)(A) of the Social Security Act provides that where physical therapy services are furnished under arrangement with a provider of services or other organization, the amount allowable for Medicare reasonable cost reimbursement purposes shall not exceed the reasonable salary that would have been paid for the same services (together with any additional costs that would have been incurred by the provider or other organization) under an employment relationship with the provider or other organization. The allowable cost (the salary equivalency) was to include other reasonable expenses incurred by the outside supplier in providing physical therapy service, such as travel time, administrative costs, etc.

The Provider points out that the Medicare regulation 42 C.F.R.' 413.106 entitled "Reasonable cost of physical and other therapy services furnished under arrangements," limits payments for services rendered by specialists (such as physical therapists) who work for Medicare providers "under arrangements" to the Salary Equivalency Guidelines. The Guidelines are supposed to be equivalent to the prevailing salary and benefit cost for employees of Medicare providers who render such services plus the cost of travel.

The Regulation at 42 C.F.R. '413.106(a) states in part:

> The reasonable cost of the services of physical, occupational, speech and other therapists, and services of other health specialists (other than physicians), furnished under arrangements (as defined in Section 1861 (w) of the Act) with a provider of services, a clinic, a rehabilitation agency, or a public health agency, may not exceed an amount equivalent to the prevailing salary and additional costs that would reasonably have been incurred by the provider or other organization had such services been performed by such person in an employment relationship, plus the cost of other reasonable expenses incurred by such person in furnishing services under such an

> arrangement....

42 C.F.R. '413.106(a).

The Provider also points out that the regulation at 42 C.F.R. '413.106(c)(1) states:

> Application (1) Under this provision, HCFA will establish criteria for use in determining the reasonable cost of physical, occupational, speech, and other therapy services and the services of other health specialists (other than physicians) furnished by individuals under arrangements with a provider of services, a clinic, a rehabilitation agency, or public health agency. It is recognized that providers have a wide variety of arrangements with such individuals. These individuals may be independent practitioners or employees of organizations furnishing various health care specialists. This provision does not require change in the substance of these arrangements.

42 C.F.R.'413.106(c)(1).

The Provider also notes that the Secretary's Provider Reimbursement Manual (HCFA Pub. 15-1) states in several places that "under arrangements" refers only to suppliers. Section 1400 states in pertinent part:

> ...the reasonable cost of the services of physical, occupational, speech, and other therapists, or services of other health-related specialists(except physicians), performed by outside suppliers for a provider of services, a clinic, a rehabilitation agency, or a public health agency, is limited to (1) amount equivalent to the salary and other costs that would have been incurred by the provider if the services had been performed in an employment relationship, plus (2) an allowance to compensate for other costs an individual not working as an employee might incur in furnishing

services under arrangements.

The Provider also argues that ' 1403 explicitly states that the "guidelines apply only to the costs of services performed by outside suppliers, not to salaries of providers' employees."

The Provider argues that the Board has ruled on at least four occasions that the Secretary's guidelines are not applicable to employee therapists. In Alma Nelson Manor of Rockford, Illinois v. Aetna Life Insurance Co, PRRB decision No. 90-D 15, February 26, 1990, Medicare & Medicaid Guide ("CCH") & 38,429. The Board held that HCFA Pub. 15-1 ' 1403 was intended to apply only to situations involving outside suppliers, such as contract therapists. The Board specifically found that the Guidelines did not apply to the salaries of providers' employees. In Summit Nursing Home, Inc. of Freehold, New Jersey v. The Prudential Life Insurance Company of America, PRRB Dec No. 88-D29, September 1, 1998, Medicare & Medicaid Guide (CCH) &37,408, the Board found that "[t]he [chapter 14] guidelines apply only to the costs of services performed by outside suppliers; not to the salaries of Providers' employees."

The Board held that ' 1403 was intended to apply only to situations involving outside suppliers, such as contract therapists, and did not apply to salaries of providers' employees. The Provider maintains that since 1993 it has had seven employee PTs who were paid on a per patient visit basis. The Medicare regulation at 42 C. F. R. '' 484.14(f) and 484.32 allow home care employees to be paid on a per visit basis and recognize the distinction between employees paid on a per visit basis and independent contractors. The Provider pays the employer=s share of FICA, FUTA and SUTA taxes and workers compensation for its PT employees. The PT employees were therefore considered employees and not independent contractors.

The Provider agrees that the prudent buyer principle as described in HCFA Pub. 15-1 '' 2103 and ' 2130 is an underlying principle of Medicare reimbursement and if it is determined that a claimed cost is substantially out of line with that of comparable providers, an intermediary may find that a cost is unreasonable. However, the prudent buyer principle does not provide HCFA with a basis to apply the Guidelines to employee PTs because the Intermediary did not perform any analysis which would indicate that the guidelines represent the upper limit of what a prudent buyer would pay. Instead, the

Intermediary applied the Guidelines to all of the Providers' PTs.

The Provider points out that BCA using the BCA Medicare Provider Appeal Decision Administration Bulletin AB 335,80.05, reversed the Intermediary's finding and held that:

> [While] it is not improper to utilize published salary equivalency guidelines as a benchmark against which an intermediary may compare salaries of employee therapists, [the Hearing Officer] finds that a strict application of these guidelines to limit employee salaries as if such employees were outside contractors goes beyond the intent of Chapter 14 of the Provider Reimbursement Manual.

Id.

BCA concluded that the Guidelines are meant to be applied only to the cost of therapy services obtained from outside suppliers. BCA further agreed that providers must comply with the prudent buyer principle with respect to any costs in general, but that it is inappropriate to limit costs of employee physical therapists to the Guideline amounts.

The Provider argues that HCFA violated the Medicare Act and the Administrative Procedure Act by adopting a new rule without notice and comment. 42 U.S. C. ' 1395hh provides that no rule, requirement, or other statement of policy that establishes or changes a substantive legal standard governing the scope of payment for services shall take effect unless it is promulgated by the Secretary after advance notice and opportunity for comment. The Administrative Procedure Act contains similar requirements. 5 U.S.C. '533.

The Provider contends that the Secretary did not provide advance notice and comment with respect to its application of the Guidelines to employee PTs. Such application clearly constituted either the establishment of or a change in the substantive legal standard governing the scope of payment for PT services, particularly in light of the Secretary's 19-year practice of not applying

Guidelines to employee PTs. Therefore, the Secretary violated 42 U.S.C. ' 1395hh and 5 U.S.C. '533 in applying the Guidelines to employee PTs. By denying the Provider notice and opportunity to comment on the application of the Guidelines to employee PTs, HCFA has also violated the Provider's procedural due process rights. Accardi v. Shauahnessy, 347 U.S. 260 (1954); Red School House, Inc. v. Office of Economic Opportunity, 386 F. Supp. 1177(D.Minn. 1974).

The Provider argues that the application of the Guidelines to employee PTs is also a violation of 5 U.S.C. '706 of the APA because the Intermediary's act is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." In applying the Guidelines to employee PTs, the Intermediary has ignored the plain language of the applicable statute and regulation (42 U.S. C. '1395x(w) and 42 C.F.R. '413.106), and interpretative rules relating to the Guidelines (PRM ' 1403 and prior decisions of the PRRB, each of which indicate that the Guidelines are only applicable to non-employee PTs providing services under arrangements, and not employee PTs. Accordingly, the Secretary and the Intermediary have acted arbitrarily, capriciously and contrary to law and have abused their discretion in applying the Guidelines to the Provider's employee PTs in violation of 5 U.S.C. '706.

The Provider contends that the Guidelines have not been updated by HCFA for 12 years. By regulation HCFA is obligated to set the Guidelines according to:

> the hourly salary rate based on the 75th percentile of salary ranges paid by providers in the geographical area, by type of therapy, to therapists working full-time in an employment relationship.

42 C.F.R. '413.106(b)(1).

However, HCFA has not analyzed therapists salary ranges paid by providers since 1982. HCFA's only revision of the Guidelines since that time has been to apply a fixed monthly percentage increase of 0.6 percent per month. That rate has fallen far behind the salaries which the market actually requires providers to pay employee PTs. PT salary ranges have increased by more than 200 percent since 1982 while the Guidelines have only increased by 100 percent. Therefore, it is unlawful for the Intermediary and HCFA to apply the

Guidelines because they have not been updated as required by duly promulgated regulation.

The Provider argues that the Intermediary failed to prove that the costs for its employee PTs are substantially out of line with physical therapy costs paid by similar home health agencies. The Provider further contends that the Intermediary adjusted the Provider's claimed costs for its employee PTs by taking a completely inapplicable reference point, the Guidelines, and blindly applying them to the employee PTs. If the Intermediary had compared the cost of the Provider's employee PTs with other similarly situated providers, the Intermediary would have determined that all of the Provider's PT costs were not substantially out of line.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the audit adjustment which added the total physical therapists cost to Worksheet A-8-3 of the Medicare cost report was made in accordance with the provisions of Medicare regulations 42 C. F. R.' 413.9 cost related to patient care and 42 C.F.R.' 413.106 Reasonable cost of physical and other therapy services furnished under arrangements, and Program instructions HCFA Pub. 15-1, Chapter 14.

The Intermediary contends that its audit adjustments are correct for the following reasons:

1. HCFA Pub. 15-1 '1403 states:

> In situations where compensation, at least in part, is based on a fee-for- service or on a percentage of income (or commission), these arrangements will be considered nonsalary arrangements, and the entire compensation will be subject to the guidelines in this chapter.

The compensation of the physical therapists in question was based solely on a fee-for-service. The compensation of these therapists must be treated as "nonsalary arrangements," the same as outside suppliers, and compared to physical therapist guidelines in Chapter 14. The Intermediary contends that

its adjustment complies with this section of the Manual.

The Intermediary points out that the HCFA Administrator's reversal of the PRRB Dec. No.
97-D35 May 20, 1997, High Country Home Health Care Inc. v. IASD Health Services Corp., Medicare and Medicaid Guide ("CCH") & 45,543[1] stated that the Intermediary properly applied the Salary Equivalency Guidelines per HCFA Pub. 15-1 Chapter 14 to the per visit compensated physical therapists.

The Intermediary points out that Community Memorial Hospital and W.S. Hundley Annex Group (South Hill, Virginia) v. Blue Cross and Blue Shield Association/Blue Cross of Virginia, PRRB Dec. No. 84-D118, May 11, 1984, Medicare and Medicaid Guide CCH & 34,099 ruled that a physical therapist who is a salaried employee and compensated on the basis of gross charges of the physical therapy department is subject to the physical therapist guidelines contained in HCFA Pub. 15-1 Chapter 14.

The Intermediary also points out that in HCFA Pub. 15-1 ' 1403 there are several situations in which compensation of a salaried physical therapist would be subject to the limitation in Chapter 14. It states in part:

> the costs of the services of a salaried employee who was formerly an outside supplier of therapy or other services, or any new salaried employment relationships will be closely scrutinized to determine if an employment situation is being used to circumvent the guidelines. Any costs in excess of an amount based on the going rate for salaried employee therapists must be fully justified. HCFA realized that certain salaried employment relationships would effectively circumvent the guidelines and provided for the circumvention in Section 1403.

The Intermediary contends that according to the Medicare regulation at 42 C.F.R.

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[1]Exhibit I-8

' 413.106(c)(5),[2] "Until a guideline is issued 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," this regulation is implemented by HCFA Pub. 15-1 ' 1403, which reads in part: "Until specific guidelines are issued for the evaluation of the reasonable costs of other services furnished by outside suppliers, such costs continue to be evaluated under the Medicare programs requirement that only reasonable costs be reimbursed." The relevancy of those quotes is in effect specific guidelines for application of the prudent buyer principle. This position is supported by HCFA and is offered as support that the audit adjustment in dispute is in accordance with Medicare regulation 42 C. F. R. '413.9 and HCFA Pub. 15-1 '2103.

The Intermediary contends that its calculation of the Hourly Salary Equivalency Amount complies with the instructions in Volume 48 of the Federal Register of September 30, 1983. The Intermediary points out that according to HCFA Pub. 15-1 section 1402.6[3] "guidelines are the amounts published by HCFA reflecting the application of the prevailing salary.... Prior to the onset of a period to which a guideline will be applied, a notice will be published in the federal register establishing the guideline amounts to be applied to each geographical area by type of service." Id.

The Intermediary argues that the Provider did not request an exception to the physical therapy cost guidelines. HCFA Pub. 15-1 section 1414.2[4] states:

> An exception may be granted under this section by the intermediary when a provider demonstrates that the costs for therapy or other services established by the guidelines are inappropriate to a particular provider because of some unique circumstances or special labor market conditions in the area...

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[2]Exhibit I-5

[3]Exhibit I-6

[4]Exhibit I-7

The Intermediary points out that the Provider did not submit evidence to substantiate its claim that the rates are insufficient.

ISSUE -2 OWNER'S COMPENSATION:

FACTS:

The Provider claimed compensation for the services of its Owner/Chief Executive Officer. The Intermediary made an adjustment to disallow a portion of the owners' compensation that it determined to be unreasonable.

PROVIDERS CONTENTIONS:

The Provider points out that the Regulation at 42 C.F.R. '413.102(c)(2) states:

> Reasonableness of compensation may be determined by reference to, or in comparison with, compensation paid for comparable services and responsibilities in comparable institutions; or it may be determined by other appropriate means.

The Provider argues that according to the regulation, reasonableness requires that the compensation allowance: (i) Be such an amount as would ordinarily be paid for compensation services by comparable institutions, (ii) Depend upon the facts and circumstances of each case, 42 C.F.R. '413.102(b)(2). The Provider also points out that HCFA Pub. 15-1 '904.2 also provides additional guidance on determining owners compensation.

The Provider maintains that in order to determine the reasonableness of owners compensation, the Medicare guidelines generally state that a person's compensation be compared with the compensation paid to other individuals by other organizations in similar circumstances. The factors to be considered in determining the compatibility of institutions are: (1) the size of the institution;(2) classification of the institution (i.e. type and range of services provided);(3) number and type of personnel employed, and, (4) geographical location. HCFA Pub. 15-1 '901.1 The Provider asserts that the Manual defines full-time work as 40 hours a week or 2080 hours a year.

The Provider argues that HCFA Pub. 15-1 '905.1 states: Intermediaries have the responsibility for evaluating the reasonableness of an owner's compensation in terms of the criteria provided in '904.1 and '904.2, also '905.2 states (S)urveys shall include all proprietary institutions and a sufficient number of comparable non-proprietary institutions in the same geographical area so that an adequate comparison can be made. The Provider argues that when there are few similar providers in the area the intermediary may need to obtain information about the ranges of compensation established for comparable institutions in nearby or similar areas. HCFA Pub. 15-1 '905.5.

The Provider contends that neither the Intermediary nor HCFA has fulfilled their responsibilities under the Secretary's own rules for creating and utilizing a method of determining reasonable owner's compensation. The result is that various subcontracting intermediaries in different states have unilaterally adopted and applied their own methodologies for adjusting owner's compensation, and those compensation methodologies thus differ between the states. In some cases a single intermediary uses several methodologies simultaneously, applying one methodology to one provider, a second methodology to another provider, and a third compensation criteria to yet another provider.

The Provider contends that the Intermediary=s methodology for determining reasonable owner=s compensation is not proper. The Intermediary disallowed a portion of the claimed compensation and benefits of the Provider's chief operating officer. This disallowance was based on the Intermediary's application of a methodology called the "Michigan Survey/Method." This method was originally developed by Blue Cross and Blue Shield of Michigan to measure Outpatient Physical Therapy ("OPT") agency owner/administrator compensation; it is also known as the "OPT Owners Compensation Guidelines" ("OPT Guidelines" or "Michigan Survey").

The Provider argues that one of the major problems with the Intermediary's methodology is that it fails to account for the actual value of a home health administrator in the Provider's geographic regions. The regional geographic differences include 1) the standard of living; (2) the wage index which largely determines area prices; (3) the density of the patient population; (4) the health

care need of the patient population; (5) the accessibility of providers; are there many or any other providers of similar services in the immediate area; and (6) the availability of skilled and experienced executives, of similar quality to those of this provider. Because compensation reflects many factors dependent on geographical location, it is important to compare from nearby or similar areas in order to achieve a valid comparison. Since California is so geographically removed from Michigan, the Michigan Survey cannot be said to be valid survey.

The Provider argues that case law supports the proposition that a methodology that does not comply with the regulations and general instructions may not be used to limit claimed administrative compensation. In El Paso Nurses Inc. v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Texas, PRRB Dec. No. 89-D2, November 3, 1988, Medicare & Medicaid Guide ("CCH") **&** 37,505, the Board ruled that an intermediary cannot utilize improper data to limit claimed owner's compensation.[5] In El Paso, the Board stated that "the intermediary's use of the Denver Regional Office's survey [to adjust a Texas provider's salaries] is inappropriate because the provider is from a different area." Id.

The Provider maintains that in Stat Home Health Care, Inc. Los Angeles, California v. Blue Cross and Blue Shield Association /Blue Cross of California, PRRB Dec. No. 96-D7, January 30, 1996 Medicare & Medicaid Guide ("CCH") **&** 44,011, the Board found that the Intermediary's adjustment to owner's compensation could not be upheld because the data the intermediary relied on was "outdated, inappropriate, and inadequate."[6] The Provider points out that the PRRB recognizes the importance of survey data and the need for data to be finely tailored so that it is appropriate for compensation adjustment purposes.

The Provider also maintains that the Board has recognized the error in using inflation factors for the purpose of determining reasonable compensation. In Condado Home Care Program Santurce, Puerto Rico v. Cooperativa De Seguros

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[5]Exhibit P-59

[6]Exhibit P-60

De Vida, PRRB Dec. No. 97-D52, April 24, 1997, Medicare and Medicaid Guide (CCH) & 45,197, the intermediary applied an inflation factor to existing data it had for owner/executive's compensation, and determined based upon that methodology that the provider's Executive Director's compensation should be adjusted.[7] Based on the facts, the Board determined that the intermediary did not properly adjust that provider=s owner=s compensation because it did not compare the owner's compensation with other like providers as required by the Medicare regulations.

The Provider argues that the Intermediary adjusted the claimed owner's compensation based upon an outdated study by applying an inflation factor. As previous Board decisions demonstrate, such a methodology violates the Medicare regulations because it fails to compare the Provider's administrator's compensation with that paid by other similar providers.

The Provider contends that the Intermediary failed to utilize a valid statistical methodology for comparing home health agencies to each other, and as a result of that deficiency, has failed to prove that the compensation is out of line with other comparable home health agencies. This is contrary to Medicare regulations that require intermediaries to reimburse providers for the actual costs of providing services to Medicare beneficiaries; unless the claimed costs are substantially out of line. The Medicare regulation at '413.9(c)(2) states:" [t]he Provision in Medicare for payment of reasonable cost of services is intended to meet the actual costs, however widely they may vary from one institution to another. This is subject to a limitation 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, and other relevant factors."

The Provider contends that the burden of proving that compensation is out of line clearly falls on the Intermediary. In Alexander's Home Health Agency v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Mississippi, PRRB Dec. No. 88-D30, September 2, 1988, Medicare & Medicaid Guide ("CCH") &37,439, Aff=d. HCFA Adm. Dec. October 31, 1988, Medicare & Medicaid Guide ("CCH") & 37,504, the Board determined that the intermediary failed to produce any documentation to substantiate that claimed

[7]Exhibit P-61

owner/executive's compensation of that provider was "substantially out of line" with that paid by comparable providers.[8]

The Provider contends that in Memorial Hospital Adair County Health Center v. Bowen, 829 F. 2d. III (D.C. Cir, 1987) the court also dealt with the issue of determining whether a cost is "substantially out of line" by means of comparison to other providers.[9] In that case the court reversed and remanded the case because the initial "decisions under review were based on comparisons of dissimilar health care services and dissimilar costs," Id. at 188. The Court found that the regulations require that intermediaries "compare apples to apples to arrive at truly comparable bases for determining whether the actual costs of a particular provider comparison is of line." Id. at II 7.

In a more recent case Call-A-Nurse v. Blue Cross and Blue Shield Association Blue Cross and Blue Shield of Il., PRRB Dec, No. 98-D50, May 20, 1998 Medicare & Medicaid Guide ("CCH") **&** 46,331, the Board concluded that there were no compensation surveys of key[10] employees in the Home Office of a chain organization that can be used to determine reasonableness of the Provider's owner's compensation. The Board also found that the Michigan Survey does not produce results that are representative of the provider's organization and therefore, cannot serve as the basis for a cost disallowance.

The Provider argues that its Intermediary failed to meet its burden of proving that the Provider's owner=s compensation is "substantially out of line" with other providers. According to both the PRRB and federal case law, the Michigan Survey data cannot be used to support a determination that the Provider's owner's compensation is "substantially out of line" because it does not provide a truly comparable basis for comparison.

The Provider contends that the application of the Michigan Survey is arbitrary, capricious and contrary to the Survey's methodology. The Intermediary determined that the owner administrator (OA) worked an average of 56 hours a

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[8]Exhibit P-62

[9]Exhibit P-63

[10]Exhibit P-72

week (56x52=2912). The OA spent 1,627 hours at the Provider, and 1,305 hours at Home Care Management Services, (1627+1305=2932). Included in the 2932 hours, was 250 hours of administrative functions. The Intermediary multiplied 55.49% (the percentage of time it had determined was devoted to the Provider administrative duties) by the maximum figure for owner's compensation derived from the Michigan Survey ($127,595) to arrive at a total allowable compensation of $70,802.[11] The Intermediary used a similar methodology to determine the allowable amount of owner-s compensation for the other owner. The Provider contends that the Intermediary failed to accurately apply its own methodology for determining reasonable compensation and arbitrarily modified the Michigan Survey to arrive at the current adjustment.

The Provider points out that the administrative component of the employee's compensation will be permitted up to a full level of full-time employment. The Level of full-time employment is equivalent to 2,080 total hours. The Intermediary divided the 1,627 by 2932 total hours to arrive at the 55.49% factor indicative of the time spent on the Provider's duties. The Intermediary should have divided 1,627 hours by 2,080 total hours to arrive at a 78.22% factor for time spent on the Provider's administrative duties. This would result in a total allowable salary of $99,806 (78.22% x $127,595).

The Provider argues that the Intermediary failed to consider other factors that influence whether the compensation should be adjusted upward based upon a careful review of the duties such as education, experience, and the quality of care. The Intermediary's application of the Michigan Survey does not correspond with the clear intent behind the Medicare regulations for determining reasonable compensation and does not correspond with the intent behind the Michigan Survey method. Therefore, the Intermediary has inappropriately misapplied its Michigan Survey methodology.

The Provider argues that the Michigan Survey is statistically invalid, and an inappropriate method for determining reasonable compensation for the Provider's Administrator and Chief Financial Officer. The Michigan survey was

[11]Exhibit P-69

completed in 1979. The Intermediary applied a yearly inflation factor to those salary ranges. Such an application of a yearly inflation factor to salary ranges created some 17 years prior to the cost year at issue is clearly contrary to the Medicare regulations that require reimbursement of actual costs incurred by the Provider.

The Provider points out that the Board has stated that owner's compensation should be evaluated on a case-by-case basis. Upper Peninsula Home Nursing v. Blue Cross and Blue Shield Association/ Blue Cross of Wisconsin, PRRB Dec. No. 97-D28 Medicare & Medicaid Guide ("CCH") &45,062 (Ex P-73); South Suburban Home Health Service, Inc. v. Blue Cross and Blue Shield Association/Health Care Service CGM., PRRB Dec. No 80-D1, Janaury 20, 1980, Medicare & Medicaid Guide ("CCH") & 30,446, Aff-d. HCFA Deputy Adm. Dec. March 6, 1980 (P-74).

The Provider contends that the Intermediary's reliance on the Missouri Alliance for Home Care Study and on the Zabaka Home-Care Salary and Benefits Report for 1996 is improper. The problems associated with the use of these two studies are similar to those that were present in the use of the Michigan Survey.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its adjustment to owner-s compensation was correct in that the owner is subject to the regulations and manual instructions concerning owners compensation. The Intermediary used salary ranges established for other classes of institutions as required by 42 C.F.R. ' 413.102(c)(2)(Exhibit 1-9) which states:

> [r]easonableness of compensation may be determined by reference to, or in comparison with, compensation paid for comparable services and responsibilities in comparable institutions; or it may be determined by other appropriate means.

The Intermediary points out that its test of reasonableness was based on a

survey of home health administrators with job duties and responsibilities of the employee in this appeal. The Provider did not submit documentation that would indicate that the administrative services are not comparable nor did the Provider submit documentation in support of the reasonableness of the owners compensation.

The Intermediary points out that it used the following procedures to test the reasonableness of the compensation of the owner/president:

1. The Michigan Survey/method. This method was developed by Blue Cross and Blue Shield of Michigan and is based on a survey of home health agencies located in large metropolitan areas in Michigan. In a recent appeal case the HCFA Administrator found this method to be a valid analytical tool for determining reasonableness of compensation;

2. The Administrator salary range and point system;

3. Cooperation of the results of the Michigan survey/method by comparing to national surveys of home health agency salaries.

The Intermediary points out that in a recent decision by the HCFA Administrator dated May 22, 1998 High Country Home Health Care, Inc. v. Blue Cross and Blue Shield Association, et al, PRRB Dec. No. 98-D33 March 18, 1998, Medicare & Medicaid Guide ("CCH") ¶ 46,172, rev'd HCFA Administrator, May 22, 1998, Medicare & Medicaid Guide ("CCH") ¶ 80,057 the administrator found that the Michigan Survey methodology is an appropriate means to determine reasonableness of owner's compensation as provided by the regulations.

The Intermediary contends that the Michigan survey/method is a valid analytical tool for determining the reasonableness of compensation. The results of the Michigan survey were compared to the Home Care Salary & Benefits Report 1994-1995[12], and the National Association for Home Care

[12] See Exhibit I-15

(NAHC) Home Health Agency Compensation Survey. The Intermediary argues that these surveys support its contention that the Administrator/owner's compensation is substantially out of line with other CEOs in the same geographic region.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

'1395hh	-	Authority to Prescribe Regulations
'1395x(w)	-	Arrangements for Certain Services

2. Law - 5 U.S.C.

'533	-	Administrative Procedure Act-Rule Making
'706	-	Scope of Review

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

''405.1835-.1841	-	Board Jurisdiction
'484.14(f)	-	Standard
'484.32	-	Condition of participation; Therapy Services
'413.102 et seq.	-	Compensation of Owners
'413.106 et seq.	-	Reasonable Cost of Physical and Other Therapy Services Furnished Under Arrangements

'413.9 et seq. - Cost Related to Patient Care

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

'901.1 - Compensation of Owners

'904.1 - Factors to be considered in determining Comparability of Institutions

'904.2 - Factors to be Applied in Evaluating Compensation Within Range for Comparable Institutions

'905.1 - General

'905.2 - Surveys

'905.5 - Few similar Providers in an area

'1400 - Reasonable Cost of Therapy and other Services Furnished by Outside Suppliers

'1402.6 - Guidelines

'1403 - Guideline application

'1414.2 - Exception Because of Unique Circumstances or Special Labor Market Conditions

'2103 - Prudent Buyer

'2130 - Life Insurance premiums

5. Cases:

High Country Home Health Care, Inc.v. IASD Health Services Corporation, PRRB Dec. No. 98-D33, March 18, 1998, Medicare and Medicaid Guide (CCH) &46,172, rev-d, HCFA Administrator, May 22, 1998, Medicare and Medicaid Guide (CCH) &80,057.

High Country Home Health Care, Inc. v. IASD Health Services Corporation, PRRB dec No. 97-D35, Medicare and Medicare Guide (CCH) & 45, 130 rev-d HCFA Adminstrator, May 20, 1997, Medicare and Medicaid ("CCH") &45,543.

High Country Home Health, Inc. v. Shalala, No. 98-CV-184-J (D.Wy. March 25, 1999).

Community Memorial Hospital and W.S. Hundley Annex Group Appeal (South Hill Virginia) v. Blue Cross and Blue Shield Association/ Blue Cross of Virginia, PRRB Dec. No. 84-D118 May 11, 1984, Medicare and Medicaid Guide (CCH) & 34,099.

In Home Health d/b/a Home Health Plus (San Leandro, Cal) v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Iowa, PRRB Dec. No. 96-D16, February 27, 1996, Medicare and Medicaid guide (CCH) '44065, HCFA Administrator Decision April 29, 1996, Medicaid and Medicaid guide (CCH) & 44,595, USDC Minnesota 1998 WL 269486 (D.Minn).

Accardi v. Shauahnessy, 347 U.S. 260 (1954).

Red School House, Inc. v. Office of Economic Opportunity, 386 F. Supp. 1177 (D.Minn. 1974).

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1988, Medicare and Medicaid Guide ("CCH") **&** 37,505.

Stat Home Health Care, Inc. Los Angeles, California v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 96-D7, January 30, 1996, Medicare & Medicaid Guide ("CCH") **&** 44,011.

Condado Home Care Program Santurce, Puerto Rico v. Cooperativa De Seguros De Vida, PRRB Dec. No. 97-D52, April 24, 1997, Medicare and Medicaid Guide ("CCH")
& 45,197.

Alexander=s Home Health Agency v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Mississippi, PRRB Dec. No. 88-D30, September 2, 1988, Medicare & Medicaid Guide ("CCH") **&** 37,439, Affm. HCFA Adm. Dec. October 31, 1998, Medicare & Medicaid Guide ("CCH") **&** 37504.

Call-A-Nurse v. Blue Cross and Blue Shield Association Blue Cross and Blue Shield of Ill., PRRB Dec. No. 98-D50, May 20, 1998, Medicare & Medicaid Guide ("CCH")
& 46,331.

Call-A-Nurse v. Shalala, 59 F. Supp. 2d 938 (E.D. Mo. 1999).

Upper Peninsula Home Nursing v. Blue Cross and Blue Shield Association/Blue Cross of Wisconsin, PRRB Dec. No. 97-D28, Medicare & Medicaid Guide ("CCH") **&** 45,062.

South Suburban Home Health Service, Inc. V. Blue Cross and Blue Shield Association/Health Care Service CGM, PRRB Dec. No. 80-D1, Janaury 20, 1980, Medicare & Medicaid Guide ("CCH") **&** 30,446, Affm. HCFA Deputy Adm. Dec. March 6, 1980.

6. Other:

BCA Medicare Provider Appeal Decision Administration Bulletin AB 335 80.05 Michigan Survey- OPT Owners Compensation Guidelines.

48 Fed. Reg. September 30, 1983

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board after consideration of the facts, parties= contentions, and evidence presented, finds and concludes:

Issue - 1 Physical Therapy Costs

The Intermediary improperly applied the physical therapy guidelines to the wages paid to the Provider=s employee physical therapists resulting in an improper adjustment to the Provider=s cost report.

The Board finds that the issue in this case is the application of the physical therapy guidelines to the wages paid to the Provider=s employee physical therapists. Based on the evidence in the record, the Board finds that the Physical therapists in dispute are bona fide employees of the Provider.

The Board finds that while the Intermediary argued the prudent buyer concept, the Board finds a lack of appropriate methodology and evaluation. It is the Board=s opinion that the Intermediary should have used a method other than that of comparing the costs of provider employee therapists to the guidelines in Chapter 14. Instead the Intermediary should have determined whether the Provider=s costs were "substantially out of line" by comparing the Provider=s costs to other similar situated providers, pursuant to the regulation at 42 C.F.R. 413.9.

The Board refers to the U.S. district court case for In Home, dated June 16,1998, in which the court pointed out that:

> the Act clearly states that physical therapy services performed "under arrangement" do not include services performed by a physical therapist in an employment arrangement with the provider, 42 U.S.C. '1395x(v)(5)(A) reads: Where physical therapy services...are furnished under arrangement with a provider of services or other organization... as the

> reasonable cost of such services (as furnished under such arrangements shall not exceed an amount equal to the salary which reasonably have been paid for such services...to the person performing them if they had been performed in an employment relationship with such provider or other organization (rather than under such arrangement).

The language of the Act distinguishes between services that are performed by employees of a provider and services that are performed "under an arrangement" and it indicates that services performed by a physical therapist in an employment relationship with the provider are different from those services performed "under an arrangement." The guidelines, therefore, do not apply to employee physical therapists who are paid on a fee-per-visit basis.

The Board finds that 42 U.S.C. '1395x(v)(5)(A) and 42 C.F.R. '413.106 provide no basis for the application of the Guidelines to the employee physical therapists. Both the legislative and regulatory history of the Guidelines indicate that their purpose was to curtail and prevent perceived abuse in the practices of outside physical therapy contractors. The Board also notes that the term "under arrangement" is commonly referred to and used interchangeably with the term "outside contractor."

DECISION AND ORDER:

The Intermediary=s adjustment applying physical therapy guidelines to the provider=s physical therapist employees was improper. The intermediary=s adjustment is reversed.

ISSUE 2- Owner=s Compensation

The Board finds that there was a lack of any comparison by the Intermediary to substantiate the salary. The Board finds that the salary range data generated from the outdated Michigan Study produced results that were not representative of the Provider=s organization, and cannot serve as the basis for the Intermediary=s disallowances. The Michigan study was designed for OPT owner/administrators, and is based on data obtained in 1979 from 16 facilities

located in the Michigan area. The Board finds that there is no assurance that the compensation data contained in the Michigan Study is representative of the compensation levels paid by contemporary home health organizations in the Provider=s geographical location.

The Board also notes that it was unable to determine how the Intermediary used the Zabka Study to corroborate its use of the Michigan Study. Notwithstanding the Board finds that the fact that the Zabka study is current and not outdated complies with the regulation at 42 C.F.R. '413.9(c)(2) which states in part:

> The costs of providers= services vary from one provider to another and the variations generally reflect differences in scope of services and intensity of care. The provision in Medicare for payment of reasonable cost of services is intended to meet the actual cost, however widely they may vary from one institution to another.

The Board finds that it must rely on the best evidence in the record that more closely complies with '413.9 to the greatest extent possible. Therefore, the Board concludes that the Zabka study is appropriate in this case.

The Board is aware that the Intermediary cited the HCFA Administrator=s decisions in High Country and Call-A-Nurse in support of its application of the Michigan Study. However, the Board notes that both of these decisions were reversed by the following district court decisions:

High Country Home Health Inc. V. Shalala, No. 98-CV-184-J (D.Wy. March 25, 1999) .

Call-A-Nurse v. Shalala, 59 F. Supp. 2d.938 (E.D.Mo. 1999); and

In the Call-A-Nurse decision, the district court stated the following:

> Upon review of the record, the court believes that reliance in this case upon the Michigan Survey was arbitrary because the OPT clinics studied in that

> survey were not comparable to Call-A-Nurse in size, organizational structure, type of services provided, personnel employed, or geographical area.
>
> The Secretary=s reliance on the Michigan Survey is especially troubling in light of the fact that the record contains a much more reliable means of determining the reasonableness of the salaries, in question, namely the Dunham evaluation.... Upon review of the entire record, the Court believes that on this issue the PRRB=s determination was well-reasoned and should have been upheld by the Secretary.

DECISION AND ORDER:

The Intermediary=s adjustment to owners= compensation was not proper. The Intermediary=s determination is modified to allow the Intermediary to adjust the owner=s compensation by the use of the Zabka Study.

BOARD MEMBERS PARTICIPATING:

Irvin W. Kues
Henry C. Wessman, Esquire
Martin W. Hoover, Jr. Esquire (concurring opinion as to issue 2)
Charles R. Barker
Stanley J. Sokolove

FOR THE BOARD:

Irvin W. Kues
Chairman