PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2000-D27

PROVIDER -
Great Rivers Home Care Inc.
St. Peters, Missouri

Provider No. 26-7262

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Cahaba Government Benefits Administrators

DATE OF HEARING-
June 30, 2001

Cost Reporting Period Ended -
June 30, 1996

CASE NO. 99-0095

INDEX

ISSUE:

Was the Intermediary=s adjustment to remove excess key employee compensation proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Great Rivers Home Care, Inc. (AProvider@) is a proprietary corporation formed in 1987. It is a home health agency (AHHA@) located in St. Peters, Missouri. In the fiscal year ended June 30, 1996, (AFY 96@) the Provider rendered 72,241 Medicare visits and had total revenue of approximately $4.4 million. In FY 96, the Provider had 400 patients and employed approximately 120 health care workers. According to Health Financial Systems (AHFS@) data, on a cost per visit basis and administrative cost per visit basis, the Provider was in the bottom 25% of all providers in the Greater Saint Louis, Missouri area in 1996. Specifically, the Provider=s administrative cost per visit was $8.37 while its average cost per visit was $14.03.[1] The Provider was below the Medicare cost caps by $863,678 in 1996.[2]

During FY 96, the Provider claimed $92,819 in salary and another $13,771 in benefits for a total of $106,590 in compensation paid to its director of clinical services/chief operating officer, Ms. Susan Taylor. Ms. Taylor had two different sets of job functions during the fiscal year under appeal. From July until September 22, 1995, Ms. Taylor was the Provider=s assistant director of nursing and on-call supervisor for the Provider. In September 1995, the Provider combined the positions of director of clinical services and chief operating officer (ACOO@). From September 22, 1995 until the present, Ms. Taylor has functioned as the Provider=s COO for both the St. Peters and Alton, Illinois offices. Ms. Taylor received a salary increase of $2,594 per month on September 22, 1995, to reflect her increased duties.[3] Ms. Taylor also served as acting Chief Executive Officer (ACEO@) of both Great Rivers agencies for at least three weeks full time plus part time stints in 1995-1996 while the CEO was recuperating from surgery.[4]

Wellmark, Inc. (AIntermediary@) disallowed $36,999 in salary and benefits on its partial use of the 1994-1995 Home Care Salary and Benefits Report[5] also known as the AZabka Survey.@

The Intermediary allowed the highest salary for a director of nurses/clinical services of twelve Missouri home health agencies responding to the Zabka Survey or $60,600. This resulted in a reduction in Medicare reimbursement of approximately $36,000. Cahaba Government Administrators took over

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1 See Provider Exhibit 22; Transcript (ATr.@) at 92-93.

2 See Provider Exhibit 25.

3 Tr. at 84.

4 Tr. at 183.

5 See Intermediary Exhibit 1.

the operations of Wellmark, Inc. The Provider appealed the Intermediary=s adjustments to the Provider Reimbursement Review Board (ABoard@). The Provider=s filing meets the jurisdictional requirements of 42 C.F.R. '' 405.1835-.1841. The Provider was represented by Charles F. MacKelvie, Esquire, of MacKelvie and Associates, P.C. The Intermediary was represented by James R. Grimes, Esquire, of Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary=s methodology for determining reasonable key executive compensation for Great Rivers is an incorrect usage of the Zabka Survey. The Intermediary determined that it should utilize job description Number 13-Director of Nurses/ Clinical Services for Missouri to arrive at an allowable compensation level for Ms. Taylor of $60,600.[6] The Zabka Survey indicates 8 St. Louis (Greater St. Louis) agencies were used to arrive at the $60,000 Zabka average. The maximum figure for a director of nursing in 1994 was $65,000.[7] However, the effective date of the data was August 1994.[8] If the Intermediary were to properly use the Zabka Survey, it should have added a bonus of between $5,448 and $6,818[9] plus fringes of 21.33%[10] to arrive at an allowable amount. For 1994, that amount would be between $80,135 and $81,797 plus an inflation factor since the 1994 data has to be updated to 1996. Therefore, correctly using the Zabka Survey for a single agency and utilizing HCFA inflation factors would yield allowable compensation for a director of nurses/director of clinical services of between $85,015 and $86,778.

The Provider observes that to adopt the Intermediary=s reasoning, Ms. Taylor would have the following job duties according to the Zabka Survey:

Director of Nurses/Clinical Services -- Plans, implements and directs nurses/clinical services to assure quality care and appropriate quantity of services. Has authority and responsibility for operation of {clinical} programs.[11]

If that job description were a true picture of Ms. Taylor's duties (ignoring all the testimony at the PRRB that she was also functioning as the organization's chief operating officer), she would occupy the

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[6] See Attachment 3 to the Provider=s Post Hearing Brief (APHB@).

[7] See Provider Exhibit 17-9.

[8] See Provider Exhibit 17-1.

[9] See Provider Exhibit 17-9, Provider Exhibit 10, 16.

[10] See Zabka p.17.

[11] See Attachment 3 to the Provider=s Post Hearing Brief.

thirteenth (13th) position in the hierarchy of a home health agency=s structure.[12]

The Provider further notes that the Zabka=s Survey=s job duties for a chief operating officer closely parallel a significant portion of Ms. Taylor's actual duties as evidenced by the internal memos the Board has requested:[13]

Chief Operating Officer/Program Director-Reports to CEO or parent organization. Responsible for assisting and coordination of agency activities for all departments. Plans, coordinates all activities. May work for a freestanding agency or operate a multi-chain branch.

The 1994-1995 Zabka Survey indicates that the average maximum salary for a COO in Missouri is $90,000 plus bonus payments of $4,167 plus fringes of 2l.33% salary and bonuses, or an aggregate total of $114,220. To that figure, an inflation factor has to be added. Accordingly, properly utilizing the Zabka Survey for a single agency, Ms. Taylor was entitled to salary and benefits of $121,180. Since her claimed salary and benefits were substantially under that figure, the use of the Zabka Survey for a single agency indicates that Ms. Taylor=s compensation was reasonable.

The Provider argues that the methodology utilized by the Intermediary disregards the Medicare regulations and general instructions, governmental, and American Institute of Certified Public Accountants auditing standards. The statistical underpinnings of the Zabka Survey to measure compensation for single agencies are flawed for a variety of reasons. First, it has a response rate of only 8.4% in the West North Central area of the United States. The responses were provided voluntarily and are not audited by anyone to verify their accuracy. In addition, home health industry compensation experts have testified at the Board in the past that for privacy and business reasons, some agencies do not always disclose the full amount they compensate their executives. Thus, the Intermediary has no way of verifying if the data on this small amount of responses (125 or 8.4% of the agencies in the area that includes Missouri) is even factually correct before it uses the Zabka Survey to establish the reasonableness of claimed compensation. There were 349 home health agencies in Missouri in 1996, including 93 Medicare certified agencies in the Missouri portion of Greater St. Louis.[14] The Intermediary witness was unable to identify which Missouri agencies or which St. Louis agencies responded to the Zabka Survey, or if any agency in the survey was comparable to the Provider.[15] That witness conceded that the largest agencies in St. Louis were comparable to the Provider, but she was unaware of those agencies executive salary costs.[16] From the Intermediary data, it is impossible to ascertain whether the agencies responding to Zabka are comparable to the Provider.

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[12] See Zabka, Attachment 3 to the Provider=s Post Hearing Brief.

[13] See Attachments 1 & 3 to the Provider=s Post Hearing Brief.

[14] Tr. at 171; See Attachment 4 to the Provider=s Post Hearing Brief.

[15] Tr. at 196.

[16] Tr. at 196.

The Provider further notes that the Zabka Survey intentionally disregards the top and bottom 25% of the survey responses prior to formulating its compensation ranges. This methodology has the effect of statistically skewing all the agencies towards the middle of the range of reported compensation. Such a methodology violates Chapter 9 of the Provider Reimbursement Manual because the compensation ranges in the Zabka Survey are not comparable to the salary ranges in the market place. It is virtually impossible to ascertain which agencies compensation is substantially out-of-line. Further, both the Zabka Survey and the Intermediary confuse the job functions and the job title, a fundamental distinction in any compensation analysis. For almost any title in the executive ranks, a job title does not define the responsibilities, job duties, accountability, responsibilities, management reporting hierarchy and the myriad of other characteristics that make up a job position. Each organization is unique and auditors must use audit tools including in depth interviews to ascertain the executive's duties, responsibilities, capabilities, organizational placement and worth to that particular organization.

The Provider observes that at the hearing the Intermediary witness conceded that neither Wellmark nor the Blue Cross and Blue Shield Association ever purchased or owned the Zabka Survey.[17] Cahaba admitted that, at most, it only possessed several pages of the survey, not the complete volume or the accompanying instructions that are sent to purchasers of it. Cahaba conceded that it did not know how the survey operated because its auditors had never read the survey in its entirety. The use of several pages of any study hardly justifies its use as an audit tool. Moreover, such possession of a partial audit tool violates both the Office of Management and Budget and General Accounting Office standards as well as the Provider Reimbursement Manual. Such data may not be used to limit claimed executive compensation. See, El Paso Nurses Unlimited, Inc. v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Texas, PRRB Decision No. 89-D2, November 3, 1988, Medicare and Medicaid Guide (CCH) ¶ 37,505 and Stat-Home Health Care, Inc. (Los Angeles, CA) v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Decision No. 96-D7, January 30, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,011. Clearly, the Board recognized the importance of survey data and the need for data to be tailored so that it is appropriate and comparable for compensation adjustment purposes.

The Provider further observes that the Intermediary=s witness also indicated that Wellmark/Cahaba used the National Association of Home Care (ANAHC@) 1992 compensation survey to support its adjustment. The workpapers from the NAHC survey are not in the record and only two summary pages are reflected in the Intermediary=s exhibit which references the same.[18] Updating 1992 averages to a 1996 compensation cap is a shocking use of statistical numbers and contrary to the Medicare Act. The use of the NAHC survey is inappropriate for numerous reasons. First, the use of this data is not authorized by NAHC. According to NAHC correspondence, neither the Blue Cross Association nor

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[17] Tr. at 176.

[18] See Intermediary Exhibit 1-1-19 and Intermediary Exhibit 1-1-20.

Cahaba purchased a copy of the survey. Neither party knows what the full survey indicates.[19] Second, the data from NAHC is raw data, which has not been audited. It is data averaged, without any indication of the highs, lows, or ranges. Third, NAHC has written all fiscal intermediaries stating that:

We advise you that that publication is far from complying with the requirements of Provider Reimbursement Manual (HIM-l5), Section 900, et seq., for use in Medicare audits. The data is not auditable or verifiable that is used for publication. You should discontinue using it as a source for comparing providers to determine reasonableness of compensation, as it was not designed to meet Regulatory mandates.

The Provider notes that the Intermediary refers to four words contained in 42 C.F.R. ' 413.102(c)(2) by other appropriate means as support for its use of the formula and methodology in question. These four words should not be viewed out of context and cannot be reasonably construed to provide the unbridled authority assumed by the Intermediary in this case, especially in light of the interactions that have existed in practice between the Medicare Program and its contractors since the inception of Medicare in 1965/1966. The more rational interpretation of these words is that HCFA (not one of its contractors) may find it practical and/or necessary to promulgate appropriate regulations or general instructions other than the survey methodologies described in the regulations and general instructions. The subcontracting intermediaries may then follow and apply such appropriately promulgated regulations or instructions. The notion that these four words allow a government contractor to conjure up its own rules to implement a federal program without the specific authority to do so is highly suspect.

The Provider observes that HCFA has not promulgated any regulation or general instructions defining what constitutes Aother appropriate means@ to determine reasonable compensation as an alternative to the surveys required under the current regulations. It is a well-settled principle in administrative law that an agency may not implement any regulation without an accompanying general instruction to define the methodology. See, generally Administrative Law Treatise, Davis and Pierce, 3rd ed., 7.1 et seq. While the regulation at 42 C.F.R. ' 413.102(c)(2) provides specific guidance on how to determine comparability, HCFA has never promulgated similar general instructions to give guidance on what objective standards will be used to review Aother appropriate means@ of determining reasonable levels of compensation.

The Provider observes that for every other appeal involving home care executive compensation in which the Blue Cross Association has been the chief fiscal intermediary, the Blue Cross Association has only utilized the Compensation Report on Management Companies (ACompensation Report@),[20] also published by the Zabka organization. Prior to this appeal, the Blue Cross Association has always recognized that multi-provider organizations are significantly different than single agency organizations.

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[19] Tr. at 16.

[20] See Attachment 5 to the Provider=s Post Hearing Brief.

In the home health portion of the Compensation Report, the average revenue per agency was $2.7 million and the average number of full time equivalents (AFTEs@) per agency was 54, both figures approximately half of those of the Provider in 1996. For a chief operating officer, Zabka reported the average salary at $95,100, the average bonus of $12,567, with the 75% percentile salary of $165,000 before the bonus of $12,567 was added. For the director of nurses/clinical services, the Zabka Compensation Report determined that the average salary of a director of nursing which each individual agency must have pursuant to the Medicare Conditions of Participation was $55,375, while the highest salary paid to such person was $76,673. She also received an average bonus of $5,235. To those amounts perquisites are added at least 22% of compensation. Therefore, the average COO received approximately $131,354, while the COOs at the 75th percentile of the Compensation Report received total compensation of $216,656 in 1994. Updated for inflation, the average COO was entitled to $139,353, while those in the 75th percentile were entitled to $229,850. According to the above compensation report, a director of nursing for a single agency received aggregate compensation, including perquisites, of $73,944, while those directors in the 75th percentile received $99,927 in 1994. Updated for inflation to 1996, an average director was entitled to $78,447 while a director paid at the 75th percentile was entitled to $106,012. As Ms. Taylor's claimed compensation is significantly lower than that reported on the Compensation Report, her compensation was substantially in line with what is reasonable in the marketplace.

The Provider observes that the Intermediary has failed to prove that the Provider claimed costs for its chief operating officer/director of clinical services compensation are substantially out-of-line with the compensation paid by comparable home health agencies in the same geographical area. Contrary to its assertions, the Intermediary has also failed to prove that Ms. Taylor=s compensation is substantially out-of-line with the compensation paid to key executives in comparable home health agencies. Intermediaries are required to reimburse providers for the actual costs in providing services to Medicare beneficiaries, unless the governmental agent demonstrates that a provider's claimed costs are Asubstantially out-of-line.@ 42 C.F.R. Section 413.9. The regulation further states:

The 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, utilization, and other relevant factors.
Id.

ASubstantially out-of-line@ is defined by Medicare policy to mean significantly higher than the next highest claimed cost.[21] PRRB case law holds that the burden of proving that compensation is substantially out-of-line clearly falls on the Intermediary. See, Alexander's Home Health Agency v. Blue Cross and Blue Shield Association/ Blue Cross and Blue Shield of Miss., Inc., PRRB Decision No. 88-D30, September 2, 1988, Medicare & Medicaid Guide (CCH) & 37439 and Memorial Hospital/Adair County Health Center v. Bowen, 829 F.2d 111 (D.C. Cir. 1987). In the latter case, the court found

[21] See IL 78-16; Provider Exhibit 5; Tr. at 165-168.

that the regulations require that intermediaries Acompare apples to apples@ to arrive at truly comparable bases for comparison in determining whether the actual costs of a particular provider are out-of-line.[22] See, also, Holy Cross Hospital v. Blue Cross and Blue Shield Association/New Mexico Blue Cross and Blue Shield, Inc., PRRB Decision No. 92-D14, January 23, 1992, Medicare & Medicaid Guide (CCH) & 40,066; Vermillion Home Health Agency, Inc. v. Secretary CCH Medicare and Medicaid Guide, 1138, 377 (W.D. La. July 28, 1989) (the intermediary bears the burden of proof in applying the substantially out-of-line principle); Home Health Care, Inc. v. Heckler, 717 F.2d 587 (D.C. Cir. 1983) (the intermediary's duty under 42 C.F.R. ' 413.9 was to compare, with common sense and care, the provider's costs and those of other providers whose services were truly comparable). In the case at hand, the Intermediary has failed to meet its burden of proving the Provider=s claimed costs for Ms. Taylor=s compensation were substantially out-of-line with those of comparable providers. The Intermediary has rejected all evidence proving that Ms. Taylor was the COO of both the St. Peters and Alton offices. She was also the acting CEO of both providers for at least three weeks during the fiscal year. According to both PRRB and federal case law, neither the NAHC Study nor the Zabka Survey data can be used to support a determination that her compensation is substantially out-of-line because it does not provide a truly comparable basis for comparison. Indeed, the PRRB has stated that executive=s compensation should not be based on a mechanical maximum but must be evaluated on a case-by-case basis. See, Upper Peninsula Home Nursing v. Blue Cross and Blue Shield Association/Blue Cross of Wisconsin, PRRB Decision No. 97-D28, January 30, 1997, Medicare & Medicaid Guide (CCH) & 45,062.

The Provider contends that the independent consulting firm of Findley-Davies has done an analysis of the Provider=s chief operating officer/director of clinical service compensation and concluded it was reasonable. Mr. Henry L. Federal, a principal with the firm of Findley Davies and recognized by the PRRB four previous times as an expert in compensation analysis, performed this analysis and concluded that Ms. Taylor was both the COO and the director of clinical services. Mr. Federal concluded that her claimed compensation was reasonable. Mr. Federal=s credentials as a compensation expert notwithstanding, his conclusions regarding Ms. Taylor's duties as COO are more credible than the Intermediary's if for no other reason than he actually went to the Provider=s office and spent considerable time interviewing management and staff regarding Ms. Taylor's duties. He concluded that in addition to her duties as director of clinical services, Ms. Taylor also functioned as the second in command of the agency and was often responsible for making management and other strategic decisions affecting the organization on a consistent basis. In contrast, the Intermediary never talked to Ms. Taylor.[23] Rather, it reviewed one of her four job descriptions concerning some of her duties. At the hearing, the Intermediary could not respond to the fact that Ms. Taylor was the Acting CEO of both Great Rivers offices for at least three weeks in 1995-1996.[24] Additionally, the Intermediary could not

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[22] Id. at 117.

[23] Tr. at 48, 170.

[24] Tr. at 179.

give a cogent response as to why it did not recognize Ms. Taylor duties and responsibilities and hence her entitlement for increased pay for being the COO of the Alton office.[25]
The Provider contends that Ms. Taylor's compensation was reasonable. Mr. Federal based his findings on the 1996 Hay Hospital Compensation Survey data on job content-based groupings.[26] Using the Hay Compensation Survey methodology, Mr. Federal concluded that Ms. Taylor's duties were similar to those of a COO at a small primary care facility of 250 employees or less. The Provider=s witness testified that a small hospital is very similar to a home health agency since a small hospital contracts many of its clinical functions and the running of certain hospital departments with outside contractors. Based on the Findley Davis analysis, Mr. Federal stated that under the Hay Compensation Survey methodology a range of total compensation between $71, 923 and $107,885 would be reasonable for Ms. Taylor's duties.[27] Therefore, the $106,590 in total compensation claimed by the Provider for Ms. Taylor was reasonable.

The Provider argues that the HFS data shows that Ms. Taylor=s compensation was not out-of-line and was therefore reasonable. At the request of the Provider, Blue & Company, a regional accounting firm which has no business relationship with the Provider, did an analysis of all home health cost reports for Missouri agencies (and later Illinois agencies) reported by HFS, a HCFA contractor. One hundred thirty seven (137) home health agencies were in Blue & Company's analysis. After adjustments for home office costs, the Provider=s administrative compensation for all of its administrators was $8.37 per visit, while the average administrator cost per visit of the survey sample was $14.03. Substantially out-of-line would be administrators= cost substantially above $17.79 per visit. Even among those agencies which rendered more than 50,000 visits in 1996 the Provider was below average. Ms. Taylor=s compensation with benefits figured as a cost per visit was $1.47, while the average agency's cost per visit for its second in command was $2.80. In order for Ms. Taylor=s compensation to be substantially out-of-line, her compensation would have to be substantially higher than $8.63 per visit. According to the HFS data, eight assistant administrators in Missouri for large home health agencies were paid substantially more than Ms. Taylor in 1996. As the Intermediary witness testified, Cahaba field audited approximately 25% of the agencies.[28] Medicare paid most of the claimed salaries of the above agencies, agencies which are comparable to the Provider.

INTERMEDIARY=S CONTENTIONS:

The Intermediary contends that the Provider claimed $106,500 in salary and benefits paid to the director of clinical services for the agency. The Intermediary reviewed the compensation pursuant to 42 C.F.R. ' 413.9 and Provider Reimbursement Manual

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[25] Id.

[26] See Provider=s Exhibit 10.

[27] Id.

[28] Tr. at 189.

' 904. It compared the compensation paid by the Provider to compensation levels paid to director of nurses as reported in the Zabka Survey. The Intermediary used the position of director of nurses for purposes of comparison because the information provided to the Intermediary indicated that the incumbent was acting as a director of nursing at this Provider.[29] The Intermediary relied on job descriptions, questionnaires, and organization charts supplied by the Provider which established that the employee was acting solely as director of clinical services. The Zabka Survey indicated the highest salary paid to a director of nursing in the Provider=s region was $60,600. The Intermediary adjusted the total reasonable compensation to $60,600. The Intermediary tested its adjustment by reviewing the NAHC Survey and found the average compensation reported for a director of nursing in an agency similar to the Provider was $54,000 when adjusted for inflation. As a result, the Intermediary believes the allowable salary of $60,600 is reasonable and in line with salaries paid by comparable organizations for comparable services.

The Intermediary believes the Provider=s evidence substantiated that the salary paid to the director of clinical services was substantially out-of-line with that of comparable providers. The Provider submitted an analysis at Exhibit P-10 which indicated a director of nursing salary and bonus would be expected to total $56,702.[30] The Intermediary believes this supports its adjustment allowing $60,600. In fact, there is no evidence anywhere in the record which would support the Provider's claim that $92,000 was a reasonable cash salary, or that $106,000 was a reasonable total compensation for the position of director of clinical services.

The Intermediary notes that failing to support its claim for the compensation level paid to the director of clinical services, the Provider attempted to argue that the director of clinical services was not just the director of clinical services, but in fact was the COO of a chain organization.[31] The director of clinical services testified that, as COO, she was responsible for: developing agency goals, supervising the day-to-day operation in the absence of the CEO, supervising the financial and human resources functions of the organization, and over-all administration.[32] Further, the Provider's witness testified that she was responsible for the entire operation of the chain, not just the Provider agency where her salary was claimed.[33] However, the Provider witness was unable to explain why none of the documentation supplied to the Intermediary during the course of the audit and finalization of the cost report ever raised the argument that the director of clinical services was also the COO. In fact, the witness was unable to explain why correspondence from the Provider[34] which sought to defend the salary paid to the director

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[29] Tr. at 145.

[30] Tr at 154.

[31] Tr. at 36.

[32] Tr. at 54-56.

[33] Tr. at 55.

[34] See Intermediary Exhibit 8.

of clinical services only described the incumbent at the director of clinical services and included organization charts showing the position as the director of clinical services. If the Provider wanted to defend the $106,000 compensation level, one would expect the defense would mention the fact that the incumbent was the chief operating officer. No mention was made of the title until the position paper was submitted.

The Intermediary contends that the Provider held the position out as director of clinical services, and that is the position that should be evaluated in determining whether the compensation paid is reasonable. However, the Intermediary further argues that if this position is truly that of the chief operating officer, then it was incorrectly included as a salary cost at the Provider agency alone. The Provider witness testified the position was responsible for all day-to-day operations as well as policy making and goal setting. In that case, the COO salary costs should be classified as a home office cost, and allocated to all reimbursable and nonreimbursable costs centers which receive the administration and policy services.[35] This treatment would mirror the proper allocation of the CEO's compensation.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Regulations B 42 C.F.R.:

'' 405.1835-.1841	-	Board Jurisdiction
' 413.9	-	Cost Related to Patient Care
'413.102 (c) (2)	-	Application

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

' 904	-	Criteria For Determining Reasonable Compensation General

3. Cases:

El Paso Nurses Unlimited, Inc. v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Texas, PRRB Decision No. 89-D2, November 3, 1988, Medicare and Medicaid Guide (CCH) & 37,505.

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

Alexander=s Home Health Agency v. Blue Cross and Shield Association/Blue Cross and Blue

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[35] Tr. at 160-161.

Shield of Miss., Inc., PRRB Decision No. 88-D30, September 2, 1988, Medicare & Medicaid Guide (CCH) **&** 37,439.

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

Holy Cross Hospital v. Blue Cross and Blue Shield Association/New Mexico Blue Cross and Blue Shield, Inc., PRRB Decision No. 92-D14, January 23, 1992, Medicare & Medicaid Guide (CCH) **&** 40, 066.

Vermillion Home Health Agency, Inc. v. Secretary, CCH Medicare & Medicaid Guide, 1138, 377 (W.D. LA. July 28, 1989).

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

Upper Peninsula Home Nursing v. Blue Cross and Blue Shield Association/Blue Cross of Wisconsin, PRRB Decision No. 97-D28, January 30, 1997, Medicare & Medicaid Guide (CCH) **&** 45,062.

FINDING OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the law, regulations, program instructions, facts, parties= contentions, evidence submitted, testimony at the hearing, and post-hearing briefs finds and concludes that the Provider=s claimed compensation for Ms. Taylor was reasonable and therefore allowable under Medicare regulations. The Board finds that there were two subissues in this case: (1) whether Ms. Taylor performed the duties of the chief operating officer/ director of nurses and (2) what salary survey properly relates to her compensation. Regarding the chief operating officer/director of nursing subissue, the Board finds that there was conflicting evidence in the record. The Intermediary was originally given information that indicated that Ms. Taylor was only the assistant director of nursing.[36] The Provider later presented evidence to the Board that she was the chief operating officer with commensurate duties.[37] An organization chart also showed that she was the chief operating officer.[38] Regardless of these conflicting facts, the Board finds that the most compelling evidence was the June 25, 1998 review of Ms. Taylor=s activities by Findley Davies, a well-recognized compensation expert. That firm=s representative actually interviewed Ms. Taylor on-sight at the Provider and determined that her actual duties were that of a chief operating officer as of October 11, 1995. This result was further supported by her significant salary increase of almost $3,000 per month as well as additional duties required of her after the above date. Further, the Board finds that the Intermediary never interviewed her, nor did it visit the Provider=s facility. Based on the above, the Board concludes that Ms. Taylor was the

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[36] See Intermediary Exhibit I-7.

[37] See Provider Exhibit 3.

[38] Id.

Provider=s chief operating officer.

Regarding the use of salary compensation surveys to measure the reasonableness of the Provider=s compensation to Ms. Taylor, the Board finds the following compensation surveys in the record: the Zabka Survey, the Hay Compensation Survey used by Findley Davies and NAHC Survey used by the Intermediary to support its audit adjustment. The Board=s analysis of the August 1994 Zabka Survey for a chief operating officer for all home health agencies in Missouri results in a compensation of approximately $76,000. Adjusting this amount for inflation (5% per year), an average bonus, and fringe benefits results in a compensation amount of $103,000. Reviewing the Hay Study results in a chief operating officer=s total compensation of between $72,000 and $108,000. Based on these analyses, the Board finds the Provider=s total compensation to Ms. Taylor of $106,590 was reasonable and not substantially out-of-line with other providers in the state of Missouri.

DECISION AND ORDER

Ms. Taylor=s compensation as chief operating officer of the Provider is reasonable and not substantially out-of-line with comparable providers. The Intermediary=s adjustment is reversed.

Board Members Participating

Irvin W. Kues
Henry C. Wessman, Esq.
Martin W. Hoover, Jr., Esq.
Charles R. Barker
Stanley J. Sokolove

Date of Decision: May11, 2001

FOR THE BOARD:

Irvin W. Kues
Chairman