PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2003-D30

PROVIDER –
Patient Care Medical Services, Inc.
Essex County, New Jersey

Provider No. 31-7060

vs.

INTERMEDIARY –
Blue Cross Blue Shield Association/
United Government Services

DATE OF HEARING-
September 17, 2002

Cost Reporting Period Ended
December 31, 1998

CASE NO. 01-1525

INDEX

ISSUE:

Was the Intermediary's adjustment to the Per Beneficiary Limit (PBL) calculation proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

This case concerns the application of the Per Beneficiary Limits (PBL) set forth in Section 4602 of the Balanced Budget Act of 1997. This act imposed a new schedule of payment limitations on home health agencies (HHAs) under the Medicare program for cost reporting periods beginning on or after October 1, 1997. The Act is codified at 42 U.S.C. § 1395 (x)(v)(1)(L). The regulation was published at 63 Fed. Reg. 15718 (March 31, 1998 and codified at 42 C.F.R. § 413.30.

Effective January 1, 1994, Chemed Corporation, a Cincinnati based public corporation whose stock is traded on the New York Stock Exchange, acquired 100% of the stock of Patient Care Medical Services, Inc. (Provider). The stock was purchased from two individuals. The stock purchase agreement was dated March 16, 1993.[1] United Government Services (Intermediary) was notified by the Provider on January 14, 1994, that a complete change of ownership and corporate restructuring of the Provider had occurred. In a letter dated June 15, 1998, the Intermediary notified the Provider that it would be designated as an "Old Provider" for purposes of the PBL assigned to the agency. In a letter dated November 6, 1998, the Provider expressed the opinion that it should have been classified as a "New Provider" due to a complete change in ownership.

The Intermediary's treatment of the Provider as an "Old Provider" results in a reduction in Medicare reimbursement of approximately $736,000. The Provider appealed the Intermediary's determination to the Provider Reimbursement Review Board (Board). The Provider's filing meets the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841. The Provider was represented by Gary P. Carpenter, Esquire, of Holtz Rubenstein & Company, LLP. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the designation of "New Provider" is warranted and appropriate for the purposes of calculating the per beneficiary limits based upon 63, Fed. Reg. 15718, 15721 (March 31, 1988), Section III (C)(3), which discusses the determination of "Old" or "New" home health agencies. It states: "[t]here are situations when the costs of operations of the HHA could change either through a change of ownership or an internal reconfiguration of the operational structure within the same HHA after FY 1994." Id. The Federal Register then cites as examples, "a freestanding agency becoming provider-based or vice-versa." Id. As these are clearly intended to be examples, it would be inappropriate to consider those particular situations to be all-inclusive.

[1] See Provider Exhibit I.

The Provider observes that the Intermediary's focal point is the language at the end of the Federal Register, addressed above, which concerns "New Providers." This language cited by the Intermediary does not address the question of a change of ownership, which is the Provider's position. The Provider believes that the above Federal Register explanation relates to agencies that do not have a change in ownership but merely undergo a restructuring or name change.

The Provider contends that Chemed Corporation's acquisition of the Provider, the parent company of the Provider, and all of its subsidiaries on January 1, 1994, resulted in significant changes in the operations of the Agency which had the impact of reducing the Provider's Medicare cost per visit by $5.04.[2] The changes included:

- A change in the Agency administrator
- A change in the Agency insurance program
- Changes in the working capital financing program
- Development of a new and enhanced computerized system.

The Provider believes that it has demonstrated that the change in ownership allowed for such significant positive operational changes at both the home office and provider levels that, in essence, a different operation or "New Agency" was created. Therefore, the Intermediary's designation of the Agency as an "Old Provider" and the reduction of Medicare allowable cost by $736,203[3] are inappropriate.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the issue must be decided under the controlling statute as implemented through Federal Register instructions. The method in place for determining the cost limits for a home health agency with a December 31, 1998 fiscal year end is set forth at 42 U.S.C. § 1395(x)(v)(1)(L)(v). Within the mechanics of the calculation, the limit was correctly calculated. The Provider concedes this point.[4]

An alternate rate is next identified for certain providers:

> (vi) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1997, the following rules apply:
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> (I) For new providers and those providers without a 12-month cost reporting period ending in fiscal year 1994, subject to clauses (viii)(II) and (viii)(III), the per beneficiary limitation shall be equal to the median of these limits (or the secretary's best estimates thereof)

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[2] See Provider's post hearing brief Exhibit No. 2.
[3] See Provider's post-hearing brief Exhibit No. 1.
[4] Transcript (TR) at 26.

> applied to other home health agencies as determined by the Secretary. A home health agency that has altered its corporate structure or name shall not be considered a new provider for this purpose.

U.S.C. § 1395(x)(v)(1)(L)(v).

The Intermediary asserts that the Provider had a 12-month cost reporting period that ended in fiscal year 1994, (December 31, 1993), and that cost report was used to set the limit. Under the statute, the Provider does not qualify for the above (vi)(I) alternate limit.

The Intermediary notes that the exact implementation of the new limit methodology was through publication of the Final Rule at 63 Fed Reg., 15718 (March 31, 1988).[5] Section III at page 15721 discusses the issue of old or new home health agency. Section III (A), (B), and (C)(1) and (C)(2) facially have no application. These sections cover HHAs that did not have the required 12-month cost reporting period opened after fiscal year 1994 or agencies that merged or consolidated.

The Intermediary argues that the undisputed facts are that the stock of the Provider's parent was purchased at the beginning of the 1994 calendar year. As a follow-up, a new administrator was hired. Other definable changes in patient care practices, leadership, purchasing methods, and technology occurred. Also, volume in terms of visits increased by twenty-five percent over five years. While these changes from a business perspective were laudatory, taken as a whole, they fall far short of reflecting a completely different method of determining overhead. The Intermediary argues that because the exception relied on by the Provider in Section III (C)(3) of the Final Rule noted above is not expressly set out in the underlying statute, the III (C)(3) exception must be strictly construed. As such, the Provider does not qualify.

The Intermediary observes that CMS's recognition of an exception for HHAs that have undergone complete changes in the operational structure reflects a broad reading of the new provider statutory exception. Therefore, the exception criteria must be narrowly construed according to the terms of the interpretive rule. The exception uses the term "complete change in the operational structure." The primary example is freestanding to provider based and vice versa. The section later discusses branches, which become sub-units in 1994 and subsequent periods. Those very limited situations reflect "complete changes." At all times, the appealing Provider was a freestanding proprietary home health agency that was wholly owned by a parent. Structurally, all that changed was the ownership of the stock of the parent. The stock purchase is not a sufficient reason to deem the Provider to be "new" and recalculate the PBL.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare statute, regulations, parties' contentions and evidence, finds and concludes that the Intermediary properly applied the PBL to the Provider and treated it

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[5] See Intermediary Exhibit 1.

as an "Old Provider." It does not qualify as a "New Provider" under 42 U.S.C. § 1395(x)(v)(1)(L).

The facts, related statutes and regulations are undisputed in this case. The law at issue is 42 U.S.C. § 1395(x)(v)(1)(L), which created an interim reimbursement formula for HHAs for cost reporting periods beginning on or after October 1, 1997. The regulation at 42 C.F.R. § 413.30 was modified to reflect this change via the 63 Fed. Reg. 15718 (March 31, 1998).[6] It is also undisputed that the Intermediary properly calculated the PBL for an existing "Old Provider."

The issue in dispute concerns whether the Provider should be treated as a "New Provider" under the above law and regulation. Specifically, the above Federal Register at 15721, Section III (C)(3) addresses treatment of a "New Provider" where there is a complete change in the operating structure of an HHA. The Provider contends that it meets this exception because its extensive operational changes (administrator, insurance, working capital financing and a new computerized system) constitute a "complete change in the operating structure of the HHA." The Board rejects this interpretation.

The Board finds these changes not to be the type of changes considered by the statute and regulation. Taken as a whole, these changes represent normal business operational changes, which generally result in better, more efficient and less costly operations. The Board concludes that they do not represent the regulatory intent of complete changes in operational structure. The above Federal Register at 15721 cites examples of the type of changes anticipated. They include a freestanding HHA becoming a provider-based agency or visa versa. This is a narrow interpretation of complete changes which the Intermediary proposes and the Board accepts.

The Board notes that the establishment of the HHA Per Beneficiary Limit was an attempt to limit Medicare's payments for HHA services. This cannot be averted by normal operational changes such as the Provider implemented upon the purchases of its stock by Chemed Corporation.

DECISION AND ORDER:

The Intermediary properly treated the Provider as an "Old Provider" in applying the PBL The Intermediary determination is affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Henry C. Wessman, Esquire
Gary B. Blodgett, D.D.S.

Date: May 14, 2003

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[6] The language in the Code of Federal Regulations was not altered to reflect this change. However, official reference to the change was made in the Federal Register references in the Code.

FOR THE BOARD:

Suzanne Cochran
Chairman