PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2005-D54

PROVIDER -
Nix Health Care System
San Antonio, TX

Provider No.: 45-0130

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Trailblazer Health Enterprises, LLC

DATE OF HEARING -
November 12, 2004

Cost Reporting Periods Ended -
December 31, 1998 and December 31, 1999

CASE NOS.: 03-0045 and 03-0046

INDEX

ISSUE:

Whether the Intermediary's classification of the Provider's home health agency (HHA) as a "new provider" for purposes of determining the per-beneficiary limits was proper?

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This dispute arises under the Federal Medicare program administered by the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA). The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. CMS is the agency of the Department of Health and Human Services responsible for administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law, regulations and interpretative guidelines published by CMS. See, 42 U.S.C. §1395(h), 42 C.F.R. §§413.20-413.24.

The statute, 42 U.S.C. §1395x(v)(1)(A), authorized the Secretary to establish limits on allowable costs incurred by a provider of services that may be paid under the Medicare program, based on estimates of the costs necessary in the efficient delivery of needed health services. The limits may be applied to direct or indirect costs or to the costs incurred for specific items or services furnished by a provider. Under this authority, HCFA maintained limits on HHAs' per-visit costs since 1979. The implementing regulations are located at 42 C.F.R. §413.30. Additional statutory provisions specifically governing the limits applicable to HHAs are contained at 42 U.S.C. §1395(v)(1)(L). These limits were subsequently replaced by the establishment of a prospective payment system (PPS) for home health services. 63 Fed. Reg. 89, 90 (January 2, 1998).

Section 1395x(v)(1)(L)(v) of the statute was amended by section 4602(c) of the Balanced Budget Act of 1997 (BBA 97) Pub. L. 105-33 and required that the Secretary establish an interim system of payment limitations prior to implementation of the HHA PPS. Payments by Medicare under this interim system of payment limitations must be the lower of an HHA's actual reasonable allowable costs, per-visit limitations in the aggregate, or per-beneficiary limits in the aggregate. 63 Fed. Reg. 15718 (March 31, 1998). The per beneficiary limit was established based on whether the provider was an "old" or a "new" provider.

Old Providers:

Section 1861(v)(1)(L)(v)(1), requires that the per-beneficiary annual limit be a blend of:

> (1) an agency specific per-beneficiary limitation based on 75 percent of 98 percent of the reasonable costs for the agency's 12- month cost reporting period ending during fiscal year (FY)1994, and

> (2) a census region division per-beneficiary limitation based on 25 percent of 98 percent of the regional average of such costs for the agency's census division for cost reporting periods ending during Federal FY 1994, standardized by the hospital wage index.

63 Fed. Reg. 42912, 42934 (August 11, 1998). The HHAs paid under this provision were known as "clause v" or old providers.

New Providers:

For new providers and providers without a 12-month cost reporting period ending in Federal FY 1994 (also known collectively as "clause vi" providers or new providers), the per-beneficiary limitation is a national per-beneficiary limitation equal to the median of these limitations applied to other HHAs as determined under section 1395x(v)(1)(L)(v). Id.

The Secretary recognized that there may be circumstances in which old versus new status would be unclear and, through regulations, provided guidance on how the determination was to be made. For example, there may be a change in the operational structure through a change of ownership or an internal reconfiguration of operational structure within an existing "old" HHA after Federal FY 1994. The Federal Register specifically addressed branch offices of an HHA, explaining that a branch does not exist as an independent agency certified by Medicare and, therefore, has no identifiable costs on the cost report separate from the main provider. Rather, all costs, including those of the branch, are reflected on the cost report as those of single HHA. However, if, after FFY 1994, the branch was certified by Medicare to operate as an independent, freestanding HHA, it would be considered a clause vi or "new" HHA for purposes of applying the per beneficiary limit. 63 F.R. 15718, 15721-22 (March 31, 1998).

In the August 11, 1998 Federal Register, the Secretary announced that, based on the comments HCFA received regarding the treatment of HHA branches as old or new providers in the March 31, 1998 Federal Register, she had reevaluated her position and modified some aspects of the policy. HCFA reviewed three types of providers involved in changes in ownership, mergers or consolidations. The providers reviewed included HHAs that: (a) had an existing provider number and agreement to participate in the Medicare program; (b) accepted assignment of a provider agreement and provider number that had a FY 1994 base year; and (c) HHAs that had gone through the certification process since the FYE 1994 base period as a new provider and had a new provider number assigned after the applicable 1994 base year. Providers that fell into categories (a) and (b) had until October 1, 1998, to ask their intermediary to consider them "old" or clause v providers. But, those providers described under (c) would remain new providers and be subject to the national per-beneficiary limitation. 63 Fed. Reg. 42912, 42922 (August 11, 1998).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Nix Health Care Systems (Provider) is an acute care hospital located in San Antonio, Texas. In early 1993, the Provider contracted with Outreach Health Services (Outreach), an experienced HHA, to establish and operate Nix Home Care as a branch of Outreach at the Provider's location. From the outset of the agreement, the parties intended to transition the ownership and operation of the HHA to the Provider. Outreach operated Nix Health Care as one of its branches and filed a FYE 1994 cost report that included Nix Health Care expenses.

In May 1995, the Provider, Nix Health Care Systems obtained a new license to operate an HHA, as well as a new provider number from CMS. For purposes of Medicare reimbursement under HHA PPS, Nix Home Care was paid as a new provider.

PARTIES' CONTENTIONS**:**

The Provider, Nix, contends that it established the HHA operation in 1993 and had a 12-month cost reporting period ending August 12, 1994.[1] The Provider argues that a change from a branch operated by Outreach to a hospital-based HHA operated by Nix is, at most, a change in corporate structure. The Provider cites 42 U.S.C. 1395x(v)(1)(L)(vi)(I) which provides that a home office that alters its corporate structure is not to be considered a new provider for purposes of application of the per-beneficiary limits. Consequently, the Provider asserts that the Intermediary should be barred from finding the HHA is a new provider for purposes of the application of the HHA per-beneficiary limits.

The Intermediary believes that the statute specifically addressed the changes in operation and ownership existing here and how these changes would impact a determination of an old or new facility for purposes of the application of the per-beneficiary limit: if an existing free-standing HHA became provider-based through a change in ownership or other means after Federal FY 1994, the agency should be considered a new agency for purposes of the application of the per-beneficiary limits. 42 U.S.C. §1395(v)(1)(L)(v)(vi).

The Intermediary also contends that the Provider could have requested that the Intermediary change its designation to that of an old provider under the process set forth in the August 11, 1998 Federal Register. Since the Provider did not make this request by the due date, such action in now barred. The Provider responds that it does not believe it would have qualified for redesignation.[2]

In addition, the Provider argues that it does not meet the definition of a new provider found in the regulations regarding exceptions, exemptions or reclassifications at 42 C.F.R. §413.30(e)(2). Under the regulatory definition, the HHA would not be considered

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[1] It is undisputed that Outreach filed cost reports for Nix Home Care as a branch office of its San Antonio operation. See, Provider Position Paper at 30, ftnt. 27.

[2] Tr. at 223-224.

a new provider because it had previously offered the same type of services and serviced the same patient population under both old and new ownership.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law, parties' contentions and evidence, the Board concludes that the Provider is not entitled to be considered an old provider for purposes of the HHA per-beneficiary limits. The statutory provision, 42 U.S.C. §1395x(v)(1)(L)(vi), requiring that the national per-beneficiary limitation be applied to a new provider, is controlling.

The Board finds that until the Provider obtained a license to operate an HHA from the state of Texas and a Medicare provider number, Nix Home Care, despite its name, operated as a branch office of Outreach Health Services rather than as a component of Nix Health Care System. As a branch office, it had no operational assets identified separately from Outreach Health Services. Therefore, when the HHA became a provider-based component of Nix Health System, it did not have a 12-month cost reporting period ending in 1994 and, therefore, has no identifiable historical costs from which an "old" provider rate could be established. Consequently, the facility cannot qualify as an old provider under 42 U.S.C. §1395x(v)(1)(L)(v).

Although CMS permitted certain providers to request to be considered old providers if they requested such a change by October 1, 1998, this HHA went through the certification process after the FY 1994 base period as a new provider and had a new provider number assigned after the applicable 1994 base year. Consequently, it would not have met the requirements identified in the Federal Register to be considered an old provider. See, 63 Fed. Reg. 42912, 42922 (August 11, 1998).

Finally, the Board finds that the Provider's reliance on the definition of new provider found in the regulations dealing with exceptions and exemptions (42 C.F.R. § 413.30) is inapplicable to HHA PPS reimbursement.[3] What constitutes a new provider for the specific purpose of reimbursement under HHA PPS was defined by the BBA '97 and codified at 42 U.S.C. § 1395x(v)(1)(L)(vi). The statute that specifically addresses this issue is controlling.

DECISION AND ORDER:

The Intermediary properly calculated the Provider's reimbursement as a new provider under 42 U.S.C. §1395x(v)(1)(L)(vi). The Intermediary's adjustment is affirmed.

[3] Tr. at 270-273

Board Members Participating

Suzanne Cochran, Esquire
Martin W. Hoover, Jr., Esquire.
Gary B. Blodgett, DDS
Elaine Crews Powell, CPA
Anjali Mulchandani-West

FOR THE BOARD:

DATE: August 12, 2005

Suzanne Cochran, Esq.
Chairman