PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2017-D22

PROVIDERS –
Mercy Des Moines/Mercy Health Network 2008-2010 Home Office Cost Report Related Party Groups

Provider No.: See APPENDIX A

vs.

MEDICARE CONTRACTOR –
Wisconsin Physicians Service

DATE OF HEARING –
April 23, 2015

Cost Reporting Periods Ended –
6/30/2008, 12/31/2008, 6/30/2009, 12/31/2009, 6/30/2010, 12/31/2010

CASE NOs.: 13-2636GC, 13-2637GC, 13-2640GC

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ISSUE

Whether the Medicare Contractor's revised determination that the Iowa Critical Access Hospitals ("Iowa CAHs" or "Providers") are not related to Mercy Medical Center-Des Moines ("Mercy"), and all cost report adjustments stemming from that determination, were appropriate.[1]

DECISION

After considering the Medicare law and regulations, the parties' contentions, and the evidence submitted, the Provider Reimbursement Review Board ("Board") finds that Mercy is an organization related to each of the Iowa CAHs within the meaning of Medicare "related organization" principles. Accordingly, the Board remands the Providers' cost reports at issue for fiscal years ("FYs") 2008, 2009 and 2010 to the Medicare Contractor for audit to determine if the costs that Mercy incurred, and the costs that the Providers included on these cost reports as home office costs, are reasonable and necessary. Subject to the audit findings, those home office costs that are found to be reasonable and necessary are to be reimbursed to the Providers in a timely manner.

INTRODUCTION

This consolidated group appeal involves three groups of CAHs located in rural areas of Iowa.[23] Each of the Iowa CAHs entered into both a management agreement and critical access hospital network agreements with Mercy, a non-profit Catholic hospital with more than 650 beds located in Des Moines, Iowa.[4] Through these agreements, Mercy provided certain home office/management functions for the affiliated Iowa CAHs.[5]

For each of the fiscal years at issue, Mercy filed a home office cost statement allocating costs to the Iowa CAHs for which it provided management and administrative services.[6] In turn, each of the Iowa CAHs claimed its share of Mercy's home office expenses on its own Medicare cost report for the relevant fiscal year.[7] Wisconsin Physicians Service, the Medicare Contractor assigned to the Iowa CAHs ("Medicare Contractor"), issued Notices of Program Reimbursement ("NPRs") in 2009, 2010 and 2011 for these cost reports reimbursing the Providers for Mercy's home office costs.[8]

However, in March 2013, the Medicare Contractor reopened these cost reports, determined that although Iowa CAHs and Mercy were affiliated through a Rural Health Network, they did not qualify as "related organizations" under Medicare rules.[9] Consequently, the Medicare Contractor

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[1] *See* Transcript of Proceedings, *Mercy-Des Moines Health Network v. Wisconsin Physicians Service* (Apr. 23, 2015) at 24 [hereinafter Tr.].
[2] *See* Providers' Consolidated Final Position Paper at Exhibit P-1.
[3] Note that Appendix A to this decision provides a table of the providers in each of the three CIRP groups.
[4] Providers' Consolidated Final Position Paper at 4-5.
[5] *Id.* at 5.
[6] *Id.* at 6.
[7] *Id.*
[8] *Id.*
[9] *Id.* at 7.

removed the home office allocations reported on Worksheet A-8-1 of the Providers' cost reports.[10] In the revised NPRs, the Medicare Contractor denied reimbursement for the Providers' costs in excess of the amount paid to Mercy in management fees.[11]

The Iowa CAHs timely appealed to the Board and met all jurisdictional requirements for a hearing. Christopher L. Keough of Akin Gump Strauss Hauer & Feld, LLP represented the Iowa CAHs. Robin Sanders of the Blue Cross Blue Shield Association[12] represented the Medicare Contractor.

STATEMENT OF THE FACTS

Each of the Iowa CAHs had a management agreement in place with Mercy for the cost reporting periods at issue.[13] These management agreements provided, among other things, that Mercy would recruit the Chief Executive Officer ("CEO") for each of the Iowa CAHs and, in most cases, that the recruited CEO would be a Mercy W-2 employee.[14] The CEO is responsible for the day-to-day operations of the relevant Iowa CAH.[15] Mercy hires, supervises and evaluates the performance of each of these CEOs.[16] At the discretion of the Iowa CAH, Mercy also could (and in some instances did) recruit and employ other senior administrative officials, such as chief financial officers ("CFOs") and nurse executives. [17] Other services provided under the management agreements included: the development of policies and procedures, compliance assistance and education, assistance in investigations concerning potential compliance lapses, financial management services, risk management support, medical staff peer review, and credentialing processes.[18]

Beyond the management agreements, each of the Iowa CAHs have a number of other agreements with Mercy, including critical access hospital network agreements.[19] These network agreements provide for referrals and transfers of the Iowa CAHs' patients to Mercy's facilities when an attending physician determines it is necessary.[20] The Iowa CAHs also had other types of agreements with Mercy including consolidated legal services contracts,[21] patient transfer agreements,[22] imaging support agreements, [23] and the Mercy Health Network Purchasing Program Participation agreement.[24]

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[10] Medicare Contractor's Consolidated Final Position Paper at 6.
[11] *See id.*
[12] Federal Specialized Services currently represents the Medicare Contractor.
[13] *See* Providers' Consolidated Final Position Paper at Exhibits P-3 to P-17, P-20 to P-32 (including copies of the hospital management agreements and the management services and affiliation agreements).
[14] *See id.*
[15] *See id.*
[16] *Id.*
[17] *See* Providers' Post Hearing Brief at 20-21; *see also* Tr. at 176, 210.
[18] *See* Providers' Consolidated Final Position Paper at 5.
[19] Providers' Consolidated Final Position Paper at Exhibits P-33 to P-47.
[20] *Id.*
[21] *Id.* at Exhibits P-64 to P-78.
[22] *Id.* at Exhibits P-48 to P-63.
[23] *Id.* at Exhibits P-90 to P-94 and Volume 3 of 3, Exhibits P-95, P-96.
[24] *Id.* at Exhibit P-119.

Federal regulations at 42 C.F.R. § 413.17 (2008) direct how Medicare handles cost for "related organizations." Section (a) of this regulation states the principle of related organization costs as follows:

> (a) *Principle*. . . . [C]osts applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. However, such cost[s] must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.

Section (b) of this regulation defines related organizations as follows:

> (1) *Related to the provider.* Related to the provider means that the provider to a significant extent is associated or affiliated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.
>
> (2) *Common ownership*. Common ownership exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider.
>
> (3) *Control*. Control exists if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

CMS provides guidance on this regulation in the Provider Reimbursement Manual ("PRM") 15-1. Specifically, Chapter 10, § 1000 reiterates the regulatory criteria of 42 C.F.R. § 413.17(a)—that the costs which related organizations furnish are includable in the provider's allowable costs and that these costs cannot exceed the price of comparable services that could be purchased elsewhere—and adds:

> The purpose of this principle is two-fold: (1) to avoid the payment of a profit factor to the provider through the related organization (whether related by common ownership or control), and (2) to avoid payment of artificially inflated costs which may be generated from less than arm's-length bargaining.

The manual further explains the situation where a contract creates the related organization relationship in § 1011.1 which states:

> If a provider and a supplying organization are not related before the execution of a contract, but common ownership **or control** is created at the time of execution by any means, the supply contract will be treated as having been made between related organizations (emphasis added).

Finally, § 1004.3 defines the term "control" as follows:

> The term "control" includes any kind of control, whether or not it is legally enforceable and however it is exercisable or exercised. It is the reality of the control which is decisive, not its form or the mode of its exercise.

The parties dispute whether the above regulatory and manual guidance on related organizations supports the Medicare Contractor's adjustments to remove the amounts claimed by the Iowa CAHs as related organization/home office costs from Mercy.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

Discussion Related to Related Party Status

The Medicare Contractor contends that the management agreements between the Iowa CAHs and Mercy did not allow the Iowa CAHs to claim Mercy's home office costs as a related organization.[25] The Medicare Contractor reasons that, with respect to each Iowa CAH, the Board of Trustees for each hospital is the governing body and is solely responsible for the policy making and direction of that hospital.[26] The Medicare Contractor points out that there are no Mercy employees on any of the Iowa CAHs' Boards of Trustees and that, as a result, Mercy has no influence over these Trustees.[27] The Medicare Contractor maintains that, while the Mercy's employees—as administrators of the various Iowa CAHs—may have some influence over their respective CAH, their influence is primarily related to their job responsibilities in their respective positions and are solely responsible for carrying out the policies as directed by the Trustees, which are similar to other non-employee administrators.[28] The Medicare Contractor concludes that the Board of Trustees controls each of the Iowa CAHs and, as a result, Mercy is not a related organization.[29] As Mercy simply provides services to the Iowa CAHs through management agreements, the Medicare Contractor finds it necessary to limit the management costs to the actual amounts that the Iowa CAHs incurred.[30]

The Medicare Contractor relies on PRM 15-1 § 2135 which provides detailed guidance related to purchased management and administrative support services.[31] The Medicare Contractor asserts that the Iowa CAHs have failed to document the costs and services associated with these contracts.[32] Specifically, the Medicare Contractor explains that the Iowa CAHs have not submitted the documentation as specified at § 2135.5 "a" through "f" and that, if the Board finds that Mercy and the Iowa CAHs are related organizations, the cases must be remanded back to the

[25] Medicare Contractor's Consolidated Final Position Paper at 6.
[26] *Id.* at 10-11.
[27] *Id.* at 10.
[28] *Id.*
[29] *Id.* at 9-11.
[30] *Id.*
[31] *See id.* at 13-15.
[32] *Id.* at 15.

Medicare Contractor for review to determine the extent to which the claimed home office costs are allowable.[33]

The Iowa CAHs disagree with the Medicare Contractor's position and maintain that Mercy significantly influences the actions and policies of each of the Iowa CAHs.[34] The Iowa CAHs point to CMS' related organization regulations which define the term "control" to mean "the power to directly or indirectly significantly to influence or direct the actions or policies of an organization."[35] They further note that PRM 15-1 contains a similar definition for "control" and this definition makes it clear that "any kind of control" will suffice "whether or not it is legally enforceable and however it is exercisable or exercised."[36] Based on these definitions, the Iowa CAHs assert the Medicare Contractor is simply wrong in its new interpretation of the related organization rules and maintains that this new interpretation cannot be applied retroactively.[37] Finally the Iowa CAHs assert that Medicare's regulations and manuals allow the CAHs to be reimbursed for its allocable share of allowable home office costs, regardless of whether the costs are greater or less than the amount paid to the home office.[38]

The Iowa CAHs further assert that the only issue in the appeal is whether the Iowa CAHs are related to Mercy through common control and the Medicare Contractor accepted the reasonableness of the home office costs when the Iowa CAHs' NPRs were issued.[39] The Iowa CAHs claim that the Medicare Contractor's argument that the Iowa CAHs cannot be reimbursed for their full allocable share of home office costs is beyond the scope of this appeal.[40] In addition, the Iowa CAHs argue that Medicare's regulations at 42 C.F.R. §405.1889(b)(2) bar any appeal of a revised determination of any matter that is not specifically revised (including any matter that was reopened but not revised).[41]

The Board finds that the Medicare regulations and PRM 15-1 define the term "control" broadly and inclusively. Specifically, 42 C.F.R. § 413.17(b)(3) defines "control" as "the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution." Similarly, the PRM 15-1 § 1004.3 defines "control" to include "any kind of control, whether or not it is legally enforceable and however it is exercisable or exercised." Based on these definitions, it is clear that Mercy controlled the Iowa CAHs because the evidence in these cases demonstrates that Mercy had significant influence over the management staff, policies and day-to-day operations of the Iowa CAHs. Thus, the Board finds that the Iowa CAHs are related to Mercy within the meaning of Medicare "related organization" principles.

In nearly every instance, Mercy employs the CEOs for each of the Iowa CAHs as well as other senior administrative officials such as the CFOs and Nurse Executives on a temporary or

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[33] *Id.* at 17.
[34] Providers' Consolidated Final Position Paper at 8.
[35] *Id.* (quoting 42 C.F.R. § 413.17(b)(3)).
[36] *Id.* (quoting PRM 15-1 § 1004.3).
[37] *Id.* at 8-9.
[38] Providers' Consolidated Responsive Brief at 5.
[39] *Id.* at 1.
[40] *Id.* at 2-4.
[41] *Id.* at 3-4.

permanent basis.[42] These individuals are on Mercy's payroll and run the day-to-day operations of the Iowa CAHs and are held answerable to Mercy.[43] The CEO of one of the Iowa CAHs testified that Mercy significantly influences her actions noting that key operating decisions are not made without first obtaining input and feedback from Mercy.[44] The record also confirms that Mercy controls both the selection process and performance review process of the CEOs for the Iowa CAHs and that these CEOs routinely rely on the advice and direction received from Mercy in the operation of the Iowa CAHs.[45]

Further, the record demonstrates that Mercy provides standardized operational policies and procedures for use and adoption by the Iowa CAHs.[46] The witnesses testified that Mercy's entire library of policies and procedures is available to the Iowa CAHs.[47] These policies and procedures are used and implemented by the Iowa CAHs in their own institutions.[48] Examples include quality initiatives, bench marking processes, compliance education programs, performance improvement plans, and human resources policies. In general, Mercy created standardization across the Iowa CAHs consistent with the affiliation, management and network agreements.[49]

Discussion Related to Reasonable and Necessary Costs

While the Board agrees that the Iowa CAHs are related to Mercy, the Board does not agree with the Iowa CAHs' characterization of the Medicare Contractors' determination on the home office costs at issue. Specifically, the Board neither agrees that the Medicare Contractor accepted the reasonableness of the home office costs when the Medicare Contractor issued the Iowa CAHs' NPRs nor that Medicare's regulations at 42 C.F.R. § 405.1889(b) bar any further review of these costs. Section 405.1889(b) states:

> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

The Board reviewed the reopening workpapers related to the revised determinations under appeal in these cases. The adjustments made as part of these reopenings removed Mercy's related organization home office costs from the Iowa CAHs' cost reports.[50] It is these specific

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[42] Providers' Post-Hearing Brief at 20.
[43] *Id.*
[44] *See id.* (discussing the testimony of Ms. Hendricks—the CEO of Madison Hospital); *see also* Tr. at 82, 182-97, & 210-12.
[45] *See* Providers' Post-Hearing Brief at 21-22 (providing citations to the record).
[46] *Id.* at 23.
[47] *Id.*
[48] *Id.*
[49] *See* Providers' Post-Hearing Brief at 23 (providing citations to the record); *see also* Providers' Consolidated Final Position Paper at Exhibit P-139 (showing the declaration of a former Mercy Senior Vice President).
[50] *See* Providers' Consolidated Final Position Paper at Exhibits P-125 to P-138.

adjustments that are at issue in this appeal.[51] The Board concludes that the Medicare Contractor's revised determinations did not accept the home office cost but rather adjusted these costs by removing them from each of the Iowa CAHs' cost reports.[52] As the Medicare Contractor adjusted these costs by removing them *in toto* at reopening, § 405.1889 (b)(1) specifically allows for these costs to be within the scope of any appeal of the revised determinations. The Medicare Contractor made no other detailed review or finding with respect to whether the allocated costs met the applicable regulatory standards to be properly reimbursable.[53] In order to ensure that proper reimbursement is made, the Board remands these appeals back to the Medicare Contractor to review and determine the appropriate amount of home office costs allowable on the Iowa CAHs' cost reports.

DECISION AND ORDER

After considering the Medicare law and regulations, the parties' contentions, and the evidence submitted, the Board finds that Mercy is an organization related to each of the Iowa CAHs within the meaning of Medicare "related organization" principles. Accordingly, the Board remands the Providers' cost reports at issue for fiscal years 2008, 2009 and 2010 to the Medicare Contractor for audit to determine if the costs that Mercy incurred, and the costs that the Providers included on these cost reports as home office costs, are reasonable and necessary. Subject to the audit findings, those home office costs that are found to be reasonable and necessary are to be reimbursed to the Providers in a timely manner.

BOARD MEMBERS PARTICIPATING:

Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA CHFP

FOR THE BOARD:

/s/
L. Sue Andersen, Esq.
Chairperson

DATE: July 18, 2017

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[51] *See* Providers' Group Appeal Request at Tab 2.

[52] As stated in PRM 15-1 § 2150, the Medicare program does not recognize home offices as Medicare providers and, as a result, does not directly reimburse home offices for their costs related to patient care. Rather, to the extent the home office furnishes services related to patient care to a provider, the reasonable costs of such services are includable in the provider's cost report and are reimbursable as part of the provider's costs.

[53] Medicare Contractor's Post-Hearing Brief at 9.

APPENDIX A

CASE NO. 13-2636GC

	Provider No.	Provider Name	FYE
1	16-1310	Adair County Memorial Hospital	6/30/2008
2	16-1326	Madison County Health Care System	6/30/2008
3	16-1327	Davis County Hospital	6/30/2008
4	16-1330	Audubon County Memorial Hospital	6/30/2008
5	16-1332	Manning Regional Healthcare Center	6/30/2008
6	16-1333	Story County Medical Center	6/30/2008
7	16-1340	Decatur County Hospital	6/30/2008
8	16-1342	Monroe County Hospital	6/30/2008
9	16-1350	Stewart Memorial Hospital	12/31/2008
10	16-1352	Clarinda Regional Health Center	6/30/2008
11	16-1358	Wayne County Hospital	6/30/2008
12	16-1373	Ringgold County Hospital	6/30/2008

CASE NO. 13-2637GC

	Provider No.	Provider Name	FYE
1	16-1310	Adair County Memorial Hospital	6/30/2009
2	16-1322	Dallas County Hospital	6/30/2009
3	16-1326	Madison County Health Care System	6/30/2009
4	16-1327	Davis County Hospital	6/30/2009
5	16-1330	Audubon County Memorial Hospital	6/30/2009
6	16-1332	Manning Regional Healthcare Center	6/30/2009
7	16-1333	Story County Medical Center	6/30/2009
8	16-1340	Decatur County Hospital	6/30/2009
9	16-1342	Monroe County Hospital	6/30/2009
10	16-1350	Stewart Memorial Hospital	12/31/2009
11	16-1352	Clarinda Regional Health Center	6/30/2009
12	16-1358	Wayne County Hospital	6/30/2009
13	16-1373	Ringgold County Hospital	6/30/2009

CASE NO. 13-2640GC

	Provider No.	Provider Name	FYE
1	16-1310	Adair County Memorial Hospital	6/30/2010
2	16-1322	Dallas County Hospital	6/30/2010
3	16-1326	Madison County Health Care System	6/30/2010
4	16-1327	Davis County Hospital	6/30/2010
5	16-1330	Audubon County Memorial Hospital	6/30/2010
6	16-1332	Manning Regional Healthcare Center	6/30/2010
7	16-1333	Story County Medical Center	6/30/2010
8	16-1340	Decatur County Hospital	6/30/2010
9	16-1342	Monroe County Hospital	6/30/2010
10	16-1350	Stewart Memorial Hospital	12/31/2010
11	16-1352	Clarinda Regional Health Center	6/30/2010
12	16-1358	Wayne County Hospital	6/30/2010
13	16-1361	Van Diest Medical Center	6/30/2010
14	16-1373	Ringgold County Hospital	6/30/2010