# CENTERS FOR MEDICARE AND MEDICAID SERVICES

*Decision of the Administrator*

| In the case of: | Claim for: |
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| **Visiting Nurse Association of Texas**<br><br>**Provider**<br>**vs.**<br><br>**Blue Cross Blue Shield Association/ Palmetto Government Benefits Administrators**<br>**Intermediary** | **Provider Cost Reimbursement Determination for Cost Reporting Period Ending: June 30, 1997**<br><br>**Review of:**<br><br>**PRRB Dec. No. 2008-D8**<br>**Dated: November 16, 2007** |

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in Section 1878(f)(1) of the Social Security Act (Act), as amended (42 USC 1395oo(f)). The parties were notified of the Administrator's intention to review the Board's decision on Issue Nos. 2 and 3. Comments were received from the CMM requesting reversal of the Board's decision on Issue Nos. 2 and 3. The Provider also submitted comments requesting affirmation of the Board's decision on Issue Nos. 2 and 3. Accordingly, this case is now before the Administrator for final administrative review on Issue Nos. 2 and 3.[1]

## ISSUES AND BOARD DECISION

Issue No. 2:

Issue No. 2 concerns whether the Intermediary's disallowance of $35,390 to remove the portion of Home Health First (HHF) management fees attributable to the cost of

[1] Issue No. 1 involved whether the Intermediary properly disallowed an adjustment to administrative and general pooled costs related to a management service organization, Home Health First (HHF). The Administrator summarily affirms the Board's decision on Issue No. 1.

a deferred compensation plan for executives was proper.[2] HHF had, as part of its executive staff retirement benefits, the FLEX Retirement Options Capital Accumulation Account (CAA). The non-qualified executive benefits plan was established by HHF on April 1, 1997.

The Board found that the Intermediary's disallowance was improper. The Board relied on the Provider Reimbursement Manual (PRM) at §2140, et seq., which set conditions for the allowability of costs related to non-qualified deferred compensation plans, and on the IRS' standards, which incorporate the necessity of some risk. The Board noted that the IRS rules establish that a core element of such a plan is the existence of "a substantial risk of forfeiture of the rights to such compensation." The Board agreed with the Provider that the plan's risk of insolvency and violation of a non-competition clause are general risks typically incorporated in non-qualified plans to defer tax liability pursuant to IRS rules. The Board found that no evidence existed that the plan was not adequately safeguarded. Thus, the Board found that, because the overall context of the PRM §2140, et seq., is to set conditions for non-qualified deferred compensation plans, the IRS standards which incorporate risk, may be considered.

Issue No. 3:

Issue No. 3 concerns whether the disallowance of $351, 012 as costs in excess of the physical therapy salary equivalency guidelines (Guidelines) was proper. The physical therapy services in dispute were provided by physical therapists who were treated as employees of the Provider paid on a per-visit basis as opposed to a salary basis. The Board found that the Intermediary's application of the Guidelines to the Provider's physical therapy costs was improper. The Board noted the statute at §1861(v)(1)(A) provides that the reasonable cost of any service shall be the actual cost incurred excluding any part of such costs found to be unnecessary in the efficient delivery of needed health services. The limits recognized reasonable costs based upon the estimates of costs found to be necessary in the efficient delivery of covered items and services.

The Board relied on §1861(v)(5)(A) of the Act which states that the Guidelines applies to physical therapy service furnished under an arrangement with a provider of services or other organization.

The Board found that the language of this controlling statute distinguished services performed by employees of a Provider from services that are performed "under an arrangement." Services performed by a physical therapist in an employment

[2] The Provider is Visiting Nurse Association of Texas, and HHF is a related party that provided management services to the Provider.

relationship with the provider are different from those services performed "under an arrangement." The Board noted that the legislative and regulatory history indicate that the Guidelines were created to curtail and prevent perceived abuses in the practice of outside physical therapy contractors. The Board also noted that the term "under an arrangement" is commonly referred to, and used interchangeably with, the term "outside contractor." Accordingly, the Board found that the Guidelines did not apply to employee physical therapists even though they are paid on a per-visit basis.

The Board referred to In Home Health v. Shalala, 188 F.3d 1043 (8th Cir. 1999) and High Country Home Health, Inc. v. Shalala, 84 F.Supp.2d 1241 (D. Wy. 1999), which held that the Guidelines do not apply to in-house physical therapy staff.

The Board further found that the Guidelines should not be used in place of a prudent buyer analysis; rather, intermediaries should determine whether a provider's costs are "substantially out of line" by a comparison of those costs to those incurred by other similarly situated providers. The Board noted that in this instance, the parties stipulated that there was no dispute as to the reasonableness of the compensation outside the issue concerning the applicability of the physical therapy salary equivalency guidelines, and accordingly, the Board found such costs allowable.

## SUMMARY OF COMMENTS

CMM commented, requesting reversal of the Board's decision in Issue Nos. 2 and 3. Regarding Issue No. 2, CMM argued that the Provider did not meet all the requirements of the PRM at §2140.3, because HHF owned the assets of the plan, rather than the employees. CMM noted that the plan summary clearly stated that "HHF owns the investments of the Capital Accumulation Account (CAA)…, and if HHF becomes insolvent, you will be an unsecured creditor and will have no preferred claim to any assets…" CMM alleged that the Provider did not use the required methods of funding under the statute. Instead, HHF actually owned the investment mechanisms which caused a total lack of protection against the very common event of bankruptcy. Thus, the plan's assets are actually the assets of the Provider. CMM argued that, since the Provider's plan did not meet the standards of a funded plan, under either §2140 or §2141.3, the Board's decision should be reversed.

CMM also requested reversal of the Board's decision on Issue No. 3. CMM argued that the Intermediary properly applied the guidelines to the therapist's compensation. CMM included comments submitted from a previous case with the identical issue, written by CMM. CMM argued that the Intermediary's application of the salary equivalency guidelines to the Provider's physical therapists paid on a fee-for-service basis was appropriate based on the agency's authority to apply the guidelines under the statute. CMM continued to maintain that the statute distinguishes between

services furnished "under an arrangement" and those provided through a salaried "employee relationship." Therefore, the Provider's physical therapists' costs, which included both a salary and commission, were subject to the Guidelines. Further, because the plain language of the statute is silent or ambiguous on the issue of whether the Guidelines should be applied to employees compensated on a per-visit basis (similar to contractors), CMS' interpretation should be upheld because it is reasonable under the statute. CMM noted that the language in the statute demonstrates that Congress assumed that an employment relationship necessarily entails compensation by salary. Further, CMM argued that the Agency has the authority under section 1861(v)(1)(A) of the Act to define reasonable cost and establish and apply cost limits to different provider costs and different classes of providers to determine that they are recognized as reasonable in determining Medicare program payments. Finally, CMM noted the similarities of the issues presented in the case to those issues presented in prior Administrator's decisions.

The Provider commented on Issue Nos. 2 and 3. The Provider commented that in Issue No. 2, the management of the plan at the time of its inception through the present indicated that adequate protections existed for plan beneficiaries with the minimum necessary risk of forfeiture that were essential for the plan to meet Internal Revenue Services (IRS) standards. The Provider argued that it would be irrational for Medicare to permit nonqualified deferred compensation plans under the IRS standards and then reject the costs of these plans if there is any risk of forfeiture, since the nature of a nonqualified plan is that there must be such a risk. The Provider further noted that the Board made a factual finding that "no evidence exists that the plan was not adequately safeguarded." The Provider argued that under Texas law, a trust had been established to provide the safeguards, and any doubts about the deferred compensation plan were erased as the conduct of the parties throughout demonstrated the bona fide nature of the plan, as all plan participants maintained control over the compensation of investment and distribution. Thus, the Provider recommended affirming the Board's decision regarding Issue No. 2.

The Provider also commented that the Board's decision regarding Issue No. 3 should be affirmed. The Provider argued that the Board's decision has been consistent over the years when the issue of whether salary equivalency guidelines were inapplicable to the Provider's therapy costs, when the therapy was provided by the Provider's employees. The Provider noted that, although the Administrator has reversed the PRRB on all known occasions when it reviewed the issue, when the issue has been addressed by a Federal court, the Administrator has been reversed. Thus, the Provider argued that in the interest of saving time and cost of further review, the Administrator should affirm the Board's decision in Issue No. 3.

## DISCUSSION

The entire record furnished by the Board has been examined, including all correspondence, position papers, exhibits, and subsequent submissions. Comments timely submitted have been included in the record and have been considered.

Until 1983, Medicare paid for covered hospital inpatient services on the basis of "reasonable cost." Section 1861(v)(1)(A) of the Act defines "reasonable cost" as "the cost actually incurred," less any costs "unnecessary in the efficient delivery of needed health services." While §1861(v)(1)(A) does not prescribe specific procedures for calculating reasonable cost, it authorizes the Secretary to promulgate regulations setting forth the methods to determine reasonable cost and the items to be included in reimbursable services.

The Secretary has promulgated regulations at 42 CFR 413.9 which provide that all payments to providers of services must be based on reasonable costs of services covered under Title XVIII of the Act and related to the care of beneficiaries. In addition, the Provider must meet the documentation requirements of both the Act and the regulations in order to demonstrate entitlement to reimbursement.[3]

Issue No. 2:

Consistent with §1861 of the Act, regarding reasonable costs, the related party rules at 42 CFR 413.17 (1997) provide that cost applicable to services, facilities, and supplies furnished to the Provider by organizations related to the Provider by common ownership and control are includable in the allowable cost of the Provider at the cost to the related organization. Moreover, such costs must not exceed the price of the comparable services, facilities or supplies that could be purchased elsewhere.[4]

In this case, HHF is a related party that provided management services to the Provider. Certain pooled costs of HHF were claimed by the Provider for management services. A portion of these claimed costs were attributable to the deferred compensation plan of HHF. However, since only the reasonable costs of

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[3] Section 1815 of the Act (42 USC 1395g); 42 CFR 413.20; 42 CFR 413.24.

[4] See, e.g., §2150 of the PRM which similarly provides that, with respect to home office costs, management fees charged between related organizations are not allowable costs, and such fees must be deleted from the provider's cost report. However, where management fees between related organizations are disallowed, the home office's reasonable costs for providing the services related to patient care are includable as allowable costs of the provider.

the related party associated with patient care are allowable, the deferred compensation managed by HHF must also meet these criteria.

The PRM at §2140 sets forth criteria governing deferred compensation plans. Specifically, the PRM §2140.1 defines the deferred compensation as:

> [r]emuneration currently earned by an employee but which is not received until a subsequent period, usually after retirement. Accordingly, a deferred compensation plan defers the receipt of income beyond the year in which it is earned. The type of deferred compensation plan considered herein is not considered a qualified plan under Internal Revenue Service requirements.[5] [Emphasis added].

The PRM at §2140.2 states that:

> Provider contributions for the benefit of employees under a defined contribution deferred compensation plan are allowable when, and to the extent that, such costs are actually incurred by the provider. Such costs may be found to have been incurred only if the requirements of this section are met. [Emphasis added].

The PRM §2141.3 outlines the requirements needed to establish a formal deferred compensation plan. It specifically states that in order to establish a formal deferred compensation plan, the provider must communicate the proposed plan to all eligible employees, and ensure that no provision of the plan may discriminate in favor of certain employees. It is a permanent plan which:

- Prescribes the method for calculating all contributions to the fund established under the plan;
- Is funded in accordance with the provisions of §2140.3B;
- Provides for the protection of the plan's assets;
- Designates the requirements for vested benefits;
- Provides the basis for the computation of the amount of benefits to be paid; and
- Is expected to continue despite normal fluctuations in the provider's economic experience. [Emphasis added].

Additionally, other provisions must be met including the provisions of §2140.3A, describing contributions, the provisions of §2140.3B, governing funding of deferred compensation plans, and the provisions of §2140.3C1 and §2140.3C3, describing the plan's assets and transactions.

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[5] See subchapter D, Internal Revenue Code of 1986, as amended, and regulations.

The PRM at §2140.3A explains contributions to the plan and states that they "may be made by the provider only, or by the provider and the employee." It also states that the provider's contribution is "established by the terms of the deferred compensation agreement and made for the sole benefit of the participating employees." The employee's contribution is generally a voluntary contribution to the fund established under the plan in addition to the provider's required contribution.

Section 2140.3B describes the funding of deferred compensation plans. In particular, §2140.3B(1) explains the provider payment for the deferred compensation plans, and states:

> A funded plan is one in which contributions are systematically made as a specific provision of the plan to a funding agency for the purpose of meeting retirement benefits. For Medicare purposes, a funding agency is either a trustee, an insurance company, or a custodial bank account which provides for the accumulation of assets to be used for the payment of benefits under the deferred compensation plan. Accordingly, both provider and employee contributions to the deferred compensation plan must be used either to purchase an insured plan with a commercial insurance company, to establish a custodial bank account, or to establish a trust fund administered by a trustee. [Emphasis added].

Additionally, PRM §2140.3(C)(1) requires that:

> All transactions involving the deferred compensation fund must be made under conditions comparable to arm's length transactions. The provider cannot transfer, either by sale or exchange, its securities and other property to the deferred compensation fund at more than adequate consideration. Likewise, a deferred compensation fund cannot sell its assets either to a provider or a third party at less than adequate consideration. All assets accumulated by the plan must be distributed exclusively to the participating employees or their beneficiaries. [Emphasis added].

In the instant case, the Administrator finds that HHF did not use the required methods of funding under §2140, et. seq., which prevent or extremely limit the use of funds by the Provider. The record provides the plan summary, which clearly states:

> Substantial risk of forfeiture. As required by the IRS, the CAA is subject to a substantial risk of forfeiture in the form of a non-competition agreement which stipulates that you will not work for a competitor (any health care entity that is not owned by HHF) within a geographical area as described in the agreement, in the same or similar job duties for a period of 24 months. If you violate the non-competition agreement, you forfeit your undistributed balance in the CAA…
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> Employer insolvency. HHF owns the investments of the Capital Accumulation Account until your distribution date. Based on IRS rules, if HHF becomes insolvent, you will be an unsecured creditor and will have no preferred claim to any assets. However, special trust has been implemented to safeguard your CAA from any other contingencies such as change of control of HHF.[6]

Accordingly, the Administrator finds that the HHF's Capital Accumulation Account failed to comply with the deferred compensation fund requirements set forth in the PRM. Specifically, §2140.3(B)(1) requires for Medicare purposes that a funding agency, which is either a trustee, insurance company, or a custodial bank account provide for the accumulation of the assets to be used for the payment of benefits under the deferred compensation plan. However, HHF did not utilize such an entity. Instead, the HHF actually owned the investment mechanisms pertaining to its deferred compensation plan resulting in a lack of protection against bankruptcy. The record shows that the plan's assets are actually the assets of HHF. Consequently, the Provider also failed to use an "arms-length transaction" involving the funding of the plan. Therefore, the Administrator finds that the deferred compensation plan does not meet the standards of a funded plan under §2140, et seq., of the PRM.

The Administrator notes that CMS has reasonably determined that it is not prudent for the Medicare trust fund to be used to reimburse providers for deferred compensation plans which can be used for some other purpose, such as satisfying provider creditors in case of bankruptcy.

Accordingly, the Administrator finds that the Intermediary properly disallowed the portion of HHF management fees attributable to the cost of a deferred compensation plan for executives. The Administrator finds that these costs are not reasonable costs of the related party, reimbursable under Medicare. Thus, the Administrator reverses the Board's decision as to Issue No. 2.

Issue No. 3:

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[6] Provider's Position Paper, Exhibit P-3.

A limitation on payments for the reasonable cost of physical therapy services under arrangement was established by §251(c) of the Social Security Amendments of 1972[7] and §17(a) of the Social Security Amendments of 1973.[8] These amendments added §1861(v)(5)(A) of the Act which provides that:

> Where physical therapy services [and other therapy services] … are furnished under an arrangement with a provider of services … the amount included in any payment to such provider … as the reasonable cost of such services … shall not exceed an amount equal to the salary which would reasonably have been paid for such services … to the person performing them if they had been performed in a employment relationship with such provider … incurred by such person, as the Secretary may in regulations determined to be appropriate. (Emphasis added.)

Section 1861(w)(1) of the Act provides that:

> [T]he term "arrangements" is limited to arrangements under which receipt of payment by the … home health agency … (whether in its own right or as agent), with respect to services for which an individual is entitled to have payment made under this title, discharges the liability of such individual or any other person to pay for the services.

The Secretary implemented §1861(v)(5)(A) of the Act through the promulgation of 42 CFR 413.106, which defines the Guidelines as reflective of the "amount equivalent to the prevailing salary and additional costs that would reasonably have been incurred by the provider … had such services been performed by such person in an employment relationship." In turn, subsection (b) defines "prevailing salary" as:

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

Consequently, the Guidelines, as explained at 42 CFR 413.106(b)(6), are the amounts published by the Secretary reflecting the application of section 413.106(b)(1) through (4) to an individual therapy service and a geographical area. Paragraph (c) of the regulation states that:

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[7] Pub. Law 92-603.

[8] Pub. Law 93-233.

> Under this provision, [CMS] will establish criteria for use in determining the reasonable costs of physical … therapy services … furnished by individuals under arrangements with a provider of services…. 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 a change in the substance of these arrangements.

The Secretary's interpretation of the reasonable cost provision of §1861(v)(1)(A), the provisions of §1861(v)(5)(A) and the regulation at 42 CFR 413.106 is set forth in §1403 of the PRM. First promulgated in 1977, §1403 of the PRM states, inter alia, that:

> The guidelines apply only to the costs of services performed by outside suppliers, not the salaries of provider's employees. However, 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 relationship, 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.
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> In situations where compensation, at least in part, is based on a fee-for-service or on a percentage of income (or commissions), these arrangements will be considered non-salary arrangements, and the entire compensation will be subject to the guidelines in this chapter. (Emphasis added.)

The Administrator disagrees with the Board's analysis of the case and the relevant law and policy. The Administrator finds that, after a review of the controlling law, legislative history of the Act, and relevant Medicare policy, the Intermediary properly applied the Guidelines to the Provider's physical therapy compensation. Contrary to the Board's finding that the employment relationship between the Provider and the physical therapists determined whether the Guidelines should be applied, the Administrator finds that the fee-for-service compensation of the Provider's therapists was the controlling factor in the application of the limits in this case.

First, in this case, the Board found that the Provider "employed" physical therapists. If the physical therapists were in fact employees, the Board asserts that the physical therapists were exempt from the physical therapy Guidelines. However, the

Administrator notes that the Secretary is not bound by the IRS provisions in determining Medicare reimbursement. The Administrator notes that these physical therapists may be employees under the IRS code but where compensation, at least in part, is based on fee-for-service, these payments are treated as non-salaried payments under §1402 of the PRM and non-employment relationships for Medicare reimbursement purposes.

The specific salary arrangements in this case are not consistent with prudent practices associated with full time employment. In this situation, the payment arrangements for physical therapists are similar to non-salaried personnel. The employment payment schemes for physical therapy services appear to be outside of a standard employment arrangement with the Provider and thus create the same opportunities for abuses as more traditionally defined contractor relationships. Consequently, wages paid on a fee-for-service or commissioned basis are governed by the Guidelines for purposes of Medicare reimbursement. The Administrator finds that §1861(v)(1)(A) of the Act authorizes the Secretary to determine reasonable costs and to implement limits on costs. That the Secretary has chosen to apply the Guidelines to the cost of employee compensation on a fee-for-service basis is not inconsistent with that authority. The law is well established that §1861(v)(1)(A) of the Act gives the Secretary "broad discretion" to determine what are reasonable costs.[9] The Administrator finds that the application of the Guidelines under these facts is a reasonable exercise of that discretion.

Moreover, with respect to the Secretary's authority to apply the Guidelines under these circumstances under the authority granted pursuant to §1861(v)(5)(A) of the Act, the Administrator finds it significant that the plain language of §1861(v)(5)(A) of the Act does not limit the application of the Guidelines only to non-employees or outside contractors. As evident from the foregoing statutory language, the phrase "under an arrangement" is not defined in the Act by reference to a legal employment situation under the IRS code, but rather, is defined in broad terms as where receipt of

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[9] See, e.g., Good Samaritan Hospital v. Shalala, 508 U.S. 402, 411, 419 (1993); Mt. Diablo County Hosp. v. Bowen, 811 F.2d 38, 3443 (7th Cir. 1987) (section 1861(v)(1)(A) gives the Secretary wide latitude in prescribing regulations governing the process of determining reasonable costs). In Good Samaritan, the Supreme Court noted that section 1861(v)(1)(A) "explicitly delegates to the Secretary the authority to develop regulatory methods for the estimation of reasonable costs," 508 U.S. at 418, and likened this authority to the "exceptionally broad authority" that Congress bestowed upon the Secretary in other areas of the Social Security Act. Id. Pursuant to this authority, the Secretary has promulgated regulations establishing cost limits, see 42 CFR 413.30, and has provided that the cost limits may be calculated on a "per admission", per discharge, per diem, per visit, or other basis," Id. at 413.30(a)(2) (Emphasis added).

Medicare payment by a provider discharges the liability of the beneficiary to pay for such services. Although the language of §1861(v)(5)(A) clearly applies in situations where there is an outside contractor relationship, the plain language of the statute does not actually define "under arrangement" with those terms and, thus, does not specifically exclude employment situations.

In addition, both the language of the statute and the legislative history of the Act support the conclusion that Congress was concerned with limiting costs associated with fee-for-service arrangements such as those in this case. In drafting the language of §1861(v)(5)(A), Congress chose to refer to the form of compensation, "salary," rather than the form of the legal relationship between provider and therapist to establish the standard for determining the applicable limits. Thus, this limit is established based on salary compensation, i.e., a fixed compensation which is periodically paid to a person for regular work or service.

Moreover, the legislative history clearly reflects that Congress expected this limit (salary-based) would be applied to fee-for-service arrangements, as Congress was concerned about the cost implications of therapy provided under fee-for-service arrangements, as opposed to salary-based compensation.[10] Thus, rather than focusing on the exact nature of the legal relationship between the provider and the therapists, Congress focused on the form of compensation to the therapists, viewing fee-for-service arrangements as the most likely area for uncontrolled costs and potential abuse.

Consequently, the statutory language of §1861(v)(5)(A) and its legislative history all indicate that Congress did not contemplate all possible forms of fee-for-service arrangements and, thus, did not contemplate fee-for-service arrangements within the context of a formal employment relationship. However, it is equally evident that the purpose of enacting §1861(v)(5)(A) of the Act was to place limits on physical therapy fee-for-service compensation costs. Because of the ambiguity of the language at §1861(v)(5)(A), the Secretary's interpretation of the statute is entitled to considerable deference as long as it is reasonable.[11] The Administrator finds that the

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[10] S. Rep. No. 92-1230, 92nd Cong., 2nd. Sess. 52 (1972) (provision will "limit reimbursement for physical and other therapist to a reasonable salary related basis rather than a fee for services basis."); H. Rep. 992-231. 92nd Cong. 1st Sess. 110 (1971) ("Committee bill includes … provisions for controlling program expenditures for therapy services … and for preventing abuse"); S. Rep No. 93-533, 93rd Cong. 1st Sess. 68 (1973) ("the cost that would have been occurred if payment had been on a reasonable salary-related basis rather than on a fee-for-service").

Secretary's interpretation of the Act, to consider the phrase "under arrangement" to include those employment situations where payment is on a per-visit or per-unit basis, is reasonable based on the ambiguous language of the statute, the clear congressional intent to control costs and abuses by limiting fee-for-service compensation, and the Secretary's concern about the possibility of providers circumventing that intent through what would appear to be employment relationships.

The language of §1403 of the PRM specifically addresses two types of "employment" situations, i.e., 1) the "newly salaried" employees which the Secretary closely scrutinizes to make sure that an "employment situation is not being used to circumvent the guidelines," and 2) the "fee-for-service" compensated employees, which the Secretary treats as "non-salary arrangement." As noted above, the Secretary's treatment of the latter situation, as a non-salary arrangement, reflects the agency's assumption that such a compensation arrangement is subject to the same possible abuses that arise in the situation of the use of an outside contractor. Section 1403 of the PRM is therefore CMS' attempt to further congressional efforts to prevent such abuses, whether they arise through a clear outside contractor situation or through a hybrid employment/contractor situation, as in this case.

As reflected at §1405 of the PRM, the Secretary believed that either way, the possibility of abusing the program for greater reimbursement was the same, and could reasonably be prevented using the same imposed compensation limits. Contrary to the Board's opinion, whether the therapist is an employee of the Provider or receives benefits from the Provider which employees typically receive, are not the significant factors in this case. To base the decision of whether the Guidelines apply simply by examining the form of the employment relationship, rather than by exploring its substance, would facilitate the types of program abuses which Congress was trying to prevent in its adoption of §1861(v)(5)(A) of the Act.

Consistent with the above, the Administrator notes that the Secretary has amended the regulations, reiterating the longstanding policy of treating fee-for-service therapist services as "under arrangement" situations. The 1998 amendments to the regulation at 42 CFR 413.106(c)(5) provide that:

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[11] See Chevron U.S.A., Inc. v. National Resources Defense Council, Inc., 467 U.S. 837, 842-43 (1984). Where a statute is silent or ambiguous on the issue in question, the interpretation of the agency charged with administering the statute is entitled to deference as long as it is a reasonable one.

> If therapy services are performed in situations where compensation to a therapist employed by the provider is based, at least in part, on a fee-for-service or on a percentage of income (or commission), the guidelines will apply. The entire compensation will be subject to the guidelines in cases where the nature of the arrangements is most like an under "arrangement" situation, although technically the provider may treat the therapists as employees. The intent of this section is to prevent an employment relationship from being used to circumvent the guidelines.

The Secretary explained in the preamble to the proposed rule of the above regulation at 42 CFR 413.106(c)(5) that:

> We are proposing to revise §413.106(c)(6) that would provide that salary equivalency guidelines will apply in situations where compensation to a therapist employed by the provider is based, at least in part, on a fee-for-service or on a percentage of income (or commission). The entire compensation would be subject to the guidelines in cases where the nature of the arrangements are most like an under "arrangement" situation, although technically the provider may treat the therapists as employees. The guidelines would be applied in this situation so that an employment relationship is not being used to circumvent the guidelines.
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> Since June 1977, there has been longstanding governing policy at §1403 of the Provider Reimbursement Manual, Guideline Application, regarding this issue for making payments to providers…. This instruction clearly requires the intermediary to apply the salary equivalency guidelines in cases where the provider is paying the physical therapists on a fee-for-service basis. This instruction considered the nature of those arrangements and that they are most like an under "arrangement" situation, although technically they are employees. Therefore, the instructions further the statutory purpose as reflected in the legislative history of the salary equivalency guidelines. This instruction addresses the fact that HCFA recognizes that certain employment relationships would effectively circumvent the guidelines and provided for these circumstances in §1403 of the Provider Reimbursement Manual.[12]

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[12] 62 Fed. Reg. 14851, 14871 (Mar. 28, 1997)(proposed rule); see also 63 Fed. Reg. 5106, 5126 (January 1, 1998) (final rule).

The Administrator finds that the foregoing regulatory language reflects a clarification in the regulation of longstanding Medicare interpretative policy. Section 1403 of the PRM interprets and clarifies existing legislation and regulatory instruction regarding the Guidelines' applicability to physical therapist compensation paid under arrangements. Moreover, in this case, as discussed above, the policy of applying the Guidelines to fee-for-service arrangements has been in §1403 of the PRM since 1977.

The Board found that the Intermediary failed to prove that the costs for its employee physical therapists are substantially out of line with physical therapy costs paid by similar home health agencies. However, the regulation at 42 CFR 413.106(c)(5) provides that these costs are evaluated so that such costs do not exceed what a prudent and cost conscious buyer would pay for the given service. The Administrator notes that the Provider's physical therapy costs exceeded the Guidelines. The Secretary has determined that in such circumstances the Provider's rate per visit was not what a prudent and cost conscious buyer would pay for the given service. However, rather than an irrebuttable presumption of unreasonableness, the Secretary in fact allows providers to demonstrate that they are entitled to exceptions to the application of the Guidelines under certain circumstances.

Accordingly, the Administrator finds that the Intermediary properly disallowed the costs in excess of the physical therapy Guidelines. Thus, the Administrator reverses the Board's decision as to Issue No. 3.

## DECISION

**Issue No. 1**

The Administrator summarily affirms the decision of the Board on Issue No. 1.

**Issue No. 2**

The Administrator reverses the decision of the Board on Issue No. 2.

**Issue No. 3**

The Administrator reverses the decision of the Board on Issue No. 3.

**THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES**

Date: **1/14/08** **/s/**

Herb B. Kuhn
Deputy Administrator
Centers for Medicare & Medicaid Services