CENTERS FOR MEDICARE & MEDICAID SERVICES

Decision of the Administrator

IN THE CASE OF:	**CLAIM FOR:**
Pioneer Home Health	**Medicare Reimbursement** **Fiscal Year Ending: 12/31/98**
Provider	
vs.	**REVIEW OF:**
Blue Cross and Blue Shield Association	**PRRB Dec. No. 2003-D46** **Dated: August 21, 2003**
Intermediary	

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the Provider Reimbursement Review Board (Board) decision. The review is during the 60-day period mandated in §1878(f)(1) of the Social Security Act (Act) [42 USC 1395oo(f)(1)], as amended. CMS' Center for Medicare Management (CMM) requested review of the Board's decision. The parties were then notified that the Administrator would review. Subsequently, the Provider submitted comments. Accordingly, the Board decision is now before the Administrator for final administrative review.

BACKGROUND

During the cost year at issue, the Provider was a home health agency (HHA) located in Bishop, California. Citing to the regulation at 42 CFR 413.30, the Provider submitted, to its Intermediary, a request for a Medicare routine cost limits (RCL) exception on September 28, 1998.[1] By letter dated December 18, 1998, the Intermediary recommended approval of the request to CMS.[2] CMS denied the request, by letter dated August 9, 1999, on the grounds that the Provider failed to meet the requirements for an

[1] See Intermediary Exhibit No. I-1.
[2] Id. at Exhibit No. I-2.

exception based on "atypical services," set forth at §413.30(f)(1).[3] However, per a September 3, 1999 letter to CMS, the Intermediary clarified that the Provider had intended the request to be considered under all of the options set forth in §413.30, not just the atypical services exception.[4] Accordingly, CMS reviewed the Provider's request to determine whether the Provider qualified for the "extraordinary circumstances" exception at §413.30(f)(2), and, by letter dated October 4, 1999, CMS denied the request. CMS explained that the regulation defines extraordinary circumstances as "strike, fire, earthquake, flood, or similar unusual occurrences…." CMS stated that neither the nature of a geographic area, nor the location of patient homes, could under any reasonable interpretation of the regulation qualify as an extraordinary circumstance as defined in the regulation. Consequently, CMS denied the Provider's request. The Provider appealed the denial of the "extraordinary circumstances" request to the Board in a timely manner.[5]

ISSUE AND BOARD DECISION

The issue is whether the CMS properly denied the Provider's request for an exception to the Medicare HHA routine cost limits due to extraordinary circumstances.

A Majority of the Board found that the Provider was entitled to the exception under §413.30(f)(2). The Majority found that the unique geographic characteristics of the Provider's service area constituted an extraordinary circumstance under the regulations. The Majority pointed out that the regulation did not limit such circumstances to the examples listed, i.e., strikes, floods, and earthquakes; rather, CMS had granted extraordinary circumstances exceptions for reasons other than natural disasters, including a significant loss of providers in a community, and high local labor costs. The Provider in this case established that its service area was remote and equal in size to the State of Maryland, with harsh mountainous terrain and long distances between population centers. In fact, the National Association of Home Care considered the Provider's service area to be a "frontier" area with fewer than seven persons per square mile. The Majority further observed that, prior to the Provider's entry, there were no home health services available

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[3] Id. at Exhibit No. I-3.

[4] Id. at Exhibit No. I-4.

[5] The Provider's appeal was of CMS' denial of its exception request based on extraordinary circumstances. (See e.g. Provider's January 17, 2000 Request for a Hearing and Board's November 1, 2001 Amended Notice of Hearing.) Accordingly, because the CMS' denial of an atypical services exception was not appealed, that determination was not properly before the Board, nor is that determination before the Administrator for review in this decision. However, even assuming, *arguendo*, that the Provider's submissions could be construed to add CMS' August 9, 1999 denial for atypical services exception to the appeal, such a denial was proper and within the plain meaning of the regulations defining atypical services.

in the area, and there were only three area hospitals, two of which were critical care access hospitals and the other a sole community provider.

The Majority agreed with the Provider's point that it could not control the location of its patients and how often they needed to be seen, and, was, therefore, limited in scheduling visits. While the average productivity for an HHA in a rural area was 5.3 visits per day for home health aides and 4.5 for nursing visits, the Provider's average was 2.9 visits per day. In sum, the Majority concluded that the Provider presented sufficient evidence of the extraordinary nature of its service area, which caused it to incur additional costs beyond its control. Thus, the Majority reversed CMS' denial of the Provider's exception request.

Two Board members concurred with the Majority's conclusion, and added that the Provider qualified for an atypical services exception based upon excess travel costs. The Board members maintained that travel is a fundamental component of service provided by HHAs and, therefore, should be considered under §413.30(f)(1) as part of atypical services. Moreover, it was not under dispute that the Provider's excess costs were reasonable, necessary, and due to the remote location of the patients.

One Board member dissented due to the Provider's failure to submit sufficient evidence of either atypical services or extraordinary circumstances. Section 413.30(f)(1) set forth the requirements for the atypical services exception, i.e., the atypicality of the provider's items or services, that they were furnished because of the extraordinary needs of its patients, and that they were necessary for the efficient delivery of health care. The Provider did not sufficiently document that its services, geographic location, and its extensive travel costs were atypical. Moreover, the Provider failed to qualify under §413.30(f)(2) for an extraordinary circumstances exception, which required the Provider to show that it incurred higher costs due to extraordinary circumstances beyond its control, such as strikes, fire, earthquake, flood, or similar unusual occurrences with substantial cost effects. Because the Provider chose its location, its excessive costs due to this was not beyond its control. In addition, the regulation required a "triggering event" or unusual occurrence to cause the additional costs. In this case, there was no such event. Thus, the Provider also did not meet the requirements for an extraordinary circumstance exception. In sum, the denial by CMS of the Provider's request for an exception to the cost limits was proper.

SUMMARY OF COMMENTS

Agreeing with the Dissent, CMM requested that the Board's decision be reversed. CMM argued that the Provider's intensive and extraordinary travel was not beyond its control, as the Provider chose a service area that required costly and difficult travel. Moreover, there was no unusual circumstance triggering an event which caused the Provider's additional costs. Thus, CMM maintained that the denial of the Provider's request based on extraordinary circumstances was proper.

Requesting affirmance of the Board's decision, the Provider maintained that, in the past, CMS and the Board recognized exceptions for extraordinary circumstances beyond natural disasters or "acts of God." Turning to its unique facts, the Provider maintained that its travel was extraordinary and beyond its control. Its location was "dictated" by its proximity to a major highway, the service area, and the patient population. The Provider observed that it was the only Medicare HHA in the service area, and that patients in Bishop, California, are required by law to have access to the same Medicare benefits as beneficiaries in the Baltimore area. The extra costs the Provider incurred were due to the placement of its patients' residences in relation to the HHA and to its caregivers. The extraordinary and atypical service costs included not only the direct in-home patient care cost but the related supportive costs of administration, billing, quality assurance, compliance, transportation, and care coordination. Moreover, the Provider argued that the clinical needs of its patients dictated the time and the day when they needed to be served, which limited its ability to economize on travel. In sum, the Provider concluded that its unique quality was due to its geographical location, the disbursement of patients throughout the region, and an "unusual aspect in relation to other home health agencies that are within the array of costs used to set the cost limits."

DISCUSSION

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

Section 1861(v)(1)(A) of the Social Security Act requires that providers of services to Medicare beneficiaries are to be reimbursed the reasonable cost of those services. Reasonable cost is defined by that section as "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included...." Section 1861(v)(1)(A) also sets forth the requirement that Medicare shall not pay for costs incurred by non-Medicare beneficiaries, and vice-versa, i.e., Medicare prohibits cross-subsidization of costs.[6]

In response to rising costs and other factors, Congress redefined "reasonable cost," authorizing the Secretary to "provide for the establishment of limits … based on estimates of the costs necessary in the efficient delivery of needed health services" under §223 of the Social Security Amendments of 1972.[7] Accordingly, the cost limits would

[6] The reasonable cost principles are implemented in the regulations at 42 CFR 413.9.
[7] Pub. L. No. 92-603, §223, 86 Stat. 1329, 1393-94 (1972), *reprinted in* USCCAN `548, 1627-29.

reflect the maximum expenses incurred by an efficient provider; costs exceeding the limits would be presumed unreasonable and would not be allowed unless they qualified for a regulatory exception.[8] Further, Congress directed the Secretary to design the cost limits to take into account both direct and indirect costs, but to "exclud[e] therefrom any such costs … which are determined in accordance with regulations to be unnecessary in the efficient delivery of services …."

Pursuant to the cost limit provisions of amended §1861(v)(1)(A), the Secretary promulgated 42 CFR 413.30, specifying the rules under which CMS would establish limits on provider costs recognized as reasonable in determining Medicare payments, and setting forth an exceptions process for providers to obtain payments above the limits in recognition of their special needs and situations. CMS has regularly published limits on HHA per diem routine service costs under the authority of the regulation, and notified participating providers of the exceptions process in the Federal Register.[9]

The Provider in this case sought an exception to the cost limits for extraordinary circumstances for the fiscal year ending (FYE) December 31, 1998, pursuant to the regulation at §413.30(f). The regulation at 42 CFR §413.30(f) states that:

> *Exceptions*. Limits established under this section may be adjusted upward for a provider under the circumstances specified in paragraphs (f)(1) through (f)(5) of this section. An adjustment is made only to the extent the costs are reasonable, attributable to the circumstances specified, separately identified by the provider, and verified by the intermediary.
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> (2). *Extraordinary circumstances*. The provider can show that it incurred higher costs due to extraordinary circumstances beyond its control. These circumstances include, but are not limited to, strikes, fire, earthquake, flood, or similar unusual occurrences with substantial cost effects.[10]

The regulator requirements that a provider demonstrate that its costs are reasonable, attributable to the circumstances specified, and separately identified are consistent with the general documentation requirements for payment set forth in §1815 of the Act and the regulation at 42 CFR 413.20 and 412.24. Section 1815(a) specifies that no payment shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider. Similarly, the regulations at 42 CFR §§ 413.20 and 413.24 place the burden of proving that claimed costs are reimbursable on the provider, who is required to keep sufficient financial records and statistical data for the accurate determination of costs.

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[8] S. Re. No. 1230, 92nd Cong. 2d Sess., 187 (1972).
[9] 44 Fed. Reg. 51542 (Aug. 31, 1979).
[10] See also §2544 of the PRM.

In this case, CMS denied the Provider's exception request stating that a provider's geographic location and the location of its patients alone does not meet the criteria for an extraordinary circumstances exception under §413.30(f)(2). The Administrator agrees that the term extraordinary circumstances within the context of the exception process denotes an unusual occurrence or event over which the provider has no control and which causes the provider to incur higher costs. Consequently, the Administrator agrees with CMS' determination that a provider's location and the location of its patients alone does not meet the definition of an extraordinary circumstance and thus, the Provider in this case cannot qualify for an extraordinary circumstances exception on that basis.[11] As the basis for the Provider's exception request does not meet the threshold elements of an extraordinary circumstance, as defined in the regulation at 42 CFR 413.30(f)(2), the Administrator reverses the Board decision in this case.[12]

[11] See also Campbell County Memorial Hospital, PRRB Dec. No. 2000-D58 at pp.8-9 (CMS denied provider's request for an extraordinary circumstances exception based upon its remote location. By letter dated August 1999, CMS stated that, under current policy, this exception was not intended to correct circumstances which are ongoing in the normal operations of the provider, such as provider's location.) affirmed in Campbell County Memorial Hospital v. Thompson. Case No. 00-CV-146-D (D.Wy. Sept 25, 2003).

[12] Because CMS denied the request on this threshold issue, CMS did not address whether the request also met the other criteria necessary for an adjustment: that the costs are reasonable, attributable to the circumstances specified, separately identified by the provider, and verified by the intermediary.

DECISION

The Administrator reverses the decision of the Board in this case.

THIS CONSTITUTUES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES.

Date: 10/23/03

/s/
Leslie V. Norwalk
Acting Deputy Administrator
Centers for Medicare and Medicaid Services