PROVIDER REIMBURSEMENT REVIEW BOARD HEARING DECISION

98-D96

PROVIDER -Reavis Homecare, Inc.
Salado, Texas

Provider No. 67-7584

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/ Blue Cross and Blue Shield of New Mexico, Palmetto Blue Cross and Blue Shield

DATE OF HEARING-
June 5, 1998

Cost Reporting Period Ended - December 31, 1995

CASE NO. 97-3046

INDEX

ISSUE:

Were the HHA cost limits issued prospectively by New Mexico Blue Cross Blue Shield for FY 95 and as applied in FY 95, correct or were the lower cost caps retroactively applied in FY 96 by Palmetto (the successor Intermediary) correct?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Reavis Homecare Inc. ("Provider") is a home health agency located near Austin, Texas. The Provider's fiscal year ends December 31st. For the period January 1, 1994 until August 30, 1994, the Provider was located in Georgetown, Texas, which is located in the Austin, Texas Metropolitan Statistical Area ("MSA"). New Mexico Blue Cross Blue Shield ("Intermediary") established cost limits for that MSA.[1] The skilled nursing visit limitation for that MSA was $95.20 per visit.

On August 30, 1994, the Provider's main office was moved to Salado, Texas, which is about twenty miles from Georgetown. Salado is in the Killeen, Texas MSA. The cost limits for the Salado office were higher than the cost limits for the Austin MSA because the cost limits for the Killeen MSA were higher.[2] The cost limits for skilled nursing in the Killeen MSA were $109.01 per visit.

Palmetto Blue Cross Blue Shield ("Intermediary") the successor intermediary, prepared a schedule which shows that for the first 241 days, the Provider limit was $95.01 (+$0.18) for each skilled nursing visit and for the next 124 days the limit was $108.83 (+$0.18) for each skilled nursing visit. HCFA policy allowed a limit change when an HHA moved from one MSA to another. The same methodology was applied to various other services that the Provider furnished.

The Intermediary continued to pay the Provider using the same schedule of payments and subject to the same cost limits as they had been paying from August 30, 1994 until December 31, 1994. The same per visit limits were applied to all HHA's in that geographical area. The limits established for each discipline for the period after August 30, 1994 by the two Intermediaries are essentially the same and the specific limit amounts are not in dispute. The dispute in this case is what was the limit for the Provider located in the Killeen, Texas MSA for the period starting January 1, 1995 under the freeze.

On September 18, 1996, the successor Intermediary notified the Provider that the cost limits established in 1995 by the former Intermediary were incorrect and that the actual limits in 1995 should have been reduced below the amount for the August 30, 1994 to December 31,

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1 Exhibit P2.

2 Exhibit P3.

1994 period to the so called "blended rate"[3]. For skilled nursing visits, for example, the "blended rate" limit was $99.89. The Intermediary's notice included a statement that the limits were reduced because OBRA '93 indicated that the schedule of limits in effect for the periods beginning on or after July 1, 1994 and before July 1, 1996 should be frozen.

The Provider disagreed with the Intermediary's determination and filed a timely appeal with the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 1835-.1841 and has met the jurisdictional requirements of those regulations. The Medicare reimbursement affect is approximately $745,040.

The Provider was represented by John W. Jansak, Esquire and Lawrence Ageloff, Esq. of Harriman, Jansak & Wylie. The Intermediary was represented by James Grimes, Esquire of the Blue Cross and Blue Shield Association, Chicago.

PROVIDER'S CONTENTIONS:

The Provider argues that the OBRA freeze means that the limit in place on December 31, 1994 should be continued in 1995. For example, the limit for skilled nursing visits of $109.01 was used by the Intermediary from August 30th to December 31, 1994. The Intermediary ruled, however, that the "Blended Rate", or prorated limit, for example, the skilled nursing visit limit of $99.89, should have been applied for the year 1995. This same pro-rated limit was applied to all limits by discipline.[4] The Provider argues that the statute freezes the cost limits for HHAs for cost reporting periods beginning on or after July 1, 1994 and before July 1, 1996. Nowhere does the statute give the Intermediary authority to use a blended rate instead of the cost limits for a HHA. The Provider points out that the rate of $99.89 was never the limit for skilled nursing visits. The Provider limit was $95.20 for skilled nursing visits up to September 1st and from thereon the limit was $109.01 for skilled visits.

The Provider contends that the "Blended Rate" is an artificial limit that is nothing more than a tool to achieve simplification of cost settlements by prorating two applicable limits into one. Moreover, the Blended Rate was never applied to interim payments, as would be an actual cost limit. The only time the $99.89 Blended Rate came into effect was for the purpose of settling the cost report where the ratio of both limits was used to establish the aggregate impact of cost limits against the aggregate cost for the entire year. However, the actual amount for the first part of the year was $95.20 per visit, and for the second part of the year the rate was $109.01 per visit.

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[3] Exhibit P4.

[4] Exhibit P4.

The Provider points out that if on June 1, 1994, a HHA became initially certified in the Medicare program in the Killeen MSA with a fiscal year ending May 31, 1994 it would have received the full 1994 cost limitation for skilled nursing services and all other disciplines, and would have had that limit for FY 1995.

The Provider points out that the cost limit for a geographical area is applied uniformly to all HHAs in that area, MSA or rural. All HHAs are prospectively notified of that limit, as provided in HCFA Pub. 15-1 § 2541. This section provides for a notification to a provider of its interim rate at least 30 days prior to a cost reporting period to which limits are applied. HCFA Pub. 15-1 also provides for an adjustment in the interim rate because of a change in cost limits. This notification to the Provider established a skilled nursing visit cap of $109.01 for fiscal year beginning January 1, 1995, (the freeze year) the same as that on December 31, 1994. OBRA '93 stated at 13564:

> The Secretary of Health and Human Services shall not provide for any change in the per visit cost limits for home health services under section 1861(v)(1)(L) of such act for cost reporting periods beginning on or after July 1, 1994, and before July 1, 1996, except as may be necessary to take into account the amendment made by subsection (b)(1).

Id.

The Provider asserts that in light of the OBRA '93, the Killeen MSA limits for HHA's with a fiscal year beginning January 1, 1995 were the same as they received on December 31, 1994. The limits apply to all HHAs in the same geographical area. The law does not provide for different limits for the same service furnished by different providers in the same area, which the Provider argues its Intermediary has done. The Provider also points out that the freeze began for this Provider on January 1, 1995 and its change of location into the Killeen MSA occurred prior to such date and in a fiscal year before the freeze began.

The Provider contends that it never received any notice until September 18, 1996 that its limit for skilled nursing visits would be $99.89 because it never had a limit of $99.89. The Provider's limit was $95.20 for 8 months of the year and $109.01 for the last four months. The Blended Rate is nothing more than a mathematical calculation and is not the actual limit that is used even when one looks at the Intermediary's own calculations,[5] where it uses $95.20 and $109.01.

The Provider points out that it did not receive a blended rate, but rather received one rate for 8 months, and a second rate for 4 months. The Provider never received any average of the two. An example of a blended rate is one that's paid to hospitals in Puerto Rico. Hospitals in Puerto Rico received a blended rate of 75% of one standard rate and 25% of another standard

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[5] Exhibit P4.

rate.[6] This is a blended rate because it is a combination of rates. This is opposed to the Provider who received one rate for 8 months of the year and a second rate for 4 months of the year. That is not a blended rate.

The Provider points out that its expert witness testified that the blended rate is an arithmetical device for weighing the proportionate share an HHA spent in two different locations in the same cost reporting year. The blended rate is used for cost reporting purposes only and is necessary when the provider moves in a single cost reporting year from one geographic area to another with different cost limits. The blended rate is not a cost limit. It is a pro-rated combination of two separate and distinct cost limits.[7]

The Provider contends that the Intermediary's reference to the HCFA memorandum issued April 23, 1996[8] is not applicable to this situation because the fiscal year in this case is a full fiscal period beginning before the freeze began. The memorandum states that if the limit is calculated "for a short period that begins before the effective date of the freeze and ends after the effective date of the freeze, the limit for that short period will apply to all cost reporting periods beginning during the freeze period." Id. The Provider points out that the last sentence in the second paragraph suggests that by analogy the Provider's limit as of September 1, 1994 to December 31, 1994 should apply in the freeze year:

> However, if the change in ownership or change in fiscal year results in a short cost reporting period for the period preceding the freeze, the cost limitation will be adjusted for the short period and apply to all subsequent cost reporting periods during the freeze.

Id.

The Provider argues that the September 1, 1994 to December 31, 1994 limit should be applied to FY 95, in accordance with OBRA 93 13564 which states in part:

> The Secretary. . . shall not provide for any change in the per visit cost limits for home health agency services. . . for cost reporting periods beginning on or after July 1, 1994 and before July 1, 1996.

Id.

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6 Exhibit P7.

7 Tr. at 81 and 82.

8 Exhibit P8.

The Provider contends that the Intermediary is trying to apply the concept applicable to short cost reporting periods beginning after July 1, 1994. In this case the Provider's cost reporting period began January 1, 1994 and continued through December 31, 1994. Accordingly, the Provider is entitled in 1995 to the limits in effect on December 31, 1994.

The Provider also points out that the Federal Register published in February 1995 also supports the Provider's argument that the limits in place from September 1, 1994 to December 31, 1994 should be the limit in FY 95. The Federal Register, 60 Fed. Reg. 8396 (1995) states:

> The effect of this provision is that a HHA's latest per-discipline cost limit for a period on or after July 1, 1993 and before July 1, 1994. . . The latest limit is the limit in place on December 31, 1994 before the freeze went into effect.

Id.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the cost limits for the cost reporting period beginning January 1, 1995 should have been frozen based on the latest per-discipline cost limits. The latest per-discipline cost limits were calculated based on the cost reporting period beginning January 1, 1994 and ending December 31, 1994. The Federal Register volume 60, dated February 14, 1995, states in part:[9]

> The effect of this provision is that a HHA's latest per-discipline cost limit for a period beginning on or after July 1, 1993, and before July 1, 1994 as calculated under this notice, without regard to subsequent adjustments under section 1861(v)(I)(L)(ii) of the Act for exceptions, will remain in effect until its cost reporting period beginning on or after July 1, 1996. . .Accordingly, there will be no changes besides those due to the elimination of the A&G add-on, to a HHA's cost limit for cost reporting periods beginning on or after July 1, 1994 and before July 1, 1996 to account for inflation, changes to the wage index or to MSA designations. In accordance with the OBRA 93 provision, the cost reporting period beginning January 1, 1994 will remain in effect until the cost reporting period beginning on or after July 1, 1996.

Id.

The Intermediary asserts that the OBRA '93 freeze provision was correctly applied to the per-discipline cost limits for FYE 1995. The application and effective period of the OBRA '93 freeze has been explained in the Federal Register, 60 Fed. Reg. 8396 (1995).

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9 Exhibit I-2.

> [t]he effect of this provision is that a HHA's latest per-discipline cost limit for a period beginning on or after July 1, 1993, and before July 1, 1994, as calculated under this notice, without regard to subsequent adjustments under section 1861(v)(1)(L)(ii) of the Act for exceptions, will remain in effect until its cost reporting period beginning on or after July 1, 1996.

Id.

The Intermediary points out that on August 30, 1994, the Provider relocated its main office from Georgetown, Texas (Austin MSA) to Salado, Texas (Killeen, MSA). The Intermediary disagrees with the Provider's argument that due to the relocation of its main office the cost limits should have been calculated based on the latter MSA. First, the provisions of OBRA '93 clearly state that there will be no changes to account for inflation, changes to the wage index or to MSA designations (OBRA '93 Section iiiB, Paragraph 1) The only changes that are allowed will be due to the elimination of the A&G add-on to HHA's, since OBRA '93 eliminated the A&G add-on for hospital-based HHAs.

The Intermediary contends that although the Provider relocated its main office in the middle of its cost reporting period beginning January 1, 1994, this does not alter the effective basis of the provision. The effective basis should reflect "the latest per-discipline cost limit for a period beginning on or after July 1, 1993, and before July 1, 1994. . ." The Intermediary was lenient to interpret "period" as a cost reporting period and not a specific time frame. Therefore, the latest per-discipline cost limits calculated for FYE December 31, 1994 are to remain unchanged or frozen until the cost reporting period beginning on or after July 1, 1996. This includes FYE December 31, 1995 and December 31, 1996.

The Intermediary points out that although the Provider changed from a lower MSA to a higher MSA in FYE December 31, 1994, this does not alter the provision or the cost limits which will be frozen for FYE December 31, 1995. However, it does effect the cost limits for FYE December 31, 1994. The Intermediary contends that it was less than conservative when it calculated a weighted average for FYE December 31, 1994. The weighted average was calculated based on the percentage of time that the Provider was located in the Austin MSA and the Killeen MSA.[10] In accordance with the provisions set forth in OBRA '93, the cost limits calculated for the cost reporting period beginning January 1, 1994 remain in effect until cost reporting periods beginning on or after July 1, 1996.

The Intermediary contends that the latest per-discipline cost limit, as identified in the Federal Register is the limit applied to the Provider as of January 1, 1994. The Provider's expert witness testified that, under Medicare Program requirements, each provider is notified of its

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[10] Exhibit I-1.

cost limit 30 days prior to the start of its fiscal year.[11] Presumably then, this Provider was notified of its cost limits for its 1994 cost year sometime before January 1, 1994. The Provider's expert witness also testified that there are no program instructions as to how to handle cost limits for providers who move during the cost year.[12] Therefore, under the regulations, the latest per-discipline cost limit for the period beginning after July 1, 1993 and before July 1, 1994 is the cost limit applied January 1, 1994. That cost limit then applies to the freeze period beginning with the January 1995 cost year.

The Intermediary further contends that nothing really changed with this Provider during 1994 except the designation of its home office. Existing staff handled administrative functions after the relocation of the home office, so that new and higher wage costs were not encountered.[13] The witness testified that the move to Salado did not result in any change in the service area for the Provider.[14] After the relocation to Salado, the Georgetown office remained open as a branch office.[15] The Provider merely opened a new office while keeping the old home office open as a branch. Administrative personnel did not change, and the service area remained the same.

The Intermediary's position is that the OBRA '93 freeze meant that the Provider was limited to the "latest per-discipline cost limit" which was established based on cost reporting periods beginning after July 1, 1993 and before July 1, 1994, and applied to the Provider beginning on January 1, 1995 (the beginning of the cost year in which the start of the freeze took effect). Yet, in the 1995 cost year the Intermediary permitted the use of a weighted average of the Austin MSA limit and the Killeen MSA limit that had been used to settle the Provider's 1994 cost report. Had the Intermediary adhered to the requirements of the February 14, 1995 Federal Register instructions, the cost limit applicable to the Provider would have been significantly lower.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - 42 U.S.C.:

§1395x(v)et seq. - Reasonable Cost

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11 Tr. at 93.

12 Tr. at 95.

13 Tr. at 32.

14 Tr. at 30.

15 Tr. at 30.

2. Regulations - 42 C.F.R.:

§ 413.30(b) - Limitations on Reasonable Cost

3. Program Instructions - Provider Reimbursement Manual, Part I (HCFA Pub. 15-1):

§ 2541 - Provider Notification

4. Other:

Omnibus Budget Reconciliation Act of 1993, Public Law 103-66.
60 Fed. Reg. 8389 (February 14, 1995).
HCFA Memorandum April 23, 1996.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board after consideration of the controlling laws, regulations and program instructions, the facts in the case, parties' contentions, evidence in the record, testimony elicited at the hearing, and post-hearing briefs, finds and concludes that the Intermediary's adjustments of the Provider's cost limits for the fiscal year ended December 31, 1995 were improper. The proper cost limit for the Provider should be the cost limit in effect for the Killeen, Texas MSA as of December 31, 1994.

The Board finds that the Intermediary's argument on changing MSA designations is covered in at 60 Fed. Reg. 8389 (February 14, 1995). The Board interprets the preamble to mean an official change by HCFA of a MSA which would not relate at all to a geographic change by the Provider. Therefore, since the Provider made a geographic change in moving from one MSA to another MSA during its December 31, 1994 cost reporting year, it is not required to have its cost limit rate frozen at the lower cost limit of the MSA from which it moved.

The Board notes that the Provider was located in two different MSAs during its December 31, 1994 cost reporting year, and the Intermediary used a blended rate to settle the Provider's cost report for that year. The Blended rate was a weighted average of the two cost limits of the two MSA's. The Board finds that the blended rate was properly used to settle the Provider's December 31, 1994 cost report. However, the Board finds that the Blended rate was only a tool used for the settlement of a cost report and was not a cost limit.

The Board finds that the blended rate was used for cost reporting purposes only and is necessary when a provider moves in a single cost reporting year from one geographic area to another area with different cost limits. The Blended rate is not a cost limit. It is a prorated combination of two separate and distinct cost limits. There is no basis for using a blended rate to establish an HHA's cost limit. A blended rate is a pro-rata accounting calculation based on two separate cost limits for two separate geographic areas. A blended rate is not

reflective of the costs in the geographic area in which the HHA was located in the last months of 1994 or 1995. The use of a blended rate as a cost limit results in inequities. By applying the freeze on an individual HHA basis, rather than the area in which each HHA was located, the HHA was given cost limits which did not reflect the concomitant higher costs associated with the MSA in which it was located for the cost reporting period beginning after July 1, 1994.

The Board finds that the Intermediary reimbursed the Provider for fiscal year 95 using the blended rate. The Board finds that under the OBRA '93 freeze, the Intermediary was required to reimburse the Provider at the last MSA cost limit that the Provider was located at in 1994. The Board rejects the Intermediary's contention that based on the freeze the Provider was only entitled to use the 1994 blended rate cost limit for fiscal year 1995. That rate was used only as a means of settling the 1994 cost report.

The Board finds Section 13564 of OBRA '93 provides that HHA cost limits would be frozen for cost reporting periods beginning on or after July 1, 1994 and before July 1, 1996. The Board further finds that the geographic location of a HHA is, and always has been, the key determining factor in establishing cost limits for an HHA. 42 C.F.R. § 413.30(b). Because the undisputed evidence shows that Congress froze the HHA cost limit and those cost limits are based on a HHA's geographic location, and not its composite or blended rate, the Board finds that the Intermediary should have used the same cost limits established by the Provider's former Intermediary.

DECISION AND ORDER:

The Intermediary's cost limits using the blended rate was improper. The Intermediary should apply the cost limit in effect at the end of 1994. The Intermediary's adjustment is reversed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esq. (Dissenting Opinion)
Martin W. Hoover, Jr., Esq.

Date of Decision September 17,1998

FOR THE BOARD:

Irvin W. Kues
Chairman

Dissenting Opinion of Henry C. Wessman

I respectfully dissent. My dissent is firmly grounded in the legislative intent which spawned OBRA '93 (Omnibus Budget Reconciliation Act of 1993, Public Law 103-66), and the plain meaning of that law. Section 13564(a)(2) of OBRA '93 amended § 1861(v)(1)(L)(iii) of the Social Security Act [Regulations promulgated at 42 C.F.R. § 413.20] to state: " . . . that there be no changes in the HHA per-visit cost limits . . . for cost reporting periods beginning on or after July 1, 1994, and before July 1, 1996." 60 Fed. Reg. 8390 (1995).

My perception of the legislative intent behind OBRA '93, at least in relationship to the Home Health Agency (HHA) industry, was to "step back", attempt to "defuse" the burgeoning, explosive HHA expansion, and its corresponding Medicare/Medicaid cost impact, via a "cooling off" period for cost-limit adjustments "for cost reporting periods beginning on or after July 1, 1994, and before July 1, l996." 60 Fed. Reg. 8389, 8390 (1995). The intent was to attenuate rapidly escalating HHA costs produced by ". . . inflation, changes in the wage index, or geographic designation until July 1, 1996." Id. at 8397, ¶ E. Change in "geographic designation" (transferring administrative headquarters from a lower paying statistical area to one which paid higher cost limits) is precisely what the Provider in this case attempted to do, espousing the very reasons, i.e., "to compete"; to move "parent office" to higher paying statistical area; (Tr. at 59, 60, 65, 66) inferred by Congress to be undesirable.

The plain meaning of the law appears to be crystal clear. As stated in the Federal Register:

> *B. No Changes in the Cost Limits*
>
> As discussed in section I.B of this notice, section 13564(a)(2) of OBRA '93 amended section 1861(v)(1)(L)(iii) of the Act to provide that there be no changes in the HHA per-visit cost limits (except as may be necessary to take into account the elimination of the A&G add-on for hospital-based HHAs) for cost reporting periods beginning on or after July 1, 1994, and before July 1, 1996. The effect of this provision is that a HHA's latest per-discipline cost limit for a period beginning on or after July 1, 1993, and before July 1, 1994, as calculated under this notice, without regard to subsequent adjustments under section 1861(v)(1)(L)(ii) of the Act for exceptions, will remain in effect until its cost reporting period beginning on or after July 1, 1996.

60 Fed. Reg. 8396 (1995)

Further, *E. Next Update of Limits* states:

> Before the enactment of OBRA '93, section 1861(v)(1)(L)(iii) of the Act required that the HHA per-discipline cost limits be updated on July 1, 1994, and every year thereafter. Section 13564(a)(2) of OBRA '93 amended that

> section of the Act to delay the next update until July 1, 1996, and every year thereafter. Accordingly, there will be no changes to the HHA per-discipline cost limits effective under this notice for cost reporting periods beginning on or after July 1, 1993 for inflation, changes in the wage index, or geographic designation until July 1, 1996.

60 Fed. Reg. 8397 (1995)

OBRA '93 was enacted on August 10, 1993. That enactment constituted at least constructive notice of congressional/agency intent. The Provider in the instant case was on a calender (January 1 to December 31) fiscal year. OBRA '93 called for "no changes", including "geographic designation," for the freeze period where cost reporting periods began on or after July 1, 1994, and before July 1, 1996. The cost reporting period for this Provider began January 1 of any given year. Plain meaning dictates that changes at January 1, 1995 would be "too late", i.e.; during the "freeze"; the cost limit for this Provider would be "frozen' back to the last allowable update prior to the "freeze", which for this Provider would be January 1, 1994. Similarly, "adjustments" normally triggered by factors such as a change in "geographic designation", such as occurred for this Provider on August 30, 1994 were well within the "freeze" period, and not available until after July 1, 1996.

The Provider's cost limit on January 1, 1994 was $95.20. Competition aside, by federal law, that is the cost limit that was in effect for this Provider at the last "allowable/legal" update date for its cost report/fiscal year change of January 1 (in this case, January 1, 1994).

As does the Provider, I find neither support nor justification for imposing the concocted "blended" cost limit put forth by Intermediary 2 (BC/BS South Carolina d/b/a/ Palmetto Government Benefits Administrators).

The Provider's additional arguments not withstanding, however, Intermediary 1 (BC/BS New Mexico) likewise had no legal basis for adjusting the Provider's cost limits in any time frame after July 1, 1994, based specifically on the Congressionally mandated "no change" due to "geographic
designation" until after the "freeze", i.e.; July 1, 1996.

The correct cost limit for this Provider for the time period beginning January 1, 1994 to July 1, 1996 is $95.20.

Henry C. Wessman, Esquire
Board Member