PROVIDER REIMBURSEMENT REVIEW BOARD HEARING DECISION

98-D97

PROVIDER -Stephens Home Health Care
Weatherford, Texas

Provider No. 67-7413

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. 97-3047

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 limits retroactively applied in FY 96 by Palmetto (the successor Intermediary) correct?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Stephens Home Health ("Provider") is a home health agency located near Ft.Worth, Texas. The Provider's fiscal year ends on December 31st. For the period January 1, 1994 until September 30, 1994, the Provider was located in Dublin, Texas, which is located in a rural area. New Mexico Blue Cross and Blue Shield ("Intermediary") established cost limits for the Provider based on the fact that the Provider was located in a non-metropolitan statistical area (non-MSA). The cost limits for that area are shown in Provider Exhibit 2. On October 1, 1994, the Provider relocated to Weatherford, Texas. Weatherford, Texas is in the Fort Worth Metropolitan Statistical Area ("MSA"). The cost limits for Weatherford, Texas were higher than the cost limits for Dublin Texas.[1]

Palmetto Blue Cross Blue Shield ("Intermediary") the successor intermediary, prepared a schedule which shows that for the first 273 days of the year the Provider's cost limit was $85.70 for each skilled nursing visit and for the remaining 92 days of the year the limit was $96.22 for each skilled nursing visit,[2] 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 HHA furnished.

After January 1, 1995, 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 HHA located in the Fort Worth, Texas MSA for the period starting January 1, 1995 under the freeze.

In September 1996, the successor Intermediary notified the Provider that the cost limits established in 1995 by the prior Intermediary were incorrect and that the actual limits in 1995 should have been reduced to the so called "Blended rate" which is below the amount allowed for the October 1, 1994 to December 31, 1994 period.[3] For skilled nursing visits the blended

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1 Exhibit P-3.

2 Exhibit P-4.

3 Exhibit P-4.

rate limit was $88.53. The Intermediary stated that the limits were reduced because OBRA '93 indicated that the schedule of limits in effect for cost reporting 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 has met the jurisdictional requirements of those regulations. The Medicare reimbursement affect is approximately $406,894.

The Provider was represented by John W. Jansak, Esq. and Lawrence Ageloff, Esq. of Harriman, Jansak & Wylie. The Intermediary was represented by James Grimes, Esq. 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 $96.38 was used by the Intermediary, from October 1 to December 31, 1994. The Intermediary ruled that the blended rate or prorated limit, for example, the skilled nursing visit limit of $88.53, should have been applied for the year 1995. This same pro-rated limit was applied to all limits by discipline.[4] The Provider points out that the $88.53 was never the limit for skilled nursing visits. The Provider limit was $85.70 for skilled visits up to October 1st and from thereon was $96.38 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. Also the blended rate was never applied to interim payments, as would an actual cost limit. The only time the blended rate came into effect was for the purpose of settling the cost report where a ratio of both limits was used to establish the aggregate impact of cost limits against the aggregate cost for the entire year. The Provider points out that the limit for the first part of the year was $85.70 per visit and then $96.38 for the second part of the year.

The Provider points out that, if on June 1, 1994 the HHA became initially certified in the Medicare program in the Fort Worth MSA with a fiscal year ending 5/31/94, 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 95.

The Provider also points out that cost limits for a geographical location are 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 notification to a provider of its interim rate at least 30 days prior to a cost reporting period to which the limits are applied.

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[4] Exhibit P-4.

The manual 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 $96.38 for fiscal year beginning January 1, 1995, (the freeze year) the same as that on December 31, 1994. OBRA '93 states at p 13564:

> The Secretary of Health and Human Services shall not provide for any change in the per visit cost section 1861(v)(I)(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 points out that based on the above cited OBRA section the Fort Worth limits for HHAs as with a fiscal year beginning January 1, 1995 were the same as they received on December 31, 1994. The limit applies 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. What is equally important is that the freeze began for this Provider on January 1, 1995 and its change of location into the Fort Worth MSA occurred prior to such date and in a fiscal year before the freeze began.

The Provider points out that it never received any notice until September 18, 1996 that its limit for skilled nursing visits would be $88.53 because it never had a limit of $88.53. The Provider's limit was $85.70 for 9 months of the year and $96.38 for the last 3 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]

The Provider points out that it never received a blended rate. It received one rate for nine months and another rate for 3 months. The Provider never received an average of the two. An example of a blended rate is that paid to hospitals in Puerto Rico.[6] They received a blended rate of 75% of one standardized rate and 25% of another standardized rate. This is a true blended rate because it is a combination of rates.

The Provider argues that the HCFA memorandum issued April 23, 1996[7] does not apply in this instance. This 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. This does not apply because the fiscal year in this case is a full fiscal period

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5 Exhibit P-4.

6 Exhibit P-7.

7 Exhibit P-8.

beginning before the freeze began. The last sentence in the second paragraph suggests that by analogy the Provider's limit as of October 1, 1994 to December 31, 1994 should apply during the freeze. However, if a 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. As stated in § 13564 of OBRA '93:

> 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.

The Provider argues 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. Therefore, the Provider contends that it is entitled in 1995 to the limits in effect in December 31, 1994.

The Provider points out that the Federal Register, 60 Fed. Reg. 8396 (1995)[8] at section iiiB, also supports the HHA's argument that the limits in place from January 1, 1994 to December 31, 1994 should be the limit in FY 95. That section 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. . ." Id. The Provider points out that the latest limit is the limit in place on December 31, 1994, before the freeze went into effect.

INTERMEDIARY'S CONTENTIONS:

The Intermediary points out that on January 1, 1994, the beginning of the Provider's fiscal year, it was located in a non-MSA. Pursuant to the program instructions, the Intermediary notified the Provider of its applicable cost limits for the year beginning January 1, 1994. OBRA '93 directed that there be no changes to the HHA per-visit cost limits during cost reporting periods beginning on or after July 1, 1994 and ending before July 1, 1996. The Federal Register, 60 Fed. Reg. 8396 (1995), provided instructions for determining the correct cost limit during the freeze period as follows:

> 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... Accordingly, there will be no changes besides those due to the elimination of the A&G add-on, to a

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[8] Exhibit P-1.

> HHA's cost limit for cost reporting periods beginning on or after July 1, 1994 and before July 1, 1996 to account for changes to the wage index or to MSA designations.

Id.

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 Providers' expert witness testified that, under Medicare Program requirements, each provider is notified of its cost limit 30 days prior to the start of its fiscal year.[9] Presumably 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 were no program instructions as to how to handle cost limits for providers who move during the cost year.[10] Therefore the Intermediary asserts that 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 argues that nothing really changed with this Provider during 1994 except the designation of its home office. The Provider's witness testified that prior to the move from Dublin to Weatherford, the Provider had maintained a branch office in Weatherford.[11] Existing staff in the Weatherford office handled administrative functions after the reallocation of the home office, so that new and higher wage costs were not encountered.[12] The witness testified that the move to Weatherford enlarged the service area the Provider served, but the same service area of Dublin and Weatherford continued to be served.[13] In fact, the witness indicated that one of the reasons the Provider relocated was to move into an MSA and get the benefit of the higher cost limits.[14] The Provider then merely designated a former branch located in an MSA as the new home office. There was no real relocation of the agency and therefore no need to recognize higher costs and cost limits typically found within an MSA.

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9 Tr. at 93.

10 Tr. at 95.

11 Tr. at 57.

12 Tr. at 58.

13 Tr. at 60.

14 Tr. at 59-60.

The Intermediary argues 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). The Intermediary points out that in the 1995 cost year it permitted the use of a weighted average of the non-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.

The Intermediary points out that the terms of OBRA '93 are specific; the latest per discipline cost limit is determined at the start of the cost year in which OBRA'93 freeze is applied to the Provider. The freeze began in the cost year beginning on January 1, 1995. The cost limit was determined based on the non-MSA location of the Provider on January 1, 1994; there is no Medicare program requirement for recognition of a change in MSA designation when relocation of a provider takes place in the same cost report year. No changes will be recognized during the freeze period to recognize a change in MSA designation. Finally, the Providers relocation was merely a resignation of a branch office as a home office, and not a true relocation.

CITATION OF LAW REGULATIONS AND PROGRAM INSTRUCTIONS:

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

   § 1395(v)(l)(A) - Reasonable Cost

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. 8396 (February 14, 1995).

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 12/31/95 were improper. The proper cost limit for the Provider should be the cost limit in effect for the Fort Worth, MSA as of 12/31/94.

The Board finds that the Intermediary's argument on changing MSA designations is covered in Section B of the Federal Register, 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 12/31/94 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 since the Provider was located in two different MSAs during its 12/31/94 cost reporting year. 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 cost limits of the two MSAs. The Board finds that the blended rate was properly used to settle the Providers 12/31/94 cost report. However, the Board also 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 report settlement purposes and was necessary in this situation because the Provider moved during a single cost reporting period from one geographic area to another 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 a HHA's cost limit. A blended rate as used by the Intermediary is a pro-rata accounting calculation based on two separate cost limits for two separate geographic areas. The blended rate was not reflective of the costs in the geographic area in which the HHA was located in the last months of 1994 or in the 1995 cost year. The use of the blended rate as a cost limit results in inequities. By applying the freeze on a individual HHA basis, rather than the area in which the HHA was located, the HHA was given a cost limit which did not reflect the concomitant higher cost associated with the MSA in which it was located for the cost reporting periods beginning after July, 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 requirement, the Intermediary was required to reimburse the Provider under the last cost limit established for the MSA that the Provider was located at which was the Fort Worth MSA. 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 the fiscal year 1995. That rate was used only as a means of settling the 1994 cost report.

The Board finds that 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 concludes that the geographic location of the HHA is, and always has been, the key determining factor in establishing cost limits for an HHA, see 42 C.F.R. § 413.30(b). The undisputed evidence shows that Congress froze HHA cost limits and those cost limits are based on a HHA's geographic location, and not its composite or blended rate. The Board concludes 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 for the MSA in which the Provider was located 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 September 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 $85.70. 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 $85.70.

Henry C. Wessman, Esquire
Board Member