# PROVIDER REIMBURSEMENT REVIEW BOARD HEARING DECISION

99-D12

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| **PROVIDER** -<br>Maximum Home Health Care, Inc.<br>Watertown, Tennessee | **DATE OF HEARING-**<br>May 20, 1997 |
| Provider No. 44-7425 | Cost Reporting Periods Ended -<br>June 30, 1990 and June 30, 1991 |
| **vs.** | |
| **INTERMEDIARY** -<br>Blue Cross and Blue Shield Association/<br>Blue Cross and Blue Shield of South Carolina | **CASE NOS.** 93-0451 & 93-1941 |

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ISSUE:

Was the Intermediary's adjustment of management fees proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Maximum Home Health Care, Inc., (" Provider"), is a Medicare-certified home health agency located in Watertown, Tennessee, with offices located in Gallatin, Murfreesboro, Nashville, and Sparta, Tennessee. On January 26, 1988, the Provider entered into a management agreement with Diversified Health Management ("Diversified"), Inc. to provide a full range of management services, effective March 1, 1988.[1] During the initial contract period, the management fee was $11.50 per visit. On April 17, 1989, the Provider executed a management agreement with Diversified for services in FYE June 30, 1990 at a rate of $13 per visit.[2] On May 17, 1990, the Provider executed a similar contract with Diversified for FYE June 30, 1991 at a rate of $13.60 per visit.[3] Pursuant to both contracts, Diversified was to provide the Provider with management services. The services furnished by Diversified[4] include, but are not limited to, the following responsibilities:

1. Collection and disbursement of funds received by the Agency.

2. Hiring and supervising adequate staff of professional, paraprofessional and other employees as needed to operate the Agency.

3. Preparing personnel policy and procedure manual.

4. Providing clinical professional staff to ensure state/federal guidelines are met. This encompasses reviewing Medicare forms before billing; developing a quality assurance program; monthly in-service educational updates for supervisory staff; claims management; and onsite review of clinical procedures.

5. Recommending employee benefit programs.

6. Providing billing and collection services.

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[1] Intermediary Position Paper at 8.

[2] Intermediary Exhibit I-A.

[3] Intermediary Exhibit I-B.

[4] Intermediary Position Paper at 9-10.

7. Purchasing supplies, furniture, equipment, etc.

8. Scheduling work of personnel and maintaining proper records for those personnel.

9. Handling accounts payable activities.

10. Evaluating the performance of administrative and professional personnel.

11. Maintaining chart of accounts, accounting systems, and statistical data gathering systems.

12. Acting as community liaison.

13. Representing the agency at meetings, workshops, conventions, etc.

14. Maintaining a current inventory of fixed and current assets.

15. Establishing and maintaining a cost containment program.

16. Preparing the Agency's capital and operating budget.

Because the management fees for FYs 1990 and 1991 represented an increase from the fees charged under the initial contract with Diversified, Blue Cross and Blue Shield of South Carolina, doing business as Palmetto Government Benefits Administrators ("Intermediary") audited the fees for both FY 1990 and 1991.[5]

It is the Intermediary's contention that Provider Reimbursement Manual § 2135.2 ("HCFA Pub. 15-1") requires that a provider demonstrate the need and cost effectiveness of obtaining services from outside contractors. The Intermediary asserts that since the Provider did not obtain competitive bids for the management contract, it first attempted to determine the Provider's prudency in obtaining outside services rather than employing the necessary personnel to perform identical duties.[6] Based on its analysis, the Intermediary determined it was prudent for the Provider to purchase management services.[7] The analysis indicated that the variance between performing the services in-house with employees as compared to purchasing the services would be over $310,000.

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[5] Tr. at 82.

[6] Intermediary Exhibit I-C at pg. 6.

[7] Id.

To test the reasonableness of Diversified's management fees, the Intermediary performed a survey of five companies which the Intermediary believed provided services similar to Diversified and were in the same geographical area as the Provider.[8] Using data obtained from the survey, the Intermediary computed an average rate per visit from the various contracts. When these contracts were compared to the Provider's management fees, the Provider's rate per visit exceeded that for all five of the other management companies. The Intermediary's survey indicated the following:

| Company Name | Rate/Visit |
|---|---|
| HCR and CMK | $ 8.25 |
| IMS | 11.00 |
| KyMo | 11.00 |
| Alpha | 10.25 |
| HFS | 8.20 |
| Total | $48.70 / 5 = $9.74 (Average rate per visit) |

Utilizing the above information, an adjustment was proposed by the Intermediary to reduce the Provider's management fees from $13 and $13.60 per visit for FYs 6/30/90 and 6/30/91 to $9.74 per visit for both fiscal years.

On December 21, 1992 and August 11, 1993, for fiscal years 1990 and 1991 respectively , the Provider appealed the Intermediary's adjustments to the Provider Reimbursement Review Board ("Board") and has met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841.[9] The Provider requested the Board to hear both cases simultaneously since the rationale which was used to make the management fee audit adjustment on the 1990 cost report was carried forward by the Intermediary for the 1991 cost report. The amount of Medicare reimbursement in dispute is $55,941 for 1990 and $74,593 for 1991.[10]

The Provider was represented by John P. Konvalinka, Esquire, of Grant, Konvalinka & Harrison, P.C. The Intermediary was represented by James R. Grimes, Esquire & Associate Counsel, for Blue Cross and Blue Shield Association.

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[8] See Intermediary Position Paper at 11-14 for specific information on the Intermediary's survey.

[9] All other issues in the original appeals have been withdrawn. See Tr. at 6.

[10] Provider Post Hearing Brief at 1, Intermediary Position Paper at 7.

PROVIDER'S CONTENTIONS:

The Provider alleges the Intermediary erred in adjusting its management fees. The Provider contends the Intermediary arbitrarily selected five (5) companies which the Intermediary mistakenly believed were comparable to Diversified, and simply averaged the base fee of those five companies. The Intermediary then allowed that average, $9.74 per visit, for each of the years at issue in this case. The Provider points out that there were no adjustments by the Intermediary on its June 30, 1989 cost report when it paid Diversified a rate of $11.50 per visit.[11] In addition, the Provider notes that the Intermediary also allowed full reimbursement for the management fees it paid to Diversified, at the rate of $14.30 per visit, for the years ending June 30, 1992, June 30, 1993, and June 30, 1994,[12] and also had allowed fees of over $13 per visit for the years ending June 30, 1990 and June 30, 1991 for some of Diversified's other Tennessee home health clients who had executed the same management services agreement as the Provider.[13]

The Provider maintains that Medicare regulations mandate payment to providers of reasonable costs, even where those costs may vary greatly. Specifically, 42 C.F.R. § 413.9(c) provides:

> (c)(1) It is the intent of Medicare that payments to providers of services should be fair to providers . . . .
>
> (c)(2) The provisions in Medicare for payment of reasonable costs of services is intended to meet the actual costs, however widely they vary from one institution to another. This is subject to a limitation if a particular institution's costs are found to be substantially out of line with other institutions in the same area that are similar in size, scope of services, utilization, and other relevant factors.

42 C.F.R. § 413.9 (c)(Emphasis added).

The Provider contends that some providers may purchase outside services necessary for proper management and administrative operation (HCFA Pub. 15-1 § 2135.1), and that the actual costs of these services are reimbursable to the provider unless they are determined to be unreasonable. HCFA Pub. 15-1 § 2102.1.

The Provider believes the Intermediary's analysis of comparing its management contract to the other five management contracts is flawed. The Provider contends the Intermediary's

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11 Tr. at 32.

12 Tr. at 32-33.

13 Tr. at 32-33, 124; Provider Post Hearing Brief at 4.

analysis ignored relevant factors critical to the determination of the reasonableness of the fees. Specifically, the Provider asserts the Intermediary failed to determine if the management companies it selected had charges in addition to the base cost per visit.[14] The Provider contends the Intermediary also ignored the fact that each of the companies it selected had terms of three or more years, while the management contract it had with Diversified was for a term of one year.[15] Further, nothing in the Intermediary's work papers reveals that the Intermediary performed an analysis or comparison of services provided by Diversified and services provided by the five companies selected by the Intermediary.[16]

In support of its contention that the five companies selected by the Intermediary were not comparable to it, the Provider refers to Memorial Hospital/Adair County Health Center Inc. v Bowen, M.D., Secretary of Health and Human Services, et al, 829 F.2d 111 (D.C. Cir. 1987), ("Memorial"). In Memorial, the court examined the language of 42 C.F.R. § 405.451(c)(2), redesignated § 413.9, in the context of the disallowance of hospital expenses for pharmacy services. In its analysis, the court stated:

> [u]nder the regulations at issue, intermediaries must arrive at truly comparable basis for comparison in determining whether the actual costs of a particular provider are out of line. It was incumbent on Blue Cross... to come up with an appropriate basis for determining whether the costs... were reasonable in light of the costs incurred by other providers ....

Id at 118.

The Provider points out that although the Intermediary's survey selected management companies that charged between $8.20 and $11 per visit, Provider witnesses familiar with management companies in Tennessee testified that depending on the services, there were other management companies charging anywhere from $4 to $20 per visit.[17] Therefore, the Provider contends that while the Intermediary selected management contracts with fees that ranged from $8.20 per visit to $11 per visit to obtain an average rate per visit of $9.74, it could have selected management companies with a $15 per visit fee, which by their analysis, would clearly make the fees in question reasonable.

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[14] Tr. at 106.

[15] Id.

[16] Id. at 105.

[17] Tr. at 38, 59.

The Provider contends that all five of the management companies the Intermediary used for its analysis, two of which were not located in Tennessee[18], provided services under contracts of at least three (3) years duration, as opposed to the one (1) year contract Diversified had with the Provider. The Provider points out that the Intermediary admitted it did not consider the terms of the contracts as a factor in determining the reasonableness of the fees.[19] In failing to consider the duration of the contracts selected for comparison, and the impact that longer terms had on the base management fee of the contracts, the Provider asserts the Intermediary failed to "arrive at a truly comparable basis for comparison in determining whether the actual costs ... were out of line." Memorial at 118.

The Provider further contends that the Intermediary simply failed to conduct an analysis of home health providers comparable to it in determining the reasonableness of management fees it paid in 1990 and 1991. The Provider contends that as with the intermediary in Home Health Services of Greater Philadelphia v. Harris, 530 F.Supp. 1236 (E.D. Pa. 1982) ("Philadelphia"), the Intermediary here has failed to follow the dictates of 42 C.F.R. § 413.9(c).[20] The Provider points out that in Philadelphia, the HCFA Administrator had upheld the intermediary's substantial reduction in reimbursement for the home health provider's management fees. The court, in reversing the administrator, stated:

> [w]e find no evidential support for this finding in the record. The record was devoid of any reference to the cost incurred by a single provider "in the same area," and "similar in size, scope of services, utilization, and other relevant factors" as required by 42 C.F.R. 405.45 l(c)(2) [now 42 C.F.R- § 413.9(c)].

Philadelphia, 530 F.Supp. at 1236.

The Provider notes that the court also criticized the intermediary and Administrator for fixing as a benchmark criteria for reasonable costs the median figure resulting from the intermediary's comparison of service vendors. The court found "this arbitrary declaration of 'reasonable cost' is contrary to the flexibility of the concept of reasonable cost inherent in 42 C.F.R. § 405.45l(c)(2). The mere fact that someone charges a higher fee ... does not mean that such a fee is unreasonable." Philadelphia, 530 F. Supp. at 1248. The Provider contends that here, as in Philadelphia, the record lacks any substantial evidence that the Intermediary has performed a comparable analysis to determine whether it's management fee expenses are "substantially out of line with other institutions in the same area that are similar in size, scope of services, utilization, and other relevant factors." 42 C.F.R. § 413.9(c)(2).

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[18] Id. at 90.

[19] Id. at 106.

[20] Provider Post Hearing brief at 11.

The Provider also rejects the Intermediary's argument that since it did not obtain competitive bids prior to signing the agreement with Diversified, it did not follow Program instructions. The Provider contends that there is no requirement that competitive bids be obtained. The Provider asserts that it is simply a factor to be considered along with the cost of comparable services among contractors. The Provider notes that the manual language states, "(g)enerally a provider is prudent to solicit competitive bids". HCFA Pub. 15-1 § 2135.2.

To further support its position, the Provider points to an analysis of the management fees charged by companies operating in the southeast region, performed by KPMG Peat Marwick ("KPMG"),[21] that indicated that the fees ranged from $7.25 per visit to $17.27 per visit.[22] The analysis revealed that, in fiscal year ending 1990, "[t]he mean charge per visit for these 8 companies was $11.38 with a low of $7.25 and a high of $17.27." [23] The study also determined that the smallest management company had fees which ranged from $11 and $13, with the higher amount being charged for full service management contracts.[24]

The study also revealed that five of the eight companies surveyed charged their home health clients fees in addition to the base management fee.[25] The Provider contends this conclusion is particularly significant when you consider the fact that, in the present case, the Intermediary ignored additional charges in assigning the cost per visit to the five companies it selected to compare to Diversified, even though they had that information available to them,[26] and at least one of which clearly had fees in addition to the base cost per visit fee.[27] The Provider asserts that these additional charges have the effect of increasing the cost per visit. As stated by the court in Memorial, "the intermediary's duty under Section 405.451(c)(2) [(redesignated 413.9)] was to compare, with common sense and care, the provider's costs and those of other providers whose services were truly comparable." Memorial at 118. The Provider contends that by ignoring additional fees charged by the companies selected for its comparison, the Intermediary failed to use common sense and care in comparing the fees to those of the Provider. The result is an average cost per visit for those companies which does not necessarily reflect the actual cost per visit paid by the providers contracting with those companies.

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21 Provider Exhibit P-4.

22 Id. at 1.

23 Id.

24 Id. at 9.

25 Id. at 11-15.

26 Tr. at 107.

27 Tr. at 55.

The Provider rejects the Intermediary's argument that the KPMG study may not be appropriate because it would include metropolitan areas that have a much higher cost of living than the Nashville area.[28] The Intermediary's witness testified on cross examination that there was no prohibition for a provider to pick a management company outside of Nashville or in the Southeast region.[29] The Provider points out that two of the companies used in the Intermediary's analysis were located out of the Nashville area. The Intermediary's witness stated that, "one management company was in Summerset which is lower Kentucky and another in Eastern Missouri which borders Tennessee."[30]

The KPMG analysis determined the mean charge per visit was $11.38, and that the cost increased when additional charges were factored in, which five of the eight companies did. The Provider contends that based on the KPMG analysis, it appears obvious that the management fees charged by Diversified were not substantially out of line with those of other management companies in the geographical area.

The Provider maintains that pursuant to Blue Cross Administrative Bulletin No. 1401,80.01,[31] the Intermediary performed a componentized analysis in determining the reasonableness of the fees paid to Diversified. The Provider contends the analysis revealed that the use of a management company would result in a savings of approximately $310,528.[32] The Provider refers to Blue Cross Administrative Bulletin Number 1401, 80.01 which provides, in relevant part,

> [o]nce it has been determined that the provider and management company are not related organizations, a test to determine the reasonableness of the management fees must be made. The best method for assessing the reasonableness of the fees is a componentized analysis.

Provider Exhibit P-2

The Provider rejects the Intermediary's contention that the field auditor did not perform a componentized analysis because he was not able to obtain any documentation from the

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[28] Tr. at 92; Intermediary Post Hearing brief at 6-7.

[29] Tr. at 110.

[30] Id. at 90.

[31] Provider Exhibit P-2.

[32] Intermediary Exhibit I-C at 5.

Provider such as progress reports as to the intensity or quantity of services performed.[33] The Provider points out that the work papers are devoid of any statement to the effect that there was a lack of documentation necessary to determine the extent or quality of services performed. In fact, the field auditor's notes specifically state: "Thus, based on observations throughout the audit and actual documentation submitted by the provider, Diversified Management Company is adequately performing its duties described in the management contract." Intermediary Exhibit I-C.

The Provider's witnesses testified that based on their experience, and in reviewing the work papers, that the componentized analysis done by the Intermediary was in accord with the Blue Cross Administrative bulletin.[34] The Provider points out that the Intermediary's witness also testified that the best way to determine reasonableness of management fees is to perform a componentized analysis.[35] The witness also admited that documentation was submitted to the field auditor and that Diversified performed the services for which it charged the Provider.[36]

To summarize, the Provider contends that the Intermediary based its determination upon a comparison among management companies arbitrarily picked by the Intermediary solely because those companies had "full service contracts", without regard to size or providers served, additional charges connected with the management services, or without the benefit of a written comparison of the services performed.[37] The Provider maintains that the Intermediary's field auditor performed a componentized analysis in accordance with Blue Cross Administrative Bulletin No. 1401,80.01; the result of which revealed that management fees were significantly below the "total reasonable cost".[38] Therefore, the Provider maintains that the fees are not "substantially out of line with a market place prices for similar packages services."[39]

INTERMEDIARY'S CONTENTIONS:

The Intermediary argues that the cost at issue in this case is governed by 42 C.F.R. § 413.9 which requires that payment to providers must be based on the reasonable cost of services

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[33] Tr. at 86.

[34] See Provider's Post Hearing brief at 19-22.

[35] Tr. at 99.

[36] Id. at 103.

[37] Provider Post Hearing Brief at 23.

[38] Intermediary Exhibit I-C at 6.

[39] Provider Exhibit P-2 at 5.

covered under the Program. The Intermediary asserts that reasonable cost is generally the actual cost to the Provider, subject to a limitation if the Provider's costs are found to be substantially out of line with other institutions in the same area that are similar in size, scope and other relevant factors.

To ensure the Medicare program is only paying for the reasonable cost of services to beneficiaries, HCFA Pub. 15-1 § 2103 adds the concept of the prudent buyer. Reasonable cost requires that the Provider behave as a prudent and cost conscious buyer who refuses to pay more than the going price, and in fact seeks to economize by minimizing cost. To verify that providers are adhering to the requirements of § 2103, intermediaries are instructed to, among other things, compare the prices paid by providers to the prices paid for similar items or services by comparable purchasers. The Intermediary also notes that § 2103 (B) further indicates that where most of the costs of a service are reimbursed by Medicare (as is the case with this Provider), the costs should be examined with particular care.

The Intermediary points out that HCFA Pub.15-1 § 2135.1 specifically recognizes purchased management services as an allowable cost when it is the most appropriate means of obtaining services. The Intermediary attempted to review the management services for reasonableness using the following guidelines from HCFA Pub. 15-1 § 2135.3:

A. [w]hether the contract results from competitive bids that are reasonable within industry norms for similar services; and

B. [w]hether the contract is between unrelated parties; and

C. [w]hether the contract provides for services that are designed to accomplish within a prescribed time frame clearly stated goals and objectives based on needs identified by the provider; and

D [w]hether the Provider maintains adequate documentation of the services rendered and the status of the accomplishment of the stated goals and objectives.

HCFA Pub. 15-1 § 2135.3

The results of the Intermediary's review, using the above criteria, follows:

A. There is no evidence of competitive bids before entering into the agreement with Diversified.

B. There is no indication that the parties are related through ownership. Whether the parties are related through control is questionable.

C. The contract is fairly specific as to the services to be performed by the management company.

D. The auditors performed a limited review to determine that the services were actually performed. However, progress reports were not provided to the Intermediary to document the quantity of the services rendered.

Intermediary Position Paper at 17.

Based on the above review, the Intermediary maintains that the Provider did not obtain competitive bids before entering into the all inclusive management contract with Diversified. Further, there was no evidence presented at hearing to indicate that the Provider had compared the prices of other management firms before entering into the agreement with Diversified.

As part of the above review, the Intermediary looked at whether the services needed by the Provider could be obtained more effectively using in house staff, as required under HCFA Pub. 15-1 § 2135.l.[40] The Intermediary witness indicated the costs used for this computation were extremely generous. Nonetheless, the Intermediary estimated the cost of providing management services in-house to be $542,903, significantly more than the $232,375 claimed on the Provider's cost report.[41] This was the basis for the determination that it was prudent for the Provider to purchase management services. It is the Intermediary's position, however, that the use of the computation found at its Exhibit I-C does not establish that the management fees paid by the Provider are reasonable simply because they are less than the estimate of what the cost would be if performed in-house.[42]

The Intermediary asserts that the attempt to capture the cost of providing management services in-house was based on estimates of cost; estimates which probably overstated costs. Even more important, the estimate does not reflect the actual cost of such services in the marketplace. The Intermediary contends it is the responsibility of the Provider to search the marketplace for the most effective means of obtaining the services. HCFA Pub. 15-1 § 2135.2. The Intermediary further contends that it is the responsibility of the Provider to minimize cost and to refuse to pay more than the going price. It is the Intermediary's position that a general estimate of the cost of the service in-house, does not establish the reasonableness of any fee paid to an outside vendor.

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[40] Intermediary Exhibit I-C at 6.

[41] Id.

[42] Intermediary Post Hearing Brief at 5.

Because the Provider did not attempt to compare prices in the market place, the Intermediary expanded its review. The Intermediary reviewed the cost of management services within the Provider's service area and compared the results to the fees paid by this Provider. The Intermediary found that there was a competitive market for management services in the area, and the going rate was less than that paid by the Provider. The Intermediary found a market in which the cost of all inclusive service arrangements ranged from $8.20 per visit to $11 per visit. The Intermediary took the average rate and applied it to the Provider's cost reports for both fiscal years. The Intermediary believes an average was reasonable since the Provider might have negotiated a rate any where in the range.

The Intermediary also refers to the KPMG study, Provider Exhibit P-4. With the exception of the one company charging $17.25, no company charged as much as Diversified's charges of $13 and $13.60 per visit. The Intermediary believes the charge of $17.25 in the Provider's survey is an aberration since no other company in either the Provider or Intermediary's survey comes close to that charge.[43] The Intermediary also believes that it is possible that the aberration may result from the fact that the Provider's study looked at the entire Southeast region of the U.S. while the Intermediary looked at the service area in which the Provider is located. The Intermediary points out that the Southeast region would include many disparate markets including high cost areas such as Miami and Atlanta which would not be indicative of costs found in Tennessee.[44]

The Intermediary believes that the studies supplied by both parties substantiate its claim that the cost of management services in this case was out of line with the going rate for such services in the marketplace. It is the Intermediary's position that the Provider made no attempt to search that marketplace. And, if it had, it would have found lower cost alternatives to the contract requiring payments of $13 and $13.60 per visit. A review of management company fees in the Tennessee and Kentucky area (the area the Provider would have looked to for such services) produces a range of $8 to $11 per visit. The Intermediary believes that the Provider's decision to pay $13 and $13.60 per visit was thus not prudent. It is the Intermediary's position that the fees paid by this Provider were out of line with the going rate in the area and should be adjusted. The Intermediary believes the average rate charged in the area is a reasonable proxy for the fee the Provider might have negotiated had it tried to minimize its cost. Therefore, the allowable fee of $9.74 per visit is reasonable.

CITATION OF THE LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§ 405.1835-.1841 - Board Jurisdiction

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[43] Intermediary Post Hearing brief at 6-7.

[44] Id. at 7.

§ 405.451(c)(2) redesignated 413.9 et seq. - Cost Related to Patient Care

2. Program Instructions - Provider Reimbursement Manual (HCFA Pub. 15-1) :

| | | |
|---|---|---|
| § 2102.1 | - | Reasonable Costs |
| § 2102.3 | - | Costs Not Related to Patient Care |
| § 2103 et seq. | - | Prudent Buyer |
| § 2135.1 | - | Purchased Management and Administrative Support Services-General |
| § 2135.2 | - | Evaluation of the Need for Purchased Management and Administrative Support Services |
| § 2135.3 | - | Determine of the Reasonable Cost of Purchased Management and Administrative Support Services |

3. Cases:

Memorial Hospital/Adair County Health Center Inc. v Bowen, M.D., Secretary of Health and Human Services, 829 F.2d 111 (D.C. Cir. 1987).

Home Health Services of Greater Philadelphia v. Harris, 530 F.Supp. 1236 (E.D. Pa. 1982).

4, Other:

BCBSA Bulletin No. 1401,80.01 - Evaluating the Reasonableness of the Fee in Management Contract Arrangements

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, evidence presented and testimony elicited at the hearing, finds and concludes that the Intermediary's audit adjustments, which reduced the management fees paid by the Provider, were based on a flawed survey, and accordingly, the adjustments are reversed.

The Board finds there is agreement between both parties that is was prudent for the Provider to enter into a management services contract rather than provide the services in-house with Provider employees. The Board also notes that there is nothing in evidence to indicate that the Provider attempted to obtain competitive bids from other management companies as suggested in HCFA Pub. 15-1 § 2135.2.

The Board finds that the Intermediary's survey, upon which it based its adjustments, is flawed for several reasons, including:

- There was little or no information in evidence regarding the manner in which the sample of five management companies was selected. The Board notes that the selection of these five companies appeared to be arbitrary. Also, there was testimony that indicated there were other companies which provided management services at rates higher than the companies included in the Intermediary's survey.

- Testimony by the Intermediary's witness indicated that the Intermediary used only base costs per visit from the contracts of the companies surveyed and did not consider additional charges or duration of the contracts.[45]

- There is no indication in the record that the Intermediary compared the services of Diversified to the services of the management companies in its survey.

The Board finds that the KPMG survey was conducted by an independent organization and consequently, the Board places great weight on this survey. The Board finds the KPMG study is much more detailed that the Intermediary's survey in that it considered a greater number of variables and a larger cohort body. The Board also finds that the KPMG survey established a mean and standard deviation for management company rates.[46]

The Board notes that the Intermediary was not consistent in its application as to the reasonableness of the management fees paid and claimed on the cost report by the Provider. Specifically, the Board notes that the Intermediary made no adjustments to the Provider's per visit fee it paid to Diversified for fiscal years 1989, 1992, 1993, and 1994, all of which were higher than the fee allowed by the Intermediary in this case. The Board also notes testimony which indicates that the Intermediary allowed management fees, in excess of those allowed in this case, for similar services for other providers in the area.[47]

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[45] Tr. at 55, 106-107.

[46] See Provider Exhibit P-4, Pg. 12.

[47] Tr. at 124.

Based on the above findings, the Board concludes that, even though no competitive bids were obtained, the Provider was prudent to use an outside contractor to provide management services.
The Board also concludes that the Intermediary's survey was flawed and that the KPMG survey is the best survey in evidence. In placing great weight on the KPMG survey, the Board is adhering to its own consistent application of surveys, means, and standard deviations in prior Board decisions. Therefore, the Board concludes that the fees paid by the Provider to Diversified are well within the mean of $11.38 per visit with a standard deviation of $2.93 identified in the KPMG study. The Board also notes that the KPMG study revealed an average total cost per visit of $51.29 which would indicate that the Provider's costs per visit of $52.44 and $52.60 in 1990 and 1991 were reasonable overall.[48]

DECISION AND ORDER:

The Intermediary's audit adjustments, which reduced the management fees paid by Provider, were not proper. The Intermediary's adjustments are reversed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esq.
Charles R. Barker

**Date of Decision:** November 25, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman

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[48] Provider Exhibit P-4, Pg. 2; Tr. at 34.