CENTERS FOR MEDICARE & MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
MGH HOME HEALTH **Provider** **vs.** **BLUE CROSS BLUE SHIELD ASSN/ CAHABA GOVERNMENT BENEFIT ADMINISTRATORS** **Intermediary**	**Reimbursement Determination for Cost Reporting Periods ending: 06/30/96 and 06/30/97** **Review of: PRRB Decision 2006-D25 Dated: June 1, 2006**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in §1878(f)(1) of the Social Security Act. The parties were notified of the Administrator's intent to review Issue No. 1 of the Board's decision. Subsequently, comments on Issue No. 1 were received from the Provider and CMS' Center for Medicare Management (CMM). Accordingly, this decision is now before the Administrator for final agency review.

ISSUE NO. 1 AND BOARD'S DECISION

Issue No. 1 involves whether the Intermediary's application of salary equivalency guidelines to the compensation of physical therapists employed by the Provider on a per visit basis was improper.[1]

The Board, reversing the Intermediary's adjustments, held that the Intermediary's improperly applied the Guidelines to the Provider's physical therapists paid on a

[1] Issue No. 2 involved whether the Intermediary's adjustment for fiscal year (FY) 1996 to include charity care home health visits in the calculation of the Provider's program reimbursement was proper. The Board held that the Intermediary's adjustment was proper. The Administrator summarily affirms Issue No. 2.

per-visit basis. The Board found that the Provider employed physical therapists to whom it paid a lump sum for each patient visit. The Board noted that the statute at §1861(v)(1)(A) [42 U.S.C. 1395(v)(1)(A)] distinguishes services performed by employee therapists from services performed by outside contractors" under an arrangement" with a provider. The Board also noted that the term under an arrangement is commonly referred to and used interchangeably with the term" outside contractor." In this case, the Board found that, although the Provider's physical therapists were paid on a fee-for-service, i.e., per visit basis, the therapists were employees of the Provider. Thus, the Guidelines do not apply.

For support that the salary equivalency guidelines do not apply, the Board cited, In Home Health, Inc. v. Shalala, 188 F.3d 1043 (8th Cir. 1999), and High Country Home Health, Inc., v. Shalala, 84 F. Supp. 2d 1241 (D. Wy. 1999), wherein each of those courts found that the salary equivalency Guidelines do not apply to the situation put forward in the instant appeal. The Board also found that the guidelines alone cannot be used to adjust the provider's costs in accordance with Medicare prudent buyer principles, but, rather, 42 C.F.R. §413.9 indicates that intermediaries must determine whether or not a provider's costs are" substantially out of line" or are unreasonable based upon a comparison of those costs to those incurred by other similarly situated providers.

Finally, the Board found that the amendment to the regulations at 42 C.F.R. §413.106(c)(5), which applies the guidelines to therapists costs where compensation is based, at least in part on a fee-for-service basis, does not apply to the instant case. The amendment was published on January 30, 1998, and is effective for services furnished on or after April 1, 1998, which is after the subject cost reporting period.

SUMMARY OF COMMENTS

The Provider commented requesting affirmation of the Board's decision. The Provider referred to its reasoning as set forth in its position paper before the Board.

CMM commented, requesting reversal of the Board's decision. CMM noted that this issue was a subject of several Administrator decisions. CMM, incorporating its comments in a prior case, SNI Home Care, Inc., PRRB Dec. No. 2003-D11 argued that the Intermediary's application of the Guidelines to the Provider's physical therapists paid on a fee-for-service basis was appropriate based on the CMS' authority to apply the guidelines under sections 1861(v)(1)(A) and 1861(v)(5)(A) of the Act. CMM maintained that the statute distinguishes between services furnished under an arrangement and those provided through a "salaried employee relationship" and therefore, the Provider's physical therapists, which were not salaried but paid on a per-visit basis, were subject to the Guidelines. Because the

plain language of the statute is silent or ambiguous on the issue of whether the Guidelines should be applied to employees compensated on a per-visit basis, CMS' interpretation should be upheld because it is reasonable under §1861(v)(5)(A) of the Act. CMM also noted that even if CMS is not mandated under statute to apply the Guidelines to therapist employees of a provider who are paid on a per-visit basis, CMS has the authority under statute to define reasonable cost and establish and apply cost limits to different provider costs and different classes of providers to determine whether such costs are reasonable in determining Medicare program payments.

DISCUSSION

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

Since the inception of the Medicare program in 1966, reimbursement of providers has been governed by §§1814(b)(1) and 1861(v)(1)(A) of the Act. Section 1861(v)(1)(A) of the Act provides:

> Reasonable costs shall be the costs actually incurred, excluding, there from, any part of incurred costs found to be unnecessary in the efficient delivery of needed health care….

In addition, the Secretary has been granted authority over §1861(v)(1)(A) of the Act to establish:

> Limits on direct and indirect overall incurred costs, or incurred costs of specific items, or services, or groups of items or services to be recognized as reasonable, based on estimates of the costs, necessary in the efficient delivery of needed health services to individuals covered by the health insurance program established under this title….

The Secretary has promulgated regulations at 42 C.F.R. §413.9, which provides that all payments to providers must be based on reasonable cost of services covered under Title XVIII of the Act and related to the care of beneficiaries. In addition, the Provider must meet the documentation requirements of both the Act and the regulations in order to demonstrate entitlement to reimbursement.[2]

Further, the regulations at 42 C.F.R. §413.106(c) (5) states in part: "[u]ntil a

[2] Section 1851 of the Act [42 USC 1395g]; 42 CFR 413.20; 42 CFR 413.24.

guideline is issued for a specific therapy or discipline, costs are evaluated so that … costs do not exceed what a prudent and cost conspicuous buyer would pay for the given service." Id. This regulation is implemented by section 1403 of the Provider Reimbursement Manual (PRM), which reads in part, "[u]ntil specific guidelines are issued for the evaluation of reasonable costs of other services furnished by outside suppliers such costs will continued to be evaluated under Medicare program's requirement that only reasonable costs be reimbursed." Id.

A limitation on payment for reasonable costs of physical therapy services "under arrangement" was established by §251(c) of the Social Security Amendments of 1972[3] and §17(a) of the Social Security Amendments of 1973.[4] These amendments added §1861(v)(5)(A), which provides that:

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

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

> [T]he term "arrangement" is limited to arrangement under which receipt of payment by the home health agency {whether in its own right or as an adjustment} with respect to services for which an individual is entitled to have payment made under this Title discharges the liability for such individuals or any other person to pay for the services.

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

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[3] Pub. Law 92-603.

[4] Pub. Law 93-233.

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

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

> Under this provision, [CMS] will establish criteria for use in determining the reasonable costs of physical … therapy services … furnished by individuals under arrangements with a provider of services…. It is recognized that providers have a wide variety of arrangements with such individuals. These individuals may be independent practitioners or employees of organizations furnishing various health care specialists. This provision does not require a change in the substance of these arrangements.

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

> The guidelines apply only to the costs of services performed by outside suppliers, not the salaries of provider employees, however, the cost of the services of the salaried employees who was formerly an outside supplier of therapy or other services, or any other new salaried employment relationship, will be closely scrutinized to determine if an employment situation is being used to circumvent the guidelines. Any costs in excess of an amount based on the going rate for salaried employee therapists must be fully justified.
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> In situation where compensation, at least in part, is based on a fee for service basis, or on a percentage of income, {commission}, these arrangements will be considered non-salaried arrangements, and the entire compensation will be subject to the guidelines…. (Emphasis added.)

The Administrator disagrees with the Board's analysis of the case and the relevant law and policy. The Administrator finds that, after review of the controlling law, legislative history of the Act, and relevant Medicare policy, the Intermediary properly applied the Guidelines to the provider's physical therapy compensation. Contrary to the Board's finding that an employment relationship between the

provider and the physical therapists determines whether the Guidelines should be applied, the Administrator finds that the fee-for-service basis for payment of the provider's therapists was the controlling factor in the application of the limits in this case.

First, in this case, the Board found that the Provider "employed" physical therapists. If the physical therapists were in fact employees, the Board asserted that that the physical therapists were exempt from the physical therapy Guidelines. However, the Administrator notes that the Secretary is not bound by the Internal Revenue Services (IRS) provisions in determining Medicare reimbursement. The Administrator notes that these physical therapists may be employees under the IRS Code but where compensation, at least in part, is based on a fee-for-service, these payments are treated as non-salaried payments under §1403 of the PRM, and non-employment relationships for Medicare reimbursement purposes.

In this situation, the payment arrangements for physical therapists are similar to non-salaried personnel. The employment payment schemes for physical therapy services appear to be outside of a standard employment arrangement with the Provider and thus create the same opportunities for abuses as more traditionally defined contractor relationships. Consequently, wages paid on a fee-for-service or commission basis are governed by the Guidelines for purposes of Medicare reimbursement. The Administrator finds that §1861(v)(1)(A) of the Act authorizes the Secretary to determine reasonable costs and to implement limits on costs. The Secretary's choice to apply the Guidelines to the cost of employee compensation on a fee-for-service basis is not inconsistent with that authority. The law is well established that §1861(v)(1)(A) of the Act gives the Secretary "broad discretion" to determine what are reasonable costs.[5] The Administrator finds that the application of the Guidelines under these facts is a reasonable exercise of that discretion.

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[5] See, Good Samaritan Hospital v. Shalala, 508 U.S. 402, 411, 419 (1993); Mt. Diablo Hospital v. Bowen, 811 F.2d 38, 343 (7th Cir. 1987) (§1861(v)(1)(A) gives the Secretary wide latitude in proscribing regulations governing the process of reasonable costs. In Good Samaritan, the Supreme Court noted that §1861(v)(1)(A) of the Act, "explicitly delegates to the Secretary, the authority to develop regulatory methods for estimation of reasonable costs." 508 U.S. at 418, and likened this authority to the "exceptionally broad authority" that Congress bestowed on the Secretary in other areas of the Social Security Act. Pursuant to this authority, the Secretary promulgated regulations establishing cost limits, see 42 C.F.R. §413.30, and has provided that the cost limits may be calculated on a "per admission", "per discharge", "per diem", "per visit" or other basis, Id. at 413.30(a)(2). (Emphasis added.)

Moreover, with respect to the Secretary's authority to apply the Guidelines, in these circumstances, under the authority granted pursuant §1861(v)(5)(A) of the Act, the Administrator finds it significant that the plain language of §1861(v)(5)(A) does not specifically limit the application of the Guidelines only to non-employees or outside contractors. As evident from the foregoing statutory language, the phrase, "under an arrangement" is not defined in the Act by reference to a legal employment situation under the IRS Code, but rather, is defined in broad terms as where receipt of Medicare payment by a provider discharges the liability of the beneficiary to pay for such services. Although, the language of §1861(v)(5)(A) clearly applies in situations where there is an outside contractor relationship, the plain language of the statute does not actually define "under arrangement" with those terms and, thus, does not specifically exclude employment relationships.

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

Moreover, the legislative history clearly reflects that Congress expected this limit (salary-based) would be applied to fee-for-service arrangements, as Congress was concerned about the cost implications of therapy provided under fee-for-service arrangements, as opposed to salary-based compensation.[6] Thus, rather than focusing on the exact nature of the legal relationship between the provider and the therapists, Congress focused on the form of compensation to the therapists, viewing fee-for-service arrangements as the most likely area for uncontrolled costs and potential abuse.

Consequently, the statutory language of §1861(v)(5)(A) and its legislative history indicate that Congress did not contemplate all possible forms of fee-for-service arrangements, and, thus, did not contemplate fee-for-service arrangements within

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

the context of a formal employment relationship. It is equally evident that the purpose of enacting §1861(v)(5)(A) of the Act was to place limits on physical therapy fee-forservice compensation costs. Because of the ambiguity of the language at §1861(v)(5)(A), the Secretary's interpretation of the statute is entitled to considerable deference as long as it is reasonable.[7] The Administrator finds that the Secretary's interpretation of the Act, to consider the phrase "under arrangement" to include those employment situations where payment is on a per-visit or per-unit basis, is reasonable based on the ambiguous language of the statute, the clear congressional intent to control costs and abuses by limiting fee-for-service compensation, and the Secretary's concern about the possibility of providers circumventing that intent through what would appear to be employment relationships.

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

As reflected at §1403 of the PRM, the Secretary believes that either way, the possibility of abusing the Medicare program for greater reimbursement is the same, and could reasonably be prevented by using the same imposed compensation limits. Contrary to the Board's decision, whether the therapists are employees of the provider, or receive benefits from the Provider which employees typically receive, are not the significant factors in this case. To base the decision of whether the Guidelines apply simply by examining the form of employment relationship, rather than by exploring its substance, would facilitate the types of program abuses which Congress was trying to prevent in its adoption of §1861(v)(5)(A) of the Act.

Consistent with, the above, the Administrator finds that the Secretary has amended the regulations, reiterating the longstanding Medicare policy of treating fee-for-

[7] See, Chevron, U.S.A., Inc., v. National Resources Defense Council, Inc., 467 U.S. 837, 842-843 (1984) (Where a statute is silent or ambiguous on the issue in question, the interpretation of the agency charged with administering the statute is entitled to deference as long as it is a reasonable one.)

service therapist services as "under arrangement" situations. The 1998 amendment to the regulations at 42 C.F.R. §413.106(c)(5) provides:

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

The Secretary explained in the preamble to the proposed rule of the above regulation at 42 C.F.R. §413.106(c)(5) that:

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

> effectively circumvent the guidelines, and provided for these circumstances in §1403 of the Provider Reimbursement Manual.[8]

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

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

Finally, the Administrator notes the Board's reliance on the Court of Appeals for the Eighth Circuit holding in the case of In Home Health and the District Court decision of High Country Home Health. These cases are not controlling in this case because the Provider is not located in a state, which is comprised in the Eighth Circuit or under the jurisdiction of that District Court.

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[8] 62 Fed. Reg. 14851, 14871 (Mar. 28, 1997) (proposed); see also 63 Fed. Reg. 5106, 5126 (January 1, 1998) (final rule).

DECISION

The Administrator reverses the Board's decision on Issue No. 1 consistent with the foregoing opinion. The Administrator summarily affirms the Board on Issue No. 2.

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

Date: 7/11/06

/s/
Leslie V. Norwalk, Esq.
Deputy Administrator
Centers for Medicare & Medicaid Services