Health Care Financing Administration Rulings On Medicare, Medicaid, Professional Standards Review and Related Matters

Department of Health and Human Services
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Foreword

Programs of the Health Care Financing Administration— including Medicare, Medicaid, and Professional Standards Review Organizations— affect millions of people throughout the United States. To fully understand these programs, it is necessary to have access to the administrative instructions and manuals which guide staffs of Federal and State agencies and HCFA contractors in implementing the programs. In addition, official public rulings of the agency show how regulations are interpreted and applied.

Thus, in publishing *HCFA Rulings*, HCFA's intent is to observe the spirit of the Freedom of Information Act: to keep the public informed about the agency's handling of the public's business. As required by law, this document contains listings and indexes of current program regulations, manuals, instructions, rulings, and decisions. In addition, it includes recent legislation and illustrative case decisions. The case decisions serve as binding precedents upon those who administer the HCFA programs and upon those who serve as hearing officials in various program appeals. These decisions are being compiled in order to promote consistency in interpretation of policy and adjudication of disputes.

HCFA Rulings should be of use to Medicare and Medicaid beneficiaries, Federal and State employees who administer the programs, intermediaries, carriers, providers of services under the programs, other contractors to HCFA, attorneys, court and hearing personnel, and interested members of the public.

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HCFAR 80-4

Publication No. HCFA 10009 (6-82) Sections 1861(v)(1), 1866, and 1978 (42 U.S.C. 1395x(v)(1), 1395CC, and 1395oo)—Provider Reimbursement—Related Organizations—Inclusion in Allowable Costs of Payments Made Pursuant to Lease and Management Agreements

42 CFR 405.419, 405.427, 405.1829, and 405.1867

Medical Center of Independence v. Harris, Medicare and Medicaid Guide, (CCH) ¶ 30,654 (8th Cir. 1980)

A provider sought reimbursement for rent, management service fees, and interest expense paid to a management company. The hospital management company had acquired the assets of a partially constructed hospital. The construction project was already in financial trouble. The management company entered into a long-term agreement to lease the facility to a corporation formed to operate the facility, to manage it for the provider, and to loan the provider up to $200,000, if needed. The management company thereafter had 43 percent representation on the provider's board of directors, had two of its employees serve as officers of the provider, and the provider's administrator became a management company employee. Only the management company had the right to cancel the lease; and, if canceled, it was to assume the assets and liabilities of the provider. Prior to their agreement, there was no relationship between the management company and the provider.

42 CFR 405.427 states that costs for services, facilities, and supplies furnished to a provider by an organization related to the provider by common ownership or control are to be reimbursed at the cost to the related organization, rather than at the cost to the provider. Similarly, 42 CFR 405.419(c) disallows interest expense paid to related organizations.

Held, applicability of the related organization rule which limits costs of a provider to those of its supplier is not necessarily determined by the absence of a relationship between the parties prior to their initial contracting, although this fact is to be considered. The applicability of the rule is determined by also considering the relationship between the parties according to the rights created by their contract. The terms of the contracts and events which occurred subsequent to the execution of the contracts in this case had the effect of placing the provider under the control of the supplier.

Further held, the management company is related to the provider by control because the management company had the power, directly or indirectly, to significantly influence or direct the actions or policies of the provider, and therefore reimbursement for rent and management services to the provider is charged at the cost to the management rather than at the cost to the provider. Also, interest expense is not recoverable.

Further held, because the Secretary has established by substantial evidence the applicability of the related organization rule to the facts in this case, the Secretary does not need to determine the unreasonableness of particular costs.

Further held, the question of whether a related organization actually exercised the power to control is immaterial to the issue of whether control exists.*

BRIGHT. CIRCUIT JUDGE:

Medical Center of Independence, Inc. (MCI), appeals from a judgment of the district court[1] denying MCI reimbursement under the Medicare program for certain management fees, interest expense, and rent. On appeal, MCI argues that the district court erred in its interpretation and application of the "related organization principle" found in 42 C. F. R. §405.427 (1979). We disagree and therefore affirm.

I. Background

MCI leases and operates a hospital facility in Independence, Missouri, with a financially troubled history. The Lutheran Missionary Homestead Association, Inc. (LMHA), began construction on the hospital in 1966. LHMA was unable to sell enough bonds to complete construction, and soon it was forced into Chapter X bankruptcy proceedings. Pursuant to a court-approved 1968 plan of reorganization. MCI was formed as a nonprofit corporation to operate the hospital when completed. Americare Center, Inc., a hospital management firm, acquired all the assets of LMHA in return for satisfying certain creditor's claims and undertaking to complete the hospital facility and lease it to MCI. MCI agreed to operate the facility as a general acute care hospital, to engage Americare as a management company, and to give notes to various creditors.

Americare completed construction of the hospital but began to fail financially and had difficulty equipping the facility. MCI advertised in health care journals in an effort to locate a successor management contractor to Americare. Having received no satisfactory response to its advertisements, MCI entered into negotiations with Hospital Affiliates International, Inc. (HAI). On June 19, 1970, HAI purchased the assets of the hospital from Americare. HAI then entered into a fifteen-year lease with MCI, to become effective August 1, 1970, and a management agreement to run concurrently with the lease. HAI also agreed as had Americare, to lend up to $200,000 in necessary working capital to MCI.

In August 1970, the bylaws of the hospital were amended to increase the number of directors from eleven to fourteen, to allow nonlocal directors to vote by proxy, and to increase the number of officers' positions. In October 1970, six HAI employees were elected as directors of MCI; two were also elected as MCI officers. Under HAI's direction the hospital began operation and soon became a successful enterprise.

Since the hospital opened, MCI has served as a provider of health services under Medicare Part A, 42 U. S. C. §§ 1395c-1395 (1976 & Supp. II 1978). *See* 42 U. S. C. §1395x(u) (1976). As such, MCI does not bill patients who are eligible under Medicare for covered services. See 42 U. S. C. §1395cc (1976 & Supp. II 1978). Instead, it is to be reimbursed

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* In upholding the decision of the district court, the appellate court did not dispute this finding in the district court.

[1] The Honorable Elmo B. Hunter, United States District Judge for the Western District of Missouri. The district court opinion is reported the *Medicare & Medicaid Guide (CCH)* ¶29,948 (1979).

by the Government for its reasonable cost of providing these services or, if lower, the customary charges for them. See 42 U. S. C. §1395(f)(b) (1976 & Supp. II 1978).

A provider may be reimbursed for services rendered to Medicare beneficiaries either directly by the Secretary of Health and Human Services (the Secretary)[2] or through a "fiscal intermediary" that acts as the Secretary's agent for purposes of reviewing claims and administering governmental payments. *See generally Blue Cross Association v. Harris*, Nos. 79-1732, 79-1733 (8th Cir. June 6, 1980); *Columbus Community Hospital, Inc. v. Califano*, 614 F. 2d 181, 183 (8th Cir. 1980). If a provider is dissatisfied with the fiscal intermediary's determination regarding its claim for costs, it may request a hearing on the matter before the Provider Reimbursement Review Board (PRRB). 42 U. S. C. §1395oo(a) (1976). The PRRB's determination is the final agency action unless the Secretary, on her own motion and within sixty days after the provider of services is notified of the PRRB's decision, reverses or modifies that decision. 42 U. S. C. §1395oo(f)(1) (1976).

Although reimbursement under the Medicare program is structured around the concept of reasonable costs, the Medicare statute sets forth only a broad guideline for determining such costs:

> The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs[.] [42 U. S. C. §1395x(v)(1)(A) (1976).]

The statute requires that the Secretary's regulations take into account the direct and indirect costs necessary for the efficient delivery of covered services to Medicare beneficiaries, so that these costs will not be borne by noncovered individuals. 42 U. S. C. §1395x(v)(1)(A)(i) (1976).

The Secretary's regulations governing reimbursement of Medicare providers are codified at 42 C. F. R. §§ 405.401-405.488 (1979). As a general rule, payments made by a provider to an outside party for interest expense, facilities, and services are eligible for reimbursement at the provider's cost so long as the payments are reasonable and related to patient care. Under 42 C. F. R. §405.427 (1979), however, if the provider and its supplier are "related organizations," reimbursement will be limited to the supplier's cost. 42 C. F. R. §405.427 (1979) provides in relevant part as follows:

> (a) *Principle*. Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. However, such costs must not exceed

[2] The Secretary was formerly known as Secretary of Health, Education and Welfare.

> the price of comparable services, facilities, or supplies that could be purchased elsewhere.
> (b) *Definitions*--(1) *Related to provider*. Related to the provider means that the provider to a significant extent is associated or affiliated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.
> (2) *Common ownership*. Common ownership exists when an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider.
> (3) *Control*. Control exists where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

When MCI's fiscal intermediary, Blue Cross of Kansas City, audited MCI's cost reports for fiscal years 1970-73, it determined that MCI and HAI were related through common control. In accordance with the terms of 42 C.F. R. §405.427 (1979), the intermediary disallowed part of the interest expense, management fees, and rental payments claimed by MCI, reducing its Medicare reimbursement for those years by over $300,000. Only the reimbursement for fiscal year 1973 is before us in this case.[3]

MCI appealed the intermediary's 1973 determination to the PRRB. The PRRB rendered a decision in MCI's favor, concluding that MCI had introduced substantial evidence that it and HAI were not related at the time that they entered into their agreement, and that HAI exercised no significant control over MCI thereafter. Subsequently, the Commissioner of Social Security (the Commissioner), acting pursuant to authority delegated by the Secretary, reversed the PRRB's decision. The Commissioner held that the PRRB erred in interpreting 42 C. F. R. §405.427 (1979) to require the actual exercise of control by one organization over another; according to the Commissioner, HAI's power to control MCI was sufficient to make them related organizations within the meaning of the regulation.

MCI appealed this determination to the district court pursuant to 42 U. S. C. §1395oo(f)(1) (1976). MCI argued before the district court (1) that the Commissioner was an improper delegate of the Secretary's authority; (2) that the Commissioner's decision was erroneous because it was not supported by substantial evidence; and (3) that the Commissioner's decision was erroneous because the related party principle does not apply to contracts between organizations that are unrelated at the time of contracting. The district court rejected all three contentions. On appeal, MCI renews its challenge to the correctness of

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[3] Because the PRRB has jurisdiction to hear appeals only for reporting periods ending June 30, 1973, or after, MCI pursued its appeals for fiscal years 1970, 1971, and 1972 through Blue Cross Association. These appeals proved fruitless and MCI sought judicial review in the district court. On July 13, 1977, the district court dismissed without prejudice MCI's claims for fiscal years 1970-72 because the court lacked federal jurisdiction and MCI had failed to exhaust its administrative remedies. *Medical Center of Independence v. Califano*, 433 F. Supp. 837 (W. D. Mo. 1977). MCI has since filed a petition in the United States Court of Claims seeking review of adverse administrative determinations for those years.

the Commissioner's decision under 42 C.F. R. §405.427 (1979), and in addition challenges the validity of the regulation as applied in this case.

II. Analysis

A. Standard of Review[4]

B. Sufficiency of the Evidence

The district court, having thoroughly reviewed the record in this case, concluded that substantial evidence supported the Commissioner's finding that HAI had "the power, directly or indirectly, significantly to influence or direct the actions or policies of [MCI]." 42 C. F. R. §405.427(b) (3) (1979). The court noted that HAI had six representatives on MCI's fourteen-member board of directors; that two HAI officials were elected to serve as vice president and assistant secretary of MCI in October 1970; and that MCI's administrator became an employee of HAI in 1972. The court also noted that only HAI could cancel the lease agreement between itself and MCI, and if it were cancelled, HAI would assume all of MCI's assets and liabilities.

We agree with the district court that substantial evidence in the record demonstrates HAI's power to control MCI. *Cf. Fallston General Hospital v. Harris*, 481 F. Supp. 1066 (D. Md. 1979) (control test satisfied where general partner in a limited partnership hospital was empowered to enter into and perform a lease agreement with a lessor owned by the general partner); *Fairfax Hospital Ass'n, Inc. v. Mathews*, 459 F. Supp. 429, 433-36 (E. D. Va. 1977), *aff'd sub nom. Fairfax Hospital Ass'n, Inc. v. Califano*, 585 F. 2d 602 (4th Cir. 1978) (pharmacist and hospital related by his power of control where he had helped organize hospital, had obtained pharmacy lease on favorable terms, and had served as an officer and director); *Hillside Community Hospital of Ukiah v. Mathews*, 423 F. Supp. 1168, 1173-75 (N. D. Cal. 1976) (seller of land and hospital building had power of control where three members of the board of directors of the hospital together owned 46.5% of the seller).

MCI on this appeal does not directly attack the substantiality of the evidence supporting the Commissioner's determination; rather, it argues that the Commissioner erred in overlooking or discounting several instances in which HAI failed to control MCI's actions. This error, MCI contends, is due to the Commissioner's equation of potential influence with actual influence or control. We note, however, that this equation is implicit in the language of 42 C. F. R. §405.427 (1979), which focuses on the power to control. Power is not necessarily lost, and may in fact be enhanced, by its infrequent exercise. *Cf. Fallston General Hospital v. Harris*, *supra*, 481 F. Supp. at 1069 (power to direct actions of provider not lost by its delegation to management company).

MCI also argues that the Commissioner erred in glossing over the question of the significance of HAI's control. In part this argument simply restates MCI's contention that

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[4] (Footnote No. 4 is in the omitted material).

potential influence is insufficient to warrant a finding of control. More importantly, MCI claims that the requirement of significant influence precludes the Commissioner from using evidence of influence gained at the time of contracting to establish control over the terms of the contract. Both challenges raise the question of whether the regulation, as interpreted and applied in this case, comports with the language and intent of the Medicare statute. To this question we now turn.

C. The Commissioner's Decision and Statutory Requirements

The Medicare Act requires reimbursement of all costs incurred by providers in serving beneficiaries, except (1) costs not actually incurred, (2) unnecessary costs, (3) costs attributable to noncovered services, and (4) costs that are unreasonable in amount. 42 U. S. C. §§ 1395f and 1395x(v)(1) (A) (1976 & Supp. II 1978). The related organization principle embodied in 42 C. F. R. §405.427 (1979) serves to screen out both costs not actually incurred and unreasonable costs. That is to say, the regulation precludes reimbursement for cost increases due solely to transactions between different parts of a single economic unit,[5] and it polices "sweetheart" contracts with suppliers that may inflate, costs to the provider.[6]

MCI does not take issue with these goals. Nor does it challenge 42 C. F. R. §405.427 (1979) as drafted.[7] MCI argues rather that the Commissioner failed in this case to apply the

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[5] As the court observed in *Fairfax Hospital Ass'n, Inc. v. Mathews, supra*, 459 F. Supp. at 433: Where "control," an issue of fact, is established, and only where it is established, the proscription of the regulations merely denies a double profit to a firm which is, in effect, dealing with itself. See also *American Medical International. Inc. v. Sec. of HEW, supra*, 466 F. Supp. at 617-18.

[6] Courts have also suggested that §405.427 serves to limit unnecessary costs, or to define reimbursable costs in general. *Fallston General Hospital v. Harris, supra,* 481 F. Supp. at 1070; *Pasadena Hospital Ass'n, Ltd. v. United States,* 628 F. 2d 728 732-34 (Ct. CI. 1980). In our view, however, this regulation does not implicate questions of necessity, either with respect to underlying transactions or with respect to particular procedures that are performed on Medicare procedures that are performed on Medicare patients. Nor do we agree that the Secretary's regulations may define "cost" as they see fit, for "cost" is a simple term of relatively fixed meaning. Moreover, if the Secretary possessed carte blanche authority to define costs, the explicit restrictions Congress imposed on reimbursable costs would be mere surplusage.

[7] Several courts have upheld the regulation against statutory and constitutional attacks. Upholding 42 C. F. R. §405.427 as consistent with 42 U. S. C. §1395x(v)(1)(A) (1976): *Schroeder Nursing Care, Inc. v. Mutual of Omaha Ins. Co.*, 311 F. Supp. 405, 410-11 (E. D. Wis 1970): *Fairfax Hospital Ass'n, Inc. v. Mathews, supra*, 405 F. Supp. at 433: *Lockwood Hospital, Inc. v. Califano*, No. 76-H-240 (S. D. Tex. Feb. 10, 1978). *aff'd per curiam sub nom. Lockwood Hospital, Inc. v. Harris*, No. 78-1975 (5th Cir. Apr. 24. 1980). Upholding 42 C. F. R. §405.427 as consistent with the Constitution: *Fairfax Hospital Ass'n, Inc. v. Mathews, supra*, 585 F. 2d at 605-10: and *Chelsea Community Hospital v. Mich. Blue Cross*, 436 F. Supp. 1050, 1061, 1061-63 (E. D. Mich. 1977).

regulation in a manner that would further the acknowledged goals of the statute. Because a provider cannot obtain forbidden profits from contracting unless there is common ownership, application of the regulation in a case of common control should focus on the potential for unreasonable costs. Here, MCI contends, HAI's control came into being only when it could no longer affect the costs incurred by MCI.

The district court, in considering this argument, rejected its empirical premises. Because MCI and HAI entered into a long-term relationship, the court observed, the terms of their agreement will be refined, modified and enforced in light of experience and the parties' respective power through the years.[8] While the absence of any prior relationship between the parties is certainly relevant to the issue of control, it is insufficient to establish a *per se* rule barring application of the related party principle.

We agree with this reasoning. In our view, the power of control over MCI enjoyed by HAI since 1970 cannot be rigidly separated from the terms of their agreements. We recognize that a contrary conclusion was reached in *Northwest Community Hospital, Inc. v. Califano*, 442 F. Supp. 949 (S. D. Ia. 1977). Like the district court in the present case, however, we find the per se rule adopted in that case unjustified by a management contractor's purported need to exercise control and inappropriate in light of our standards of review.

We hold, therefore, that the Commissioner's application of 42 C. F. R. §405.427 in this case did not violate the Medicare statute. The regulation, as applied, serves as a rough prophylactic rule barring the reimbursement of presumptively unreasonable costs. *See Mourning v. Family Publications Service, Inc.*, 411 U. S. 356, 372-74 (1973); *Fairfax Hospital Ass'n, Inc. v. Califano, supra*, 585 F. 2d at 606-07.[9] We emphasize that, while the regulation relieves the Secretary of the need to determine the unreasonableness of particular costs, she must establish by substantial evidence the applicability of the regulation to the facts of each case. Here, as we have noted, the Secretary has satisfied this burden.

Accordingly, the judgment of the district court is affirmed.

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[8] This fact distinguishes a case heavily relied on by MCI, *South Boston General Hosp. v. Blue Cross of Va.*, 409 F. Supp. 1380 (W. D. Va. 1976). See *id.* at 1383-84.

[9] We are unpersuaded by MCI's argument that state corporation law and the Internal Revenue Code, each of which contains a different related organization principle, require a very narrow construction of the rule in the context of this case.