PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

98-D33

PROVIDER -
High Country Home Health Care, Inc.
Laramie, Wyoming

Provider No. 53-7025

vs.

INTERMEDIARY -
IASD Health Services Corporation

DATE OF HEARING-
October 8, 1997

Cost Reporting Period Ended -
June 30, 1993

CASE NO. 95-2125

INDEX

ISSUE:

Did the Intermediary properly disallow a portion of the owner's compensation?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

High Country Home Health Care, Inc. ("Provider") is a proprietary, for-profit, home health agency located in Laramie, Wyoming. During its Medicare cost reporting period ended June 30, 1993, the Provider rendered 54,934 home care visits. The Provider's Medicare utilization during this period was approximately 47 percent based upon 25,825 home care visits to Medicare beneficiaries.[1]

Also during its Medicare cost reporting period ended June 30, 1993, one of the Provider's owners functioned as the agency's administrator while performing home care visits as a physical therapist for a related organization.[2] IASD Health Services Corporation ("Intermediary") reviewed the Provider's cost report for the subject period and determined that the amount of compensation claimed by the Provider for the owner/administrator's services was unreasonable.[3] On May 31, 1995, the Intermediary issued a Notice of Program Reimbursement ("NPR") perfecting final settlement of the cost report. The NPR contained an adjustment reducing the amount of the owner's compensation allowed for Medicare reimbursement from $91,498 to $33,458.[4] On June 8, 1995, the Provider appealed the Intermediary's adjustment to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841, and has met the jurisdictional requirements of those regulations.[5] The amount of Medicare reimbursement in controversy is $45,167.[6]

The Provider was represented by Charles F. MacKelvie, Esq., of MacKelvie & Associates, P.C. The Intermediary was represented by Bernard M. Talbert, Esq., of the Blue Cross and Blue Shield Association.

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1 Intermediary's Position Paper at 3.

2 Intermediary's Position Paper at 5.

3 Id.

4 Intermediary's Position Paper at 6. Exhibit P-1

5 Exhibit P-2.

6 Intermediary's Position Paper at 4. Provider's Post Hearing Brief at 3.

PROVIDER'S CONTENTIONS:

The Provider contends that the amount of compensation claimed for the owner/administrator is reasonable and not "substantially out of line" with compensation paid by comparable providers in the same geographical region. The Provider asserts that it maintained time records indicating that the owner/administrator spent more than 1600 hours performing administrative services during the subject cost reporting period.[7] In post-hearing submissions, the Provider supplied the Board with a cost report analysis of 80 Wyoming and Colorado home health agencies. This analysis shows that the Provider's cost per visit and administrative cost per visit was in the lowest 10 percent of claimed costs of that 80 agency universe.[8]

The Provider contends that the Intermediary's adjustment is improper for several reasons. First, the Intermediary's determination is based upon a legally invalid methodology. Pursuant to Medicare regulations and general instructions, the Intermediary is required to determine the reasonableness of an owner's compensation by comparing it to the compensation paid by other comparable institutions that provide comparable services.[9] 42 C.F.R. § 413.102, Provider Reimbursement Manual, Part I ("HCFA Pub. 15-1") § 904.

The Intermediary, however, did not comply with these requirements. Specifically, the Intermediary failed to take the Provider's geographical location into account because it relied upon data contained in the "Michigan Survey" to perform its comparison. The Provider adds that geographic location is among the factors which must be considered in determining comparable institutions pursuant to HCFA Pub. 15-1 § 904.1, noting that Michigan is at least 1200 miles away from Wyoming.[10]

In contrast, the Provider asserts that it presented geographical data supporting its position that the amount of owner's compensation claimed is reasonable. The Provider adds that a 1974 survey of the Denver Region[11] conducted by the Bureau of Health Insurance, the predecessor to the Health Care Financing Administration ("HCFA"), would, if properly updated, show that the claimed compensation is reasonable. The maximum allowable compensation for a home health administrator in 1974 for a 10,000 visit per year agency was $36,000. Extrapolating this figure forward, and depending upon which inflationary index is used, yields

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7 Provider's Post Hearing Brief at 1.

8 Provider's Post Hearing Brief at 4.

9 Transcript ("Tr.") at 14 and 20. Provider's Post Hearing Brief at 10.

10 Id.

11 Medicare & Medicaid Guide (CCH) ¶ 5623.75

a maximum allowable compensation range between $118,120 and $145,378 for a full time individual working 2080 hours per year. The Provider asserts that these figures clearly support the amount of owner's compensation at issue in this appeal.[12]

With respect to case law,[13] the Provider cites El Paso Nurses Unlimited, Inc. v. Blue Cross and Blue Shield of Texas, PRRB Dec. No. 89-D2, November 3, 1988, Medicare & Medicaid Guide (CCH) ¶ 37,505, in which the Board held that "the Intermediary's use of the Denver Regional Office's survey [to adjust a Texas provider's salaries] is inappropriate because the provider is from a different area;"[14] Stat Home Health Care, Inc. (Los Angeles, Cal.) v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 96-D7, January 30, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,011, where the Board found that the intermediary's adjustment to owner's compensation could not be upheld because the data the intermediary relied on was "outdated, inappropriate, and inadequate;"[15] and, Condado Home Care Program (Santurce, Puerto Rico) v. Cooperativa De Seguros De Vida, PRRB Dec. No. 97-D52, April 24, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,197, a case in which the intermediary applied an inflation factor to existing owner's compensation data, and where the Board found that "the Intermediary did not properly adjust the Provider's owner's compensation because it did not compare the owner's compensation with that of other like providers as required by Medicare regulations.[16]

The Provider reasons that previous Board decisions demonstrate that the Intermediary's methodology violates Medicare regulations because it fails to compare the Provider's owner's compensation to compensation paid by similar providers. The Intermediary's methodology is clearly invalid considering that it used data from the Michigan Survey particularly when it had access to local data contained in the Denver Survey.[17]

The Provider contends that the Intermediary's adjustment is also improper because the Michigan Survey is statistically invalid, outdated, and an inappropriate method for determining reasonable compensation for home health agencies since it was designed for Outpatient Physical Therapy Clinics ("OPT").[18] In support of this argument, the Provider

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12 Tr. at 95. Provider's Post Hearing Brief at 11.

13 Provider's Post Hearing Brief at 12.

14 Exhibit P-20.

15 Exhibit P-21.

16 Exhibit P-22.

17 Provider's Post Hearing Brief at 13.

18 Tr. at 99. Provider's Post Hearing Brief at 17.

points to the lack of underlying data used to create the Michigan Survey's salary ranges and the inability of the Intermediary to answer questions about the survey, itself. The Provider argues that the most crucial elements to verify the accuracy of the Michigan Survey are not available and are unknown. The Provider argues that Blue Cross of Michigan, the developer of the OPT survey, recognized the survey's limitations with respect to Iowa providers, and that the survey was never contemplated to be used to evaluate home health agency compensation.[19] The Provider quotes a Senior Appeals Analyst for Blue Cross of Michigan as stating:

> [p]lease note with caution that the guidelines and attached questionnaires were designed using Michigan survey data and salary ranges were updated using Michigan cost of living indices. I strongly advise against applying these guidelines without modification to [Iowa] OPTs . . . . 3) The Guidelines must be applied with care and reason and the resulting figure cannot be blindly accepted, but must be judged and perhaps modified by common sense.

Letter to Blue Cross of Iowa, Dated November 5, 1981.[20]

Further, the Provider argues that the study is outdated since it was developed in 1979, 14 years prior to the cost reporting period at issue, and was not updated except for the application of a yearly inflation factor. The Provider asserts that such an update is only valid in the short term until new survey data is received as both Dr. Dunham and Hay Consulting, Inc. have testified in other cases.[21]

The Provider contends that the Intermediary's adjustment is also improper because the Intermediary failed to prove that the amount of owner's compensation at issue is "substantially out of line" in accordance with 42 C.F.R. § 413.9(c)(2), which states in part:[22]

> [t]he provision in Medicare for payment of reasonable cost of services is intended to meet the actual costs, however widely they may 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

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19 Provider's Post Hearing Brief at 18.

20 Exhibit P-29.

21 See Exhibit P-30. Provider's Post Hearing Brief at 19.

22 Provider's Post Hearing Brief at 13.

> area that are similar in size, scope of services, utilization, and other relevant factors.

42 C.F.R. § 413.9(c)(2) (emphasis added).

The Provider cites decisions holding that an intermediary has failed to meet its burden of proving that a cost is "substantially out of line." See Alexander's Home Health Agency v. Blue Cross and Blue Shield Association, PRRB Dec. No. 88-D30, September 2, 1988, Medicare & Medicaid Guide (CCH) ¶ 37,439; Memorial Hospital/Adair County v. Health Center, Inc. v. Bowen, 829 F.2d 111 (D.C. Cir. 1987); Holy Cross Hospital v. Blue Cross and Blue Shield Association, PRRB Dec. No. 92-Dl4, January 23, 1992, Medicare & Medicaid Guide (CCH) ¶ 40,066; Vermillion Home Health Agency, Inc. v. Secretary, Medicare & Medicaid Guide (CCH) ¶ 38,377 (W.D. La. July 27, 1989); Home Health Care, Inc. v. Heckler, 717 F.2d 587 (D.C. Cir. 1983).[23]

Accordingly, the Provider asserts that the burden is on the Intermediary to prove that its owner's compensation is "substantially out of line", and the Intermediary failed to meet this burden because it did not perform a comparison test using data from comparable institutions.

The Provider contends that the Intermediary's adjustment is also improper because the Intermediary incorrectly calculated the maximum amount of compensation the owner/administrator should be allowed.[24] The Intermediary calculated the maximum compensation amount by first determining the percentage of time the owner/administrator spent performing administrative duties to the total time the individual worked. This percentage, the "administrative component", was then applied to the maximum compensation limit of $92,299 derived from the OPT model.

The Intermediary's determination is as follows:

> 60 hours worked per week x 52 weeks =3,120 total hours worked.
> 1,989 physical therapy visits performed x 1 hour per visit = 1,989 visit hours.
> 3,120 total hours less 1,989 visit hours = 1,131 administrative hours.
> 1,131 administrative hours ÷ 3,120 total hours = 36.25 percent.
> $92,299 x 36.25 percent = maximum allowable compensation of $33,458

The Provider asserts there are essentially two problems with the Intermediary's determination. First, the OPT guidelines permit the administrative component of an employee's compensation up to a full-time level of 2,080 hours per year. Therefore, the Intermediary should have determined the administrative percentage using 2080 hours as the denominator in

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[23] Exhibits P-23 through P-27, respectively.

[24] Provider's Post Hearing Brief at 16.

its calculation rather than 3,120 hours.[25] This correction would increase the administrative component to about 54 percent.

Next, the Intermediary based its determination of the total number of hours worked on speculation rather than actual time.[26] The Provider asserts that the Intermediary was given actual time records showing that the owner/administrator spent over 1600 hours performing administrative duties. Therefore, had the Intermediary followed the OPT Guidelines and the Intermediary's own policy, and divided the documented administrative hours (1600) by 2,080, it would have concluded that 77 percent of the owner's time was spent on administrative duties. This percentage would increase the maximum allowable compensation level to about $71,070.[27]

The Provider adds that the Intermediary's determination also failed to consider several other factors that influence the reasonable compensation level of an owner/administrator such as the administrative duties performed, the individual's experience, the quality of care provided by the agency, and the efficiencies generated as a result of the administrator's efforts.[28]

The Provider contends that the Intermediary's adjustment is improper because the Intermediary's attempt to justify it based upon an unsupported 1992 Missouri Alliance for Home Care ("MACH") Study and the Zabka Home Care Salary and Benefits Report for 1995 ("Zabka Study"), is misplaced.[29] The Provider argues that the problems associated with the use of these two studies are similar to those that were present in the use of the Michigan Survey.

First, the MAHC Study was not produced by statisticians. Rather, it is the product of the Research and Analysis Committee of the Missouri Alliance for Home Care. The data reported is only from small agencies in Missouri since the large Missouri agencies failed to respond to the survey. Furthermore, the Intermediary provided no support for the applicability of the unaudited MAHC Study to a Wyoming home health agency located approximately 700 miles away.

Additionally, the Intermediary provided no evidence to support the validity of the MAHC Study as representative of Missouri health care providers. The National Association for Home Care 1996 Home Care and Hospice Directory lists approximately 342 home care

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25 Tr. at 92.

26 Id.

27 Provider's Post Hearing Brief at 17.

28 Id.

29 Tr. at 102-106. Provider's Post Hearing Brief at 20. Exhibits I-4 and I-5.

agencies in Missouri (not including hospices). The MAHC Study only polled 51 providers in Missouri, or 14.9 percent of the home care universe in that state.

The Zabka Study, as proffered by the Intermediary, is incomplete and fundamentally flawed. To conduct this study a survey questionnaire was sent to approximately 12,400 home care agencies and hospices throughout the United States. Only 1,493 responses were received. Therefore, the surveyors experienced a response rate of only 12.1 percent. The response rate was even lower in Region VIII at 6. 1 percent.

Also, the Intermediary treated the "high" compensation level derived from the study as a cap upon which to base the owner's compensation at issue in this case. This is contrary to the description in the Zabka Survey since the salary data is presented in terms of low, median and high quartiles. The Intermediary has treated the high quartile number as the highest amount of compensation paid in a particular region. However, this is incorrect since the high quartile represents the 75th percentile and not the 100th percentile of the survey responses, and because the Zabka surveyors eliminated the high and low salary numbers and used only the middle 50 percent of the data. Such facts indicate that the Zabka Survey statistics contained compensation numbers in excess of the 75th percentile, up to $220,000 in base salary alone. Therefore, treating the 75th percentile as the absolute cap on compensation ignores some of the respondents compensation figures that were above the 75th quartile. The Provider also asserts that the average high salary in the Zabka Study was $77,260. To this figure one must add a bonus figure of 9 percent or approximately $6,953, plus 13 types of fringe benefits and perquisites, the most common of which are long term disability, mobile phones, and life insurance.

Finally, the Provider argues that it is apparent from its analysis of 80 Wyoming and Colorado agencies that the amount of compensation at issue in this case is reasonable. While the Intermediary criticized the fact that the owner/administrator's compensation exceeded $170,000, it should be noted that this individual worked in excess of 3600 hours during the reporting period.[30] This effort translates to a rate of $47.22 an hour since the Provider did not pay any fringe benefits to its employees. In contrast, Zabka reports that the average physical therapist earned $47.66 a visit in 1993, not counting fringe benefits averaging close to 30 percent of salary. Thus, the average physical therapist earned $61.96 per visit with fringe benefits, according to Zabka.[31]

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[30] The Board notes that a 70 hour work week and 3600 hour work year are referenced in the Provider's testimony and post hearing submissions, while a 60 hour work week is reference in the Provider's Position Paper.

[31] Provider's Post Hearing Brief at 23.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its adjustment reducing the amount of owner's compensation claimed for the subject individual is proper. The adjustment reduced the amount claimed to a reasonable level in accordance with 42 C.F.R. § 413.9 - Cost Related to Patient Care, 42 C.F.R.
§ 413.102 - Compensation of Owners, and HCFA Pub. 15-1 § 900 ff. - Compensation of Owners. Specifically, the subject individual was, in fact, the Provider's owner thereby subject to the aforementioned rules and manual instructions, and proper procedures were used to determine the "reasonable compensation" amount as outlined in 42 C.F.R. § 413.102(c)(2), and HCFA Pub.
15-1 § 905.5. In particular, the Intermediary used salary ranges established for other classes of institutions in accordance with 42 C.F.R. § 413.102(c)(2), which states in part:[32]

> [r]easonableness of compensation may be determined by reference to, or in comparison with, compensation paid for comparable services and responsibilities in comparable institutions, or it may be determined by other appropriate means.

42 C.F.R. § 413.102(c)(2).

The Intermediary explains that it used the Michigan Survey/Method to determine the reasonableness of the claimed owner's compensation. This survey/method was developed by Blue Cross and Blue Shield of Michigan and is based on a survey of home health agencies located in large metropolitan areas in Michigan. The Intermediary asserts that its calculation of reasonable compensation is accurate and without bias toward the Provider; salaries paid in the Michigan Survey area are higher than salaries paid in the Provider's geographical location, and no adjustment was made for this differential. Additionally, the determination takes into consideration all of the factors listed in HCFA Pub. 15-1 §§ 904.1 and 904.2, e.g., the size of the institution, its classification, the number and types of personnel employed, and the qualifications of the owner and his or her duties.[33]

The Intermediary asserts that the Board has repeatedly accepted the Michigan Survey/Method as a valid analytical tool for determining the reasonableness of administrative compensation.[34] The Michigan Survey/Method includes salaries and fringe benefits from 16 home health agencies located in Michigan. The survey includes annual compensation ranges (i.e., low and

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[32] Tr. at 30. Intermediary's Position Paper at 6.

[33] Tr. at 155. Intermediary's Position Paper at 7-8.

[34] Intermediary's Position Paper at 10. See Ruston Physical Therapy and Rehabilitation Agency v. Blue Cross and Blue Shield Association, PRRB Decision No. 91-D3, Exhibit I-6.

high) for years 1975 through 1980 for four common key administrative positions: Administrator/Director, Assistant Administrator/Assistant Director, Controller and Business Manager/Office Manager. These ranges are updated to subsequent cost reporting periods in accordance with Intermediary Part A Manual, Part II, § 2120, using update factors issued by HCFA.[35] This process resulted in a reasonable compensation level for the subject owner/administrator, for the subject cost reporting period, in the amount of $92,299 for the year for full-time service.[36] This amount was derived by placing the subject individual within the established salary ranges using a point system. In accordance with the survey's methodology, relative weights (points), by category, were assigned to the owner/administrator as follows:[37]

Category	Maximum Points (A)	Points Awarded (B)	Percentage B ÷ A
Education	20	10	50
Experience	20	20	100
Volume	30	15	50
Job Duties	20	14	70
Geographic Location	10	8	80
Total	100	67	67 percent

Education - 5 points awarded for a Bachelors Degree and 5 points for Special Courses.

Experience - 20 maximum points based on 2 points per year as a practicing administrator up to a maximum of 10 years. Experience as a practicing administrator in excess of 10 years is a substitute for education - Masters Degree in Business Administration (MBA) at ½ points per year for an additional 10 years of experience.

Volume - 30 maximum points with a minimum of 5 points for less than 10,000 patient visits. 15 points awarded for Provider's 54,934 patient visits. .

Job Duties - 20 maximum points depending upon the level of personal involvement and responsibility. 14 points awarded based upon job descriptions, Key Personnel and Compensation Questionnaires, Exhibit 1-7, and organizational structure (i.e., to the extent that key employees such as controller, assistant administrator and office manager are employed).

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35 Exhibit I-2.

36 Intermediary's Position Paper at 6 and 12.

37 Tr. at 159. Intermediary's Position Paper at 10-12. See Exhibit I-1

	Maximum Points		Points Awarded	
External/Professional Relations	6.0		4.5	
Fiscal Administration		6.0		4.5
Office Personnel Administration and Supervision	4.0		3.0	
Office Management	4.0		2.0	
Total		20		14

Geographic Location (population) - 10 maximum points awarded providers located in metropolitan areas with a population exceeding 200,000, and 5 points minimum awarded providers located in rural areas with a population of less than 20,000. 8 points awarded for the Provider's urban location with a population between 20,000 and 200,000.

The Intermediary contends that its determination using the Michigan Survey/Methodology, i.e., a reasonable compensation level of $92,299 per year for full-time service, is corroborated by other studies.[38] According to a national survey of home health agency salaries prepared by the National Association for Home Care,[39] the average compensation for a chief executive officer during the subject cost reporting period, including both salary and fringe benefits, would equal $55,238 per year.[40] The Zabka Home Care Salary and Benefits Report 1995 - 96 identifies the low, median, and high salary levels for an Executive Director/Administrator in the Denver Region as $46,462, $61,636, and $72,930, respectively. And finally, the 1992 MAHC Home Care Salary Survey conducted by the Missouri Alliance for Home Care ("MAHC") results in an average annual salary of $95,488, which includes fringe benefits.[41]

The Intermediary emphasizes that the above comparisons reflect compensation paid for full-time service. Therefore, the owner/administrator's compensation at issue in this case, $91,498 for part-time administrative activities, is "substantially out of line" with the compensation paid to other administrators. The Intermediary asserts, therefore, that the maximum compensation to be allowed for program reimbursement is $33,458 or 36.25 percent of the reasonable compensation level of $92,299 determined using the Michigan Survey. This percentage reflects the relationship of the amount of time the owner/administrator spent performing administrative activities to the total time worked performing all activities. This calculation is based on the Provider's records which show that

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38 Tr. at 163-164. Intermediary's Position Paper at 8 and 10.

39 Exhibit I-3.

40 Intermediary's Position Paper at 8.

41 Intermediary's Position Paper at 9. Exhibits I-4 and I-5.

the owner/administrator worked an average of 60 hours per week or 3,120 for the year, and performed 1,989 home care visits which the Intermediary estimates at 1 hour per visit. The result is an "administration component" of 1,131 hours (3,120 total hour less 1,989 home care hours) or 36.25 percent of the total hours worked.[42]

The Intermediary disagrees with the Provider's argument that the administrative component should be determined based upon 2,080 hours since that is the number of hours upon which the Michigan Survey is based.[43] As noted above, a base of 3,120 hours was used to determine the administrative component due to the fact that the Provider was able to support that the owner/administrator's average work week consisted of 60 hours as opposed to 40 hours. The Intermediary asserts that if a 2,080 hour base were strictly applied than only 91 hours could be construed to relate to administrative duties, i.e., 2080 total hours less 1,989 hours dedicated to home care visits. The Intermediary concludes that since it recognized a 60 hour work week that it is appropriate to use the base of 3,120 hours, and an administrative component of 1,131 hours.

The Intermediary further asserts that using 3,120 hours as the base in its determination is a more reasonable approach than strictly applying the standard 2,080 hour work year since the Provider was able to document that the owner/administrator worked an average of 60 hours per week. In support of this position the Intermediary cites Home Health Concepts, Inc. v. Blue Cross and Blue Shield Association, PRRB Decision 93-D58, July 19, 1993, Medicare & Medicaid Guide (CCH) ¶ 41,607 ("Home Health Concepts").[44] In that decision, the owner reported that he worked 40 hours per week for the agency and 15 to 20 hours per week at a pharmacy. He also did not maintain time studies. The Board found that the owner's time was divided between the home health agency and the pharmacy and recommended a disallowance based upon the time the owner worked at the pharmacy in relation to the overall hours worked. The circumstances in the instant case are similar; the owner split his time between performing physical therapy home visits for a related organization and his duties as Administrator of the Provider. He did not maintain time studies. The one difference between the Home Health Concepts case and the instant appeal is that, in the instant case, the owner received a separate salary from the related physical therapy operation amounting to $85,527 during the subject cost reporting period.[45] The Intermediary concludes that by using 3,120 hours as a base to determine reasonable compensation, it applied the same principle applied in Home Health Concepts, i.e., it disallowed the time spent by the owner/administrator making physical therapy visits for the related organization in relation to the total time worked.

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42 Tr. at 27-29 and 152-162. Intermediary's Position Paper at 13.

43 Id.

44 Exhibit I-11.

45 Intermediary's Position Paper at 6.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§ 1395x(v)(1)(A)	-	Reasonable Cost

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

§ 405.1835-.1841	-	Board Jurisdiction
§ 413.9	-	Cost Related to Patient Care
§ 413.102	-	Compensation of Owners

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

§ 904	-	Criteria for Determining Reasonable Compensation
§ 905.5	-	Procedures for Determining Reasonable Compensation

4. Case Law:

Alexander's Home Health Agency v. Blue Cross and Blue Shield Association, PRRB Dec. No. 88-D30, September 2, 1988, Medicare & Medicaid Guide (CCH) ¶ 37,439, aff'd HCFA Admin., October 31, 1988, Medicare & Medicaid Guide (CCH) ¶ 37,504.

El Paso Nurses Unlimited, Inc. v. Blue Cross and Blue Shield of Texas, PRRB Dec. No. 89-D2, November 3, 1988, Medicare & Medicaid Guide (CCH) ¶ 37,505, declined rev. HCFA Admin. December 6, 1988.

Ruston Physical Therapy and Rehabilitation Agency v. Blue Cross and Blue Shield Association, PRRB Decision No. 91-D3, October 25, 1990, Medicare & Medicaid Guide (CCH) ¶ 38,933, declined rev. HCFA Admin. December 6, 1990.

Holy Cross Hospital v. Blue Cross and Blue Shield Association, PRRB Dec. No. 92-Dl4, January 23, 1992, Medicare & Medicaid Guide (CCH) ¶ 40,066, aff'd HCFA Admin. April 13, 1992, Medicare & Medicaid Guide (CCH) ¶ 40,421.

Home Health Concepts, Inc. v. Blue Cross and Blue Shield Association, PRRB Decision 93-D58, July 19,1993, Medicare & Medicaid Guide (CCH) ¶ 41,607, declined rev. HCFA Admin. September 9, 1993.

Stat Home Health Care, Inc. (Los Angeles, Cal.) v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 96-D7, January 30, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,011, declined rev. HCFA Admin. March 15, 1996.

Condado Home Care Program (Santurce, Puerto Rico) v. Cooperativa De Seguros De Vida, PRRB Dec. No. 97-D52, April 24, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,197, declined rev. HCFA Admin. June 13, 1997.

Memorial Hospital/Adair County v. Health Center, Inc. v. Bowen, 829 F.2d 111 (D.C. Cir. 1987).

Vermillion Home Health Agency, Inc. v. Secretary, Medicare & Medicaid Guide (CCH) ¶ 38,377 (W.D. La. July 27, 1989).

Home Health Care, Inc. v. Heckler, 717 F.2d 587 (D.C. Cir. 1983).

5. Other:

Michigan Blue Cross OPT Owner's Compensation Guidelines.

The National Association for Home Care Home Health Agency Compensation Survey.

The Missouri Alliance for Home Care 1992 MACH Home Care Salary Survey.

John R. Zabka Associates, Inc. Homecare Salary & Benefits Report 1995-96.

Surveys Developed by HCFA Regional Offices (Medicare & Medicaid Guide (CCH) ¶ 5623.75).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, and evidence presented, finds and concludes that the Intermediary's adjustment disallowing a portion of the owner/administrator's compensation is improper. The means by which the Intermediary determined the "reasonableness" of the compensation at issue, which resulted in the subject disallowance, was inappropriate.

Medicare regulation 42 C.F.R. § 413.102 explains that the reasonableness of compensation paid to the proprietor of a health care organization may be determined by comparing it to the compensation paid for like services performed in comparable institutions or "by other appropriate means." Program instructions at HCFA Pub. 15-1 § 904.1 provide factors which are to be considered in determining the comparability of institutions. These factors include

but are not limited to the size of the institution, its classification by type and range of services provided, personnel employed, and geographical location.

Consistent with the broad language of the aforementioned regulation, the Intermediary used the Michigan Survey to determine the reasonableness of the subject owner/administrator's compensation. The Board finds, however, that in the instant case the Michigan Survey does not produce results that are necessarily representative of the Provider's organization and, therefore, cannot serve as the basis for a cost disallowance. The Board finds there is no assurance that the compensation data contained in the Michigan Survey is representative of the compensation levels paid by health care organizations in the Provider's geographical location, nor representative of the type and range of services furnished by the provider, and that it is anachronistic.

The Board finds that the Michigan Survey is based upon data obtained in 1979 from 16 facilities located in the Michigan area. The Provider is located in Laramie, Wyoming, approximately 1200 miles away. While the Intermediary argues that its determination is accurate and unbiased because salaries in Michigan are generally higher than salaries in Wyoming, the Board disagrees. The Board believes that data generated approximately 14 years prior to the subject cost reporting period and pertaining to facilities located in a significantly different and distant locale is unreliable. Adding to the Board's concern is the fact that the Michigan Survey was designed for OPT owner/administrators rather than home health agency owner/ administrators. Clearly, there is a difference in the range of services performed by these two different types of providers, the types of personnel employed, etc., as addressed in HCFA Pub. 15-1 § 904.1.

The Board rejects the Intermediary's contention that its determination is corroborated by other studies. The Board finds the data contained in both the 1992 MACH Home Care Salary Survey and the Zabka Study, as referenced by the Intermediary, to be statistically insignificant as applied to this case. Specifically, the data contained in the 1992 MACH Survey represents only about 14 percent of the providers located in Missouri. This data also represents providers located in a geographical area that is significantly distant and different from that of the Provider. Similarly, the data contained in the Zabka Study represents only about 12.1 percent of the providers surveyed in that study. The response rate for providers located in Region VIII, which includes the Provider, was even less at about 6.1 percent. Also regarding the Zabka Study, the Board notes that the surveyors eliminated the highest and lowest salary numbers when establishing their data base, and used only the middle 50 percent of the data received. This indicates that some owner/administrator salaries are far greater than the high range concluded in the study.

The Board also finds evidence indicating that the amount of compensation at issue in this case may, in fact, be reasonable. At the Board's request, the Provider furnished copies of cost reports pertaining to home health agencies located in Colorado and Wyoming, which the Provider had obtained in order to conduct its own analysis of regional costs. The Board's

analysis of this data, which included eighty (80) cost reports for cost reporting periods ended in either 1993 or 1994, shows that the Provider's average cost per visit and its administrative cost per visit are very low in comparison to other providers. In particular, the Board finds that the Provider's administrative cost per visit is in the lowest 10 percent of the cohort group.

The Board also finds that the Intermediary's adjustment is not substantively supported in accordance with 42 C.F.R. § 413.9(c)(2), Cost related to patient care-Application. This regulation provides that necessary and proper costs are reimbursed however widely they may vary from one institution to another. Program payments are subject to a limitation, however, "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." (Emphasis added.) The Board cannot conclude from the evidence presented that the amount of compensation at issue is substantially out of line with the compensation paid by like providers as described in 42 C.F.R. § 413.9(c)(2).

DECISION AND ORDER:

The Intermediary's adjustment disallowing a portion of the owner/administrator's compensation is improper. The Intermediary's adjustment is reversed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire

Date of Decision: March 18, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman