PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
98-D105

PROVIDER -Canterbury House

DATE OF HEARING-
September 15, 1998

Provider No. 50-5344

Cost Reporting Period Ended -
December 31, 1993

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Blue Cross of Washington and Alaska

CASE NO. 96-0590

INDEX

ISSUE:

Was the Intermediary's audit adjustment reducing charges for occupational and speech therapy services based upon the prudent buyer concept proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Canterbury House ("Provider") is a Medicare-certified skilled nursing facility ("SNF") located in the State of Washington in the Seattle Metropolitan Statistical Area ("MSA"). Blue Cross of Washington and Alaska ("Intermediary") issued the Provider's Notice of Program Reimbursement for fiscal year 1993, the year under appeal, on August 30, 1995. The Intermediary disallowed the Provider's occupational therapy ("OT") and speech therapy ("ST") costs in excess of a $76 per hour limit it had established for the Seattle MSA.[1]

During fiscal year 1993, the Provider furnished OT and ST services to its patients under arrangements with an outside therapy contractor. Previously, the Provider had obtained these same services under contract with two separate outside contractors. At issue in this appeal is the Intermediary's disallowance of portions of the costs claimed by the Provider for these OT and ST services pursuant to the application of the prudent buyer concept. Relying primarily on a survey done principally by Ætna Life Insurance Company ("Ætna") of the rates therapy contractors charged SNFs in the State of Washington, the Intermediary determined allowable amounts for the Provider's OT and ST services based on professional judgement. In disallowing the costs at issue, the Intermediary determined that the Provider failed to follow the Medicare program's prudent buyer rule in contracting for therapy services.[2]

The Ætna survey that formed the basis of the adjustments in this case emanated from an increasing concern by the Health Care Financing Administration ("HCFA") over the rising cost of therapy services. In response to this concern, on June 20, 1994, Ætna sent a bulletin and questionnaire to the State of Washington SNFs that it serviced.[3] The bulletin advised that HCFA had yet to establish salary equivalency standards for OT and ST services, and that the prices the SNFs were currently paying to contracted therapy companies may be excessive. While the SNFs were allowed to provide for these services under contractual arrangements, Ætna advised that

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1 Provider Exhibit 1.

2 The Provider and the Intermediary have stipulated to a hearing on the record, based on the record in Eagle Healthcare - 1993 Prudent Buyer Group Appeal v. Ætna Life Insurance Company, PRRB Dec. No. 97-D83, July 17, 1997, Medicare and Medicaid Guide ("CCH") ¶ 45,504, rev'd HCFA Administrator, September 15, 1997, Medicare and Medicaid Guide ("CCH") ¶ 45,727 ("Eagle Healthcare").

3 Provider Exhibit 13, Eagle Healthcare..

reimbursement for these services must be made on a reasonable cost basis. In this regard, the bulletin cited the following provisions from the Provider Reimbursement Manual:

> [i]mplicit in the intention that actual costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service. If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable under the program.

HCFA Pub. 15-1 § 2102.1.

> Intermediaries may employ various means for detecting and investigating situations in which costs seem excessive. Included may be such techniques as comparing the prices paid by providers to prices paid for similar items or services by comparable purchasers . . .

HCFA Pub. 15-1 § 2103.

In order to establish a going rate for OT and ST services in the area, Ætna asked the SNFs to complete the form attached to the bulletin indicating how their facility was billing the Medicare program for these services. Ætna asked the SNFs to submit their data by August 5, 1994. Approximately 72 percent of the 125 SNFs serviced by Ætna in the State of Washington responded to the questionnaire. Upon receipt of these responses, Ætna prepared a summary list of the SNFs together with the names of the contractors that furnished the OT and ST services.[4] The summary list also reported the hourly and quarter-hourly cost of OT and ST services which Ætna determined based on the reported data and its review of contractual agreements submitted by the SNFs. Based on their review of the data submitted in response to the survey request, Ætna and the Intermediary developed reasonable rates for OT and ST services furnished by outside contractors to SNFs operating in the State of Washington. A separate hourly rate was established for each MSA in the State of Washington that ranged from $72.00 to $92.00 for OT services, and from $72.00 to $90.00 for ST services. For the Seattle MSA, Ætna and the Intermediary established a limit of $76.00 per hour for these services. The rate established for OT and ST services furnished in rural areas (i.e., areas not located in an MSA) was $80.00.

In order to apply the survey results to their audit process, Ætna and the Intermediary prepared a reasonable rate listing to be used by their auditors when reviewing costs for OT and ST services reported by Washington SNF providers.[5] The listing included a notation that the

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[4] Provider Exhibit 14, Eagle Healthcare.

[5] Id.

established rates were determined based on the survey of Washington SNF providers contracting for OT and ST services and that these rates should be used in reviewing therapy costs in accordance with the prudent buyer principle. The notice further stated that the criteria used in developing the reasonable rates were based on:

1. All free standing Washington SNF providers contracting for speech and occupational therapy services.

2. The geographical location.

3. Professional judgement taking into consideration the rate you could purchase the service from a therapy company that has the ability to provide it.

The Provider in this appeal believes that the Intermediary improperly adopted and applied retroactive cost limits on the basis of the survey conducted by Ætna. The Intermediary, through audit adjustment number six, disallowed a portion of the costs incurred by the Provider in obtaining OT and ST services from its outside contractor. Accordingly, the Provider appealed the Intermediary's determination 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. The Provider was represented by Ronald N. Sutter, Esquire, and Christopher L. Keough, Esquire, of Powers, Pyles, Sutter & Verville, P.C. The Intermediary's representative was Bernard M. Talbert, Esquire, of Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's disallowance of the OT and ST costs, and the limits on which the adjustments are based, are contrary to the Medicare Act, regulations and long-standing precedents construing Medicare reasonable cost principles. In addition, the Provider argues that the adjustments are arbitrary and capricious, not based on substantial evidence, and are otherwise contrary to law. Further, the limits established and applied by Ætna and the Intermediary (1) were never published or adopted by HCFA; (2) were established after the Provider incurred the costs to which they were applied; (3) were derived from flawed and unreliable data which was based on an illegal and defective survey; and (4) were selectively enforced based on vague utilization and exception criteria that the Intermediary subjectively applied based on its judgement as to the reasonableness of rates charged by selected therapy companies.

The Provider asserts that it is entitled to payment for the actual costs of OT and ST services obtained from its outside contractor pursuant to existing law and regulations. The statutory provisions of 42 U.S.C. § 1395x(v)(5)(A) authorize the adoption of regulations limiting the reasonable cost of particular therapy services obtained from outside contractors to the cost that would have been incurred if a provider had furnished those services directly through an

employee. Pursuant to the implementing regulations at 42 C.F.R. § 413.106, HCFA is required to approve and provide advance notice of separate salary-equivalency limits for each type of therapy services through publication in the Federal Register prior to their effective date. While HCFA has adopted salary-equivalency limits for physical therapy and respiratory therapy services furnished under arrangement by outside contractors, no salary-equivalency limits on the costs of OT or ST services obtained from outside contractors have been approved or published by HCFA for the cost reporting period at issue. Accordingly, it is the Provider's position that the OT and ST services at issue should be reimbursed on the basis of the Medicare program's reasonable cost principles as set forth under the statutory provisions of 42 U.S.C. § 1395x(v)(1)(A) and the governing regulations at 42 C.F.R. § 413.9.

The Medicare law at 42 U.S.C. § 1395x(v)(1)(A) provides that reasonable cost shall include costs actually incurred by a provider, 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. In accordance with the statute, the regulatory provisions of 42 C.F.R. § 413.9 state that the payment of reasonable cost is intended to meet the actual costs incurred, however widely they may vary from one institution to another. While the Intermediary has imposed cost limits established in 1994-1995, the Provider asserts that there are only two possible legal authorities for the sort of limit applied by the Intermediary in this case. The first concerns the regulation at 42 C.F.R. § 413.30 that governs the establishment and application of prospective cost limits pursuant to 42 U.S.C. § 1395x(v)(1)(A). The second is the limitation on costs found to be substantially out of line with costs incurred by comparable providers for comparable services, which has been in place since the inception of the Medicare program and is currently codified in the regulations at 42 C.F.R. § 413.9(c). The Provider insists that the Intermediary has not satisfied the requirements for either of these legal authorities.

The Provider argues that neither the Intermediary nor Ætna complied with any of the requirements for 42 C.F.R. § 413.30 in establishing the cost limits applied in this case. First, the limits were never published as required by the regulation. Further, the limits established did not take into account the type of therapy services furnished by different SNFs, the size of the SNFs, or the type and mix of services furnished and patients treated by the SNFs. Moreover, the limits are lower than the mean costs incurred by the SNFs for OT and ST services obtained from outside contractors. The Provider points out that every prospective cost limit ever published by HCFA has been set at an amount greater than the mean, which is consistent with the intent of Congress in enacting Section 223 of the 1972 amendments of the Social Security Act.[6] Accordingly, the Intermediary's limits are clearly inconsistent with the legislative intent of the cost limits authority in 42 U.S.C. § 1395x(v)(1)(A). The Provider further notes that the limits were not established prospectively, which is contrary to the Supreme Court's decision in Bowen v. Georgetown University Hospital, 488 U.S. 204, 109 S.

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[6] S. Rep. 92-1230, 92d Cong., 1st Sess. 189 (1972) - Provider Exhibit 204, Eagle Healthcare.

Ct. 468 (1988). In that case, the Court ruled that retroactivity is not favored in the law and that the Medicare Act does not authorize HCFA or its agents to impose retroactive cost limits.[7]

With respect to the reasonable cost provisions of 42 C.F.R. § 413.9, the Provider argues that the Intermediary's establishment and application of its OT and ST limits is clearly inconsistent with the substantially out-of-line standard set forth in that regulation. Neither the governing law nor implementing regulations authorize the Intermediary to subjectively determine what is a reasonable cost for an item or service or to declare which therapy supplier is competent and capable of providing therapy services to all SNFs in an area. While the substantially out-of-line standard under 42 C.F.R. § 413.9(c)(2) does grant an intermediary limited authority to disallow a provider's cost, it does not grant broad and unfettered discretion to simply declare what is a reasonable cost on a retroactive basis. Consistent with the authority set forth in the regulation, the intermediary must specifically demonstrate on a case-by-case basis that a provider's costs are substantially out of line with costs incurred by truly comparable providers for truly comparable services. In lieu of the required case-by-case, provider-specific comparative analysis, the Intermediary in the instant case applied its OT and ST cost limits without regard to the Provider's size, the scope of services furnished, the patient mix and acuity, the type and quality of services rendered, or any other relevant factors. Furthermore, the limits are lower than the mean costs of OT and ST services obtained from outside contractors and clearly do not reflect amounts that are substantially out of line. Thus, the application of the limits is distinctly inconsistent with the regulations in several critical respects. The Provider cites numerous authorities in support of is position, including the decision of the United States Court of Appeals for the District of Columbia Circuit in Memorial Hospital/Adair County Health Center v. Bowen, 820 F. 2d 111, 117 (D.C. Cir. 1987).[8]

In order to sustain a substantially out-of-line disallowance under 42 C.F.R. § 413.9(c)(2), the Provider professes that the Intermediary should have considered a minimum of four factors. These factors are: geographic area, size, scope of service, and utilization (i.e., patient mix, type of illness, etc.). In applying the OT and ST limits in this case, the Intermediary did not consider the size of the facility or the amount and type of therapy services furnished by the Provider and the SNFs included in the survey sample. The Provider further notes that, while variations in the quality of service and ability to staff a facility are important distinguishing factors among competing therapy suppliers that clearly justify different costs, the Intermediary performed no analysis of the comparability of OT and ST services furnished to the SNF in this appeal and the SNFs in the Ætna survey sample. The Provider insists that these factors significantly affect the comparability of services and must be taken into account

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[7] Georgetown University Hospital, 109 S. Ct. at 471, 475 - Provider Exhibit 201, Eagle Healthcare.

[8] Provider Exhibit 23, Eagle Healthcare.

in reviewing the reasonableness of a provider's cost under the substantially out-of-line standard.

Regarding the comparability of costs, the Provider contends that the Intermediary has mixed apples and oranges in computing the costs of OT and ST services obtained from outside contractors. While the substantially out-of-line standard requires an analysis of costs that are truly comparable and comprised of the same basic elements, the Intermediary's rate determinations erroneously assumed that all therapy companies bill only for 15-minute or one-hour increments of direct therapy service furnished to a patient. The Provider advises that this assumption is patently false in that therapists and therapy contractors employ many different types of billing measures for OT and ST services furnished to SNFs. Based on its analysis of the survey data, the Provider observes that some contractors charged on the basis of visits, some charged for all time spent in the provider's facility, some charged different amounts for different types of therapy services, and many therapy contracts did not specify the unit of measure used in their billings to providers.[9] The Provider maintains that the Intermediary's failure to recognize and properly account for the variations in billing arrangements is clearly inconsistent with the substantially out-of-line test required under 42 C.F.R. § 413.9(c)(2).

Even assuming arguendo that the Ætna survey cost data are accurate, and also setting aside the numerous deficiencies in the establishment and application of the cost limits, the Provider contends that the OT and ST limits computed by the Intermediary do not reflect costs that are substantially out of line with the costs incurred by the SNFs that were included in the Ætna survey. The Provider argues that the computed limits bear no relationship to the range or distribution of costs incurred by the SNFs that responded to the survey. The Provider cites the following examples to support its position that the payments made for OT and ST services were not substantially out of line:

- The mean cost of ST services furnished to 38 SNFs in the Seattle MSA was $86 per hour. Thus 26 out of the 38 SNFs in the Seattle area incurred an hourly cost in excess of the established $76 per hour limit. Assuming the accuracy of the Ætna data, the $76 per hour limit reflects only the thirty-second percentile of the range of costs incurred by the survey respondents in the Seattle MSA.[10]

- Based on the Ætna survey data, the costs of OT services furnished to 12 SNFs in the Yakima MSA ranged from a low of $92 per hour to a high of $100 per hour. The data also show that five SNFs incurred a cost of $100 per hour and six incurred a cost of $96 per hour. The mean cost was $97 per hour. Only

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9 Provider Exhibit 139, Eagle Healthcare.

10 Provider Exhibit 14, Eagle Healthcare.

> one SNF allegedly incurred a cost of $92 per hour, which is the Intermediary's established limit. However, that facility ("Walnut Grove") is not even located in Yakima County. Thus, the limit of $92 for OT services in the Yakima MSA is $4 lower than the lowest cost incurred by any SNF which is actually located in that area.[11]

The Provider points out that the regulation at 42 C.F.R. § 413.9(c)(2) does not provide a bright-line rule as to how "out of line" a provider's costs must be in order to be "substantially out of line." Nevertheless, costs must obviously be substantially in excess of the average or median cost in order to be found substantially out of line. Since OT and ST costs may vary significantly due to the quality and intensity of services furnished to SNF patients, the Provider believes that any prospectively established limit would have to be set sufficiently above the average amount so that only cases with extraordinary expenses would be subject to any limitation. Certainly costs that are lower than or near the norm are not "substantially out of line." Moreover, it is beyond dispute that the substantially out-of-line limitation does not authorize the Intermediary to establish limits based solely on its subjective opinion as to what is a reasonable cost.

The Provider rejects the Intermediary's argument that it need not comply with the substantially out-of-line standard because the establishment and application of its limits comply with the necessary cost criteria set forth under the prudent buyer instructions at HCFA Pub. 15-1 § 2103. The Provider asserts that the Intermediary's construction of the manual provision is not only misplaced, but it is also contrary to the reasonable cost concept set forth in the law and regulations. The statutory provisions of 42 U.S.C. § 1395x(v)(1)(A) provide for the reimbursement of reasonable cost determined in accordance with the regulations, which, in turn, may provide for the establishment of limits on incurred costs of specific items or services. While the law authorizes the Secretary of the Department of Health and Human Services to adopt regulations and establish limits on reasonable cost, there is no provision within the law that grants an intermediary the authority to declare a cost reasonable and necessary based on a subjective reasonableness determination. The Provider further notes that neither the reasonable cost regulations at 42 C.F.R. § 413.9 nor the implementing instructions at HCFA Pub. 15-1 § 2103 authorize a reasonable and necessary cost determination based solely on an intermediary's subjective judgement. The "prudent buyer" instructions in HCFA Pub. 15-1 § 2103 clearly relate to the substantially out-of-line standard in 42 C.F.R. § 413.9(c)(2), and cannot be construed in a manner that is inconsistent with the plain meaning of that regulation. Consistent with the substantially out-of-line regulation, the prudent buyer instructions must be read as requiring a comparison of prices paid by comparable providers for comparable services.

In summary, the Provider contends that the Intermediary had no authority to establish and apply unpublished, retroactive cost limits to disallow costs incurred for OT and ST services

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[11] Id.

obtained from an outside contractor. Even if the Intermediary had such legal authority, the limits established were based on unreliable survey data that were statistically invalid and unfairly applied to only 24 of the 275 SNFs located in the State of Washington. The Intermediary's selective enforcement of the limits is arbitrary and capricious and a violation of the Provider's due process rights because it was not given prior notice of their application to fiscal year 1993. While the Intermediary alleges that it would have allowed an exception to the limits if the Provider had shown that it was prudent by soliciting competitive bids or contracting for OT and ST services at the lowest possible cost, the Provider was given no prior notice of those retroactive unpublished standards. Moreover, since there are no provisions in the Medicare statute or regulations requiring a provider to obtain competitive bids for OT and ST services or to contract for OT and ST services at the lowest possible cost, there is no basis for the adjustment imposed by the Intermediary in this case. The Provider requests that the Board reverse the Intermediary's disallowance of OT and ST costs in excess of the established cost limits because the determination is inconsistent with the Act and regulations, arbitrary and capricious, not based on substantial evidence, and otherwise contrary to law.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its adjustment to the Provider's claimed costs for OT and ST services was based on the application of the prudent buyer principle in accordance with the reasonable cost provisions of 42 U.S.C. § 1395x(v)(1)(A) and the controlling regulation at 42 C.F.R. § 413.9. In defining costs related to patient care, the regulation at 42 C.F.R. § 413.9 states the following:

> (a) Principle. All payments to providers of services must be based on reasonable cost of services covered under Medicare and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs incurred in furnishing the services, . . .
> . . .
>
> (c) Application. (1) It is the intent of Medicare that payments to providers of services should be fair to the providers, to the contributors to the Medicare trust funds, and to other patients.
> (2) The costs of providers' services vary from one provider to another and the variations generally reflect differences in scope of services and intensity of care. The 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 area that are similar in size, scope of services, utilization, and other relevant factors.

> (3) The determination of reasonable cost of services must be based on cost related to the care of Medicare beneficiaries. Reasonable cost includes all necessary and proper expenses incurred in furnishing services, such as administrative costs, maintenance costs, and premium payments for employee health and pension plans. It includes both direct and indirect costs and normal standby costs. However, if the provider's operating costs include amounts not related to patient care, specifically not reimbursable under the program, or flowing from the provision of luxury items or services (that is, those items or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed health services), such amounts will not be allowable. The reasonable cost basis of reimbursement contemplates that the providers of services would be reimbursed the actual costs of providing quality care however widely the actual costs may vary from provider to provider and from time to time for the same provider.

42 C.F.R. § 413.9.

In addition to the reasonable cost limitations instituted under the statutory and regulatory provisions, the Intermediary advises that its adjustment is fully justified under the prudent buyer principle found in HCFA Pub. 15-1 § 2103 which states:

> A. General. -- The prudent and cost-conscious buyer not only refuses to pay more than the going price for an item or service, he also seeks to economize by minimizing cost . . . . Any alert and cost-conscious buyer seeks such advantages, and it is expected that Medicare providers of services will also seek them.
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> B. Application of Prudent Buyer Principle. -- Intermediaries may employ various means for detecting and investigating situations in which costs seem excessive. Included may be such techniques as comparing the prices paid by providers to the prices paid for similar items or services by comparable purchasers, spot checking, and querying providers about indirect, as well as direct, discounts. . . . In those cases where an intermediary notes that a provider pays more than the going price for a supply or service, or does not try to realize savings available under warranties for medical devices or other items, in the absence of clear justification for the premium, the intermediary excludes excess costs in determining allowable costs under Medicare.
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> C. Examples of Application of Prudent Buyer Principle. --
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> 1. Provider A consistently purchases supplies from supplier R and makes no effort to obtain the most advantageous price for its supplies.

> Supplier W sells identical or equivalent supplies at a lower cost and is also convenient to A. Unless the provider can clearly justify its practice of purchasing supplies from R rather than W, the intermediary should exclude any excess of R's charges over W's charges. . . .

HCFA Pub. 15-1 § 2103.

The Intermediary insists that the statute, regulations and manual instructions all support its disallowance of costs that are found to be unnecessary in the delivery of patient care services. In the instant case, the Intermediary believes that the Ætna survey of OT and ST services furnished to SNFs by outside contractors fully demonstrated that costs over and above the going rate were unnecessarily incurred because the Provider had failed to comply with the prudent buyer rule in contracting for these services.

In spite of the Provider's attempt to discredit the authenticity and accuracy of the SNF survey, the Intermediary insists that the survey before the Board is a valid measurement of OT and ST costs rendered by outside contractors to Medicare-certified SNFs in the State of Washington. Except for the possible inclusion of more providers in the survey, the Provider has not suggested a better procedure for conducting the survey. At the hearing before the Board in Eagle Healthcare, the person responsible for directing the survey testified as the intermediary's (that is, Ætna's) witness. As part of his direct testimony,[12] the witness testified that all of the 125 SNFs serviced by Ætna in the State of Washington were sent a survey questionnaire, of which 90 submitted a reply to the survey. The Intermediary believes that the survey questionnaire was simple and straightforward in that it asked whether the SNF had any contracted therapy and, if so, the charges for the OT and ST services performed. The SNFs were also asked to attach copies of any contracts with outside contractors to the completed survey.

Upon receipt of the responses, the charge data was reviewed and arranged by type of service into rural and urban categories for comparative analysis. When a question about a response or a contract occurred, the administrator of the SNF was contacted for clarification. At the suggestion of the HCFA Regional Office, Ætna pooled with its results those obtained by the Intermediary in a similar survey of its Washington SNFs to establish an overall comparative amount for both intermediaries. A comparison basis of 15 minute increments was utilized since this is the standard used by outside therapy contractors in billing for services rendered. Since the survey showed therapy rates that varied between $35 and $140 an hour, Ætna determined allowable amounts based on the professional judgement of its auditors who planned the survey and gathered its results. Relying on the use of focused reviews and audits for OT and ST services, Ætna examined about 20 SNFs using the reasonable rate listing developed from the survey as its guideline for determining reasonable costs. The Intermediary notes that five providers submitted documentation showing that they acted as

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[12] Tr. II at 5 - 31, Eagle Healthcare.

prudent buyers in the purchase of therapy services. With respect to the instant appeal, it is the Intermediary's position that the Provider failed to follow the prudent buyer requirements and the costs of its OT and ST services obtained under contractual arrangement were limited to the guidelines established by the survey of Washington SNFs.

Contrary to the Provider's claim, the Intermediary contends that the survey results do compare apples with apples because they compare each SNF's provision of the highest practicable therapy care with those of other SNFs. In the provision of health care services, the capability of making exact comparisons is rarely possible because the facilities, their services, and personnel vary greatly from provider to provider. However, because of the tight regulatory structure the Federal Government places on Medicare-certified SNFs and their services, the Intermediary argues that the differences in contracted therapy services among SNFs are not as prominent as the Provider claims. Under the Medicare program, a SNF must provide services to attain or maintain the highest practicable physical, mental and social well-being of each resident. Accordingly, this permits little variance in the type, quality and necessity of the medical services rendered.

It is the Intermediary's position that the results of the survey demonstrated that costs paid over and above the going rate for OT and ST services were unnecessarily incurred. While the Provider believes that the substantially out-of-line test under 42 C.F.R. § 413.9 must be applied in this case, the Intermediary maintains that the prudent buyer concept supports its adjustment and exists as a separate and distinct standard against which to measure cost. The Intermediary further argues that the prudent buyer doctrine may be applied separate and apart from the substantially out-of-line test. As an interpretive provision drafted by HCFA, the Intermediary argues that the prudent buyer concept set forth in HCFA Pub. 15-1 § 2103 is valid and must be followed unless it is plainly erroneous or inconsistent with the regulation. In support of this assertion, the Intermediary refers to the dissenting opinion rendered in the Supreme Court's decision in Shalala v. Guernsey Memorial Hospital, 115 S. Ct. 1232 (1995). In the instant case, the prudent buyer concept compliments the statutory scheme by precluding the reimbursement of services that are more expensive than those generally considered necessary for the provision of needed health services. Accordingly, it is the Intermediary's position that the prudent buyer concept stems from the unnecessary service language in the statute and regulations and, thus, any unnecessary costs that a provider incurs are nonallowable regardless of whether they are substantially out of line. If the higher costs were avoidable, they should not be reimbursed under the Medicare program.

The Intermediary believes the incorporation of the substantially out-of-line requirement into the prudent buyer concept renders the provision a nullity. The substantially out-of-line concept serves a purpose that is apart from the unnecessary requirements to which the prudent buyer concept is directed. Whereas the substantially out-of-line requirement under 42 C.F.R. § 413.9(c)(2) addresses the variation in costs that occurs between institutions, it is not concerned with the necessity of the incurred costs or with who is responsible for the excessive amount. The Provider in this case received OT and ST services from prior outside contractors

before it became involved with the current contractor. As a SNF, it underwent annual surveys from federal and state officials who reviewed the level and type of care that these institutions rendered. Although the Intermediary is unaware of any deficiencies in therapy services before the new therapy vendor became involved, the cost of providing OT and ST services increased after the new contractor began providing services. While the new contractor purportedly offered better services with increased supervision and more monitoring, the need for increased services is not apparent. The Provider was never cited for deficiencies in therapy services because it was in compliance with the statutory standards under the previous contractors. Accordingly, the additional services of the new contractor added nothing to the Provider's obligations to meet the statutory requirements.

In response to the Provider's contention that the cost of the OT and ST services must be found to be substantially out of line, the Intermediary notes a way in which this reasonable cost standard would apply. At the hearing in Eagle Healthcare, the providers' witness admitted that a small price margin could be significant if a high volume of services were purchased.[13] In the instant case, a dramatic increase in utilization occurred in addition to cost increases. Thus, the significant increase in the volume of OT and ST services furnished to the Provider should be taken into account when making a substantially out-of-line determination.

With respect to the Provider's argument that the cost adjustment in this case resulted from retroactive rulemaking or the application of cost limits, the Intermediary advises that the OT and ST study does not impose an absolute limit on costs as occurs with the routine cost limits. Whereas cost limits are imposed centrally by HCFA, the OT and ST cost adjustments applied pursuant to the study were reversible if the Provider could demonstrate that it acted as a prudent buyer. The Intermediary insists that this case is no different than one where an intermediary adjusts owner's compensation during an audit that takes place after the end of a fiscal year. Since there are no provisions under the Medicare statute or regulations which prohibit an intermediary from devising methods to review whether costs are substantially out of line or do not meet Medicare's prudent buyer provisions, the Intermediary respectfully requests that the Board affirm its adjustments to the Provider's OT and ST costs.

CITATIONS OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§ 1395x(v)(1)(A)	-	Reasonable Cost
§ 1395x(v)(5)(A)	-	Therapy Services Furnished Under Arrangement

[13] Tr. I at 213, Eagle Healthcare.

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

§ 405.1835-.1841	-	Board Jurisdiction
§ 413.9	-	Cost Related to Patient Care
§ 413.30	-	Limitations on Reimbursable Costs
§ 413.106	-	Reasonable Cost of Physical and Other Therapy Services Furnished Under Arrangements

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

§ 2102.1	-	Reasonable Cost
§ 2103	-	Prudent Buyer

4. Case Law:

Universal Rehabilitation Inc. v. Independence Blue Cross, PRRB Dec. No. 98-D46, April 24, 1998, Medicare and Medicaid Guide (CCH) ¶ 46,272.

Bowen v. Georgetown University Hospital, 488 U.S. 204, 109 S. Ct. 468 (1988).

Shalala v. Guernsey Memorial Hospital, 115 S. Ct. 1232 (1995).

Memorial Hospital/Adair County Health Center v. Bowen, 829 F. 2d 111, 117 (D.C. Cir. 1987).

Eagle Healthcare - 1993 Prudent Buyer Group Appeal v Ætna Life Insurance Company, PRRB Dec. No. 97-D83, July 17, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,727.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration and analysis of the controlling law, regulations and manual guidelines, the facts of the case, parties' contentions, documentary evidence, testimony presented at the hearing, and post-hearing briefs, finds and concludes that the Intermediary's audit adjustments were derived from an improper application of the Medicare program's reasonable cost doctrine. The reductions applied by the Intermediary to the costs incurred by the Provider for the OT and ST services obtained under arrangements with outside therapy contractors were not imposed consistent with the reasonable cost limitations established by

the governing provisions of 42 C.F.R. § 413.9. It is the Board's conclusion that the Provider's costs of OT and ST services obtained from outside contractors were reasonable and are fully allowable in determining reimbursable costs under the Medicare program.

Based on the facts presented in this case, the Board finds that the cost adjustments at issue concern reasonable cost determinations which the Intermediary applied to the Provider's cost reports as part of its audit/settlement of the cost reporting period at issue. The Board finds no basis for the Provider's argument that this case involves the Intermediary's retroactive establishment of cost limits pursuant to the regulations at 42 C.F.R. § 413.30. The record is void of any evidence which would support the premise that the Intermediary's survey was authorized and performed under the cost limitation rules and procedures of 42 C.F.R. § 413.30, and that the results of the survey would be universally applied by HCFA to Medicare-certified SNFs participating in the Medicare program. Moreover, the Board notes that in its survey bulletin to the Washington SNF providers that it serviced, the Intermediary cites the reasonable cost provisions of HCFA Pub. 15-1 § 2102.1, and states that the SNF survey is being conducted to establish the going rate for OT and ST services furnished under arrangement.[14] Accordingly, the Board views the Intermediary's use of a survey in this case as a method of determining reasonable costs pursuant to requirements of 42 C.F.R. § 413.9.

In support of its reasonable cost determinations, the Intermediary takes the position that its study demonstrated that the costs incurred by the Provider were over and above the going rate and, thus, were unnecessarily incurred under the prudent buyer concept set forth under HCFA Pub.
15-1 § 2103. The Intermediary maintains that the prudent buyer concept exists as a separate and distinct standard against which to measure costs, apart from the substantially out-of-line test.[15] The Board does not dispute the co-existence of the "prudent buyer concept" and the "substantially out-of-line standard" in determining reasonable cost under the Medicare program. This is precisely what the Intermediary attempted to demonstrate in this case by performing a survey of Washington SNFs to determine the going rate of OT and ST services furnished under arrangement by outside contractors. It is in its structure, analysis, and application of the survey, however, where the Intermediary fails to carry the burden of proof to show that the Provider is either "substantially out of line", or imprudent. The Board concurs with the Provider's position that the prudent buyer instructions in HCFA Pub. 15-1 § 2103 clearly relate to the substantially out of line standard in 42 C.F.R. § 413.9, and should not be construed in a manner that is incompatible with the plain meaning of that regulation.

The regulation at 42 C.F.R. § 413.9 sets forth the Medicare program's basic tenet for the reimbursement of reasonable cost related to the provision of patient care. The regulation broadly defines reasonable cost by stating:

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[14] Provider Exhibit 13, Eagle Healthcare.

[15] Intermediary's Post-Hearing Brief at 10, Eagle Healthcare.

> (c) Application. (1) It is the intent of Medicare that payments to providers of services should be fair to the provider, to the contributors to the Medicare trust funds, and to other patients.
> (2) The costs of providers' services vary from one provider to another and the variations generally reflect differences in scope of services and intensity of care. The 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 area that are similar in size, scope of services, utilization, and other relevant factors.

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

The Board recognizes that there are a number of problems that inhibit the effective exercise of the authority established under the regulation for the disallowance of incurred costs that are not reasonable. The disallowance of costs that are substantially out of line with those of comparable providers is generally limited to instances that can be specifically proved on a case-by-case basis, and clear demonstration of the specific reason that a cost is high is generally very difficult. However, this does not relieve the Intermediary of its burden to prove that the Provider's costs of OT and ST services were substantially out of line with other institutions in the same area that are similar in size, scope of service, utilization and other relevant factors.

As the Administrator notes in her reversal of the Board's decision in Eagle Healthcare, section 2103 of the PRM describes a prudent buyer as one who "not only refuses to pay more than the going price for an item or service, he also seeks to economize by minimizing cost." Intermediaries may determine if costs are excessive in various ways, including " comparing the prices paid by providers to the prices for similar . . .services by comparable purchasers..." Administrator's Decision at 8. The Board also notes that there are additional techniques, such as gathering supplier data, provider competitive bidding, and salary equivalents, which can be utilized in a decision tree to determine imprudent and unreasonable cost.

It is in the "determination" and the application of comparable data, where the Intermediary fails in the instant case. There was no attempt on the part of the Intermediary to employ any rational statistical analysis of the gathered data. The Ætna auditor(s) used raw data and "professional judgment" in lieu of scientific analysis to establish the "benchmarks" for the cost of OT and ST services which they would deem acceptable. The result is predictable: the "benchmark" for ST services ranged from a low at the 7th percentile of service costs to a high at the 32nd percentile, with the lowest cost SNF (1 of 15) chosen as the benchmark. The "benchmark" was at $72/hour, the mean cost identified in the survey was at $103/hour.

In the opinion of the Board, it is imprudent for the Intermediary to choose (not statistically set) one survey response (the lowest response) as the "benchmark" (at an extreme low on the range of the 7th percentile) by which all Provider's above that benchmark will be judged to be "imprudent". Similarly, the mean of OT costs was $97/hour; the "benchmark" was set at $92/hour, clearly below the mean. Using the Intermediary's rationale, virtually all Providers would be either "substantially out of line" with the subjectively established benchmark, or "imprudent."

This treatment of survey data which establishes an artificially low benchmark, somewhere between the 7th to the 32nd percentile, does not appear to reflect either Congressional nor HCFA parameters for "substantial" or imprudent. See: Eagle Healthcare Provider Position Paper Exhibits 171, 204. It is obvious that a retroactive adjustment disallowing ancillary OT and ST costs under the substantially out of line standard, or under reasonable cost/imprudence, cannot be sustained unless the costs are shown to be extraordinarily high in relation to the average cost incurred by comparable providers for comparable services. Eagle Healthcare Provider Position Paper at 45. For example, HCFA itself uses the 75th percentile to compute the "prevailing cost" of physical therapy services furnished by employed therapists, for purposes of establishing the salary equivalency guidelines for physical therapy services under 42 C.F.R. § 413.106. Thus, any amount which would be below the 75th percentile would not be imprudent/unreasonable. Eagle Healthcare Provider Post Hearing Brief at 45, footnote 15 [sic]. In the opinion of the Board, it should thus be beyond dispute that the reasonable cost/prudent buyer rule does not authorize the Intermediary to establish limits based solely on its subjective opinion as to what is a reasonable cost. At a minimum, the foregoing demonstrates that when a survey of providers is used and when there are differences among providers, to be imprudent means costs must be substantially above the average or median cost, or "benchmark". The Board notes that there is a joint duty for both the intermediary and the provider in that the intermediary must develop reasonable benchmarks, and the provider must demonstrate that their procurements are not imprudent. In conjunction with the above, the Board also notes that a provider can be demonstrated to be "substantially out of line", but not "imprudent" in their procurement activities, based on individual provider factors. Conversely, a group of providers can be found to be not "substantially out of line", but still to be "imprudent" - the so-called "false positive" outcome. In the opinion of the Board, in the instant case, it is primarily the Intermediary's unreasonable benchmark, and its application, that turns this case toward the Provider.

Further, the Board suggests that solid statistical analysis, such as that demonstrated by the Intermediary in Universal Rehabilitation Services, Inc. v. Independence Blue Cross, PRRB Dec. No. 98-D46, April 24, 1998, Medicare and Medicaid Guide (CCH) ¶ 46,272 rises to the level of providing an acceptable burden of proof by the Intermediary as to what constitutes costs that are "substantially out of line" or unreasonable/imprudent.

The Board finds that the Intermediary has failed to comply with the regulatory requirement of making a truly comparable analysis of the cost of services which clearly demonstrated that the

Providers' costs were substantially out of line. Although the Intermediary argues that it did consider the necessary factors in its determinations, there is no evidence in the record to substantiate this claim. The Intermediary has presented no data which shows that the application of its survey took into consideration the size of the providers, the scope of services furnished, or the utilization of the providers in terms of patient mix and acuity.

Quite to the contrary, the Provider in this case, Canterbury House, had employed different contractors (Puget Sound Therapy Service for OT: Northwest Hospital for ST) for services prior to switching to the Intermediary-disallowed contractor because the initial contractors failed to keep the Provider adequately apprised of the therapy staff assigned to the facility, or of patient progress; they did not attend the Care Conferences or Medicare meetings, and did not maintain consistent services schedules. Provider Position Paper at 3. Thus, after considering other alternatives, including hiring in-house, Canterbury determined it was more prudent and cost-effective to contract with NovaCare. Id. at 4. Puget Sound Therapy Service was the very contractor promoted by the Intermediary as their "standard of excellence and reasonableness" for establishing the benchmark for their study. Id. at 10. These incongruities speak to the lack of comparability found in the application of the survey results with the "real world". In the absence of such relevant factors which have a notable bearing on the comparability of services and their associated costs, the Board finds the Intermediary's survey data unacceptable in meeting either the substantially out of line or prudent buyer requirements established under the controlling regulatory provisions of 42 C.F.R. § 413.9.

In addition to its foregoing conclusive findings, the Board concurs with the Provider's contention that the Intermediary's reasonable cost determinations do not properly effectuate the substantially out of line standard under 42 C.F.R. § 413.9(c)(2). Even assuming that the Intermediary's survey data were accurately determined and properly applied, the Provider has presented convincing evidence that the OT and ST limits computed by the Intermediary do not reflect costs that are substantially out of line with the costs incurred by the SNFs that were included in the Intermediary's survey, nor are they imprudent or unreasonable. As summarized in the post-hearing brief submitted by the Providers in Eagle Healthcare,[16] the limits established by the Intermediary for the Seattle MSA and the Yakima MSA bear no relationship to the range or distribution of costs incurred by the responding SNFs. With respect to the Seattle MSA, an analysis of the Intermediary's survey data shows that the established $76 per hour limit for ST services is approximately $10 lower than the mean cost of $86 per hour. Accordingly, 26 out of the 38 SNFs in the Seattle area exceed the established $76 per hour limit, and the limit reflects "benchmarks" set from a low of the 7th percentile to a high of the thirty second percentile of the range of costs incurred by the survey respondents. Regarding the Yakima MSA, the Intermediary's limit of $92 per hour for OT services is $4 lower than the lowest cost incurred by any SNF actually located in that area. The Board notes that the factual data supporting the Provider's analysis and conclusive findings have not been refuted by the Intermediary. Given the fact that the Intermediary's

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[16] Eagle Healthcare Provider's Post-Hearing Brief at 42-44.

hourly limits in the above examples were established below norm cost for the services rendered, the Board finds no basis for using such amounts as the standard for declaring a cost substantially out of line, or imprudent/unreasonable. Such a determination does not appear to be within the intent of Congress, and certainly establishes no semblance of rational statistical treatment of the data that would recognize the words "mean" and "standard deviation" as words of art.

DECISION AND ORDER:

The Intermediary's audit adjustments reducing charges for occupational and speech therapy services based upon the prudent buyer concept were not proper. The Intermediary's adjustments are reversed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire
Martin W. Hoover, Jr. Esquire
Charles R. Barker

FOR THE BOARD:

Irvin W. Kues
Chairman