IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

MERCY HOME HEALTH	:	CIVIL ACTION
	:	
v.	:	NO. 03-6860
	:	
MICHAEL O. LEAVITT[1],	:	
Secretary Of Health And	:	
Human Services	:	

MEMORANDUM and ORDER

Juan R. Sánchez, J. **March 10, 2005**

Mercy Home Health (Mercy), a subsidiary of Mercy Home Health Services (home office) and a Medicare provider, filed a Motion for Summary Judgment claiming it was improperly denied Medicare reimbursement because its home office was not permitted to accurately allocate costs to Mercy. Michael O. Leavitt, Secretary of Health and Human Services (Secretary), filed a cross-Motion for Summary Judgment claiming Mercy did not prove its proposed method of cost allocation was more accurate than the Secretary's default method and, therefore, is not entitled to further Medicare reimbursement. We grant the Secretary's motion.

BACKGROUND[2]

This case arises from the Medicare[3] program, which is administered by the Centers for

[1]Tommy G. Thompson is no longer the Secretary of Health and Human Services. Leavitt, the new Secretary, is automatically substituted for Thompson according to Fed.R.Civ.P. 25(d).

[2]A background of relevant statutes, regulations and the Secretary's interpretive rules is provided to create a framework for the Court's decision.

[3]Medicare, established under Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq., provides federally-funded health insurance for eligible elderly and disabled individuals.

Medicare and Medicaid Services of the United States Department of Health and Human Services. Medicare pays health care providers, including home health agencies, for services rendered to Medicare beneficiaries. 42 U.S.C. § 1395 et seq. The providers must, however, enter into written agreements with the Secretary in order to receive reimbursements for services provided to Medicare beneficiaries. 42 U.S.C. § 1395cc. The provider also prepares a cost report at the close of each fiscal year, which serves as the basis for its total allowable Medicare reimbursement. 42 C.F.R. § 405.1801(b). The cost report shows the provider's costs and the percentage of those costs allocated to Medicare services. 42 C.F.R. §§ 413.20(b), 413.24(f).

The provider files the cost report with a "fiscal intermediary," usually an insurance company chosen by the Secretary. 42 U.S.C. § 1395h. The intermediary performs many of the Medicare program's administrative functions and is responsible for auditing the cost report when necessary and issuing a written "notice of amount of program reimbursement." This notice determines the total payment the provider will receive for Medicare services during the reporting period. 42 C.F.R. § 405.1803. This decision is subject to review by the Provider Reimbursement Review Board (PRRB), the Secretary, and ultimately the courts. 42 U.S.C. §§ 1395oo (a), (b), (f)(1).

The Secretary reimburses providers for all "reasonable costs" incurred from providing medical care to Medicare beneficiaries. The "reasonable costs" of a provider are defined as "the cost actually incurred," less any costs "unnecessary in the efficient delivery of needed health services." 42 U.S.C. § 1395x(v)(1)(A). Congress has authorized "the Secretary to promulgate regulations 'establishing the method to be used' for determining reasonable costs." *Shahala v. Guernsey Memorial Hospital*, 514 U.S. 87, 91-92 (1995) (quoting 42 U.S.C. § 1395x(v)(1)(A)). The Secretary's regulations provide guidance in determining which costs are reasonable and require the

provider to keep accurate financial data to support Medicare reimbursements. 42 C.F.R. §§ 413.9,[4] 413.20,[5] 413.24.[6] The objective of these regulations is to ensure "the costs with respect to individuals covered by [Medicare] will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by [Medicare]. These regulations also provide for . . . suitable retroactive adjustments after the provider has submitted fiscal and statistical reports." 42 C.F.R. § 413.9(b)(1).

Providers ordinarily receive their Medicare reimbursements through an intermediary, who is bound by the Secretary's regulations and interpretive rules in the Provider Reimbursement Manual (PRM). 42 U.S.C. § 1395h; 42 C.F.R. § 421.100(h). The intermediary must follow the Secretary's rules in the PRM when determining how home office costs should be allocated between their Medicare and non-Medicare subsidiaries. The PRM provides a process by which home offices can calculate their reimbursable costs. First, the home office must total all of its costs, for Medicare and

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[4] § 413.9 states:

> (a) Reasonable cost includes all necessary and proper costs incurred in furnishing the services, subject to principles relating to specific items of revenue and cost.

[5] § 413.20 states:

> (a) The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program [Medicare].
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> (b) Cost reports are required from providers on an annual basis with reporting periods based on the provider's accounting year. In the interpretation and application of the principles of reimbursement, the fiscal intermediaries will be an important source of consultative assistance to providers and will be available to deal with questions and problems on a day-to-day basis.

[6] § 413.24 states:

> (a) Providers receiving payment on the basis of reimbursable cost must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors.

non-Medicare providers alike, and subtract all costs not allowed under Medicare.[7] PRM § 2150.3.A. Second, the home office must directly allocate costs attributable to Medicare and non-Medicare providers. "Allowable costs incurred for the benefit of, or directly attributable to, a specific provider or nonprovider activity must be allocated directly to the [subsidiary] for which they were incurred." PRM § 2150.3.B. For example, if a home office employee spends all of her time working on matters for one subsidiary provider, her salary will be allocated directly to that provider.

Third, the home office must allocate as many items as possible on a "functional basis" among its subsidiaries to equitably allocate costs for services the home office provides to its components. PRM § 2150.3.C. After the home office completes the three steps above, a "pool" of allowable costs incurred for general management or administrative services remains. PRM § 2150.3.D. These pooled costs also must be allocated a specific way.[8] The PRM states,

> Pooled home office costs must be allocated to [subsidiaries] on the basis of total costs if the [home office] is composed of either unlike health care facilities (e.g., a combination of short-term hospitals, long-term hospitals, and home health agencies) or a combination of health care facilities and nonhealth care facilities . . . . Under this basis, **all [subsidiaries] will share in the pooled home office costs in the same proportion that the total costs of each [subsidiary] bear to the total costs of all [subsidiaries] in the chain**.

PRM § 2150.3.D.2(b) (emphasis added). Consequently, if a Medicare providing subsidiary has higher costs than a non-Medicare providing subsidiary, then more pooled home office costs will be allocated to the Medicare provider.

The steps outlined above constitute the default procedure the Secretary promulgated for allocating home office costs to subsidiary providers. A provider may, however, use a more precise

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[7]Costs not covered by Medicare include certain advertising costs, costs of non-competition agreements, and certain membership costs.

[8]The underlying issue in this case is how to allocate the home office's pooled costs to Mercy.

allocation if it properly seeks approval from the intermediary. The PRM states, "[i]f evidence indicates that the use of a more sophisticated allocation basis would provide a more precise allocation of pooled home office costs to the [subsidiaries], such basis can be used in lieu of allocating on the basis of . . . total costs." PRM § 2150.3.D.2(b). The PRM also specifies "intermediary approval must be obtained before any substitute basis can be used. The home office must make a written request with its justification to the intermediary responsible for auditing the home office . . . . The effective date of the change will be the beginning of the accounting period for which the request was made." *Id.*

The Secretary's regulations also provide for a reopening of intermediary cost determinations, further ensuring intermediaries properly reimburse Medicare providers. 42 C.F.R. § 405.1885. Cost determinations must be reopened within three years of the intermediary's decision. *Id.* An intermediary's determination must be reopened and revised if, within three years of the initial decision, the Secretary finds the determination "inconsistent with the applicable law, regulations . . . or [the Secretary's] general instructions." 42 C.F.R. § 405.1885(b)(1)(i).[9] Once three years pass, the intermediary's decision becomes final, unless "fraud or similar fault" is found. 42 C.F.R. § 1885(d).

FACTS

Mercy, the only subsidiary of the home office that is a Medicare provider, seeks more

[9]The Secretary's interpretive rule in the PRM § 2931.2 specifies:

> Whether or not the intermediary will reopen a determination, otherwise final, will depend upon whether new and material evidence has been submitted, or a clear and obvious error was made, or the determination is found to be inconsistent with the law, regulations and rules, or general instructions.

reimbursement from the Secretary for costs its home office incurred providing services to Mercy.[10] On July 12, 1993, the home office sent a letter to its intermediary, Independence Blue Cross, requesting an alternate allocation method for its costs. In the letter, the home office said, "[s]ince the majority of our business is service oriented, the costs in the home office should be largely allocated to those subsidiaries with high personnel costs, [such as Mercy]." (A.R. 141). The methodology the home office proposed would utilize salaries, benefits, and professional contractor fees to allocate home office costs. (A.R. 141).

Blue Cross responded on August 3, 1993 by asking the home office to explain why they should deviate from the standard allocation methodology.[11] On November 15, 1993, the home office sent a second letter outlining the benefits for an alternative allocation methodology. The letter included the following:

> 1. In July of 1993, Liberty purchased a DME company. The nature of this business's expenses are highly weighted towards Cost of Goods Sold and Depreciation. Under our current cost to cost allocation methodology, home office cost would be unfairly allocated based on the total costs of each subsidiary. This would then include [the Cost of Goods Sold and Depreciation for the DME subsidiary,] for which the home office provides little support. The DME company provides its own delivery, warehousing, purchasing and bookkeeping personnel, for which the home office has oversight only to the extent personnel, payroll and benefits are concerned.
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> 2. The methodology would total salaries, benefits and contractors by subsidiary company, ascertain percentages of the subsidiaries costs to the total, and then alloate home office cost based on these percentages.

[10]The other three subsidiaries include a private duty nursing agency, a home care staffing agency and a durable medical equipment (DME) supplier.

[11]Blue Cross specifically asked the home office to explain why the default allocation mechanism, which allocated 85% of the home office's costs to Mercy and the home care staffing agency, needs improvement.

A.R. 146-47. The home office believed an allocation of costs to all of the subsidiaries on a cost-to-total cost basis, the default method, would result in an inappropriately large allocation of home office costs to the DME subsidiary.

Blue Cross approved the home office's request on February 11, 1994.[12] The home office used this intermediary-approved method from 1993 through 1996. On June 26, 1996, Blue Cross advised the home office its cost allocation method of using salaries, benefits and contracted cost would no longer be accepted.[13] Blue Cross's decision, however, was prospective and would not take affect until 1997.

Blue Cross voluntarily terminated its contract as a Medicare fiscal intermediary in 1997. Wellmark Blue Cross and Blue Shield of Iowa (Wellmark) and Cahaba Government Benefit Administrators (Cahaba) became the new intermediaries and were responsible for auditing Mercy's 1995 and 1996 cost reports and the home office's cost statements.[14] Despite Blue Cross's decision to apply its decision prospectively, Wellmark disallowed the home office's allocation method for 1995 and 1996. Wellmark and its successor, Cahaba, required the home office to use the default cost-to-total cost methodology for 1995 and onward. PRM § 2150.3D (A.R. 873). The intermediaries claim the home office's cost allocation method for pooled costs was not more accurate than the default method.[15] Mercy claims these retroactive adjustments resulted in

[12]Blue Cross's approval letter also reminded the home office that all methods Blue Cross approves are subject to verification during audit.

[13]Blue Cross made its determination after auditing the home office for fiscal year 1994. Blue Cross did not, however, specify what caused it to make this decision.

[14]Wellmark succeeded Blue Cross on August 4, 1997 and Cahaba succeeded Wellmark on June 1, 2000. (A.R. 6).

[15]The intermediaries and Secretary claim the home office did little direct and functional allocation of costs to subsidiaries which actually incurred such costs. Consequently, there was an uncustomarily large amount of pooled costs left for allocation. The intermediaries also allege the

reimbursement losses totaling $272,000 in 1995 and $451,000 in 1996. (A.R. 2461, 2471).

Mercy timely appealed the intermediaries' decision for fiscal years 1995 through 1999 to the PRRB. (A.R. 2461-2528).[16] The PRRB held a hearing on November 6, 2002 and found in favor of Mercy regarding the 1995 and 1996 fiscal years. The PRRB issued its decision on August 22, 2003 and held, the "provider's reliance on [the] intermediary's written instruction should be protected even if [the] intermediary subsequently changes position." (A.R. 92).

The CMS Administrator notified the parties of his intent to review the PRRB's decision.[17] The Administrator ultimately reversed the Board's decision regarding fiscal years 1995 and 1996. (A.R. 35-36). The Administrator held the PRRB's decision "elevate[d] the PRM prior approval provisions above the requirements of the statute." (A.R. 7). The Administrator further held the prior approval provision should not be given more weight than the statutory and regulatory provisions. The Administrator also held the statutes and regulations prohibit cross-subsidization of costs and place the burden on the provider to produce sufficient evidence demonstrating costs are allowable. (A.R. 7-8). The Administrator found Mercy did not "collect data or provide any specific computations or reasonable justification to support their contention that the alternative method . . . resulted in [a] more equitable and accurate allocation of costs." (A.R. 8-9). The Administrator consequently held Mercy did not meet its burden. Mercy subsequently appealed the Administrator's decision to this Court.

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home office did not substantiate why the factors it used in its cost allocation method would produce a more accurate result than the default method.

[16]Only fiscal years 1995 and 1996 are at issue before this Court.

[17]The Secretary's authority to review PRRB decisions has been delegated to the CMS Administrator. This authority has been further delegated to the Deputy Administrator of CMS. 42 Fed. Reg. 13,262 (1977) and 42 Fed. Reg. 57,351 (1977).

DISCUSSION

This Court has jurisdiction to review the Secretary's final decision under 42 U.S.C. § 1395oo(f)(1).[18] The administrative agency's decision should be affirmed unless it is found to be unsupported by substantial evidence, arbitrary and capricious, an abuse of discretion or otherwise not in accordance with the law. 5 U.S.C. § 706(2)(A), (E); *Robert Wood Johnson University Hospital v. Thompson*, 297 F.3d 273, 280 (3d Cir. 2002). According to the Administrative Procedure Act (APA), the "action, findings, and conclusions" of such an agency hearing provided by statute are to be held "unlawful and set aside" by the reviewing court if they are "unsupported by substantial evidence." 5 U.S.C. § 706(2)(E).

"Substantial evidence is more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. Accordingly, it must do more than create a suspicion of the existence of the fact to be established . . . . [I]t must be enough to justify, if the trial were to a jury, a refusal to direct a verdict when the conclusion sought to be drawn from it is one of fact for the jury." *Monsour Medical Center v. Heckler*, 806 F.2d 1185, 1190 (3d Cir. 1986) (internal quotations omitted) (quoting *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 477, 71 S.Ct. 456, 459, 95 L.Ed. 456 (1951)).

The court shall review the whole record in determining if substantial evidence supports the Secretary's decision. 5 U.S.C. § 706(2)(E); 42 U.S.C. § 405 ("The findings of the Secretary as to any fact, if supported by substantial evidence, shall be conclusive . . . ").[19] Overall, this test is

[18]The Administrator's determination is the Secretary's final decision and is, therefore, subject to judicial review. 42 C.F.R. § 405.1877(c).

[19]The substantial evidence test "requir[es] that the evidence be 'substantial' after the reviewing court takes into account 'whatever in the record [fairly] detracts from its weight.' Thus, the evidence must be sufficient to support the conclusion of a reasonable person after considering the evidentiary record as a whole, not just the evidence that is consistent with the agency's finding."

deferential and we will afford such deference to the Secretary's decision if it is supported by substantial evidence, "even [where] this court acting *de novo* might have reached a different conclusion." *Hunter Douglas, Inc. v. NLRB,* 804 F.2d 808, 812 (3d Cir. 1986).

The parties dispute the level of deference we must afford to the Secretary's decision. We must first determine "whether 'the intent of Congress is clear' as to 'the precise question at issue.' If, by 'employing traditional tools of statutory construction,' we determine that Congress' intent is clear, 'that is the end of the matter.'" *Regions Hospital v. Shalala,* 522 U.S. 448, 457 (1998) (quoting *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-43 (1984)). However, "if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute. If the agency's reading fills a gap or defines a term in a reasonable way in light of the Legislature's design, we give that reading controlling weight, even if it is not the answer the court would have reached if the question initially had arisen in a judicial proceeding." *Id.*; *see also Robert Wood Johnson University Hospital*, 297 F.3d at 282 (holding broad deference is even more appropriate in cases involving "complex and highly technical" regulatory programs, such as Medicare).

We find Congress' intent is clear in providing the Secretary the ability to take retroactive actions to remedy incorrect Medicare reimbursements. We accordingly afford substantial deference to the Secretary's determination. 42 U.S.C. 1395x(v)(1)(A) permits the Secretary to determine a provider's reasonable costs incurred in providing Medicare services. The statute specifically allows the Secretary to promulgate regulations which will "provide for the making of suitable **retroactive corrective adjustments** where, for a provider of services for any fiscal period, the aggregate

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Monsour Medical Center, 806 F.2d at 1190 (quoting *Universal Camera Corp.*, 340 U.S. at 488).

reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." 42 U.S.C. 1395x(v)(1)(A)(ii) (emphasis added). The regulations elaborate on Congress' mandate to make retroactive corrective adjustments. 42 C.F.R. § 405.1885(b)(1) provides, "[a]n intermediary determination . . . must be reopened and revised by the intermediary if, within the 3-year period . . ., CMS (i) [p]rovides notice to the intermediary that the intermediary determination . . . is inconsistent with the applicable law, regulations, CMS ruling, or CMS general instructions in effect, and as CMS understood those legal provisions, at the time the determination or decision was rendered by the intermediary."

Although the statute and regulation above do not specifically address retroactive adjustments to providers who were allocated costs from their home office, we find this factual discrepancy inconsequential. Congress' intent is clear. The Secretary must have control to adjust inaccurate Medicare reimbursements for a time period specified in the regulations.

The first intermediary, Blue Cross, approved the home office's cost allocation method for 1995 and 1996. The second intermediary, Wellmark, reversed that decision in 1997, within the 3-year time period the regulations prescribe. 42 C.F.R. § 405.1885(b)(1).[20] After auditing Mercy's 1995 and 1996 cost reports and home office cost statements, Wellmark did not find the home office's cost allocation method more accurate. The Secretary similarly argues the home office merely used a selective version of the method set forth in the PRM. According to the Secretary, the home office chose cost categories which were disproportionately high for its home health agency in its calculation. Def.'s Mot. for Summ. Judg., p. 17. The Secretary also claims insufficient

[20]The interpretive rule in the PRM specifies, "[w]hether or not the intermediary will reopen a determination, otherwise final, will depend upon whether new and material evidence has been submitted, or a clear and obvious error was made, or the determinations is found to be inconsistent with the law, regulations and rules, or general instructions." PRM § 2931.2.

documentation was provided to support the home office's allocation method and the factors it proposed disproportionately allocated costs to Mercy. *Id.*

The Secretary's decision is given broad deference here because the Medicare statutes and regulations implicated in this case pertain to a "complex and highly technical regulatory program" and "require significant expertise and entail the exercise of judgment grounded in policy concerns." *Thomas Jefferson University*, 512 U.S. at 512. Although Mercy sought and obtained prior approval from intermediary Blue Cross for its proposed cost allocation, consistent with 42 C.F.R. § 413.24(d)(2)(ii) and PRM 2150.3D, the Secretary found Blue Cross' determination was incorrect. We find the Secretary's decision is supported by substantial evidence and is consistent with Congress' intent. Finding otherwise would place Mercy's compliance with procedure over the Secretary's promulgation of substance. Accordingly, we enter the following:

ORDER

AND NOW, this 10th day of March, 2005, Defendant's Motion for Summary Judgment (docket #16) is GRANTED and Plaintiff's Motion for Summary Judgment (docket #12) is DENIED.

BY THE COURT:

\s\ Juan R.Sánchez

Juan R. Sánchez, J