CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of: **Welch Community Hospital**	**Claim for Payment** **Determination for Cost** **Reporting Period Ending:** **June 30, 2005**
Provider **vs.**	
Blue Cross Blue Shield Association/ **Palmetto GBA**	**Review of:** **PRRB Dec. No. 2014-D9** **Dated: May 29, 2014**
Intermediary	

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in § 1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). Accordingly, the parties were notified of the Administrator's intention to review the Board's decision. Comments were received from the CMS Center for Medicare. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue is whether the Intermediary's adjustment to reclassify Rural Health Clinic (RHC) visits associated with contracted physicians, and the associated full-time equivalents (FTEs), from the cost report Worksheet M-2, line 9 to Worksheet M-2, line 1 was proper.[1]

The Board held that the Provider properly reported the RHC visits associated with contracted physicians on line 9 of Worksheet M-2 of CMS Form 2552-96. In reaching this determination the Board reviewed the cost report instructions for

[1] A Rural Health Clinic is a provider of services for purposes of a right to a hearing before the Board pursuant to section 1878(j) of the Social Security Act.

Worksheet M-2 of Form CMS 2552-96, the RHC productivity screening guidelines as described in the Federal Register in 1982[2] and 1992[3] and set forth in the Medicare Claims Processing Manual (MCPM) 100-04, Chapter 9, § 40.3 and concluded that the guidelines are to be applied to healthcare staff "employed" by the clinic. In this case, since none of the physicians' services under agreement were employees of the Provider or owners of the facility the Board held that the Intermediary's adjustment inappropriately subjected the contracted physicians to the RHC productivity screening guidelines. Finally, the Board stated that the revisions made by CMS to Chapter 13 of the Medicare Benefit Policy Manual, CMS Pub. No. 100-01(MBPM 100-02) was not applicable to this case since the policy change when into effect on January 1, 2014, well after the time period at issue.

SUMMARY OF COMMENTS

CM submitted comments requesting that the Administrator reverse the Board's decision. CM argued that Medicare's longstanding policy has been to apply the productivity screening standards to all physician services performed at a RHC, regardless of whether the physician's relationship to the clinic was termed employed, contracted, or on a full or part-time basis. In 1978, Congress mandated the use of the productivity screening guidelines to test the reasonableness of the productivity of the RHC's health care staff. The regulations at 42 C.F.R. § 405.2412(a) provide that "*Physicians' services that are performed by a physician at the clinic or are performed away from the clinic by a physician whose agreement with the clinic provides that he or she will be paid by the clinic for such services*." (Emphasis added). Additionally, the preamble discussion that established the productivity screening guidelines stated that "the productivity guidelines are as follows: (1) At least three visits per hour per physician for rural health clinic services provided at the clinic…"[4]

CM asserted that the aforementioned regulations and the discussion in the proposed and final rules must be read with the context of 42 C.F.R. § 405.2412. In this case, the RHC is staffed only with contracted personnel from a third party and no other physicians. Hence, these are the physicians that control the productivity in the clinic and are therefore subject to the productivity screening standards. The Provider cannot conveniently play upon words set forth in a cost report manual reserved for a different type of employment arrangement, 'physician services under agreements,' to advance the erroneous position that the physicians were not

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[2] 47 Fed. Reg. 54163, 54165 (Dec. 1, 1982).
[3] 57 Fed. Reg. 24961, 24967 (June 12, 1992).
[4] 43 Fed. Reg. 8258, 8,260 (March 1, 1978).

'employed by' the provider and hence, not subject to the productivity guidelines. Medicare's longstanding intent of the productivity guidelines is clear…*all physician services performed at the clinic are subject to productivity guidelines*. (Emphasis added). Longstanding Medicare policy did not ever intend for an RHC to escape productivity requirements by classifying their physicians as non-employees. Therefore, in accordance with the regulation and policy in effect during the period of the cost reports in question, a physician who provides services at a RHC is subject to the productivity standards, rendering the Intermediary's adjustment to be appropriate.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

The Rural Health Clinic Service Act of 1977 (RHCSA) added RHC services as a new benefit under Part B of the Medicare program.[5] RHCs were established to address and inadequate supply of physicians serving Medicare beneficiaries in underserved rural areas, and to increase the utilization of nurse practitioners (NPs) and physician assistants (PAs) in these areas for primary care services. This was also addressed in part by allowing the payment for services of the latter types of practitioners.[6] RHCs have been eligible to participate in and furnish RHC services under the Medicare program since March 1, 1978.[7]

Before the Balance Budget Act (BBA) of 1997[8], reimbursement formulas differed for provider-based facilities and independent facilities.[9] Independent facilities were

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[5] Pub. L. No. 95-210, 91 Stat. 1485 (Dec. 13, 1977).

[6] *Supra No*. 3 at 8259. Until the enactment of Pub. L. 95-210, Medicare limited coverage of primary care services to those furnished by physicians, with only certain limited exceptions. Since the services provided by the NPs and PAs to Medicare beneficiaries were not generally eligible for Medicare reimbursement, these services were either paid for out-of-pocket by the beneficiary, supported through a grant, or treated by the clinic as bad debts or charity. As a result of these and other factors, individuals who lived in such areas often did not have access to adequate health care services.

[7] *Id. See also* 47 Fed. Reg. 54,164 (Dec. 1, 1982).

[8] Pub. L. No 105-33, 111 Stat. 251 (Aug. 5, 1997).

[9] 42 C.F.R. § 405.2462 *et. seq.*, (2004). *See also* 68 Fed. Reg. 74,792, 74,793-74794 (Dec. 24, 2003).

reimbursed an all-inclusive rate (AIR) for a bundled package of core services and the provider-based facilities were reimbursed reasonable costs for the individual services provided (unbundled).[10] Section 4205(a) of the BBA 97 amended § 1833(f) of the Act and eliminated those differences and extended the AIR and related payment limits to provider-based RHCs except in hospitals with fewer than 50 beds.[11] Therefore, since 1997 Medicare reimbursement for both provider-based and independent RHCs have been based on an interim payment of the AIR as determined by a cost report.

Pursuant to the proposed and final preamble language and the implementing regulations the AIR is calculated by the Intermediary at the beginning of each year, paid on an interim basis, adjusted periodically during the year and subject to the tests of reasonableness.[12] At the end of each cost reporting period there is a reconciliation of allowable cost using standard Medicare methods for cost estimation and claims for services provided. If the total costs are greater than the sum of the AIR payments made during the cost reporting period, Medicare pays the balance to the RHC; if there are overpayments, the RHC must return the excess funds to Medicare. The AIR is calculated on the RHC's estimated costs and estimated number of patient visits for the period.[13] The number of visits determines the denominator for the calculation of the AIR. Either the actual number of visits is used in this calculation or a calculated number of visits, based on minimum productivity is used. The Intermediary pays the clinic 80 percent of the AIR for each Medicare covered visit, if the patient has fully incurred the Medicare Part B deductible.[14]

As stated above, the AIR is subject to the tests of reasonableness in accordance with the regulations found at 42 C.F.R. § 405.2468. In addition, the tests include screening guidelines intended to identify situations where costs will not be allowed

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[10] *Id*. Payment to provider-based RHCs for services furnished to Medicare beneficiaries was made on a reasonable cost basis by the provider's Intermediary in accordance with Medicare regulations at 42 C.F.R. Part 413. Payment to independent RHCs for services furnished to Medicare beneficiaries was made on the basis of a uniform all-inclusive rate payment methodology in accordance with part 405, subpart X. Payment to independent RHCs was also subject to a maximum payment per visit as set forth in § 1833(f) of the Act.

[11] *Supra, No*. 8.

[12] 42 C.F.R. § 405.2464 *et. seq.,* (2004). *See also* 47 Fed. Reg. 54,163 (Dec. 1, 1982).

[13] *Supra, No.* 8 .

[14] 42 C.F.R. § 405.2466 *et. seq.,* (2004).

without acceptable justification by the RHC.[15] Specifically, § 405.2468(c) and (d) provide that:

> (c) *Tests of reasonableness for rural health clinic cost and utilization*. Tests of reasonableness authorized by sections 1833(a) and 1861(v)(1)(A) of the Act may be established by CMS or the carrier with respect to direct or indirect overall costs, costs of specific items and services, or costs of groups of items and services. Those tests include, but are not limited to, screening guidelines and payment limitations.
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> (d) *Screening guidelines*. (1) costs in excess of amounts established by the guidelines are not included unless the clinic or center provides reasonable justification satisfactory to the intermediary.
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> (2) Screening guidelines are used to assess the costs of services, including the following:
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> > (i) Compensation for the professional and supervisory services of physicians and for the services of physician assistants, nurse practitioners, and nurse-midwives.
> > (ii) Services of physicians, physician assistants, nurse practitioners, nurse-midwives, visiting nurses, qualified clinical psychologists, and clinical social workers.
> > (iii) The level of administrative and general expenses.
> > (iv) Staffing (for example, the ratio of other clinic or center personnel to physicians, physician assistants, and nurse practitioners).
> > (v) The reasonableness of payments for services purchased by the clinic or center, subject to the limitation that the costs of physician services purchased by the clinic or center may not exceed amounts determined under the applicable provisions of subpart E of part 405 or part 415 of this chapter.[16]

These screening guidelines measure, *inter alia*, the reasonableness of RHC costs in terms of staffing levels relative to levels of utilization (i.e., productivity).[17] In addition, CMS stated that "[*t]he productivity guidelines apply to the total time the*

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[15] 42 C.F.R. § 405.2468 *et. seq*., (2004).
[16] *Id*. The Administrator notes that Subpart E of part 405 addresses reasonable charges and Part 415 addresses physician services furnished under a fee schedule.
[17] See 43 Fed. Reg. 42,787, 42,788 (Sept. 21, 1978).

physician or other practitioner actually spends in patient care activities or is available to provide patient care services."[18] (Emphasis added). Thus, productivity standards are used to help determine the average cost per patient for Medicare reimbursement in the RHC. Physician services not subject to the screening guidelines because they represent "purchased physician services" are subject to the usual limits for such physician services set forth at 405 and 415 of the regulations.

To date, these baseline productivity standards are 4,200[19] annual visits per 1.0 FTE[20] physician employed by the clinic and 2,100[21] annual visits per 1.0 FTE for non-physician practitioners (i.e., PAs, NP or CNM) employed by the clinic. Productivity standards may be combined for a "medical team" if staffing levels at the clinic consists of a combination of physicians and non-physician practitioners.[22] Thus, visits are used as the basic unit of measure for patient utilization.[23]

In the case of a provider-based RHC, the FTEs and visits associated with employed physicians and non-physician practitioners are reported on Form CMS 2552-96, Worksheet M-2.[24] With respect to Worksheet M-2, line 1, the cost report instructions state that:

> Enter the number of FTEs and total visits furnished to facility patients by staff physicians working at the facility on a regular ongoing basis. Also include on this line, physician data (FTEs and visits) for services furnished to facility patients by staff physicians working under contractual agreement with you on a regular ongoing

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[18] 43 Fed. Reg. 42,787, 42788 (September 21, 1978).
[19] Medicare Claims Processing Manual, CMS Pub 100-04, Ch. 9, § 40.3. *See also* 47 Fed. Reg. 54163, 54165 (Dec. 1, 1982).
[20] A full-time equivalent (FTE) is defined as the number of hours per year for which one employee of that type must be compensated to meet the clinic's definition of a full-time employee, or a minimum of 1,600 hours per year.
[21] *Id.*
[22] *Id.*
[23] 42 C.F.R. § 405.2463 defines a visit as "a face-to-face encounter between a clinic or center patient and a physician, physician assistant, nurse practitioner, nurse-midwife, or visiting nurse."
[24] Worksheet M-2 summarizes the number of facility visits furnished by the health care staff and calculates the number of visits to be used in the rate determination. Lines 1 through 9 list the types of practitioners (positions) for whom facility visits must be counted and reported.

> basis in the RHC facility. These physicians are subject to productivity standards. See 42 CFR 491.8. (2004).[25] (Emphasis added).

These instructions relate to the visits furnished by staffed physicians and non-physician practitioners. With respect to visits for physician services under agreement, which are reported on line 9 of Worksheet M-2, the cost report instructions state that:

> Enter the number of visits furnished to facility patients by physicians under agreement who do not furnish services to patients on a regular ongoing basis in the RHC facility. Physicians services under agreement with you are (1) all medical services performed at your site by a nonstaff physician who is not the owner or an employee of the facility, and (2) medical services performed at a location other than your site by such a physician for which the physician is compensated by you. While all physician services at your site are included in RHC/FQHC services, physician services furnished in other locations by physicians who are not on your full time staff are paid to you only if your agreement with the physician provides for compensation for such services.[26]

The regulations at 42 C.F.R. § 405.2412(a)(2004) provides that "Physicians' services are professional services that are performed by a physician at the clinic or are performed away from the clinic by a physician whose agreement with the clinic provides that he or she will be paid by the clinic for such services. Finally, the staffing and physician responsibilities are described in the regulations at 42 C.F.R. §§ 491.8 and 491.9. Paragraph (c) of 42 C.F.R. § 491.9 provide that:

> (c) *Direct services*—(1) *General*. The clinic or center staff furnishes those diagnostic and therapeutic services and supplies that are commonly furnished in a physician's office or at the entry point into the health care delivery system. These include medical history, physical examination, assessment of health status, and treatment for a variety of medical conditions.

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[25] *See* Provider Reimbursement Manual (PRM) – Part 2 (Pub. 15-2), chapter 36, § 3663. (05-08). The Administrator notes that prior to this date there was no line description for line 1. *See* PRM Transmittal 8 (September 2001).

[26] *See* PRM – Part 2 (Pub. 15-2), chapter 36, § 3663. (09-01).

The regulations at 42 C.F.R. § 491.9(d) requires, as a condition of participation that RHCs make available other services not offered at the center. Specifically, § 491.9(d) states that:

> (d) *Services provided through agreements or arrangements*. (1) The clinic or center has agreements or arrangements with one or more providers or suppliers participating under Medicare or Medicaid to furnish other services to its patients, including:
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> (i) Inpatient hospital care;
> (ii) Physician(s) services (whether furnished in the hospital, the office, the patient's home, a skilled nursing facility, or elsewhere); and
> (iii) Additional and specialized diagnostic and laboratory services that are §not available at the clinic or center.

The Administrator finds that, 42 C.F.R. § 491.9(d) clearly distinguishes between, and describes, the services the RHC furnishes directly at paragraph (c) and those furnished through "agreement or arrangement" at paragraph (d). Relevant to this case, the physician services furnished through "agreement or arrangement" are those not provided directly at the RHC but furnished outside the RHC. The use of the term "services provided through agreement or arrangement" under that description is not synonymous with "contracted." The use of the term through "agreement or arrangement" does not include in its description services provided directly at the RHC on a regular basis such as "those diagnostic and therapeutic services and supplies that are commonly furnished in a physician's office or at the entry point into the health care delivery system These include medical history, physical examination, assessment of health status, and treatment for a variety of medical conditions." The Provider has not argued that the services at issue in fact did not meet the description of paragraph (c).

The Administrator finds that, the use of the term of physicians "under agreement" as describe in Worksheet M-2, line 9 of Form CMS 2552-96, pertains to the above regulatory requirement at 42 C.F.R. §491.9(d). CMS has interpreted the term physicians "under agreement" as describe in Worksheet M-2, line 9 of Form CMS 2552-96, as being intended for specialists to whom patients are referred (i.e., Cardiologists, Dermatologists, Podiatrists) and which are intermittent and not used on a regular basis. Among other things, these visits can take longer than a normal visit and therefore, are not held them to productivity standards. Moreover, such physician services are subject to the test of reasonableness as "purchased services" under the physician fee schedule, in accordance with 42 C.F.R. § 405.246(d)(2)(v) (2004).

Therefore, in accordance with the regulation and policy in effect during the cost reporting period in question, the Administrator finds that, the intent and applicability of "[t]he productivity guidelines applies to the total time the physician or other practitioner actually spends in patient care activities or is available to provide patient care services" regardless of whether the physician's relationship to the clinic was termed employed, contracted, or on a full or part time basis so long as the services furnished to facility patients were on a regular ongoing basis in the RHC facility. In this case, the Provider contracted physicians through a third party to provide 100 percent of its physician staffing (i.e., productivity) during all hours of operation at the RHC. The record shows that the Intermediary moved 11,223 physician visits from line 9, column 2 of Worksheet M-2, to line 1. These visits included 5,324 visits for the Internal Medicine Clinic (IMC), 2,400 visits for the Walk in Clinic (WIC), and 3,499 visits for Pediatric Clinic (PC). The Administrator finds that, the above physician services provided by the physicians were direct 'physician services' within the meaning of 42 C.F.R. § 405.2412(a) and direct services under §491.9(c). The Medicare longstanding policy with respect to applicability of the productivity guidelines is clear; all physician services performed at the clinic are subject to productivity guidelines if they are provided *on a regular ongoing basis in the RHC facility*. Only physician services purchased on a limited and intermittent basis should be reflected on worksheet M-2, line 9 and subject to the test of reasonableness as "purchased physician services" under either the respective reasonable charge limits or physician fee schedule, as applicable. The Administrator finds that, Medicare's longstanding policy does not allow for an RHC to avoid productivity requirements by classifying their physicians as non-employees. As the RHC is staffed only with contracted physicians that are providing services on a regular ongoing basis in the RHC as non-employees. IN this case, the RHC is staffed only with contracted physicians through a third party and not other physicians, thereby, directly responsible and reflective of the productivity and reasonableness of the per visit costs of the clinic and are thus subject to the CMS productivity standards.[27]

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[27] Were these service not found to be subject to the limit, because they represent "purchased physician services", they would be subject to the usual limits for such physician services set forth at 405 and 415 of the regulations. Another words, although not specifically acknowledged by the Provider, all physician services are going to be subject to some form of a test of reasonableness.

DECISION

The decision of the Board is reserved in accordance with the foregoing opinion.

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

Date: 7/31/14 /s/

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services