PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2007-D36

PROVIDER -
VNA of Albany, Inc.
Albany, New York

Provider No.: 33-7019

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
United Government Services, LLC

DATE OF HEARING -
January 24, 2006

Cost Reporting Period Ended -
December 31, 1995

CASE NO.: 98-2095

INDEX

ISSUES:

1. Whether the Intermediary's adjustment to related party transaction cost was proper.

2. Whether the Intermediary's adjustment to disallow portions of membership dues expense was proper.

3. Whether the Intermediary's adjustment to disallow certain meeting/conference expenses was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See 42 U.S.C. §1395h, 42 C.F.R. §§413.20(b) and 413.24(b)

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board or PRRB) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY

Visiting Nurse Association of Albany, Inc. (Provider) is a voluntary, not-for-profit Medicare certified home health agency. The Provider rendered patient service visits to the general public in three counties in the State of New York.

The Intermediary (United Government Services, LLC) issued the NPR for the cost reporting period ended December 31, 1995 on September 30, 1997, and the Provider filed its appeal timely with the Board on March 26, 1998. The Provider has met the jurisdictional requirements of the Medicare regulations at 42 C.F.R. §§405.1835-405.1841.

The Provider was represented by Jeffrey J. Sherrin, Esquire, of O'Connell and Aronowitz. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross and Blue Shield Association.

BACKGROUND- ISSUE 1 (RELATED PARTY TRANSACTION COST):

During 1995, the Provider utilized the services of the Visiting Nurse Association of Albany Home Health Care Corporation d/b/a Visiting Nurses Home Care (VNHC) to provide skilled nursing and home health aide services. The VNHC is related to the Provider.[1] In its Medicare cost report for FYE 12/31/95, the Provider reported billed charges of $766,371 paid to VNHC for services provided.[2] The Intermediary disallowed $21,870 of the cost claimed, concluding that the exception at 42 C.F.R. §413.17(d) did not apply.

PROVIDER'S CONTENTIONS- ISSUE 1 (RELATED PARTY TRANSACTION COST):

The Provider does not dispute the Intermediary's calculations, but it contends that the amount of related party expense claimed on its Medicare cost report met the requirements for the exception in 42 C.F.R. §413.17(d)(1) and Provider Reimbursement Manual (P.R.M.), Part 1, §1010, based on the following factors:

1. The supplying organization is a bona fide separate organization.

VNHC is, a separate for-profit corporation that is licensed by the State of New York with its own provider numbers and operating certificate, subject to its own bylaws and with its own board of directors.[3]

2. A substantial part of the supplying organization's business activity of the type carried on with the provider is transacted with other organizations not related to the provider and the supplier by common ownership or control, and there is an open, competitive market for the type of services, facilities, or supplies furnished by the organization.

In 1995 a substantial part (57%) of VNHC's revenue was derived from servicing unrelated organizations, a substantial part of VNHC's licensed service area (15 out of 18 counties) did not correspond with the Provider's service area, and the Provider was just one of eighteen organizational clients of VNHC.[4] Moreover, the Intermediary's reliance on the P.R.M. §1010 language which states that the exception is intended to cover situations where large quantities of goods and services are supplied to the general public and only " incidentally" furnished to related organizations is misconstrued and contradictory to the regulation at 42 C.F.R. §413.17.

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[1] Provider's revised position paper at 8 and the hearing transcript (Tr.) at 77.
[2] Provider's revised position paper at 8.
[3] Provider's revised position paper, Exhibits P-7 and P-8. Tr. at 67-68, 79-81.
[4] Provider's revised position paper, Exs. P-14, P-15, P-21.

3. The services, facilities, or supplies are those which commonly are obtained by institutions such as the Provider from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such institutions.

The Intermediary has stipulated that this element is satisfied.[5]

4. The charge to the Provider is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.

The rate paid to VNHC was established using the same negotiating process used for unrelated suppliers and the rate was, in fact, less than the rate negotiated with several unrelated suppliers.[6]

Based on the above factors, the Provider believes that it qualified for an exception to the related organization principle based on the criteria set forth in the regulations and P.R.M. Part I, §1010.

INTERMEDIARY'S CONTENTIONS- ISSUE 1 (RELATED PARTY TRANSACTION COST):

The Intermediary contends that the exception provided at 42 C.F.R. §413.17(d) and P.R.M. Part I, §1010 does not apply because 43% of VNHC's revenue in 1995 was derived from related party transactions. The Intermediary argues that this does not meet the standard set forth in the example provided in P.R.M. Part I, §1010.1 that the services are only incidentally furnished to a related party.

FINDINGS OF FACTS, CONCLUSIONS OF LAW, AND DISCUSSION- ISSUE 1 (RELATED PARTY TRANSACTION COST):

The Board majority finds that the Intermediary's adjustment should be reversed, as the Provider met the 42 C.F.R. §413.17 (d)(1) and P.R.M. §1010 exception criteria to the related party principle.

Under Medicare regulations, a provider is entitled to claim costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control at the cost to the related organization as long as the cost does not exceed the price of comparable, services, facilities or supplies that could be purchased elsewhere. 42 C.F.R. §413.17(a). However, there is an exception to this rule. 42 C.F.R. § 413.17(d), provides that the charge made by the related supplier to the Provider is allowable as "cost" provided the following criteria are met:

(i) The supplying organization is a bona fide separate organization;

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[5] Tr. at 117-118.
[6] Provider's Exhibit P-24 and Tr. at 91-94.

> (ii) A substantial part of its business activity of the type carried on with the provider is transacted with others than the provider and organizations related to the supplier by common ownership or control and there is an open, competitive market for the type of services, facilities, or supplies furnished by the organization;
>
> (iii) The services, facilities, or supplies are those that commonly are obtained by institutions such as the provider from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such institutions; and
>
> (iv) The charge to the provider is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.

P.R.M. Part I, §1010 sets out the same exception criteria as stated above; in addition, it offers examples of where this exception would apply:

> The exception is intended to cover situations where large quantities of goods and services are supplied to the general public and only incidentally are furnished to related organizations.
>
> Example No. 1: The owner/operator of a drug store is a principal stockholder in the proprietary corporation that operates a skilled nursing facility. The drug store operates as an independent business, serving both the general public and the skilled nursing facility. A substantial amount of the business of the drug store is done with the general public. Skilled nursing facilities customarily do not provide pharmaceutical services with in-house resources. Therefore, the exception to the principle applies and the amounts charged to the provider by the drug store are allowable as costs, not to exceed the amounts charged to the general public or to other institutions for similar services.

The Board majority notes that the only exception criterion in dispute is the second criterion.[7]

The Board majority finds that the record clearly supports the existence of an "open competitive market" for the type of services furnished by VNHC.[8] Moreover, based upon the totality of the circumstances, the Board majority finds that a "substantial part" of VNHC's business was conducted with unrelated organizations. In this case, "revenue" is the best gauge to determine whether a "substantial part" of VNHC's business was

[7] The Board majority also finds that the record contains unrefuted evidence to support a finding that the first, third, and fourth criterion were met.

[8] See, Provider's Revised Position Paper, Ex.16.

conducted with unrelated organizations. Accordingly, since 57% of VNHC's revenue was generated from unrelated organizations, the Board majority concludes that the "substantial part" criterion was met.[9]

Moreover, the Intermediary's argument that the Provider did not meet the P.R.M. Part I, §1010.1 standard because the services were not "incidentally" furnished to a related party is misplaced. The Board majority disagrees with the Intermediary's interpretation of the manual that "incidental" is the only test to be applied; rather the P.R.M simply gives an example which falls within the parameter of the regulations. Nevertheless, even if the Intermediary is correct in its assertion that the P.R.M. example is the test to be applied, the Board majority finds that the P.R.M. section is irreconcilable with the regulatory requirement at 42 C.F.R. 413.17(d)(1)(ii), which uses the "substantial" standard.

BACKGROUND- ISSUE 2 (ASSOCIATION MEMBERSHIP DUES):

In 1995, the Provider was a member of the National Association for Home Care (NAHC), the New York State Association of Health Care Providers, Inc. (NYSAHCP) and the Home Care Association of New York State (HCANYS). The Intermediary disallowed $2,714 of dues expense that it attributed to lobbying activities for the aforementioned associations.[10]

Additionally, in 1995 the Provider was a member the New York State VNA Network, Inc. (VNA Network), and the Intermediary disallowed 100% of the dues expense incurred for that membership. ($16,000.00)[11]

PROVIDER'S CONTENTIONS- ISSUE 2 (ASSOCIATION MEMBERSHIP DUES):

A. NAHC, NYSAHCP, and HCANYS -- The Provider maintains that while NAHC, NYSAHCP, and HCANYS reported on their invoices that a certain percentage of their revenue derived from membership dues is associated with lobbying activities, such language was dictated by the Internal Revenue Code, and the evidence also establishes that none of the dues paid was actually used for lobbying activities. Moreover, as a not-for-profit entity, the Provider is not subject to the IRS provisions which the Intermediary relied upon for its determination. Also, while P.R.M. Part I, §2139 allows the Provider the option of relying on other non-CMS agency rules, the section does not mandate that such rules be applied. Additionally, all of the organizations furnished letters to the

[9] The Board majority also notes that while not determinative, the application of other gauges also supports that a substantial part of VNHC's business activity was transacted with others than the provider and organizations related to the supplier. Specifically, the Provider was only one of eighteen organizations serviced by VNHC (the remaining being unrelated organizations), and VNHC's service area overlapped the Provider's service area in only three out of eighteen counties.

[10] See, Provider's revised position paper at 5, Intermediary's position paper at 6.

[11] See, id.

Provider stating that the funds used for lobbying activities were generated solely from non-dues income sources.[12]

B. VNA Network- The Provider contends that its VNA Network membership was related to patient care, as it was utilized to address the participation requirements that Medicare managed care entities needed to satisfy in order to continue to service Medicare patients who transitioned to managed care. The Provider explained that New York State has a unique, highly regulated Certificate of Need system that regulates the establishment of new Medicare certified home health agencies and had a moratorium in place in 1995 barring the establishment of any new agencies.[13] Accordingly, the Provider and other VNA's were faced with the prospect of being unable to service their Medicare patients because of their inability to meet the health maintenance organizations' requirement that they be able to service broad geographic regions. The Provider sought to form alliances to ensure that it could continue to service its Medicare patients (both fee-for-service and managed care) but had no plan to reorganize.[14] The Provider contends that its membership in the VNA Network falls within the confines of P.R.M. Part 1, §2138.1, which states that a professional organization is one whose:

> … functions and purposes can be reasonably related to the development and operation of patient care facilities and programs, or the rendering of patient care services. Memberships in these organizations, while not restricted to providers, are generally comprised of providers, provider personnel, or others who are involved or interested in patient care activities.

The Provider notes that the Intermediary's main objection to the VNA Network organization's membership dues relates to references regarding "market penetration" found in a document entitled "Criteria for Initial Network Membership."[15] The Intermediary contends that the organization's "marketing" efforts are aimed at expansion, and such activity is not reasonably related to patient care within the context of the Medicare program. The Provider maintains that there is nothing inappropriate about the association's goal to reach a certain level of market penetration, and the Intermediary's representative conceded that the cost of a provider entering a new area or providing a new service would be considered an allowable cost.[16] This is also reflected in 42 C.F.R.§413.5(b)(6), which provides that in formulating reimbursable costs, "there should be a recognition of the need of hospitals and other providers to keep pace with growing needs and to make improvements."

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[12] Intermediary Exhibit 3, p 4; Provider Exhibit P-26.
[13] Tr. at 54-55.
[14] Tr. at 207-209, 216.
[15] See, Intermediary's Exhibit I-17.
[16] See, Tr. at 308.

INTERMEDIARY'S CONTENTIONS- ISSUE 2 (ASSOCIATION MEMBERSHIP DUES):

A. NAHC, NYSAHCP, and HCANYS - The Intermediary contends that the NAHC, NYSAHCP, and HCANYS billing invoices indicate the percentage of revenue used for lobbying activities and supports the adjustment made under P.R.M. §2139. P.R.M. §2139.3 states that the portion of an organization's dues or other payments relating to lobbying and political activities is an unallowable cost. Moreover, P.R.M. §2139.2 states that providers may follow the rules of other government agencies on lobbying activities in determining unallowable lobbying costs. P.R.M. §2139.3 explains that P.R.M. §2139.2 applies to an organization's dues, and that for tax purposes, tax-exempt organizations are required to report the nondeductible portion of dues related to lobbying and political activities.

B. VNA Network - The Intermediary contends that the VNA Network is not a "professional" organization within the meaning of the Medicare regulations, and that the primary purpose of the organization was to market, expand and promote the services of its members within Medicare and non-Medicare patient markets. The Intermediary further contends that the VNA Network activities constituted patient solicitation and were analogous to the costs deemed non-allowable under P.R.M. §2113.2.

FINDINGS OF FACTS, CONCLUSIONS OF LAW, AND DISCUSSION- ISSUE 2 (ASSOCIATION MEMBERSHIP DUES):

A. NAHC, NYSAHCP, and HCANYS: P.R.M. §2138.1 establishes that the Medicare program considers membership in a professional, technical, or business related organization to be an allowable cost. The section defines allowable costs as including "initiation fees, dues, special assessments, and subscriptions to professional, technical or business related periodicals." P.R.M. §2139.3 provides, however, that any portion of an organization or association's dues attributable to lobbying and political activities is not an allowable cost.

The Board finds that the evidence establishes that none of the Provider's membership dues in NAHC, NYSAHCP, and HCANYS was used for lobbying activities, as alleged, and therefore should not have been subject to partial disallowance. The record discloses that while the associations' statements on their respective invoices may have raised some questions as to whether an allocation should be made for lobbying activity expenses, the evidence shows that the statements relied upon by the Intermediary were related specifically to certain Internal Revenue Code requirements that are inapplicable to the Provider.[17] In addition, the Board finds that under P.R.M. §2139.2(A), the application of non-CMS agency rules is permissive and at the option of the Provider.[18]

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[17] See Intermediary's revised position paper, Exhibit I-3, pp. 4, 6 & 9; Provider's Revised Position Paper, Exhibits 4 & 26; see also, 26 U.S.C. § 162(e).

[18] P.R.M. §2139.2(A) states, in relevant part, "…if a non CMS agency, e.g., the IRS, has developed policies and procedures defining lobbying activities and addressing the costs, CMS does not expect providers to follow different rules in determining

B. VNA Network: The Board finds that the evidence establishes that the membership dues attributable to the VNA Network were related to patient care and therefore are an allowable cost. The testimony of the Provider's representative established that the VNA Network was a professional organization made up of similarly situated Visiting Nurse Associations and was formed for the purpose of ensuring that these organizations could continue to service existing and future patients enrolled in Medicare manage care plans.[19] Such dues were reasonable and indirectly related to patient care.

BACKGROUND- ISSUE 3 (MEETING/CONFERENCE EXPENSES:

In 1995 the Provider sponsored a symposium to explore the continuum of care concept and the establishment of collaborative strategic alliances. The Intermediary disallowed $8,114 in meeting and training expenses of which $7,804 related to this symposium.[20]

PROVIDER'S CONTENTIONS- ISSUE 3 (MEETING/CONFERENCE EXPENSES:

The Provider maintains that the conference was related to patient care, as it assisted the Provider's long-range planning committee activities, educated the Provider's management and staff on the continuum of care concept, and educated potential alliance members on how to avoid reorganization by forming strategic alliances.[21]

INTERMEDIARY'S CONTENTIONS- ISSUE 3 (MEETING/CONFERENCE EXPENSES:

The Intermediary originally denied these costs as an activity leading to a reorganization. However, this position was subsequently abandoned, and the Intermediary now contends that the conference was a marketing tool and therefore not an allowable cost related to patient care.[22]

FINDINGS OF FACTS, CONCLUSIONS OF LAW, AND DISCUSSION- ISSUE 3 (MEETING/CONFERENCE EXPENSES):

The P.R.M. at §2102.2 defines "costs related to patient care" to include costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Furthermore, P.R.M. §2113.4 provides that a home health agency such as the Provider may undertake education and liaison activities to establish ties with the rest of the health care system. The issue before the Board is whether the

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Medicare payment. Rather, providers subject to rules of non-CMS agencies on lobbying can follow those rules in determining payment under Medicare to the extent such rules are in accordance with Medicare policy which disallows any costs of lobbying activities." (emphasis added.)

[19] Tr. at 206-209, 258-259.

[20] Intermediary's Revised Position Paper at 15, Provider's Post hearing Brief at 14.

[21] Tr. at 222-230.

[22] Tr. at 287-288.

meeting/conference expenses incurred by the Provider in sponsoring a symposium were allowable costs as related to patient care or the provision of provider education.

The testimony of the Provider's representative established that the primary goal of the symposium was to assist the Provider's long-range planning committee's effort to develop programs and strategies to support the organization's mission in light of Medicare's focus on the provision of a continuum of care.[23] The record also establishes that the costs were reasonable in relation to the number of attendees (of which approximately 50% were from the Provider's staff and management) provided educational training.[24] The Board finds, therefore, that the meeting/conference expenses for the symposium were reasonable and allowable as related to patient care.

DECISION AND ORDER:

Issue 1: Related Party Transaction Costs

The Intermediary's adjustment is reversed.

Issue 2: Association Membership Dues

The Intermediary's adjustment is reversed.

Issue 3: Meeting/Conference Expenses

The Intermediary's adjustment is reversed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esq.
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West (dissenting on Issue 1)
Yvette C. Hayes

DATE: May 22, 2007

FOR THE BOARD:

Suzanne Cochran
Chairperson

[23] Tr. at 221-227.
[24] Tr. at 223, 260.

Dissenting Opinion of Anjali Mulchandani-West with respect to Issue 1: Whether the Intermediary's adjustment to related party transaction cost was proper.

The Board majority found that the Intermediary's adjustment should be reversed because the Provider met the 42 C.F.R. §413.17(d)(1) and P.R.M. §1010 exception criteria to the related party principle. I respectfully dissent.

42 C.F.R. §413.17(d)(1) allows the provider an exception to the related party principle if it demonstrates to the intermediary that it has met four criteria. The regulation at issue in this case, 42 C.F.R. §413.17(d)(1)(ii), states that "a substantial part of [the supplying organization's] business activity of the type carried on with the provider is transacted with others than the provider and organizations related to the supplier by common ownership or control. . ."

Neither the regulations nor the Medicare program instructions specify a particular standard of measurement for defining the term "substantial part" as used in the regulation above. However, P.R.M. Section 1010.1 entitled Examples of Applying the Exception interprets the regulation by stating that "the exception is intended to cover situations where large quantities of goods and services are supplied to the general public and only incidentally are furnished to related organizations."

In this case, the record indicates that approximately 57% of VNHC's revenue was derived from unrelated organizations. Approximately 43% of VNHC's revenue was derived from the Provider. Further analysis of the record reveals that while VNHC serviced a total of 61[25] clients during the fiscal year ended December 31, 1995, 43 of them were individual private patients, and therefore, probably constituted a small portion of its revenues. Of the home health agencies that VNHC contracted with during that year[26], the provider represented the largest share of sales (42.05%). The second largest home health agency only accounted for 27.46% of VNHC's sales for that year and the share of sales for each of the remaining home health agencies was less than 10%.

Based on the record, it is clear that, in relation to its other clients, VNHC conducted a significant portion of its business with the provider and that it considered the provider to be a major client. The provider has not been able to demonstrate that VNHC conducted a substantial part of its activity with organizations other than those related to it.

I disagree with the Board majority's conclusion that the P.R.M. interpretation of the regulation cannot be reconciled with the "substantial" standard of the regulation. I believe that the instruction is reasonable in its interpretation and when applied to this case, clearly demonstrates that the services furnished to the provider by VNHC were significantly more than "incidental." The provider has failed to meet the "substantial" requirement of the regulation.

[25] Provider Exhibit 14
[26] Provider Exhibit 21 page 4

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Anjali Mulchandani-West