CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
VNA of Albany, Inc.	**Determination for Cost Reporting Period Ending: December 31, 1995**
Provider	
vs.	
Blue Cross Blue Shield Association / United Government Services, LLC	**Review of: PRRB Dec. No. 2007-D36 Dated: May 22, 2007**
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)). CMS' Center for Medicare Management (CMM) submitted timely comments, requesting reversal of the Board's decision concerning Issue Nos. 1 and 2. The parties were notified of the Administrator's intention to review the Board's decision with respect to Issue Nos. 1 and 2. The Provider submitted timely comments requesting affirmation of the Board's decision concerning Issue Nos. 1 and 2. The Intermediary submitted comments requesting reversal of the Board's decision concerning Issue Nos. 1 and 2. Accordingly, this case is now before the Administrator for final agency review..[1]

[1] The Parties did not submit comments nor request review of Issue No. 3 in this case. Issue No. 3 involved whether the Intermediary's adjustment to disallow meeting/conferences expense was proper. The Board found that the Provider demonstrated that the conferences were related to patient care and that the costs were reasonable. The Administrator summarily affirms the Board's decision as it relates to Issue No. 3.

ISSUE NO. 1 AND BOARD'S DECISION

Issue No. 1 is whether the Intermediary's adjustment to related party transaction cost was proper.

The Board majority found that the Intermediary's adjustment should be reversed since the Provider met the exception criteria to the related party principle in the regulations and manual instructions. The Board majority stated that the record supports the existence of an "open competitive market" for the type of services furnished by VNHC and that a "substantial part" of VHNC's business was conducted with unrelated organizations.

The Board minority dissented to the Board majority's decision stating that neither the regulations nor the program instructions specify a particular standard of measurement for defining the term "substantial part" as used in the regulation. However, the program instructions state 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. Therefore since VNHC conducted a significant portion of its business with the Provider and has not demonstrated that it conducted a substantial part of its activity with organizations other than those related to it, the exception requirement is not satisfied.

ISSUE NO. 2 AND BOARD'S DECISION

Issue No. 2 is whether the Intermediary's adjustment to disallow portions of membership dues expense was proper.

The Board found that none of the Provider's membership dues for NAHC, NYSAHCP and HCANYS were used for lobbying activities, as alleged, and therefore should not have been subject to partial disallowance. The Board also found that the evidence establishes that the membership dues attributable to the VNA Network were related to patient care and therefore an allowable cost.

SUMMARY OF COMMENTS

ISSUE NO. 1

CMM submitted comments requesting that the Administrator reverse the Board's decision concerning Issue No. 1. CMM states that there are no specific percentages or objective rules to establish and determine substantial ownership. Instead, each determination of ownership is made on the basis of the facts of each case. CMM states that all the criteria must be met in order for the allowable cost not to be limited by the principle on cost to related organizations.

The Intermediary stated that the Board's decision on this Issue should be reversed. The Intermediary reiterated the dissenting Board member's opinion that the issue is not simply a debate over whether a certain percentage constitutes a "substantial part", instead all requirements of the exception criteria must be met.

The Provider commented, stating that the Board's decision on this issue should be affirmed. The Provider asserted that there is nothing in the program instructions to support the argument that "incidentally" should be read to have a quantitative meaning. Thus, the facts of the situation would then be evaluated to determine if the "substantial part" of the business was conducted with unrelated organizations.

ISSUE NO. 2

CMM submitted comments requesting reversal of the Board's decision on this issue relative to the dues paid to NAHC, NYSAHCP and HCANYS. CMM disagreed with the Board stating that Section 2139 of the Provider Reimbursement Manual (PRM) provides that provider costs related to political and lobbying activities are unallowable, and section 2139.3 provides that any portion of organization dues related to these activities is unallowable.

The Intermediary submitted comments requesting reversal of the Board's decision on this issue relative to the dues paid to NAHC, NYSAHCP and HCANYS. The Intermediary challenged the Board's finding as to the lobbying portion of this issue. The Intermediary stated that the IRS provisions put an obligation on organizations like the ones at issue in this case, to accurately report to their membership how funds are used.

The Provider submitted comments requesting affirmation of the Board's decision on this issue. The Provider argued that the IRS provision at issue does not apply to the Provider since it is only applicable to for-profit entities. Therefore, it is consistent with the manual instructions to elect not to follow the IRS provision and to instead provide suitable proof to the Intermediary regarding the true allocation of its membership dues to lobbying.

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 were received timely and are included in the record and have been considered.

ISSUE NO. 1

Section 1861(v)(1)(A) of the Social Security Act establishes that Medicare pays for the reasonable cost of furnishing covered services to program beneficiaries, subject to certain limitations. This section of the Act also defines reasonable cost as "the cost actually incurred, excluding there from any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." The Act further authorizes the Secretary to promulgate regulations establishing the methods to be used and the items to be included in determining such costs.

Under the 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.[2] However, there is an exception to this rule. Under 42 C.F.R. §413.17(d), an exception is met if a provider demonstrates by convincing evidence that it satisfies all of the following criteria are met;

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

(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 . . .[first prong] and there is an open, competitive

[2] 42 CFR §413.17(a).

> market for the type of services, facilities, or supplies furnished by the organization [second prong]; and
>
> (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…; 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.

PRM 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 skilled nursing facility. A substantial amount of 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 costs, not to exceed the amounts charged to the general public or to other institutions for similar services.

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

The 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. 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. In its Medicare cost report for fiscal year ending (FYE) 12/31/95, the Provider reported billed charges of $766,371 paid to VNHC for services provided. The Intermediary disallowed $21,870 of the cost claimed, concluding that the exception at 42 CFR §413.17(d) did not apply.

The record indicates that approximately fifty seven percent (57%) of VNHC's revenue was derived from unrelated organizations. Approximately forty three percent (43%) of VNHC's revenue was derived from the Provider. The record also shows that VNHC serviced sixty one (61) clients during the FYE December 31, 1995, forty three (43) of them were individual private clients, and therefore, probably constituted a small portion of its revenues.

Of the home health agencies that VNHC contracted with during that year, the Provider represented the largest share of sales forty two point zero five percent (42.05%). The second largest home health agency only accounted for twenty seven point four six percent (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 ten percent (10%).

Base on the record, the Administrator finds that VNHC conducted a significant portion of its business with the Provider and it considered the Provider to be a major client. Quite opposite to the regulatory and manual instructions above, VNHC has demonstrated that the substantial portion of its business is derived from the Provider, instead of outside organizations. As stated in the manual instructions, 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.[3] This implies that the incidental services supplied to the provider should not be the sustaining source of revenue or sales to the related party.

Thus, based on the foregoing, the Administrator concludes that the Provider has not demonstrated by convincing evidence that the related organization provided a substantial portion of its services to entities other than the Provider.[4] Accordingly, the Administrator reverses the Board's decision as to Issue No. 1.

---

[3] See e.g. Condado Home Care Program v. Secretary, 775 F.2d 457 (1985), with respect to the "incidental" element of the criteria ("We would wonder if it would not have to be ruled as a matter of law that 37 percent is more than incidental.")

[4] A review of prior Administrator and Board decisions on this issue, including Health Central Inc., PRRB Dec. No. 78-D40 and American Medical International v. Secretary, 466

ISSUE NO. 2

Section 2138.1 of the PRM establishes that the Medicare program considers membership in a professional, technical, or business related organization to be an allowable cost. This section defines allowable costs as including "initiation fees, dues, special assessments, and subscriptions to professional, technical or business related periodicals." PRM §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.

In addition, Section 2139.3 of the PRM provides that Federal income tax rules that require tax-exempt organizations to report to their members the non-deductible portion of dues related to the organization's lobbying and political activities satisfies Medicare's requirement for identifying the dues related to these activities. This section provides that if an organization is not required to report such information to its members, the portion of dues for these activities remains unallowable for Medicare purposes. Therefore, whether or not a Provider is subject to the Federal income tax rules, the portion of the dues related to lobbying activities is an unallowable Medicare cost.

Finally, Section 2139.2A of the PRM provides that for Medicare purposes, a Provider can follow rules of non-CMS agencies on lobbying in determining payment under Medicare "to the extent such rules are in accordance with Medicare policy which disallows any costs of lobbying activities." The intent of that language is that the portion of dues identified by an organization as related to lobbying, is unallowable for Medicare purposes.

In 1995, the Provider was a member of the National Association of 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. Additionally, in 1995 the Provider was a member of the New York State VNA Network, Inc.

F. Supp. 605, 618 (D.C. 1979)(finding revenue from unrelated providers of 52 percent, 64 percent and 67 percent was not substantial within the meaning of the criterion) aff'd, 677 F. 2d 118 (D.C. Cir. 1981), indicates that the Tip of Illinois Health Services, Inc., Admin. Dec. No. 93-D29, finding on "substantial" was not consistent with prior decisions and may have been relying on the type of service being provided, i.e., daycare. However, Administrator decisions are not precedential.

(VNA Network), and the Intermediary disallowed one hundred percent (100%) of the dues expense incurred for that membership totaling $16,000.

In light of the foregoing, the Administrator finds that the Board should be reversed on the specific portion of Issue No. 2 that relates to dues paid by the Provider to NAHC, NYSAHCP, and HCANYS.[5] As evidenced in the record, NAHC, NYSAHCP, and HCANYS billing invoices indicate the percentage of revenue used for lobbying activities. As indicated in the manual instructions above, such costs are unallowable for Medicare purposes. As such, the Intermediary's adjustment made under PRM §2139.3 for such costs were properly found to be unallowable costs.

Therefore, the Administrator concludes that the Provider is not allowed to claime costs associated with lobbying activities resulting from membership dues paid to NAHC, NYSAHCP, and HCANYS. Accordingly, the Administrator reverses the Board's decision as to Issue No. 2 specific to membership dues paid to NAHC, NYSAHCP, and HCANYS. The Administrator affirms the Board's decision as to Issue No. 2 as it relates to membership dues attributable to the VNA Network.

[5] The Administrator affirms that aspect of the Board's decision specifically finding that the Providers membership dues payable to VNA Network is an allowable cost since those activities are related to patient care.

DECISION

In accordance with the foregoing opinion, the Administrator finds as follows:

ISSUE NO. 1

The decision of the Board as it relates to Issue No. 1 is reversed.

ISSUE NO. 2

The decision of the Board as it relates to Issue No. 2 is modified. That aspect of the Board's decision is reversed as it relates to membership dues paid to NAHC, NYSAHCP, and HCANYS. That aspect of the Board's decision is affirmed at it relates to membership dues attributable to the VNA Network.

ISSUE NO. 3

The decision of the Board as it relates to Issue No. 3 is summarily affirmed.

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

Date: 7/18/07

/s/
Herb B. Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services