PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

99-D 68
REISSUED DECISION

PROVIDER -
VNA Health Care Services, Inc
VNA of Brooklyn

Provider No.
VNA HealthCare Services, Inc. 33-7005
VNA of Brooklyn 33-7002

vs.

INTERMEDIARY -
United Government Services

DATE OF HEARING-
February 18-19, 1999

Cost Reporting Period Ended -
December 31, 1995

CASE NO.
VNA Health Care Services Inc. 98-2042 &
VNA of Brooklyn 98-2046

INDEX

This decision is a reissuance of the original PRRB Dec. No. 99-D68 issued on September 17, 1999. In the original decision, the Board modified the Intermediary's adjustment and specified a new utilization and apportionment statistic. The parties' to the decision asked the Board to clarify how the adjustment should be implemented. This decision more clearly defines the adjustment methodology.

ISSUES:

1. Was the Intermediary's adjustment to home health aide hours proper?

2. Was the Intermediary's adjustment to public relations costs proper?

3. Was the Intermediary's adjustment to medical supply costs proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Visiting Nurse Association Health Care Services, Inc. ("VNAHCS") and Visiting Nurse Association of Brooklyn ("VNAB"), also referred to as the Providers, are Medicare certified home health agencies located in Staten Island, New York and Brooklyn, New York, respectively. For the year ended December 31, 1995, both VNAHCS and VNAB filed Medicare cost reports with United Government Services, Inc. ("Intermediary"); which resulted in the issuance of a Notice of Program Reimbursement ("NPR") to each Provider.

The Intermediary, in analyzing the Providers' cost reports, identified variances in home health aide visit length, visit costs, and cost to charge ratios between Medicare and non-Medicare patients. Following a study of patient records, the Intermediary identified what it believed to be improper cost apportionment and cost shifting. The NPRs reduced the total reimbursement to each agency by decreasing the number of hours for home health aide visits on Worksheets C and S-3 of the home health agency cost report.[1] At VNAB, the hours in question were moved out of the home health aide cost center and the costs associated with those hours were disallowed. The home health aide costs for VNAHCS were moved out of the home health aide cost center and placed in a non-reimbursable cost center.

The Intermediary also disallowed two separate VNAHCS public relations expenditures, citing non-allowable advertising expenses, and meal costs not related to patient care.[2] In addition, the Intermediary determined that VNAB incorrectly included non-routine medical supplies within the routine medical supply cost center.[3]

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[1] Provider's Hearing Exhibits,Volume 1, P-B-4
Id at Volume 2, P-S-36 a, b, & c.

[2] Intermediary Exhibit S- VNA Health Care Services, Inc.

[3] Intermediary Exhibit S- VNA of Brooklyn

Both VNAHCS and VNAB timely appealed the Intermediary's adjustments to their NPRs and have met the jurisdictional requirements of 42 C.F.R. §§ 405.1835 - .1841. The Board agreed to hear both cases together with the nexus being the commonality of the primary issue. At the hearing, all parties agreed that the hearing would be designated as a concurrent hearing. [4]

The total amount of Medicare reimbursement in dispute for VNAHCS is $ 301,216; for VNAB, the amount is $ 1,695,656.[5] The Providers were represented by Connie A. Raffa, Esq. and Robert E. Wanerman, Esq. of Arent Fox Kintner Plotkin and Kahn, PLLC. The Intermediary was represented by Bernard M. Talbert, Esq. and Eileen Bradley, Esq. of the Blue Cross and Blue Shield Association.

Issue No. 1. Home Health Aide Hours and Costs

Facts

The dispute between the parties centers on the method used by the Intermediary to determine the hours spent by home health aides with patients during a visit that may be included in the home health aide cost center. The Intermediary's review of cost report statistics revealed that the average length of time for a home health aide visit to a Medicare patient was approximately 4 hours; while the time of an aide visit to a non-Medicare patient was approximately 50% greater at VNAHCS and approximately 100% greater at VNAB.[6] A comparison of the aide service provided to Medicare patients with that provided to non-Medicare patients shows that more visits, of a longer duration, were provided to the non-Medicare patients (mostly Medicaid beneficiaries). The calculation used by both Providers to determine the Medicare home health aide cost per visit utilized a disparate number of hours of service provided to the non-Medicare patients. This resulted in a significantly higher cost per visit statistic which was then applied to Medicare visits.

The Intermediary concluded that the inclusion of other aide hours in the Medicare cost reports resulted in an inappropriate apportionment and cost shifting to the Medicare program. It conducted a study of patient records to look behind the differences in home health aide visit length between Medicare and other payers. The stated purpose of the study was to determine if a number greater than the 4 hours per visit could properly be attributable to services provided to non-Medicare patients. The Intermediary determined it would be proper to include non-Medicare aide hours which would serve to raise the average hour per visit (Medicare like hours) to 4.63 hours at VNAHCS,[7] and 4.375 hours at

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[4] Tr. at pages 4, 5.

[5] See Intermediary Exhibit(s) R in both cases.

[6] See Intermediary Exhibit(s) B in both cases.

[7] Intermediary Exhibits G and Q - VNAHCS.

VNAB.[8] Hours exceeding that amount were deemed to represent hours used to provide non-allowable services. Therefore, the costs were viewed as non-allowable, and not subject to apportionment. Specifically, costs related to home health aide visits were reduced by $ 293,595 at VNAHCS; $ 1,691,700 at VNAB.[9]

Medicare Statutory and Regulatory Background:

The disagreement between the parties centers around the interpretation of three different Medicare regulations.

42 C.F.R. § 413.9 Cost related to patient care

> (a) Principle. All payments to providers of services must be based on the 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 subject to principles relating to specific items of revenue and cost.
>
> (b)(1) The objective is that under the methods of determining costs, the costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program.

42 C.F.R. § 413.53 Determination of cost of services to beneficiaries

> (a) Principle. Total allowable costs of a provider will be apportioned between program beneficiaries and other patients so that the share borne by the program is based upon actual services received by program beneficiaries. The methods of apportionment are defined as follows:
>
> (3) Cost per visit by type-of-service method- HHAs. For cost reporting periods beginning on or after October 1, 1980, all HHAs must use the cost per visit by type-of-service method of apportioning costs between Medicare and non-Medicare beneficiaries. Under this method, the total allowable cost of all visits for each type of services is divided by the total number of visits for that type of service. Next, for each type of service, the number of Medicare covered visits is

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[8] Intermediary Exhibits G and O - VNAB.

[9] Intermediary Exhibit Q.- VNAHC; Intermediary Exhibit O- VNAB.

> multiplied by the average cost per visit just computed. This represents the cost Medicare will recognize as the cost for that service, subject to cost limits published by HCFA.

42 C.F.R. § 409.45(b) Home health aide services

> This regulation provides that the reason for visits by the home health aide must be: [t]o provide hands-on personal care to the beneficiary or services that are needed to maintain the beneficiary's health ... section (b)(1); [o]rdered by a physician in the plan of care; and provided by the home health aide on a part-time or intermittent basis ... section (b)(2); [r]easonable and necessary... section (b)(3); and [i]ncidental to a visit that was for the provision of care ... section (b)(4).

PROVIDER'S CONTENTIONS:

The Providers contend that the Intermediary incorrectly imposed coverage requirements, applicable only to the payment of individual claims, on the cost apportionment process set forth in 42 C.F.R. § 413.53(a)(3).

They point out that the United States Supreme Court has held that "the logical sequence of a regulation or a part of it can be significant in interpreting its meaning." Shalala v. Guernsey Memorial Hospital, 514 U.S. 87, 115 (1994). The Court observed that the cost reimbursement regulations in 42 C.F.R. Part 413 set out a sequence that formally embodies a three step process to calculate reimbursement. First, all costs are determined. Second, nonallowable costs are removed. Third, the allowable costs are then apportioned between the Medicare program and other payors. Id. See also 42 C.F.R. § 413.50(a). The apportionment consists of determining the average cost per visit for each of the six disciplines of services provided by home health agencies and multiplying that average cost per visit by the number of Medicare covered visits for a particular discipline. Thus, home health aide costs for services that constitute personal care under the medical care plan are first placed in the home health aide cost center and then divided by the total number of home health aide visits to determine the average cost of a home health aide visit. The Providers contend that these regulations speak for themselves; there is no cross reference in Part 413 to the eligibility and coverage regulations of 42 C.F.R. § 409.42, or the corresponding manual provisions in HCFA Pub.-11 § 203, that are used to pay individual claims. Therefore, the Providers contend that when determining the average cost of a visit by discipline, the only test is whether the costs and hours represent home health aide services as defined in subparagraphs 1, 3, and 4 of 42 C.F.R. § 409.45(b), but not subparagraph 2, which discusses specific Medicare coverage criteria (ordered by physician, in plan of care, on a part time or intermittent basis). The Providers point out that the Intermediary's position was summarized at the hearing by the testimony of the Intermediary witnesses.[10] Both witnesses testified that the adjustments to the home

[10] Tr. at p. 578.

health aide cost center, which removed costs and hours from the statistical data, were made because the Intermediary applied the eligibility and coverage criteria that are used when reviewing an individual claim for payment by Medicare to the cost report process of determining the average cost of a home health aide visit.[11] Thus, the Providers are not in agreement with the Intermediary position that the only costs that can be entered in the home health aide cost center are for (1) home health aide services provided to patients who are homebound patients under the care of a physician with a plan of care for a skilled service, and (2) home health aide services provided on a part time or intermittent basis. The Providers contend that these requirements for payment of individual claims are the Medicare "beneficiary qualifications for coverage of services" regulation, 42 C.F.R. § 409.42.

By imposing requirements for Medicare reimbursement for individual beneficiary claims on cost reporting principles, the Intermediary has mixed oranges and apples and created a theory that renders the apportionment step in cost reporting moot and ignores the concept of an average cost. The Providers argue that if the costs of only Medicare covered home health services provided to patients who meet Medicare eligibility requirements are included in the home health aide cost center, then the resulting cost per visit reflects the costs for Medicare services only and is not a true provider cost report.

If the average cost of a home health aide visit is the average cost of only Medicare covered home health aide visits, then nothing is left to apportion.

The Providers further contend that the Intermediary erred by equating allowable costs with Medicare covered costs in making the adjustments to the home health aide cost center.
One of the crucial regulations in this appeal is 42 C.F.R. § 413.53(a)(3), entitled "Determinations of Cost of Services to Beneficiaries: Cost per visit by type of service method HHAs." The relevant language in this regulation states:

> For cost reporting periods beginning on or after October 1, 1980, all HHAs must use the cost per visit by type-of-service method of apportioning costs between Medicare and non-Medicare beneficiaries. Under this method the total allowable cost of all visits for each type of services is divided by the total number of visits for that type of service. Next, for each type of service, the number of Medicare covered visits is multiplied by the average cost per visit just computed. This represents the cost Medicare will recognize as the cost for that service, subject to cost limits published by HCFA.

Id.

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[11] Tr. at p. 441, 494-503, 539-40.

The Providers contend that the Intermediary's misunderstanding of the terms "allowable cost" and "Medicare covered visits" is one of the basic flaws in the Intermediary's position. The Intermediary witness initially testified that "Medicare considers covered and allowable in the same context, meaning that for the purposes of a Medicare visit, if the services meet the definition of a Medicare-covered service, they would automatically become allowable for payment by Medicare."[12] However, when questioned by a Board member, the witness agreed that "the costs of services, not necessarily covered services" are allowable costs.[13] This confusion appeared to be caused by the Intermediary's interjection of eligibility and coverage requirements into the cost reporting methodology discussed above. Allowable costs for home health aide visits, or any of the other five disciplines of services, are costs that are related to patient care, are reasonable and necessary for the provision of care, are not substantially out of line with other similarly situated home health agencies, are not luxury items, and are not for fund raising, solicitation, or personal use. See 42 C.F.R.§ 413.9, and HCFA Pub. 15-1 § 2102 et seq.

The Providers contend that identifying what portion of the allowable costs should be reimbursed by Medicare, as opposed to other payors, is addressed in the apportionment step of §413.53(a)(3) when the average cost per visit is divided between the number of Medicare and other payor visits. In the instant case, the Intermediary never justified its rationale for the adjustments by alleging that the costs were not allowable.[14] Instead, it attempted to convert the meaning of "allowable costs" to "covered costs," contrary to the plain meaning of 42 C.F.R. § 413.53(a)(3). The term "Medicare type service," referenced by the Intermediary, does not appear in § 413.53(a)(3), or in any of the cost report instructions for Worksheet C of the Medicare cost report prior to 1995.[15]

The Providers also argued that the Intermediary incorrectly relied on the differences between Medicare and Medicaid reimbursement when it determined that the average cost of a Medicare visit exceeded that of a Medicaid visit. The Providers pointed out that the Medicare program reimburses home health aide visits on an average cost per visit basis, while the New York State Medicaid program pays for these visits on an hourly basis.

The Intermediary 's position suggests that the difference in reimbursement methodologies between Medicare and Medicaid created a "distortion in cost apportionment" because a 12-hour visit is not separated into a "four hour component" for a Medicare visit and a separate 8 hour "Medicaid" visit.[16] The alleged distortion results from the realities of payment: Medicare pays on an average cost per visit

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[12] Tr. at p 612, 628.

[13] Tr. at p. 651-653.

[14] Tr. at p. 50-51.

[15] Tr. at p. 59-69.

[16] Tr. at p. 450.

basis which, in the Intermediary's calculations, reflects an average visit of 6 hours in length. However, the Intermediary contends that because the average visit billed to Medicare under the claims process was only 4 hours long, only 4 hours should be entered in the home health aide cost center. Furthermore, since Medicaid pays the home health agency on an hourly basis for the additional 8 hours above the first four, the Intermediary believes that the provider has been made whole.[17]

Both Providers contend that they complied with 42 C.F.R. § 413.53(a)(3), and the cost report instructions describing the methodology to compute the average cost of a home health aide visit. Those requirements instruct that the costs included in the home health aide cost center and hours included in the statistical data must consist of home health aide visits that meet the definition of 42 C.F.R. § 409.45(b)(1)and (3-4), irrespective of the length of the home health aide visit.

Therefore, there is no "double billing" or aberrant activity in billing an individual claim for a 12 hour home health aide visit to a dual eligible patient by splitting the hours and billing a 4 hour visit to Medicare to comply with part-time or intermittent coverage requirements, and the remaining 8 hours to Medicaid. The fact that Medicare pays on an average cost per visit basis and Medicaid pays on an hourly basis is not under the Providers' control. VNAB and VNAHCS were merely complying with two distinct methods of reimbursement for individual claims for services provided to a dually eligible patient. Both Providers complied with two sets of regulatory schemes with two separate purposes: one scheme covered payment of individual Medicare claims, while the other addressed computing the average cost per visit. The Providers contend that the Intermediary adjustments are not supported by regulations because they co-mingle two different regulatory schemes.

The Providers point to testimony presented at the hearing which illustrates the Intermediary's blurring of these parallel systems. First, the Intermediary witnesses acknowledged that the coverage and eligibility requirements do not apply to the determination of an average cost per visit in 42 C.F.R. § 413.53(a), and that an "allowable cost" is not interchangeable with a "covered cost."[18] Second, limiting the number of home health aide hours billed to Medicare in a week to comply with the individual claims reimbursement coverage requirements does not mean that the rest of the hours in that one home health aide visit are not home health aide services as defined in 42 C.F.R. § 409.45(b)(1) and (3-4).[19] The remainder of the hours in that one visit should be included in the home health aide cost center to determine the average cost of a home health aide visit because they are home health services.[20]

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[17] Tr. at p. 450-451.

[18] Tr. at pages 626-29 & 651-53.

[19] Tr. at p. 288.

[20] Tr. at 199-201.

Third, contrary to the Intermediary position, there is no time limit on the length of a visit as defined at 42 C.F.R. § 409.48.[21] Therefore, denial of services based on numerical utilization screens, diagnostic screens, diagnosis or specific treatment norms is not appropriate.[22] Furthermore, the Board has held that "neither the regulations nor the Provider Reimbursement Review Manual link hours and visits." See Confident Home Health Care v. Blue Cross and Blue Shield Association, Blue Cross and Blue Shield of Iowa, PRRB Decision No. 98-D5,1997-2 Medicare and Medicaid Guide (CCH) ¶ 45,760 (1997), declined rev. HCFA Administrator Dec. 17,1997.

Fourth, HCFA policy as expressed in HCFA Pub. 11 § 206.7 states that "home health aide and /or skilled nursing care in excess of the amounts of care that meet these definitions of part-time or intermittent may be provided to a home care patient or purchased by other payers without bearing on whether the home health aide and skilled nursing care meets the Medicare definitions of part-time or intermittent." Thus, contrary to the Intermediary's testimony, a home health aide visit that is longer than the part time or intermittent claims reimbursement requirement is still a home health aide visit that can be included in the home health aide cost report to calculate the average cost of a home health aide visit.[23]

Fifth, the Intermediary witness testified that because home health aide services were provided to some patients on the "Expedited Hospital Discharge Program," commonly referred to as the Bridge Program, the costs and hours of home health services used to compute the average cost per home health aide visit contained some medical and some social service functions that Medicare doesn't [pay for] in terms of eligibility," resulting in cost shifting.[24] This argument has no factual merit in this case as two Provider clinical witnesses testified that the patients in the samples reviewed by the Intermediary, which form the basis of these adjustments, were receiving home health aide services as defined in federal regulations and not home attendant, homemaker, housekeeper, personal care aide, bath aide, or custodial services.[25]

Also, both Providers have a non- reimbursable cost center (commonly known as "below the line" costs) where costs for these types of services were and are placed.[26] This is consistent with the Intermediary's protocol for the home health aide audits in the "Desk and Field Audit Instructions,"

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[21] Tr. at pages 292, 513, & 565.

[22] Tr. at p. 291.

[23] Tr. at p. 632-33.

[24] Tr. at p. 458-59, 501.

[25] Tr. at pages 280-81, 284, 286, 297-320, 322, 367, 382-411, 424, & 430.

[26] Tr. at pages 68-69 & 155-56.

which directed auditors to consider whether the provider had a non-reimbursable cost center.[27] Thus, the Provider contends there is no factual basis to substantiate that any cost shifting was occurring.

The Providers also contend that the Intermediary relied on an invalid statistical methodology with regard to its medical review effort. Specifically, they challenge the sample used by the Intermediary to conduct its review of cases and the resulting inference that only 4.375 hours (in the case of VNAB) per visit constituted "Medicare like" services. At the hearing, the Providers produced an expert witness who testified that: (1) the sample was drawn from a different universe than the universe of all Medicaid-eligible patients treated by each agency during 1995;[28] (2) the sample was selected in a manner that intentionally excluded all cases with visits of four hours or less,[29] and (3) the Intermediary used a simple arithmetic mean to calculate the average length of a visit, and failed to weight any element in the sample to correct for either the probability of selection or the number of visits each patient received.[30] Based on the above, the Providers rely on HCFA Ruling 86-1,[31] and the Board's decision in Girling Health Care, Inc. v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Iowa, PRRB Dec. No. 97-D96, Medicare and Medicaid Guide (CCH) ¶ 45,646 to support their position that unless the sample complies with acceptable statistical methods, no inferences can be drawn from the sample and projected to the universe of claims or costs under review.

Finally, the Providers contested the findings of the Intermediary's primary medical reviewer, who reviewed a sample of records and concluded that many of the hours included in the home health aide cost centers did not meet the scope of home health aide services. The Providers presented testimony from two witnesses to establish that the adjustment made by the Intermediary based on the sample cases did not accurately reflect a review of the entire patient record and overlooked significant information about the patients' clinical condition and requirements.[32]

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that cost shifting or cross subsidization has occurred as the result of the Providers' aggregating all costs in a combined cost center and using the identified visits as a common apportionment statistic. This produces a distorted result in which Medicare assumes a significant part

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27 Tr at p. 155-156.

28 Tr. at p. 215-216.

29 Tr. at pages 214-215, 236.

30 Tr. at pages 219-220, 223-228, 239-240.

31 Provider Exhibit P-B/S-40b

32 Tr. at pages 350-377.

of the cost of non-Medicare patients. In support of its position, the Intermediary points to an analysis of statistics taken from the VNAB Medicare cost report. (The fact pattern at VNAHCS was substantially similar).

In FYE December 31, 1995, VNAB filed a Medicare cost report wherein the total cost of home health aide services was approximately $ 5,700,000, and the total number of visits was approximately 60,000. The resulting average cost of $ 95.00 was applied to the 24,000 Medicare visits. An analysis of the visit hours revealed that the average hours for the visits covered by Medicare was approximately 4; while the average hours for the non-Medicare visits were closer to 8. It was this disparity in the average hours between the Medicare visits and non-Medicare visits that underlies the issue.

The Intermediary points out that a significant number of Medicaid patients were referred to VNAB through the New York City Expedited Hospital Discharge Program, commonly referred to as the "Bridge Program". The Medicaid program substantially differs from the Medicare Program in at least two important respects. First, Medicaid pays for homemaker and companion care, which is not deemed to be a Medicare covered service. Secondly, the New York Medicaid program, unlike Medicare, does not require that Medicaid service be provided on a part time or intermittent basis. As a result of the Bridge Program, a significant number of Medicaid patients received extended home health aide care which the Intermediary deemed custodial in nature. The inclusion of custodial care along with Medicare covered service increased the time required by the aides to perform the visits, which in turn burdened the Medicare Program with non-reimbursable costs. Based on the fundamental differences in the Medicare and Medicaid programs, the Intermediary contends that any attempt to simply average the costs and visits into one cost center and to use the result for Medicare reimbursement is wrong.

The Intermediary contends that cost shifting is a statutorily identified element of reasonable cost. The statutory definition of reasonable cost is found at 42 U.S.C. §1395x(v)(1)(A), and states:

> [T]he reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, 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 for various types or classes of institutions, agencies or services. Such regulation shall (I) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this subchapter) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by

> individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs.

Id.

The Intermediary states that, in the instant case, the applicable Medicare regulations at 42 C.F.R. § 413.9 (reasonable costs), and 42 C.F.R. § 413.24 (cost apportionment) must be read in an integrated manner with the objective of determining fair reimbursement and precluding cost shifting. This was confirmed by the testimony of the Intermediary witness who explained how the concepts of covered services and apportionment were related.[33]

The Intermediary also contends that the Providers' criticism of the approach used by the Intermediary to calculate its adjustments is without merit. The Intermediary asserts that a recalculation of the Medicare average based upon weighting the number of visits (as suggested by the Provider) does not result in any significant change. Further, the Intermediary notes that Providers did not present any alternative statistical analysis. Finally, the Intermediary points out that its study resulted in a favorable determination on behalf of the Provider, in that it did not remove all non-Medicare activity for cost finding purposes. The Intermediary could have adjusted the non-Medicare home health aide hours down to the Medicare average, resulting in less reimbursement to the Provider.

Issue No. 2 - Public Relations Costs:

Facts

VNAHCS distributed calendars to current patients, physicians, clergy, and other social service agencies on Staten Island. The calendars contained information on general health and well-being along with a brief description of its services and how it could be contacted.[34] In addition, the Provider also sponsored a dinner during National Home Care Week to recognize the contributions of many volunteers whose efforts are an integral part of the services that VNAHCS provides. In its 1995 cost report, the Provider claimed $ 6,935 for the cost of the senior health calendars. The Intermediary disallowed the entire amount. $ 10,664 of the costs associated with National Home Care Week were disallowed by the Intermediary. Of that amount, the Provider is appealing $ 3,648.

PROVIDER'S CONTENTIONS:

The Provider contends that the costs incurred for printing and distributing the calendars is an allowable expense under HCFA Pub. 15-1 § 2136.1. The Provider's witness presented uncontradicted

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[33] Tr. at pages 605-606, 641-643.

[34] Provider Exhibit P-S 37.

testimony that the calendars contained general health information related to exercise, diet, and preventive care. The text of the calendars was neither focused on home health care nor even within the Provider's control. The witness testified that the text was written by the company that printed the calendars, which does not provide health care services at all.[35]
The Provider also relies on the Board's decision in Pacific Hospital of Long Beach (Long Beach, CA) v. Aetna Life Insurance Company, PRRB Dec. No. 94-D4 Medicare And Medicaid Guide (CCH) ¶ 42,050, which found that health calendars did meet the test in Section 2136.1 of HCFA Pub. 15-1.

With regard to the National Home Care week activities, the Provider contends that the dinner it hosted for its volunteers is an accepted practice in the Staten Island area. Moreover, it argues that the dinner is related to patient care because it helps foster the recruitment and retention of volunteers who comprise the agency's board of directors and staff significant community outreach programs. The Provider points to Sid Peterson Memorial Hospital v. Blue Cross and Blue Shield Association of Texas, PRRB Dec. No. 99-D24, Medicare & Medicaid Guide (CCH) ¶ 80,161. In that case, the intermediary disallowed costs incurred by the hospital to reward employees who demonstrated exceptional care toward others with free dinners, parking etc. However, the Board rejected the Intermediary's contention that the recognition was intended to increase utilization. The Provider contends the facts in the instant case are much the same, and that the recognition of its volunteers was directly related to patient care in the agency.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that where advertising, such as the calendars distributed by the Provider, exceeds mere informational purposes, the Medicare guidelines and regulations prohibit the expense. HCFA Pub. 15-1 § 2136.1 states that allowable advertising costs includes material involving professional and patient contacts, " if the materials primarily refer to the provider's operations or contain data on the number and types of patients served ... or ... apprise them of the availability of the provider's covered services. Such contacts make known what facilities are available to persons who require such information... and serve other purposes related to patient care." Id.

In this case, the Intermediary asserts that the Provider's use of the printed materials was focused upon increasing the patient utilization. This assertion was based on the type of circulation and the recipients of those calendars. As such, the Intermediary points to HCFA Pub. 15-1 § 2136.2 which states that: " Costs of advertising to the general public which seek to increase patient utilization of the provider's facility are not allowable." Id.

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[35] Tr. at pages 252-254.

Issue No. 3 - Medical Supply Costs:

Facts

The Intermediary removed $ 3,956 from Worksheet A-5, but failed to reclassify these costs as allowable non-routine medical supplies and add them back to the medical supply cost centers on Worksheets A and B. At the hearing, the Intermediary counsel stipulated that the adjustment for medical supply costs would be reversed and withdrawn.[36]

PROVIDER'S CONTENTIONS:

The Provider requests that the Board retain jurisdiction over this issue to allow a means for relief should the Intermediary fail to make the reversal of the adjustment within one year of the date that the administrative record is closed.

INTERMEDIARY'S CONTENTIONS:

The Intermediary has indicated it will reverse this adjustment.

CITATION OF LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS:

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

§ 1395x(v)(1)(A)	-	Reasonable cost

2. Regulations - 42 C.F.R.

§§ 405.1835-.1841	-	Board Jurisdiction
§ 409.42	-	Beneficiary qualifications for coverage of services
§ 409.45(b) et seq.	-	Home health aide services
§ 409.48	-	Visits
§ 413.9	-	Cost related to patient care
§ 413.24	-	Adequate Cost data and cost finding.

[36] Tr. at page 695.

§ 413.50 et seq.	-	Apportionment of allowable costs
§ 413.53	-	Determination of cost of services to beneficiaries
§ 413.53(a)(3)	-	Cost per visit by type-of-service method-HHAs

3. Program Instructions - Home Health Agency Manual, (HCFA Pub. 11):

§ 203	-	Covered home health services
§ 206.7(c) et seq.	-	Part time or intermittent services

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

§ 2102 et seq.	-	Definitions
§ 2136.1	-	Allowable advertising costs
§ 2136.2	-	Unallowable advertising costs

5. Case Law:

Shalala v. Guernsey Memorial Hospital, 514 U.S. 87 (1994)

Confident Home Health Care v. Blue Cross and Blue Shield Association/Blue Crossand Blue Shield of Iowa, PRRB Dec. No. 98-D5, October 31, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,760, declined rev. HCFA Administrator, December 17, 1997.

Girling Health Care, Inc. v. Blue Cross and Blue Shield Association/Blue Cross of Iowa, PRRB Dec. No. 97-D96, September 10, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,646 , declined rev. HCFA Administrator, November 5, 1997.

Pacific Hospital of Long Beach v. Ætna Life Insurance Company, PRRB Dec. No. 94-D4, December 29, 1993, Medicare & Medicaid Guide (CCH) ¶ 42,050, declined rev. HCFA Administrator, February 8, 1994.

Sid Peterson Memorial Hospital v. Blue Cross and Blue Shield Association/Blue Cross of Texas, PRRB Dec. No. 99-D24, February 23, 1999, Medicare & Medicaid Guide (CCH) ¶ 80,161.

6. Other:

HCFA Ruling 86-1.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, evidence presented, and testimony elicited at the hearing, finds and concludes as follows:

Issue 1- Adjustment to Home Health Aide Hours

The Board finds that the Providers determined their home health aide costs in accordance with the regulation at 42 C.F. R. § 413.53 which states:

> (a) Principle. Total allowable costs of a provider will be apportioned between program beneficiaries and other patients so that the share borne by the program is based upon actual services received by program beneficiaries. The methods of apportionment are defined as follows: ... (3) Cost per visit by type-of-service method-HHAs. For cost reporting periods beginning on or after October 1, 1980, all HHAs must use the cost per visit by type-of-service method of apportioning costs between Medicare and non-medicare beneficiaries. Under this method, the total allowable cost of all visits for each type of service is divided by the total number of visits for that type of service. Next, for each type of service, the number of Medicare covered visits is multiplied by the average cost per visit just computed.

Id.

The Board notes that upon review the Intermediary identified major variances in home health aide visit length and cost per visit between Medicare and non-Medicare patients. This resulted, in large part, from extended services rendered to patients who were participants in the New York City Expedited Home Discharge or "Bridge Program." The Intermediary concluded that the averaging of the longer "Bridge Program" visits (along with their higher related costs) with the shorter Medicare visits resulted in inappropriate cost shifting to the Medicare program.

The Board also notes that the Intermediary computed its reduction to home health aide costs based on a study conducted in 1995 which focused on patients serviced in prior years. Using that study, the Intermediary calculated adjustments at both Providers, which reduced those home health aide costs associated with the extended visits referenced above.

The Board notes that the Medicare law at 42 U.S.C. § 1395x(v)(1)(A) states that the Secretary in promulgating regulations to define and determine reasonable cost, must ensure that, under the method

of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs.

With this principle in mind, the Board finds that the average Medicare aide visit was approximately 4 hours, while the non-Medicare aide visit was approximately 50% longer at VNAHCS, and approximately 100% longer at VNAB. The Board finds the Providers' attempt to average these extended hours and related costs and use the result for Medicare reimbursement produces a distorted result; whereby Medicare assumes significant costs for non-Medicare patients.

The Board also finds that in the dually eligible situation, UNAB would be able to bill $ 13.25 per hour from Medicaid, and at the same time recover approximately $ 84.00 per visit from Medicare. The Board finds this is clearly contrary to the statutory authority noted above, and also results in a cross subsidization of the Medicaid program by Medicare.

The Board finds that the identified Medicare cost per visit (at both Providers) is burdened with costs associated with extended non-Medicare visits. However, the Intermediary approach to adjusting costs raises several questions. First, a plain reading of 42 C.F.R. § 413.53, as well as testimony at the hearing does not result in any linkage of § 413.53 to the eligibility and coverage regulation at 42 C.F.R. § 409.42. Secondly, testimony indicated that the Intermediary never attempted to justify its rationale for its adjustments by alleging that any billed costs were not allowable.

The Board also has a number of reservations with respect to the mechanics of the Intermediary's adjustments. First, persuasive testimony at the hearing revealed that the sampling methodology used by the Intermediary in its 1995 study may have rendered the data invalid for projecting adjustments to the cost report years at issue. Secondly, the Providers' witnesses presented very compelling testimony regarding patient acuity and the necessity for extended aide services.

The Board finds that, in the instant case, neither the methodology used by the Intermediary to calculate its adjustments, nor the cost per visit methodology produce the most accurate or equitable Medicare reimbursement. The Board finds that a better common denominator would be the utilization of a cost per hour methodology, given the significant amount of non-Medicare aide costs factored into the cost per visit computation.

The Board also finds that to properly implement this decision the following actions are required:

1. The starting point is to first eliminate the Intermediary's original adjustments to home health aide costs/statistics which impact this issue.

2. Total hours and Medicare hours should be substituted for visits on Worksheet C of the Medicare cost report, and will serve as the basis for cost apportionment. Schedule C should then be recalculated and the Medicare reimbursable costs will be properly

reflected on Worksheet D of the Medicare cost report. Finalized costs and statistics should be utilized in these calculations.

Issue 2- Adjustment to Public Relations Costs

The Board finds that testimony presented at the hearing and the evidence in the record demonstrate that the calendars contained general health care information. The Board also refers to its previous decision in Pacific Hospital, which held that calendars meet the required test set forth in HCFA Pub. 15-1 § 2136.1. Therefore, the Board concludes that the cost of printing and distributing the calendars is an allowable expense.

The Board finds that the dinner sponsored by VNAHCS to recognize volunteer work is an allowable expense related to patient care. The Board notes that the volunteers enhance the Provider's preventive health program which relates to overall patient care. The Board is not persuaded by the Intermediary's argument that the purpose of the dinner was to increase patient utilization. The Board points to the recent decision in Sid Peterson Memorial Hospital, wherein costs (including meals) incurred to reward hospital employees were found to be related to patient care.

Issue 3. Medical Supply Costs

The Board notes that at the conclusion of the hearing the Intermediary counsel stipulated that the adjustment for medical supply costs would be reversed.

DECISION AND ORDER:

Issue 1 - Adjustment to Home Health Aide Hours

The Board finds an adjustment to home health aide visits/costs is appropriate. However, the Intermediary's original adjustments are reversed. Total hours are to be substituted on Worksheet C of the Medicare cost report to serve as a basis for cost apportionment. Medicare reimbursable costs will then be calculated and reflected on worksheet D of the Medicare cost report.

Issue 2 - Adjustment to Public Relation Costs

The Board finds sufficient evidence in the record, as well as testimony in the hearing, to support the Provider's costs relating to calendars and a dinner recognizing volunteer workers. The Intermediary's adjustments are reversed.

Issue 3 - Supply Costs

In that the Intermediary's counsel stipulated at the hearing that the adjustment would be reversed, the Board agrees to retain jurisdiction over this issue in the event the Intermediary does not reverse its adjustment within one year of the date that the administrative record is closed.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esquire
Martin W. Hoover, Esquire
Charles R. Barker

Date of Reissued Decision: March 27, 2000

FOR THE BOARD:

Irvin W. Kues
Chairman