

**MEDICARE COST REPORTING REQUIREMENTS  
ASSOCIATED WITH MEMBERSHIP DISTRIBUTIONS  
FROM PREMIER PURCHASING PARTNERS LP  
TO ITS MEMBERS**

**PREPARED BY  
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DECEMBER 1, 2008**

## I. Background

In its letter dated July 11, 2003, Premier advised its members that the Office of Inspector General (OIG) of the Department of Health and Human Services had conducted onsite reviews of several Premier members inquiring as to their cost report treatment of distributions from Premier and that OIG audit staff had stated informally to Premier that it was their position that distributions from Premier should be reflected on cost reports. Accordingly, we recommended that each recipient consult with their advisors as to the treatment of their distributions.

According to press reports and public statements issued by several medical supply vendors, in 2003 the United States Attorney in Dallas, Texas commenced a criminal investigation to determine whether vendor payments distributed by Novation, a group purchasing organization (“GPO”) with corporate offices in Dallas, to Novation members in the form of dividends or distributions (“**distributions**”) have been properly disclosed to Medicare.<sup>1</sup> Federal prosecutors issued subpoenas to Novation, as well as medical suppliers that contract with Novation such as Becton Dickinson, Merck, Bristol-Myers Squibb, Genetech, G.E. Healthcare, and Cardinal Health. Connecticut Attorney General Richard Blumenthal conducted a parallel investigation to the federal investigation relating, among other areas, to distributions paid to Connecticut hospitals by Novation. Neither Premier, Inc. (“**Premier**”) nor Premier’s affiliated GPO, Premier Purchasing Partners LP (“**Purchasing Partners**”), received a subpoena in connection with either investigation.

As you will recall, the Office of Audit Services of the OIG completed a review of Premier safe harbor compliance and issued a final report in January 2005. In connection with that review, Premier agreed voluntarily to assume responsibility for direct reporting of administrative fees to individual hospital members, a task previously delegated to owners.

On January 19, 2005, the OIG issued a report relating to GPOs, entitled “Review of Revenue From Vendors at Three Group Purchasing Organizations and Their Members,” A-05-03-00074, which can be found on the web at <http://oig.hhs.gov/oas/reports/region5/50300074.pdf>. This report (the “OIG Report”), which reviewed the activity of three GPOs (including Premier) and selected members of those GPOs, provided important new guidance as to how OIG and the Centers for Medicare and Medicaid Services (CMS) believe distributions should be treated for cost reporting purposes.

The OIG Report indicated that both OIG and the Centers for Medicare and Medicaid Services (CMS) believe distributions should be reflected as a reduction in costs on the cost report. OIG suggested that CMS provide additional guidance as to how distributions should be apportioned among the various cost centers, but CMS at that time

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<sup>1</sup> Mary Williams Walsh, Wide U.S. Inquiry Into Purchasing for Health Care, New York Times (August 21, 2004) at A6; Mary Williams Walsh, U.S. To Address Possible Abuses In Hospital Supply Industry, New York Times (September 14, 2003) at C1.

declined to do so, stating that no additional guidance was needed. The OIG issued a second report in May 2005 discussing the results of a review of three additional GPOs. In the second report, the OIG reiterated that clarification of CMS instructions to hospitals was needed in addressing how to reflect GPO distributions on the hospital cost report.

In response, CMS posted an FAQ on its website, subsequently withdrawn without comment. CMS stated in FAQ 4851 that GPO profit distributions to members should be treated on the cost report as any other discount, allowance, refund, or rebate. However, CMS offered no additional guidance as to how to allocate GPO distributions among cost centers given that the distributions cannot be traced to specific purchases. In the FAQ, CMS also noted the general rule that "where a purchase occurs in one period and the allowance or refund is in a later period, the provider is expected, where possible, to accrue for the allowance or refund in the period of purchase and reduce the cost accordingly. If an accrual cannot be done, amounts received are used to reduce comparable expenses (in the same cost center(s)) in the period received."

## II. Compliance Issue/Structure

In light of the increased federal and state scrutiny afforded to disclosure of distributions, and the release of the OIG Report, we expect some owners and members will decide to review their current Medicare cost reporting practices with respect to such payments. This White Paper is intended to present general considerations that Premier GPO owners and members, in consultation with their legal and reimbursement advisors, may wish to note in undertaking any such review.<sup>2</sup>

This White Paper focuses on the cost report treatment of distributions only. Distributions constitute additional value to Premier owners beyond discounts. All vendor discounts, whether classified as discounts, bonus discounts or rebates (i.e., reductions in price credited after the sale) must be accurately reflected on the cost report. Medicare cost reporting instructions mandate that a provider disclose on its Medicare cost report all "discounts, allowances, refunds, and rebates" received on items for which reimbursement is sought in the cost report. Medicare payment rules provide that discounts and rebates should not be treated as income; rather, they are to be applied to offset the specific costs to which they relate on the Medicare cost report. The OIG Report found a high degree of compliance with this requirement among the members of all three GPOs reviewed.

For purposes of this discussion, we view Purchasing Partners as having three different types of owners: single hospitals, multi-hospital health systems, and contracting organizations with hospital members who are not subsidiaries or corporate affiliates of that contracting organization ("**Contracting Organizations**"). Each owner receives distributions in accordance with such owner's partnership capital account. Capital

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<sup>2</sup> Owners and members may also decide to review past Medicare cost reporting practices. The same general considerations outlined here would apply to such a review. We note that in the OIG Report, OIG found no prior CMS guidance specifically addressing the reporting of net revenue distributions to GPO members. CMS agreed that no specific guidance in this area had ever been issued, but indicated that such distributions were subject to the general rule requiring that purchase discounts, allowances, refunds and rebates be treated as reductions on the cost report in the applicable cost center.

accounts are re-set periodically based on the aggregate purchasing volume of each owner's constituent providers under Premier GPO contracts relative to other owners over a given period.<sup>3</sup>

### III. Treatment of GPO Distributions For Medicare Cost Reporting Purposes

Based on our research, and confirmed by the OIG Report, CMS has not published guidance specifically addressing whether, under what specific circumstances, or how distributions must be disclosed on a hospital's Medicare cost report. Historically, there were essentially three alternative approaches to disclosure of distributions for cost reporting purposes. We provide an overview of each, and the impact of the OIG Report on their continued viability.

#### A. Allocation Approach

In the OIG Report, CMS indicates that any distributions received by a GPO member should be reported as an offset to the specific corresponding cost centers on the recipient hospital's annual Medicare cost report, but not to exceed the total costs of the cost center. While not addressed in the Report, in the case of a multi-hospital system, CMS might contend that distributions should be "pushed down" to each hospital's cost report in a similar manner.

Specifically, CMS states in the OIG Report that a distribution is in the nature of a "rebate" subject to the Medicare cost reporting obligations applicable to rebates. Medicare cost reporting instructions mandate that a provider disclose on its Medicare cost report all "discounts, allowances, refunds, and rebates" received on items for which reimbursement is sought in the cost report.<sup>4</sup> The Medicare Provider Reimbursement Manual defines the term "rebate" broadly to include any "refund of a part of the cost of goods or services," typically "based on the value of purchases" from the vendor.<sup>5</sup> CMS concludes in the OIG Report that "[a]lthough the net revenue distributions addressed in the report are not specifically articulated in the policy they are, nevertheless, encompassed in the policy and, therefore, must be used to reduce costs on the cost report under that policy."<sup>6</sup>

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<sup>3</sup> Purchasing Partners also has contractual relationships with non-owner Contracting Organizations pursuant to which the Contracting Organization receives compensation based on administrative fees related to purchases by the Contracting Organization's hospital members. The analysis of the fees distributed by such Contracting Organizations to their hospital members would be the same as set forth below for owner Contracting Organizations with regard to owner distributions.

<sup>4</sup> CMS Publication 15-1 ("Provider Reimbursement Manual") § 804.

<sup>5</sup> Provider Reimbursement Manual § 802.41.

<sup>6</sup> CMS has in other contexts shown a predisposition to disregard attempts by hospitals to avoid reporting monetary payments from vendors on the grounds that they are something other than rebates. For example, CMS has explicitly instructed hospitals that they cannot avoid treating a payment from a vendor as a "rebate" for cost reporting purposes merely by couching it as a "contribution" or "unrestricted grant." CMS instructed its fiscal intermediaries that, except in limited circumstances, such payments must be reported as rebates on the provider's Medicare cost report. Provider Reimbursement Manual § 806.

While CMS declined to provide any additional guidance as to how GPO distributions specifically should be accounted for on the cost report, there are generally-applicable reporting guidelines for disclosing rebates on a Medicare cost report. We address how these principles might be applied with respect to each of the various types of Premier owners and members.

1. Recipient Is A Single Hospital and an Owner

Medicare payment rules provide that “rebates” should not be treated as income; rather, they are to be applied to offset the specific costs to which they relate on the Medicare cost report (but not to exceed the total costs of the cost center).<sup>7</sup> Under this standard, distributions — like rebates — would be apportioned to the various routine, ancillary, general service, and non-reimbursable cost centers in which the corresponding items or services purchased from the vendor(s) are reported. This would be true even if the actual purchasing function were centralized within the hospital (i.e., under this analysis a hospital with centralized purchasing should not treat a distribution as merely an offset of the administrative costs of the central purchasing office).<sup>8</sup>

However, allocation of funds received among the various cost centers might prove more challenging in connection with distributions than typical rebates given that distributions are typically (1) made from the GPO’s general revenue pool funded by administrative fees from most or all contracting vendors (including those from whom the GPO member hospital has made no purchases) and (2) thereafter apportioned to GPO member hospitals based upon their aggregate purchase volumes from all vendors through the GPO.

The best approach given these practical limitations on a precise allocation might be for the hospital to develop and apply consistently a reasonable methodology to allocate rebates on a proportionate basis to those routine, ancillary, general service, and non-reimbursable cost centers in which the corresponding costs are reported. For example, one might consider apportioning distributions to cost centers based upon the relative value of purchases made by each such cost center through the GPO. If such data is not readily available, the hospital could apportion the distributions to cost centers based upon the relative value of supply purchases made by each cost center from any source. Alternatively, if GPO purchases could at least be broken down by the hospital into general categories (e.g., radiology equipment, dialysis supplies) or even — failing that — more general categories (e.g., equipment purchases, medical supply purchases), the distributions could be apportioned among cost centers based upon the relative proportion of such costs which are recorded in the specific cost center during the reporting year. So long as the methodology is reasonable and applied consistently, regulatory exposure should be reduced. Of course, even greater comfort could be afforded through consultation with the hospital’s fiscal intermediary.

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<sup>7</sup> 42 C.F.R. § 413.98(c); Provider Reimbursement Manual § 804.

<sup>8</sup> Provider Reimbursement Manual § 808.

Were CMS to apply mechanistically its guidance relating to the reporting of rebates, it could argue that a hospital has an obligation to report distributions in the same cost report period in which they are earned, even if they are not paid until the following cost reporting year.<sup>9</sup> Such an accrual approach was referenced by CMS in FAQ 4851 (now withdrawn). Under that analysis, CMS could require that a GPO member (1) make a good faith estimate of total distributions likely to be received for purchases reflected elsewhere in the cost report, (2) use that estimate in calculating cost reporting obligations for the year, and (3) reflect any surplus or deficit between the estimate used and the actual distributions received in the calculation of aggregate distributions paid in the following cost reporting period.<sup>10</sup> Unlike true rebates, however, the amount of distributions received is less predictable, given that distributions constitute a net income amount after a third party's expenses, and retained capital. Thus, estimates of distributions may prove to be inaccurate.

## 2. Recipient Is A Multi-Hospital System and an Owner

If the GPO owner is a multi-hospital system, CMS might take the position that distributions — whether or not actually distributed by the System to its constituent hospitals — must be allocated among the constituent hospitals for cost reporting purposes. Such a conclusion might be extrapolated from CMS' instruction that even when paid to a centralized purchasing unit within a hospital and even if derived from purchases covering numerous cost centers within the hospital, rebates should be allocated to the specific cost centers in which the associated purchase costs are recorded and neither be treated as income received by the central purchasing function nor an offset specifically to centralized purchasing costs.<sup>11</sup>

The System would need to make a decision whether to treat the distributions as a cost recovery, which, if the owner prepared a home office cost report, could be used either to offset the costs allocated to its operating expenses or, alternatively, seek to allocate the distributions in a consistent, equitable manner which is reasonably tied to the volume of each hospital's purchases under the GPO contract and report the distribution to Medicare in the manner described immediately above.

## 3. Recipient is a Contracting Organization

It is our understanding that some Contracting Organizations retain distributions without making further distributions to their unaffiliated hospital members. Thus, no part of the distributions to the Contracting Organization directly or indirectly are returned to, or offset the costs incurred by, the constituent hospitals. Therefore, it would be difficult for CMS to contend that they should be reported — whether as revenue or costs — by the constituent hospitals. If the Contracting Organization chooses to pay a portion of the distribution over to the unaffiliated provider, the unaffiliated provider would have to choose one of the reporting strategies described above.

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<sup>9</sup> Provider Reimbursement Manual § 804.

<sup>10</sup> Provider Reimbursement Manual § 804.

<sup>11</sup> Provider Reimbursement Manual §§ 804, 806, 808.

4. Recipient Is an Owner with Sponsored (non-owned /leased/managed) Hospitals

It is our understanding that some Premier owners who are single hospitals or multi-hospital health systems act as “sponsors” for hospitals or health systems which they neither own, operate, or manage and with which they have no corporate affiliation. It is our further understanding that although the unaffiliated providers obtain access to Premier contracts through the owner’s sponsorship, the distributions attributable to such purchases are paid to the owner. If the owner chooses to pay a portion of the distribution over to the unaffiliated provider, the unaffiliated provider would have to choose one of the reporting strategies described above. If, as we believe is commonly the case, distributions are predicated upon purchases of an unaffiliated provider but retained by the sponsoring owner, treatment of those distributions as if they were based on purchases by the owner’s owned, leased or managed hospitals would, if anything, understate the constituent hospital’s true costs and should therefore be of less concern to regulators from a cost-reporting perspective.

B. Overhead Offset Approach

One could contend that distributions should be treated as a current period cost recovery which may be used to offset purchasing costs and other overhead expenses. Specifically, Medicare has allowed providers in certain contexts to apply revenue to offset general overhead costs when it is not possible to identify the precise costs to which the revenue relates so as to permit a targeted reduction in those precise costs from which the revenue was generated. One could argue that such an approach would be appropriate in connection with distributions given that numerous factors confound a provider’s ability to accurately apportion the aggregate distribution to the specific purchase costs incurred through GPO contracts:

- Distributions received by a GPO owner are made from the GPO’s general revenue which reflects payments from numerous vendors, some of whom have likely sold no products whatsoever to the pertinent member, as well as other sources unrelated to group purchasing like investment income.
- While the relative proportion of the overall distributions paid to a GPO owner generally correlate to that owner’s relative proportion of the aggregate sales volume under the GPO’s contracts, the administrative fees paid by vendors to the GPO are not fixed at a common rate applicable to all items from all vendors and therefore a GPO owner’s distributions are not likely to accurately reflect on a proportionate basis the amount vendors paid to the GPO as a result of that GPO owner’s purchases.
- Distributions are paid only after the GPO deducts its expenses and retains a specified amount of revenue for working capital. Expenses are not allocated to purchasing contracts and expenses

may vary significantly from purchasing contract to purchasing contract; limiting the correlation between net income and any particular owner's purchases.

Thus, given the factors limiting the ability to accurately match distributions to specific supply costs, one could argue that the most accurate method of reflecting such distributions is to report them as revenue offsetting the recipient's procurement and related overhead costs. In the case of a multi-hospital health system with a centralized purchasing function, such an offset could be reported on the health system's home office cost report.

While the above arguments have some merit, in the OIG Report CMS suggests at several points that the offset should be made to the individual cost centers to which the purchases (and hence the distributions) relate. Unfortunately, the OIG did not indicate whether any of the hospitals reviewed utilized the overhead offset approach, and if so, whether OIG treated such offsets as appropriate. Rather, the OIG concluded simply that 28% of the hospitals "did not fully account for" or "did not offset" the GPO distributions on their Medicare cost reports.

### C. Non-Disclosure Approach

Finally, one could contend that distributions are effectively a return on investment and do not need to be reported as a cost on a Medicare cost report. Specifically, one could argue that the distribution is the same as any return on a capital investment in any business: (1) Purchasing Partners owners are required to make an up-front contribution to capitalize Purchasing Partners, (2) Purchasing Partners' business broadly speaking is to negotiate contracts with vendors, (3) there is risk associated with such a business enterprise as with any other business as to the amount, if any, of return, (4) those investing in Purchasing Partners (not the federal government) bear the risk that Purchasing Partners will fail and their capital contribution will be lost or produce little or no return, (5) Purchasing Partners is an ongoing concern which has the right to retain its earnings and invest in other business activities or entities, and (6) given that the owners make the entire capital contribution and bear all of the business risk associated with Purchasing Partners operations, they (not the federal government) should be entitled to the full benefit of any resulting investment distributions. Under the foregoing line of reasoning, the recipient of distributions should be no more obligated to disclose them on a Medicare cost report than would be the case with partnership distributions or stock dividends paid to a provider generally.

While these arguments could have been advanced historically in good faith, CMS appears to have rejected this position in the OIG Report. Accordingly, this approach has regulatory risks that are particularly significant on a going-forward basis. In the OIG Report, for the first time, CMS expressly indicated that it believes GPO distributions are a form of "purchase discounts, allowances, refunds and rebates" subject to the requirement that they be used to offset costs on the cost report. In the OIG Report, CMS states that "any receipt of funds by a provider related to its purchase of items or services, whether typical vendor rebates or, in this case GPO net revenue distributions,

are to be offset against the applicable costs, not to exceed the total costs of the cost center, so that the provider properly reports its net costs incurred related to the purchases.” Furthermore, the OIG Report concludes that 78% of the hospitals reviewed did offset the distributions against costs on their Medicare cost reports.

#### IV. Conclusion

This White Paper provides an overview of the principal potential options which Premier owners and members might consider should they review their current practices with respect to the treatment of distributions on their Medicare cost reports. Each of the foregoing options will present its own challenges which must be weighed in light of the owner’s and member’s historical treatment of distributions in consultation with the owner’s and member’s legal and reimbursement advisors.