PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2001-D47

PROVIDER –
Home Comp Care, Inc.
Matteson, Illinois

Provider No. 14-7525

vs.

INTERMEDIARY –
Blue Cross/Blue Shield Association/
Palmetto Government Benefits
Administrators

DATE OF HEARING-
August 21, 2001

Cost Reporting Period Ended -
April 30, 1994

CASE NO. 96-0225

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ISSUE:

Was the compensation paid to HCC=s owner reasonable?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Home Comp Care, Inc. (AProvider@) was a home health agency certified by the Medicare Program on November 11, 1992, and located in Matteson, Illinois. On July 21, 1997, Home Comp Care, Inc. (HHC) filed a voluntary petition for Chapter 11 bankruptcy protection. Unable to maintain the financial viability of the agency, in December 1997, HHC was forced to file Chapter 7, (termination of the corporation/agency) in Bankruptcy Court.[1]

For the fiscal year ended (AFYE@) April 30, 1994, the Provider incurred compensation costs for the Owner/CEO of the home health agency, which it claimed on its cost report for the purpose of obtaining reimbursement from the Medicare program. The Intermediary disallowed $175,788 of the Provider=s wages for various reasons. However, the Provider is only pursuing the elimination of $150,000 for owner=s compensation. [2]

HHC=s cost report was audited by Blue Cross and Blue Shield of Illinois now represented by Palmetto Government Benefits Administration (AIntermediary@). On September 26, 1995, the Intermediary issued a Notice of Program Reimbursement (ANPR@) based on its review of the Provider=s April 30, 1994 cost report. On November 14, 1995, the Provider appealed the Intermediary=s adjustments to the Provider Reimbursement Review Board (ABoard@) and has met the jurisdictional requirements of 42 C.F.R. '' 405.1835-.1841.[2] The application of the Intermediary=s adjustment reduced Medicare reimbursement by approximately $150,000.

The Provider was represented by James M. Ellis, Esquire, of Holleb & Coff. The Intermediary=s representative was James Grimes, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER=S CONTENTIONS:

The Provider contends that the Intermediary disallowed $150,000 paid to Dr. Alexander (owner/CEO of the agency) because the amount was not deemed reasonable and the promissory note was not properly executed ensuring that the accrued salary was liquidated. The Provider contends that the amount of compensation claimed for the owner/CEO is reasonable and that the Provider correctly implemented a promissory note evidencing the accrued salary in question.[3]

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[1] See Provider=s Final position paper at 4, 5 respectively.

[2] See Intermediary=s Final position paper at 1, 3 respectively.

[3] See Provider=s Final position paper at 12 and Exhibit 3.

The Provider asserts that the Intermediary=s application of the 1979 Dunham Study to the Owner=s compensation in this case is not accurate. The salary ranges developed by Dr. Dunham and illustrated in the 1979 Dunham Study are not representative of Atotal compensation ranges@ for hospital executives. Rather, the salary ranges set forth in the 1979 Dunham Study are only indicative of the base salary paid to executives in the hospital industry that participated in the survey. The Dunham Study does not include such employee benefits as deferred compensation or health insurance.

The Provider cites Northside Home Health Care, Inc. v. Health Care Service Corp.\Blue Cross Blue Shield Association, PRRB Dec. No. 79-D97, April 1, 1993, Medicare and Medicaid Guide (CCH) & 41,399, declined rev. HCFA Admin., May 21, 1993.[4] The typical benefits in this case, included social security, pension, insurance and other expenses that the organization incurred on behalf of the employee. The Provider claims that other intermediaries recognize that the Dunham survey does not include such benefits as deferred compensation or health insurance coverage. Specifically, in Harriet Holmes Health Care Services, Inc. v. Blue Cross and Blue Shield Association of Iowa, PRRB Dec. No. 88-D17, March 1, 1988, Medicare and Medicaid Guide (CCH) & 37,026, declined rev. HCFA Admin., April 1, 1988,[5] Blue Cross and Blue Shield of Iowa submitted a supplemental position paper wherein it argued that the Provider=s total compensation, exclusive of deferred compensation and disability insurance coverage, should be compared with the 1979 Dunham Study.

The Provider asserts that the Intermediary updated the owner salary ranges by cost of living increase factors communicated to Commerce Clearing House (CCH) and published in Medicare and Medicaid Guide (CCH) & 5,623. However, the Provider insists that the Intermediary failed to apply the Dunham Study properly by excluding a 30% increase to the compensation for employee benefits, based on the Dunham Study=s results.

Since the Provider believed that the Intermediary relied so heavily on the Dunham Study, it decided to contract with Dr. Dunham to perform a compensation study for the agency. Based on the documentation submitted, Dr. Dunham determined that reasonable compensation for the owner/CEO should be between $125,000 and $168,000 for the fiscal year in question. This compensation did not include a 20% increase to account for employee benefits. The addition of 20% for employee benefits would increase the reasonable compensation for the CEO to between $150,000 and $201,000.[6] Accordingly, the total compensation paid to the CEO for fiscal year 1994 was reasonable.

> The Fiscal Intermediary Blue Cross is only a hired hand, an independent contractor selected by the government to conduct audits. Blue Cross

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[4] See Provider Final position paper at 12.

[5] See Provider=s Final position paper at 12.

[6] See Provider=s Exhibit 2.

> cannot speak with finality for the Secretary on the interpretation of regulations and certainly cannot make policy pronouncements.

The Provider also cited Monongahela Valley Hospital, Inc. v. Bowen, 728 F. Supp. 1172, 1175 (W.D. Pa. 1990).[7] Thus, the Medicare Act precludes Blue Cross from acting in the absence of, or contrary to, direction from the Secretary or HCFA or one of its regional offices. The Provider maintains that the Intermediary determination was not in accordance with Provider Reimbursement Manual, HCFA Pub. 15-1 ' 904, 905.1, and (AHCFA Pub. 15-1@) 42 C.F.R. ' 413.102.[8] The regulation states:

> [r]easonableness of compensation may be determined by reference to, or in comparison with, compensation paid for comparable services and responsibilities in comparable institutions; or it may be determined by other appropriate means.

The Provider contends that the Intermediary=s methodology of determining reasonable compensation was in violation of Medicare regulations and laws. The Intermediary has failed to prove that the Provider=s reported compensation is substantially out of line in comparison to others in the same industry. The Provider asserts that Medicare regulations require the Intermediary to reimburse providers for their actual, reasonable costs in providing services to Medicare under 42 C.F.R. ' 413.9.

The Provider argues that the PRRB has consistently placed the burden on intermediaries to determine that claimed compensation costs are substantially out of line with comparable providers. For example, in Alexander=s Home Health Agency v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Mississippi, Inc. PRRB Dec No. 88-D30,[9] September 2, 1988, aff=d HCFA Admin. Nov. 1, 1988, Medicare and Medicaid Guide (CCH) **&** 37,439, the Board unanimously held that the Intermediary did not demonstrate that the Provider=s costs were substantially out of line. See also, Holy Cross Hospital v. Blue Cross and Blue Shield Association of New Mexico, PRRB Dec No. 92-D14, January 23, 1992, Medicare and Medicaid Guide (CCH) **&** 40,066, aff=d HCFA Admin. Feb. 14, 1992, and Memorial Hospital/Adair County Health Center, Inc., v. Heckler U.S. Court of Appeals for the District of Columbia, 829, F. 2d. 111, 117 (D.C. Circuit September 18, 1987), Medicare and Medicaid Guide (CCH) **&** 36,636.[10]

The Provider contends that the Intermediary failed to establish that the Provider=s claimed compensation was substantially out of line with comparable home health agencies. The Provider goes on to attest that the methodology used by the Intermediary was statistically invalid as it failed to comport with Medicare

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[7] See Provider=s Final position paper at 14.
[8] See Provider=s Final position paper at 15.
[9] See Provider=s Final position paper at 17.
[10] See Provider=s Final position paper at 17.

regulations governing reasonable costs. Additionally, the Intermediary=s chosen treatment of compensation costs did not take into consideration the size, scope of services, utilization, and other relevant factors as required by 42 C.F.R. ' 413.9.[11]

Finally, the Provider argues that the Intermediary has failed to support its adjustment to owner=s compensation for the said fiscal year. The compensation claimed by the Provider is reasonable when compared to compensation paid for similar services by comparable agencies, and such amounts are clearly not Asubstantially out of line@ with the compensation levels available in the relevant market. Therefore, the Intermediary=s proposed adjustments cannot be upheld under the Medicare Act and regulations.

INTERMEDIARY=S CONTENTIONS:

The Intermediary contends that its determination to disallow $150,000 of owner=s compensation was due to the Provider=s failure to liquidate the promissory note (negotiable instrument) within a reasonable amount of time.

When reviewing key employees= compensation the Intermediary performs a number of audit steps: 1) identify key personnel and their total compensation package, 2) reconcile compensation from the provider=s records to the as-filed cost report, 3) perform a reasonableness test, 4) ensure that the amounts in question have been liquidated. Once the Intermediary realized that the owner=s compensation had not been liquidated it ceased to continue on with its reasonableness test, as it did not seem warranted, since the Provider had not paid the liability in question.[12]

The Intermediary maintains that the Provider had not liquidated its liability of $150,000[13] for the owner=s compensation in accordance with HCFA Pub. 15-1 ' 2305, 2305.2(D) and 906.4(A). Section 2305 (Transmittal No. 336, August 1986) requires that a short-term liability be liquidated within one year after the end of the cost reporting period in which the liability is incurred, subject to exceptions in sections 2305.1 and 2305.2. Moreover, section 2305 allows for the liquidation of liabilities to be made by check or other negotiable instruments, cash or legal tender of assets.[14] However, this section also provides that:

> [w]here liquidation is made by check or other negotiable instrument, these forms of payment must be redeemed through an actual transfer of the provider=s assets within the time limits specified in this section.

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[11] See Provider=s Final position paper at 14.

[12] See Intermediary=s Final position paper at 3.

[13] See Intermediary=s Final position paper Exhibit I-6, w/p 2-8A 2.

[14] See Intermediary=s Final position paper at 3.

Id. [Emphasis added].

Section 2305.1 allows for an exception to the one-year time limit. If the Provider presents to the Intermediary sufficient written justification based on documentation evidence for the nonpayment of a short-term liability within the one-year time limit, the cost associated with the liability may continue to be allowed. Moreover, Section 2305.2 explains the policy for the liquidation of liabilities applies to all costs except those described in the PRM sections Awhich mandate liquidation within 75 days after the end of the cost reporting period in which the liability was incurred.@ Id. However, the Intermediary asserts that Section 2305.1 is not applicable in this case, for the Provider has not applied nor furnished sufficient written justification for the nonpayment of the liability.

With respect to unpaid compensation section, HCFA Pub. 15-1 ' 906.4 provides that:

> The compensation of stockholder employees and individuals described in Section 901 (other than sole proprietors and partners) shall be included for a cost reporting period if earned within the period, even if not paid until after the close of the period. However, payment must be made (whether by check or other negotiable instrument, cash or legal transfer of assets such as stock, bonds, real property, etc.) within 75 days after the close of the period. If payment is not made within the cost reporting period or within 75 days thereafter, the unpaid compensation is not includable in allowable costs either in the period earned, or in the period when actually paid. For this purpose, an instrument to be negotiable must be in writing and signed, must contain an unconditional promise to pay a certain sum of money on demand or at a fixed determined future time, and must be payable to order or to bearer.

Id.

The Intermediary acknowledges that the Provider=s position paper contained a promissory note, dated May 1, 1994, in the amount of $150,000 payable to the order of Anthony Alexander, M.D., CEO (owner of the Agency). The terms of the note appeared to be monthly. However, at the option of the holder the note is immediately due and payable upon failure to make any payment within 365 days of its due date. The note appeared to meet the requirement that a negotiable instrument be payable upon demand or within a fixed determinable future time. The Intermediary also observed that the note was witnessed but not notarized.[15]

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[15] See Provider=s Final position paper Exhibit 3.

The Intermediary argues that since the note has not been liquidated and the Provider has not supplied any evidence to support such a claim they failed to meet the necessary requirements under Medicare regulations and law. The Intermediary states that it has been HCFA=s long standing policy to recognize, for the purpose of program payment, a Provider=s claim for costs when it has not actually expended funds during the current cost reporting period. 42 C.F.R. ' 413.24(b)(2)[16] provides that under the actual accrual basis of accounting, revenue is reported in the period in which it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid. Under that definition providers have claimed costs without evidence of having incurred actual expenditures or the assurance that liabilities associated with accrued costs will ever be fully liquidated through an actual expenditure of funds. To the extent that challenges to this policy were successful, the Program would be forced to pay for accrued liabilities that either may not be liquidated timely or may never be liquidated.

However, HCFA=s clarification to the regulations to incorporate longstanding Medicare policy regarding timely liquidation of liabilities associated with these accrued expenses will minimize the unwarranted payment of Federal funds, that is Medicare recovers its payment for the accrued costs claimed by the Provider. The publishing of these regulations will avoid any confusion regarding the policy.

In closing, the Intermediary emphasizes that the Provider has not properly addressed the issue at hand, while contending that the Intermediary=s determination was made based on reasonableness, instead of the timeliness of the liquidation of liabilities. The Intermediary contends that even at the date of the position paper the debt in question still has not been liquidated.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - 5 U.S.C.:

   ' 553 et seq. - Rule Making

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

   ' 1395x(v)(1)(A) - Reasonable Cost

3. Regulations - 42 C.F.R.:

[16] See Intermediary=s Final position paper at 4.

'' 405.1835-.1841 - Board Jurisdiction

' 413.20 - Financial Data and Reports

' 413.24(b)(2) - Adequate Cost Data and Cost Finding

' 413.9 - Cost Related to Patient Care

' 413.102 - Compensation of Owners

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

' 904 et seq. - Criteria for Determining Reasonable Compensation

' 905.1 - Procedures for Determining Reasonable Compensation-General

' 905.2 - Procedures for Determining Reasonable Compensation-Surveys

' 906.4 - Unpaid Compensation

' 2305 - Liquidation of Liabilities-General

' 2305.1 - Liquidation of Liabilities-Exception to 1 year Limit

' 2305.2 et seq. - Liquidation of Liabilities-Application and Exceptions

' 2182.6F - Liquidation of liabilities

5. Case Law:

Northside Home Health Care, Inc. v. Health Care Service, Corp.\Blue Cross and Blue Shield Association, PRRB Dec. No. 79-D97, April 1, 1993, Medicare and Medicaid Guide (CCH) & 41,399, declined rev. HCFA Admin., May 21, 1993.

Harriet Holmes Health Care Services, Inc. v. Blue Cross and Blue Shield Association of Iowa, PRRB Dec. No. 88-D17, March 1, 1988, Medicare and Medicaid Guide (CCH) & 37,026, declined rev. HCFA Admin., April 1, 1988.

Alexander=s Home Health Agency v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Mississippi, Inc., PRRB Dec No. 88-D30, September 2, 1988, aff=d HCFA Admin., Nov. 1, 1988, Medicare and Medicaid Guide (CCH) & 37,439.

Monongahela Valley Hospital, Inc. v. Bowen 728 F. Supp. 1172 (W.D. Pa. 1990).

Holy Cross Hospital v. Blue Cross and Blue Shield Association of New Mexico, PRRB Dec No. 92-D14, January 23, 1992, Medicare and Medicaid Guide (CCH) & 40,066, aff=d. HCFA Admin., Feb. 14, 1992.

Memorial Hospital/Adair County Health Center, Inc., v. Heckler, 829 F. 2d. 111 (D.C. Circuit September 18, 1987).

6. Other

Dunham Study

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board after consideration of the facts, parties= contentions, and evidence presented, finds and concludes that the Intermediary properly disallowed accrued owner=s compensation of $150,000.

The Provider=s position paper contends that the issue before the Board relates to the reasonableness of owner=s compensation using the Dunham Study.[17] However, the Board after reviewing the Intermediary=s workpapers and position paper,[18] determined that this case represents accrued owner=s compensation with the submission of a promissory note to determine whether or not the liability was liquidated within a reasonable timeframe. Therefore, the Provider=s arguments for this case were not appropriate and could not be used by the Board to render a decision in its favor.

The Provider accrued owner=s compensation in the amount of $150,000 for its 1994 cost reporting period. In order to liquidate the liability pursuant to HCFA Pub. 15-1 ' 2305, the Provider issued a promissory note for $150,000 unpaid owner compensation, and the note was signed by the owner on

[17] See Provider=s Final position paper at 13.

[18] See Intermediary=s Final position paper Exhibit I-6, workpaper 2-8A 2.

behalf of the agency. The note was dated May 1, 1994, a day after the end of the cost reporting period which the Board recognized met the requirements of HCFA Pub. 15-1 ' 906.4 (75 day rule).

However, the Board finds that the accrued compensation was not allowable under the provisions of section 2305, since the promissory note was not liquidated within one year after the end of the cost reporting period and there was no documentation in the record that evidenced an actual transfer of Provider assets.

Furthermore, the Board notes that the Provider missed the opportunity to exhaust its remedies by requesting an exception specified in section 2305.1, which allows an extension for the liquidation of the liability for a period which may not extend beyond 3 years after the end of the 1994 cost reporting period. The Provider has not presented justification based on documented evidence for nonpayment of the accrued owner=s compensation within a reasonable timeframe. In addition, the Provider has not submitted any evidence that the liability had been liquidated by April 30, 1997, the three-year limit within which the liability must be liquidated in order to be allowable.
In summary, the Board finds that the Provider=s accrued compensation is not an allowable cost actually incurred in rendering patient care, pursuant to 42 C.F.R. ' 413.9, for the following reasons:

1. The Provider did not pay the accrued owner=s compensation within one year after the end of the 1994 cost reporting period in which the liability was incurred, and there was no documentation in the record that evidenced an actual transfer of Provider assets as required by Section 2305 of HCFA Pub. 15-1.

2. The Provider did not seek an exception, as provided by section 2305.1 which would allow the Provider until three years after the end of the 1994 cost reporting period to liquidate the liability.

3. The Provider has not documented that the liability for accrued owner=s compensation has ever been paid.

DECISION AND ORDER:

The Provider=s accrued owner=s compensation is not allowable. The Intermediary=s adjustment is affirmed.

BOARD MEMBERS PARTICIPATING:

Irvin W. Kues
Henry C. Wessman, Esquire
Stanley J. Sokolove

Date of Decision: September 14, 2001

FOR THE BOARD

Irvin W. Kues
Chairman