PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2002-D32

PROVIDER –VNA Gregoria Auffant
94-97 Deferred Comp Group

Provider Nos. - Various

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
United Government Services, LLC

DATE OF HEARING
November 19, 2001

Cost Reporting Periods Ended -
June 30, 1994 ; June 30, 1995; June 30, 1996 and June 30, 1997

CASE NO. 00-3418G

INDEX

ISSUE:

Was the Intermediary's adjustment to the non-qualified deferred compensation plan proper?

FACTS:

Visiting Nurse Association Gregoria Auffant, Inc. ("Provider") is a not-for-profit home health agency located in San Juan, Puerto Rico. United Government Services ("Intermediary") reviewed the Provider's cost reports for fiscal years 1996 and 1997 and determined that the deferred compensation plan put in place by the Provider in July, 1994 did not comply with the provisions of the Medicare statute, regulations and manual procedures. The Intermediary also reopened the prior fiscal years cost reports for 1994 and 1995 to adjust those cost reports.

The Provider took exception to the Intermediary's determination as to the allowability of the deferred compensation plan and originally filed an appeal for fiscal years 1996 and 1997. Upon the Intermediary's reopening and revising of the cost reports for FY 1994 and 1995, the Provider filed a subsequent appeal for those years. The Provider Reimbursement Review Board ("Board") granted the Provider's request for a group appeal as the Provider had complied with the group appeal filing requirements. The Board determined that it had jurisdiction over the group appeal in accordance with the regulations at 42 C.F.R. §§ 405.1835 -.1841. The amount of Medicare reimbursement in contention is approximately $353,521.

The Provider established a deferred compensation plan as of July, 1994 into which a deferred "salary differential" was paid by the Provider for each employee eligible under the plan. The plan was a non-qualified plan set up pursuant to the standards established by the Employee Retirement Income Security Act of 1974 ("ERISA"). The plan provided that the employer would make payments to certain eligible employees at a future date as compensation for their present services. Funds for these future payments came from the Provider by including the cost of the plan as a Medicare cost on the Provider's Medicare cost report beginning with fiscal year 1994. The amount to be funded in each year, i.e., the charge to the Medicare program, was calculated by the Provider in accordance with an established formula.

The Provider funded the plan over the years since 1994 to the extent of $387,000, and has made employee distributions in accordance with the terms of the plan in the amount of $91,298. Funding of the plan was contingent upon receiving Medicare payments for deferred compensation costs. The Provider did not contribute any non-Medicare funding,

except to the extent of interest accumulations or investment appreciation within the fund. From July, 1994 until April, 1998, the funding of the plan was not under the control or direction of any trust, trustee, or other fiduciary. In April, 1998 the plan assets, consisting of certificates of deposit and securities maintained in a Paine-Webber account, were then placed in a trust administered by First Financial Group of Puerto Rico.

The Provider was represented by Hector J. Perez, Esq., of Goldman, Antonetti & Cordova P.S.C.. The Intermediary was represented by James R. Grimes, Esq., of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the plan met all of the requirements imposed by the Provider Reimbursement Manual ("PRM") ("CMS Pub. 15-1") § 2140.3. The testimony of the Provider's Human Resources Director and the Provider's information in the personnel bylaws[1] demonstrated that the terms of the plan were set forth in writing, and that they were communicated to all employees via meetings and orientations. The bylaws also indicated the method for calculating all contributions to the plan. The evidence also established that the plan was funded and protected. The plan met the requirement that it must be expected to continue despite normal fluctuations in the Provider's economic experience. The plan was maintained with the intent that it be a permanent and continuing arrangement, except for the valid reason that it becomes insolvent due to lack of Medicare funds.

The Provider argues that even if during previous years the plan assets were not placed in a separate trust, the surrounding circumstances and good faith shown by the Provider in establishing the plan does not justify the adjustments made by the Intermediary. At most, if there were a violation, it would be *de minimis*. Moreover, the Board is not, bound by the general instruction or the interpretative rules.

The Provider argues that, as of 1994, neither the Medicare statutes nor the regulations specified the treatment to be given to costs arising from deferred compensation plans. The statute simply provided, and still provides, that "reasonable costs are the costs actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." 42 U.S.C. § 1395x(v)(1)(A). The Medicare statutes have never required any particular structure for the establishment and/or maintenance of a deferred compensation plan as a precedent for reimbursement of reasonable costs. It simply required the Secretary of Health and Human Services ("Secretary") to promulgate regulations that interpret "reasonable costs" pursuant to

[1] Exhibit P-4.

"principles generally applied by national organizations," such as Generally Accepted Accounting Principles ("GAAP").

The Provider further points out that, pursuant to the regulations, payments to providers "must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries." 42 C.F.R. § 413.9 et seq. It further states that costs that are reimbursable include not only medical costs but also include "all necessary and proper expenses incurred in furnishing services, . . . such as premium payments for employee health and pension plans." Id. Like the statute, the Medicare regulations do not require a particular structure or maintenance of a deferred compensation plan as a condition for reimbursement of reasonable costs.

The Provider contends that as of the date the plan in controversy was instituted, the statute and regulations provided that the creation of a debt and the payment of such debt was determinative of a reimbursement. The Intermediary admitted during the hearing that the plan incurred a debt to those participants vested since the inception of the plan.[2] The Intermediary also admitted that the plan incurred a debt to the employees during the period between 1994 and 1995.[3] As of the date a plan is instituted, it is well settled that a hospital accrues a reasonable cost when the hospital incurs a debt to the employees

for services rendered, regardless of when paid. Charlotte Memorial Hospital and Medical
Center v. Bowen, 860 F.2d 595 (4th Cir. 1988).

The Provider also points out that the regulations never imposed funding, vesting, coverage, diversification and disclosure requirements on a provider's deferred compensation plan. That obligation was created by the CMS Pub. 15-1. Thus, as for the fiscal years 1994 and 1995, no trust for the plan's protection of its assets was required. It was sufficient that the plan incurred a debt.

The Provider points out that for fiscal years 1996 and 1997, the Secretary amended its regulation on June 27, 1995 to provide that "reasonable provider payments made under deferred compensation plans are included as allowable costs only during the cost reporting period in which actual payment is made to the participating employee." 42 C.F.R. §413.100(e)(2)(vii)(A); 60 Fed. Reg. 33,136, (June 27, 1995), as amended at 64 Fed. Reg. 51,909 (Sept. 27, 1999).

Although after June 27, 1995, reimbursements were conditioned upon actual payment to

[2] Tr. at 184.
[3] Tr. at 233.

the participant employee, the payments for the fiscal years 1996 and 1997 should be included as allowable costs in the fiscal year 1998, when the Provider placed the accounts in a trust fund.

The Provider points out that it made actual payments to the participants or plan before the Intermediary issued its final determination on September 1, 1999. The plan assets were placed in a trust fund in 1998. Accordingly, the Intermediary's witness testified at the hearing that the Provider did not fail to make actual payments to the participant employees. The Intermediary found no deficiencies in that regard.[4] The Provider's witness testified that as far as the cost reports at issue (fiscal years 94, 95, 96 and 97) the plan was fully funded.[5]

The Provider maintains that even in those fiscal years where reimbursement was conditioned upon actual payment, the Medicare regulations did not require the plan to be funded. A provider could establish and maintain an unfunded deferred compensation plan. The fact that the plan was unfunded would not prevent it from being eligible for reimbursement. Such reimbursement would be included in an unfunded plan as of the date when actual payment was made.

The Provider argues that while the Secretary is encouraged to issue interpretive guidelines to add detail to a regulation and how to go through the process of determining what is reasonable cost. The Provider does not agree as to the extent an administrative agency may add detail to its regulations without formal rule making. In Shalala v. Guernsey Memorial Hospital, 514 U.S. 87 (1995), the Supreme Court clearly stated that formal rule making is required when the Secretary of Health and Human Services' interpretative rules are inconsistent with any of its existing regulations. Id. at 99. Therefore, the Secretary cannot add detail to the PRM when such details are inconsistent with its regulations. Id. To the extent the PRM changes substantive law or creates an alternative method of enforcement not available under the regulations, such interpretive rules are invalid for not being subject to formal rule making. Id. Such interpretive rules do not have the force of law and are not accorded that weight in the adjudicatory process. Id.

The Provider maintains that the Secretary has always interpreted the statute and the regulations in a manner inconsistent with the Act and regulations. Pursuant to CMS Pub. 15-1 § 2140. et seq., reimbursement to a provider is conditioned upon a formal plan that meets all of the following conditions:

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[4] Tr. at 237.

[5] Tr. at 146.

a) The plan must be permanent

b) The plan must be communicated to all eligible employees

c) The plan must prescribe the method for calculating all contributions to the fund established under the Plan

d) The plan must be funded

e) The plan must provide for the protection of the plan's assets

f) The plan must provide for the computation of the amount of benefits to be paid

g) The plan must be expected to continue despite normal fluctuations in the provider's economic experience.

The Provider points out that, according to the Secretary's interpretation, a Provider would not receive reimbursement when it incurs a debt for services rendered under a deferred compensation plan unless it meets all of the funding, vesting, asset protection and nondiscrimination rules specified in CMS Pub. 15-1. The Provider argues that such interpretation is totally inconsistent with the requirements imposed by the statute and regulations. The statute and regulations do not specify, either directly or indirectly, the treatment to be given the costs arising from a deferred compensation plan. They simply specify the timing of the reimbursement.

The Provider maintains that to the extent the Secretary is mandating benefit structures and benefits through an interpretive manual, which is not a federal rule or regulation, it is preempted by § 514 et seq. of ERISA. Section 514 et seq. of ERISA only exempts from preemption federal laws and regulations, not interpretative manuals.

INTERMEDIARY' S CONTENTIONS:

The Intermediary contends that CMS Pub. 15-1 § 2140 et seq. sets out the criteria under which contributions to a deferred compensation plan will be reimbursable by the Medicare program. The Intermediary argues that the Provider did not meet the criteria during the cost reporting periods under appeal. While there were some written documents describing
aspects of the plan, there was no formal written document which described the essential terms of the plan, including the vesting requirements, contribution or benefit computations, or funding mechanisms. Prototype documents were submitted but not

adopted.[6] Later, the Provider submitted pages from a personnel bylaws document of a formal plan.[7]

The Intermediary further argues that the assets of the deferred compensation plan were not adequately protected, as the contributions were not made to a funding agency as required by CMS Pub. 15-1 § 2140 et seq. The funds were held in the name of the agency and placed in accounts in the agency's name.[8] The contributions were co-mingled with other operating funds of the agency and not held in a segregated account under the control of a trustee or third party fiduciary.[9] There were also indications that because the funds were co-mingled with other agency monies, investment gains and interest were not accurately assigned to the deferred compensation plan assets.[10]

The Intermediary contends that the vesting requirements of CMS Pub. 15-1 § 2140.3 were not met, as no document clearly identified the vesting schedule or that vesting would occur by normal retirement age.[11] The vesting was further confused by the fact that the plan seemed to give credit for prior service and award benefits for prior service.[12] CMS Pub. 15-1 § 2140 permits deferred compensation plans which are based on current costs, i.e. costs incurred in the current reporting period. Some of the Provider's claimed cost was for prior reporting periods, dating back to 1992, before any deferred compensation plan was put in place.[13]

The Intermediary maintains that the Provider did create a formal trust to hold the assets of the plan in 1998, after the close of the cost years under appeal. In addition, the Provider developed and executed a formal written document covering the plan in the year 2000.[14] This supports the Intermediary's contention that a deferred compensation plan, meeting the requirements of CMS Pub. 15-1 § 2140 did not exist until the year 2000 cost reporting

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[6] Tr. at 156-7.

[7] Tr. at 163.
[8] Tr. at 170-171.
[9] Tr. at 245.
[10] Tr. at 173.
[11] Tr. at 169.
[12] Tr. at 170.
[13] Tr. at 170.
[14] Tr. at 175.

period. The fact that the Provider may have finally adopted a deferred compensation plan in the year 2000 cannot affect prior years' costs because § 2140 et seq. covers only currently earned remuneration.

CITATIONS OF LAWS, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§ 1395x(v)(1)(A)	-	Reasonable Cost

2. Regulation – 42 C.F.R.:

§ 405.1835-.1841	-	Board Jurisdiction
§ 413.9 et seq.	-	Reimbursement
§ 413.24	-	Reasonable Cost
§ 413.l00(e)(2)(vii)(A)	-	Reasonable Cost

3. Program Instructions-Provider Reimbursement Manual Part I (CMS Pub.15-1):

§ 2140 et seq.	-	Deferred Compensation Plans

4. Cases:

Charlotte Memorial Hospital and Medical Center v. Bowen, 860 F.2d 595 (4th Cir. 1988).

Shalala v. Guernsey Memorial Hospital, 514 U.S. 87 (1995).

5. Other

Employee Retirement and Income Security Act of 1974

60 Fed. Reg. 33,136 (June 27, 1995)

64 Fed. Reg. 51,909 (Sept. 27, 1999)

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the law, regulations, program instructions, facts, parties' contentions, evidence submitted, post-hearing briefs, and testimony at the hearing, finds that the Provider is entitled to be reimbursed for its contributions to its deferred compensation plan for the years at issue.

The Board finds that the Provider informed the Intermediary of its July 1, 1991 deferred compensation plan. In communications between the Provider and the Intermediary during the period from 1991 to 1994 the Intermediary never informed the Provider that the deferred compensation plan was not acceptable.

The Board finds that:

1. In July, 1994 the Provider instituted a deferred compensation plan for its Employees.
2. The Provider used outside advisors and consultants to establish the plan.
3. The Provider's advisor prepared a proposal for the plan, but it was rejected by the Provider's board of directors because it only included key personnel.
4. A revised proposal was presented to the Provider and approved on or about August, 1994.
5. The terms of the plan were set forth in writing in the Provider's personnel bylaws.
6. The plan was communicated to all eligible employees through the personnel bylaws.
7. The method of calculating all contributions to the plan was contained in the personnel bylaws.
8. The plan provided for the computation of the amount of benefits to be paid to the participants.
9. The Provider established the plan with the intent that it be a permanent and continuing arrangement.

The Board notes that the Provider engaged consultants to advise them of a proper plan. The Intermediary did not audit the plan until the fall of 1998. The Intermediary performed two desk audits prior to the field audit at which time the issue was raised. The Board further notes that in communications between the Provider's consultant and the Intermediary, the Intermediary found no problem with the plan.

The Board finds that non-qualified payments were deposited into the fund in accordance with the PRM instructions. The evidence indicated that the accounts were auditable during the years in contention.

The Board finds that the trustee of the plan was a member of the Provider's organization. This is allowable under the CMS Pub. 15-1 § 2140 et seq. which states in part:

> When a provider establishes a trust fund for a deferred compensation plan, the trustee(s) are appointed by the executive board or a committee of the provider to protect
>
> the fund's assets and its distribution to the beneficiaries under the plan. The trustee may be either a member of the provider's organization or a third party trustee. (emphasis added).

The Board finds that the Provider properly handled the funds of the plan and that there

was financial integrity by the Provider in handling of the plan's assets.

The Board finds that the Provider properly communicated the terms and conditions of the plan to its employees. The Board finds that the testimony indicated that each employee was advised of the terms of the plan and that each employee was given an accounting of the monies in the plan.[15] Based on the Board's findings, the Board concludes that the Provider was in substantial compliance with the provisions of CMS Pub. 15-1 § 2140 et seq.

The Board finds that the Provider adopted a formal plan with revisions recommended by the Intermediary. It was adopted in August of 1994. The elements of the plan were communicated to the employees by way of the personnel bylaws. In regard to the concern regarding protection of the plan's assets, the Board finds that the Provider provided adequate financial integrity by the use of certificates of deposit. The Board notes that the accounts were auditable and that the accounts were identified as certificates of deposit. The Board also finds that there was no evidence of any instances where the assets were mishandled. The Board also finds that the certificates of deposit were converted to a trust account held by a third party trustee.

The Board notes that Medicare's well established cross-subsidization principle would be violated and a disproportionate cost would be placed on non-Medicare patients if the Intermediary's adjustments were to stand. That rule states in part:

> [T]he necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this chapter 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, .

[15] Tr. at 49-53.

. . . 42 U.S.C. § 1395x(v)(1)(A).

DECISION AND ORDER:

The Intermediary's adjustment to the Provider's non-qualified deferred compensation plan was not proper. The Intermediary's adjustment is reversed.

Board Members Participating

Irvin W. Kues
Henry C. Wessman, Esquire
Stanley J. Sokolove
Dr. Gary Blodgett
Suzanne Cochran, Esquire

Date of Decision: August 09, 2002

FOR THE BOARD

Irvin W. Kues
Chairman