PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2003-D44

PROVIDER –
Wilmac Corporation Group
York, Pennsylvania

Provider Nos. – Various (See Appendix)

vs.

INTERMEDIARY – Blue Cross Blue Shield Association/Veritus Medicare Services

DATE OF HEARING -
February 24, 2003

Cost Reporting Period Ended
December 31, 1997

CASE NO. 02-0901G

INDEX

ISSUE:

Was the Intermediary's disallowance of liabilities not liquidated timely on the Medicare cost report proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Wilmac Corporation owns and operates five Medicare certified skilled nursing facilities ("Providers") located in the State of Pennsylvania. During the Providers' cost reporting periods ended December 31, 1997, they were engaged in contractual agreements with TheraTx, Inc. (later a subsidiary of Vencor, Inc.) to obtain therapy services for their patients. However, due to disputes related to the contracts, the Providers did not immediately pay TheraTx, Inc. for the services it furnished. Rather, the Providers included the full amount of TheraTx, Inc. billings in their Medicare cost reports (collectively $3,395,000) and requested an extension to Medicare's 1-year rule pertaining to the liquidation of liabilities. On April 14, 1999, the Providers were advised that the Centers for Medicare and Medicaid Services had granted an extension to the liquidation of debt due TheraTx, Inc., to December 31, 2000.

On May 26, 1999, Vencor, Inc. filed a Request for Arbitration seeking to recover the $3,395,000 due from the Providers. In response, however, the Providers filed an Answering Statement or offset claim alleging that TheraTx, Inc. had engaged in activities during the term of the contracts that caused Providers financial harm estimated to exceed $3.6 million. On December 1, 2000, the Providers and Vencor entered into a settlement agreement pursuant to which the Providers agreed to make a cash payment of $1 million to Vencor, and to allow Vencor the additional $2,395,000 owed as an offset against the Providers' claim for damages. In effect, the settlement accounted for the entire $3,395,000 at issue, i.e., the $1 million cash payment in addition to the $2,395,000 offset for damages.

Subsequently, Veritus Medicare Services, Inc. ("Intermediary") reviewed the settlement agreement between the Providers and Vencor as well as some additional information. Based upon this review, the Intermediary concluded that Vencor had released the Providers from their full liability, i.e., the $3,395,000 in exchange for the $1 million payment. Consequently, the Intermediary reopened the Providers' cost reports and disallowed the balance of $2,395,000 that had initially been included in those reports for Medicare reimbursement.[1]

In September 2001, the Intermediary issued Revised Notices of Program Reimbursement perfecting its adjustment to each of the Providers' effected costs reports.[2] On February 25, 2002, the Providers appealed the disallowances to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841 and met the

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1 Providers' Position Paper at 1.

2 Exhibit P-10.

jurisdictional requirements of those regulations. The amount of Medicare funds in controversy is approximately $2,225,000.[3]

The Providers were represented by Stuart M. Langbein, Esq., of Hogan & Hartson L.L.P. The Intermediary was represented by James R. Grimes, Esq., Associate Counsel, Blue Cross Blue Shield Association.

PROVIDERS' CONTENTIONS:

The Providers contend that the Intermediary misconstrued the nature of their settlement agreement with Vencor. The Providers assert that in reality they properly liquidated their liability to Vencor in the form of a cash payment in addition to a legal transfer of assets (i.e., its award of damages from Vencor). The legal effect of this transaction is the same as if the Providers had given Vencor a check for $3,395,000 for therapy services while Vencor simultaneously gave the Providers a check for $2,395,000 for damages.[4]

The Providers contend that cash and a legal transfer of assets is a proper means of liquidating liabilities pursuant to Medicare rules, legal authorities outside of Medicare, and Generally Accepted Accounting Principles ("GAAP").

With respect to Medicare rules, the Providers cite Provider Reimbursement Manual, Part I ("HCFA Pub. 15-1") § 2305, which states in part: "[l]iquidation must be made by check or other negotiable instrument, cash or legal transfer of assets such as stocks, bonds, real property, etc." (emphasis added). The Providers assert that their transfer of assets to Vencor was a legal transfer of assets as it was part of a signed contract between Wilmac and Vencor. Therefore, their liquidation was proper pursuant to HCFA Pub. 15-1 § 2305.

The Providers further assert that this conclusion is supported by Wyckoff Heights Hospital v. Blue Cross and Blue Shield Association, PRRB Decision No. 89-D34, March 21, 1989, Medicare & Medicaid Guide (CCH) ¶ 37,805, aff'd. CMS Administrator, May 19, 1989, Medicare & Medicaid Guide (CCH) ¶ 37,870 ("Wyckoff"). In that case, the Board found that the provider properly liquidated its debt to a pension fund even though it did not have to write a check for the full amount of the liability because of a reversionary amount it was due from the fund.[5]

With respect to legal authorities outside of the Medicare Program, the Providers cite the bankruptcy court's decision in Hedback v. American Family Mutual Insurance Company, 207 B.R. 631 (Bankr. D. Minn. 1997). According to the Providers, the court's holding in that case, which involved an automobile accident, is dependent upon the conclusion that

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[3] Exhibit P-11.

[4] Providers' Position Paper at 3. Providers' Post Hearing Brief at 5. Transcript ("Tr.") at 179.

[5] In response to the Intermediary's attempt to distinguish Wyckoff from the instant case because it does not involve the offset of mutual obligations by different entities, the Providers explain that different entities were, in fact, involved in Wyckoff – the hospital and the trustee insurance company. Providers' Position Paper at 6. Providers' Post Hearing Brief at 10.

the debtor's ability to bring bad faith claims against the liability insurer was an asset that could be transferred.

The Providers further assert that under GAAP the amount they were owed from Vencor as a result of the settlement agreement was an asset that they legally transferred to Vencor pursuant to the Statement of Financial Accounting Concepts ("FAC") No. 6. According to FAC No. 6, assets "are probable future economic benefits obtained or controlled by a particular entity as a result of past transactions or events."
The Providers further assert that the amount owed to them by Vencor meets all three aspects of this definition, i.e., the Vencor debt reflects a future economic benefit, it was controlled by the Providers, and the settlement agreement had already occurred.

The Providers dispute the Intermediary's argument that they did not transfer an asset to liquidate the liability but instead replaced the liability with an advance due to their home office. The Providers assert that it is of no importance that their liability was actually liquidated by their corporate parent on their behalf and charged back to them as amounts due the parent.

In response to Board questions regarding the problems that led to the Providers' claim against Vencor, the Providers submit Exhibits A-E as part of their Post Hearing Brief. The Providers assert that these problems express no concern over the professional therapy services furnished by TheraTx, Inc.[6]

Finally, the Providers contend that contrary to any argument the Intermediary may make, their claim against Vencor was for damages unrelated to the provision of therapy services that Vencor furnished.[7] The Providers assert that the evidence before the Board shows that they never contested the services Vencor provided to their patients, the quality of those services, or the amount of Vencor's invoices.[8] The Providers explain that the Intermediary obtained and reviewed Vencor's invoices and affirmed that the services were, in fact, performed. And, since Vencor's service rates were set in the contracts, there can be no dispute that the Providers incurred $3,395,000 in costs.[9] Notably, the record contains numerous statements made by the Providers regarding this matter as well as the satisfactory quality of the services furnished by Vencor.[10]

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the real issue in this case is the determination of the Providers' liability to Vencor. The Intermediary asserts that the Providers clearly did not believe Vencor's services were worth $3, 395,000 as evidenced by the Providers' Answering Statement. In it, the Providers claim that they suffered serious damages as a

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6 Providers' Post Hearing Brief at 3. Tr. at 95.
7 Providers' Post Hearing Brief at 6.
8 Id.
9 Tr. at 29, 121-123.
10 Provider's Post Hearing Brief at 8. Exhibits P-5, P-6, and P-7. Tr. at 72 and 160. Providers' Post Hearing Brief at Exhibit D.

result of various activities or non-performance by representatives of Vencor. The Intermediary maintains that it is clear the Providers did not believe they owed Vencor the $3,395,000 for therapy services.[11]

The Intermediary contends that the $2,395,000 reduction made to the subject liability is not a "transfer of assets" as argued by the Provider. Rather, the only mention of these monies is a statement in the parties' Settlement Agreement indicating that the Providers had made such a claim. However, there is no indication that the claim was ever developed beyond a mere conclusory allegation or that it was ever validated or agreed upon by Vencor.[12]

The Intermediary disputes the Providers' reliance upon the Board's decision in Wyckoff explaining that the provider's liability in that case was established under normal actuarial rules and there was no question as to the amount of the debt. In contrast, there was no external determination of the value of the Providers' claim of offset here. Wyckoff does not address the mutual offset of obligations by different entities as in the instant case and, notably, there was no determination that the Providers held an asset worth $2,395,000 nor did the Providers record such an asset in their accounting records.[13]

Finally, the Intermediary contends that even if the Providers would have paid Vencor $3,395,000, and Vencor would have paid the Providers $2,395,000 in separate transactions, Vencor's payment would represent a recoverable expense and reduction to the Providers' liability rather than a separate asset.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of Medicare law and Program instructions,the parties' contentions and evidence presented, finds and concludes as follows:

The Providers contracted with Vencor, Inc. to obtain therapy services for their patients. During the subject cost reporting period, Vencor billed the Providers $3,395,000 for the services it rendered. The Providers did not, however, immediately pay these bills because they alleged that Vencor committed certain acts that caused them financial harm. Ultimately, the Providers liquidated this liability through a settlement agreement wherein the Providers made a cash payment of $1,000,000 to Vencor and released Vencor from any claims they may have had for damages caused by Vencor's performance.

In general, the Providers argue that they actually paid Vencor the full $3,395,000 at issue, and that amount should be allowed for determining Medicare reimbursement. The Providers explain there is no relevance to the fact that they paid Vencor with $1 million in cash and a "transfer of assets" totaling $2,395,000, which represented their claim against Vencor for damages that the Providers insist are unrelated to the quality of Vencor's therapy services. Essentially, the Providers argue there is no difference

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11 Intermediary's Post Hearing Brief at 3. Exhibit P-5.

12 Id. Tr. at 100.

13 Tr. at 77.

between this method of payment and one where Vencor would have given them a check for $2,395,000 for damages while they gave Vencor a check for $3,395,000 for services rendered.

In contrast, the Intermediary argues that the Providers clearly did not believe they owed Vencor the full amount of its charges. Rather, the Intermediary maintains that the Providers had, in reality, re-valued Vencor's services down to the $1,000,000 level and that is the amount that should be recognized as an allowable Medicare cost.

The Board finds that the Providers and Vencor did, in fact, enter a settlement agreement as discussed immediately above. Moreover, program instructions at HCFA Pub. 15-1 § 2305 explain that assets other than cash may to be used to liquidate liabilities such as the Providers' debt to Vencor, i.e., a transfer of assets as argued by the Providers. However, the Board also finds that the charges raised by the Providers against Vencor, to an extensive degree, relate to services included in Vencor's billing rates and, therefore, relate to the value of those services to the Providers. In part, the Providers charge that some of Vencor's services may not have been reimbursable; some rehabilitation services that were performed may not have been well advised; some lacked support with respect to certain other bills; and Vencor failed to fulfill certain other contractual obligations such as establishing health care and recruitment programs whose costs would also appear to be included in Vencor's billing rates.[14]

In a letter dated December 14, 1998, the Providers asked the Intermediary for an extension of time to liquidate their liability to Vencor. In part, the Providers explain that they had identified certain documentation issues concerning Vencor's therapy services and expressed their understanding that they are not required to pay for any therapy services where reimbursement is denied for failure to comply with applicable rules and regulations. In a letter dated January 14, 1999, the Providers dispute certain bills for therapy and management services furnished by Vencor and advise that the matter had been referred to their respective attorneys. Moreover, the Providers furnished the American Arbitration Corporation a listing of damages they allegedly incurred "as a result of various activities of or non-performance by representatives of [Vencor]." The Board finds the Providers' stated concerns over Vencor's billings as well as the items listed for arbitration compelling; that is, the Providers disputed Vencor's performance with respect to the provisions of its contracts with them and the value of that performance.

The Board also finds no evidence in the record supporting the Providers' argument that their claim against Vencor was entirely for damages outside of its contractual obligations and outside of the Providers' costs for Vencor's services. According to the record, no formal claim was ever developed and filed by the Providers, and there is no evidence showing the substantive makeup of the $2,395,000 in claimed damages. Moreover, there is no evidence that Vencor ever agreed to or recognized the propriety of the Providers' alleged claim in any way.

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[14] The Board notes that the record in this case does not contain copies of the individual contracts entered into between the Providers and Vencor.

The Board, having found that the relevant transactions between the Providers and Vencor were not separate and apart from the services payable under Vencor's contracts, concludes that the Intermediary properly adjusted the Providers' contracted therapy costs. The offset of the Providers' liability to Vencor is effectively a "discount " received on the purchase of Vencor's services. Medicare regulations at 42 C.F.R. § 413.98 specifically address this matter. In pertinent part, the regulations state:

> (a) *Principle.* Discounts and allowances received on purchases of goods or services are reductions of the costs to which they relate.
> (b) *Definitions*- (1) *Discounts* . Discounts, in general, are reductions granted for the settlement of debts.

42 C.F.R. § 413.98 (emphasis added).

The Board also cites HCFA Pub. 15-1 § 810.1, which states in part:

> General.—Monetary damages received by a provider as a result of a court decision, settlement, legal action, or other claim for damages, are considered reductions of cost if they represent recoveries of previously allowed costs.

HCFA Pub. 15-1 § 810.1.

DECISION AND ORDER:

The Intermediary's disallowance of the costs claimed by the Providers for therapy services obtained from Vencor, Inc. was proper. The Intermediary's adjustments are affirmed.

Board Members Participating:

Suzanne Cochran, Esq.
Henry Wessman, Esq.
Dr. Gary B. Blodgett
Martin W. Hoover, Jr., Esq.
Elaine Crews Powell, CPA

DATE: August 21, 2003

FOR THE BOARD:

Suzanne Cochran, Esq.
Chairman