COMMONWEALTH OF PENNSYLVANIA

PENN HEALTH CORPORATION	:	BEFORE THE BOARD OF CLAIMS
	:	
VS.	:	
	:	
COMMONWEALTH OF PENNSYLVANIA,	:	
DEPARTMENT OF PUBLIC WELFARE	:	DOCKET NO. 1515

FINDING OF FACTS

1. Plaintiff is Penn Health Corporation, a Pennsylvania Corporation with its principal place of business located in Los Angeles, California, and a wholly owned subsidiary of Maxicare Health Plans, Inc. (hereinafter referred to as "Maxicare"), a California Corporation. (Complaint and Answer, ¶ 2)

2. Defendant, Department of Public Welfare, (hereinafter referred to as "DPW"), is an executive agency of the Commonwealth of Pennsylvania, responsible for administering and operating the Medical Assistance Program (hereinafter referred to as "Medicaid") in Pennsylvania. (Complaint and Answer, ¶ 3)

3. Jurisdiction over the parties and the Claim is vested in the Commonwealth of Pennsylvania, Board of Claims pursuant to 72 P.S. § 4641-4.

4. Title XIX of the Social Security Act of 1965, 42 U.S.C. § 1396 et seq., establishes a joint federal-state Medicaid Program to provide essential medical services and supplies to eligible low income persons. (42 U.S.C. § 1396; 42 C.F.R. § 430.0)

5. Under the Medicaid Program, the Federal Government reimburses States a percentage of the States' costs of providing medical treatment and supplies to Medicaid recipients ("Federal Financial Participation" or "FFP"). (42 U.S.C. § 1396; 42 C.F.R. § 430.0)

6. As a condition for receiving FFP, a State must adopt and implement a "State Plan for medical assistance" (hereinafter referred to as "State Plan") which must be approved by the Health Care Financing Administration (hereinafter referred to as "HCFA") of the United States Department of Health and Human Services. (42 C.F.R. § 1396a(a)(1))

7. A State Plan must set forth the services, benefits, utilization review standards, reimbursement rates, and other required features of the State's Medicaid Program, including the designation of "a single State agency established or designated to administer or supervise the administration of the plan." (42 C.F.R. § 431.10(b); 42 U.S.C. § 1396(a))

8. Pennsylvania has a HCFA approved State Plan and DPW is the "sole agency" authorized to apply for, receive and use Federal Medicaid funds in Pennsylvania. (Pa. Stat. Ann. titl. 62 §§ 201(1) & 406)

9. Prior to 1985, DPW provided Medicaid benefits to all Pennsylvania enrollees on a fee-for-services basis. (N.T.L. [1]562)

10. Under its fee-for-service program, DPW made medical assistance payments on behalf of eligible low income persons directly to health care providers for medical services and supplies furnished. (Pa. Stat. Ann titl. 62 §§ 443.1)

11. In the early 1980s, in Pennsylvania, as elsewhere, the cost of the Medicaid fee-for-service system was spiraling out of control. (N.T.D. 314; Penn Health Exhibit 25)

12. Under its fee-for-service program, "Medicaid expenditures in Pennsylvania more than quadrupled in [the mid-1970s to mid-1980s] despite the fact that the number of eligible recipients increased by only 12 percent." (Penn Health Exhibit 25)

13. DPW, the administrator of Pennsylvania's Medicaid program, believed that the high cost and lower quality of the Medicaid fee-for-service program was being caused by several factors; the opportunity for providers to perform unnecessary services and generate excessive billings when reimbursement is based on cost; lack of physician continuity and familiarity with patients; lack of preventive medical care; restricted access to primary health care which caused Medicaid recipients to often use the emergency room as their primary health care provider; and a general lack of monitoring over quality care. (N.T.L. 562-63; N.T.D. 314)

14. In an effort to remedy the problems and deficiencies in the Medicaid fee-for-service system in the early 1980s, DPW initiated a demonstration project entitled HealthPASS. (Penn Health Exhibit 25; N.T.L. 565, 740)

15. DPW's purpose in creating HealthPASS was to provide approximately 90,000 Medicaid recipients residing in the south and southwest portions of Philadelphia with a continuous web of health care services and quality monitoring via a pre-paid capitated primary care case management system, i.e., a managed care alternative to fee-for-services. (Penn Health Exhibit 25; N.T.L. 565, 740)

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[1] Proceedings in this case were bifurcated. The Liability Phase Trial was from July 6, 1994 through July 25, 1994 and will be referred to as N.T.L. The Damage Phase was from September 19, 1995 through November 30, 1995 and will be referred to as N.T.D.

16. HealthPASS was also designed to save the Commonwealth approximately $25 million to $30 million in tax dollars annually by substituting a capitated payment system for the fee-for-service program. (N.T.D. 313)

17. DPW designed the HealthPASS managed care initiative to be implemented through a health insuring organization (hereinafter referred to as "HIO"). (Penn Health Exhibit 215)

18. An HIO is defined by federal law as "an entity that (a) pays for medical services provided to [Medicaid] recipients in exchange for a premium or subscription charge paid by the [state Medicaid] agency; and (b) assumes an underwriting risk." (42 C.F.R. § 434.2; Penn Health Exhibit 18 at 1)

19. Unlike the fee-for-service program where payments to providers were made by the Commonwealth after the services were provided and invoices submitted to DPW, the HealthPASS program called for DPW to make prospective capitation payments to the HIO contractor on a monthly pre-recipient basis. Using these monthly per-recipient payments, the HIO contractor would then pay the health care providers for services rendered to HealthPASS patients. (N.T.L. 562-65)

20. In order for DPW to maintain its FFP eligibility while operating HealthPASS, it needed to obtain from HCFA a waiver of certain federal Medicaid requirements. (N.T.D. 313; 42 U.S.C. § 1396n(b))

21. Anticipating the HCFA approval in 1984, DPW issued a request for proposal ("RFP") for the creation of an HIO for its HealthPASS program and selected HealthAmerica, a California Corporation, as the successful bidder for both the development and operation of the HealthPASS program. (DPW Exhibit 15 at 1; N.T.L. 632, 639, 708)

22. HealthAmerica established Penn Health as a wholly owned subsidiary to be the contracting party with DPW for the single purpose of administering HealthPASS as an HIO. (DPW Exhibit 15 at 1; N.T.L. 632, 639, 708)

23. In December 1985, DPW received HCFA approval of its waiver request which allowed DPW to implement HealthPASS, a primary care case management system through an HIO with 100% Medicaid enrollment. (DPW Exhibit 15 at 1)

24. DPW entered into two Contracts dated November 1, 1984 with Penn Health under which Penn Health was to develop and implement the HealthPASS program: (l) the HealthPASS Development Agreement; and (2) the HealthPASS Operational Agreement (together referred to as the "Contract"). (DPW Exhibit 1)

25. The Contract includes five written amendments executed by the parties (hereinafter referred to as "Exhibit 1"). (Amend. I, II, III, IV, V)

26. The Contract originally contemplated that Penn Health would have a five month period, from November 1, 1984 to March 31, 1985, to develop the HealthPASS program and would begin to deliver services to HealthPASS enrollees on April 1, 1985. (DPW Exhibit 1, Appendix C)

27. The Contract originally contemplated an operational term of two years which would commence on April 1, 1985 and run through March 30, 1987. After the expiration of the original two year term, the Contract could be renewed on a year-to-year basis. (DPW Exhibit 1, § H.2.)

28. Penn Health created the HealthPASS network by contracting with an array of health care providers, including primary care physicians, specialty physicians, pharmacies, health clinics and hospitals. The health care professionals provided HealthPASS enrollees with the same services that they provided to Medicaid recipients under the traditional fee-for-service program. (N.T.L. 405, 635)

29. The actual implementation of HealthPASS was delayed nearly a full year and HealthPASS, in fact, commenced operations on March 1, 1986 ("Contract Year One"). (DPW Exhibit 1 (Amend. II); DPW Exhibit 15 at 1)

30. In November 1986, Maxicare, a Los Angeles based health care conglomerate, purchased HealthAmerica and assumed responsibility for all of Penn Health's assets and liabilities under the HealthPASS Contract with DPW. (DPW Exhibit 15 at 1)

31. The second year of the Operational Contract began on March 1, 1987, and ended on February 29, 1988 ("Contract Year Two"). (DPW Exhibit 1 (Amend II § F))

32. The third year of the operational Contract commenced on March 1, 1988 and ended on February 28, 1989 ("Contract Year Three"). (DPW Exhibit l (Amend III § A))

33. The last Contract period was for the four month period which began on March 1, 1989 and ended on June 30, 1989 ("Contract Year Four"). (DPW Exhibit 1 (Amend IV § A))

34. Under the Contract, DPW compensated Penn Health for administering HealthPASS in two ways: (1) Monthly capitation payments; and (2) other annual payments based on specific contractual provisions relating to (I) risk-sharing, (II) retroactive fee adjustments; and (III) adjustments relating to category mix. (DPW Exhibit 1 at § F)

35. The formulas for calculating payments under the risk-sharing, retroactive fee adjustments and category mix adjustments differed for the various Contract years. (DPW Exhibit 1 (Amend. I, II, III & IV at § F))

36. Penn Health and DPW executed Amendment I to the Agreement on or about October 21, 1986. Section Y of Amendment I modified Section F.3 of the Agreement. Pursuant to Section Y of Amendment I, DPW accepted responsibility for adjusting the capitated payments, on a quarterly basis, to reflect the mix of the eligibility categories of the HealthPASS enrollees. (Exhibit D-1, Amendment I, Section Y; N.T.L. 279-280, 291)

37. Penn Health and DPW executed Amendment II to the Agreement to be effective beginning March 1, 1987. Under Section H of the Amendment, DPW agreed to share with Penn Health the financial risk associated with operating a capitated health program. DPW agreed to reimburse Penn Health for all losses in excess of $2 million (the "$2 million deductible") experienced by Penn Health in the First and Second Program Years. (Exhibit D-1, Amendment II, Section H; Exhibit PH-47; N.T.L. 98, 327-329; N.T.D. 42)

38. Penn Health and DPW executed Amendment III to the Agreement on or about February 2, 1988. Pursuant to Section F.8 of Amendment III, DPW assumed responsibility for retroactively adjusting all capitation payments to Penn Health to ensure that the capitation payments reflected 92% of the **actual** per enrollee cost for services under the Medicaid fee-for-service program. (Emphasis added) (Exhibit D-1, Amendment III, Section F.8; N.T.L. 100-101)

39. Penn Health and DPW executed Amendment V to the Agreement on or about February, 1989. Pursuant to Section C.20, an escrow account was created for the purpose of depositing funds to pay Fourth Program Year health care claims. All funds remaining in the escrow account after all claims were satisfied were to be paid to Penn Health. (Exhibit D-1, Amendment V, Section C.20)

40. Penn Health claims in this proceeding that DPW breached the contractual provisions relating to risk-sharing, retroactive fee adjustments and category mix payments. (Penn Health Exhibit 65)

41. Under the Agreement, DPW initially agreed to compensate Penn Health for the First Program Year by paying Penn Health capitation payments based on the number of enrollees in the HealthPASS program. DPW allegedly fixed these capitated payments at a rate that approximated 90% of DPW's traditional cost for providing similar services to eligible Medicaid recipients in the fee-for-service program. (Exhibit D-1, Sections F.1 and F.8; N.T.L. 96-97)

42. During the First Program Year, it became clear that the capitated fees contained in the Agreement did not accurately reflect the actual costs incurred under the fee-for-service program. It further became clear that the original capitated fees were inadequate to support the HealthPASS program. (N.T.L. 434-436)

43. In February of 1987, the parties amended the Agreement to include a risk sharing provision (new Section F.2 to the Agreement) under which DPW agreed to reimburse Penn Health for all financial losses incurred during the first two program years in excess of $2 million. (Exhibit D-1, Amendment II, Section H -- new Section F.2(a) of the Agreement; N.T.L. 97-98, 437)

44. In entering into contracts with the health care providers, Penn Health was required to contract only with providers who met with DPW approval and executed forms of agreement that had received DPW approval. (DPW Exhibit 1 § C.7; N.T.L. 483)

45. If DPW terminated a provider from the Medicaid program during the period when the Penn Health Contract was in effect, Penn Health was required, likewise, to terminate its agreement with that provider. (DPW Exhibit 1 § C.7; N.T.L. 483)

46. In exchange for receiving monthly capitation payments from DPW, Penn Health agreed under its HIO Contract to make timely payments to providers for medical services related to HealthPASS patients. (DPW Exhibit 1 § C.20)

47. In addition, Penn Health agreed to remain "financially responsible (out of the capitation payments described in Section F.1) for the provision, when medically necessary, of service to eligible clients." (DPW Exhibit 1, Amend. III § C.1)

48. The DPW capitation payments to Penn Health were to pay health care providers for delivering medical services and to pay for Penn Health's administrative expenses. (N.T.L. 634-635, 745)

49. DPW's capitation payments constituted virtually the sole source of Penn Health's revenue which, in turn, were the source from which the HealthPASS hospitals, physicians, pharmacists and other providers would ultimately be paid. (N.T.L. 213-214, 638-639)

50. DPW entered into, or kept in force, independent Contracts with each of the HealthPASS providers who had also contracted with Penn Health. (N.T.L. 495-496; N.T.D. 394-395; DPW Exhibit 39-41)

51. These DPW-provider agreements explicitly assured the providers that DPW would pay for medical assistance services rendered by providers to Medicaid enrollees: "[t]he Department [DPW] agrees to reimburse the provider for services covered under the [Medical Assistance] Program [i.e. Medicaid Program] in accordance with applicable statutes and regulations." (DPW Exhibit 39-41)

52. DPW's obligations under these provider agreements included a duty to reimburse health care providers for services they performed in the HealthPASS program. (N.T.D. 1445)

53. Beginning as early as 1987, health care providers servicing Medicaid patients under HealthPASS began to experience problems with Penn Health's claims processing. (N.T.L. 885, 890; N.T.D. 321)

54. Claims processing problems included untimely payments, arbitrary denial and underpayment of claims, as well as lack of documentation for claims processing decisions. (N.T.L. 886-888, 1134-1137)

55. Richard Braksator, Penn Health's Chief Financial Officer, testified that Penn Health's initial review of provider claims resulted in claims being incorrectly denied or inaccurately paid nearly 50% of the time. (N.T.L. 1137)

56. Martha Waters, Penn Health's Executive Director and Vice President, admitted that Maxicare directed Penn Health to reduce patient hospitalization, without medical justification, in order to save money and to deny providers' claims arbitrarily in order to improve cash flow. (N.T.L. 671-672)

57. Martha Waters, Penn Health's Executive Director and Vice President, admitted that Penn Health arbitrarily denied claims:

> I was directed to reduce the days. They didn't really care how I reduced them, whether I denied days that had already been approved, or denied admissions. They really didn't care.
>
> (N.T.L. 671-672)

58. In the spring and summer of 1988, DPW officials became aware from articles in various national health care and financial publications that Maxicare, Penn Health's parent, was suffering severe financial difficulties. (N.T.L. 573; DPW Exhibit 48)

59. DPW officials met with Maxicare officials in the autumn of 1988 in order to attempt to assure the continuity of health care services to the HealthPASS Medicaid enrollees. (N.T.L. 574, 1061 (Schoen-Githens Dep. at 36-37)

60. In their meeting with Maxicare officials, DPW officials sought assurances that Penn Health's ability to perform under the HealthPASS Contract was not jeopardized by Maxicare's financial difficulties and that Penn Health's funds would be maintained separately from Maxicare's. (N.T.L. 574-576, 1061 (Schoen-Githens Dep. at 36-37)

61. Maxicare officials offered assurances to DPW that Penn Health's profitability confirmed its ability to appropriately perform the HealthPASS Contract, that Maxicare was separately

addressing its own financial problems, and that Maxicare would not use Penn Health's monies for purposes other than HealthPASS medical assistance payments. (N.T.L. at 576-577, 1061 (Schoen-Githens Dep. at 37)

62. Despite such assurances from Maxicare, hospitals, pharmacists and physicians experienced an increased slow down in claims payment from Penn Health. (N.T.D. 413-414, 675; N.T.L. 581, 600-601, 893 & 1042)

63. At the same time, Penn Health's claim approval rates, that were normally at 85% of submitted claims, fell to between 40% to 60%. (N.T.L. at 581, 600-601, 893 & 1042; N.T.D. at 413-414)

64. In order to assure the continuity of timely and quality medical services to HealthPASS enrollees, DPW decided to review other alternatives to the continuation of the Contract with Penn Health. (N.T.L. at 578-579)

65. Pursuant to Section H of Amendment II, Section F.2(h) of the Agreement mandated that "The audits provided for in Section H-12(g) of this agreement shall serve as the basis for determining profits or losses" for the two year period. (Exhibit D-1, Section H-new Section F.2(h) of the Agreement; Exhibit D-1, Section H.12(g)(4).

66. In response to questions from HCFA concerning this risk-sharing payment, DPW stated: "The contractor's financial losses are to be determined by an audit." (Exhibit PH-37, attachment 4 at p. 3; N.T.L. 98, 438)

67. In accordance with Section H.12(g) (4) of the Agreement, Penn Health's financial statements were audited by Ernst & Whinney, certified public accountants, at the end of the First and Second Program Years. Ernst & Whinney performed the audit in accordance with Generally Accepted Auditing Standards ("GAAS") and Penn Health's financial statements were prepared in accordance with Generally Accepted Accounting Principles ("GAAP"). (Exhibit D-1, Section H.12, Exhibit PH-5; N.T.L. 117, 327-329, 350-354)

68. Pursuant to GAAP, Penn Health's financial statements were maintained on an accrual basis. The financial statements, therefore, included both actual claims paid and amounts for claim expenses incurred in any given program year but not actually paid in that program year. (N.T.L. 117, 327-329, 350-354)

69. Penn Health's outside auditors, Ernst & Whinney, performed an audit which showed that Penn Health had sustained cumulative net losses in the amount of $21,550,826.00 in excess of the $2 Million Deductible during the First and Second Program Years. (Exhibit PH-5; N.T.L. 98, 1130; N.T.D. 42)

70. DPW paid Penn Health $5,697,972.00 for losses incurred during the First Program Year. DPW did not reimburse Penn Health for the outstanding balance of the audited cumulative net loss sustained during the First and Second Program Years in excess of the $2 Million Deductible. This amount equals $15,852,854.00 (the "Unpaid Risk Sharing Payment"). (Exhibit PH-5; N.T.L. 98-99, 113-114)

71. The Unpaid Risk Sharing Payment was due "not later than December 31, 1988." (N.T.L. 752)

72. To date, DPW has not paid Penn Health any portion of the claimed Unpaid Risk Sharing Payment. (N.T.L. 99)

73. DPW ultimately determined that the rebidding of the HealthPASS program was the most prudent approach to ensure the quality and continuity of the HealthPASS program. (N.T.L. 579; DPW Exhibit 47)

74. DPW initiated the rebidding process through an RFP released in October 1988. (N.T.D. 305-306; DPW Exhibit 47)

75. The risk-sharing provisions of the Contract do not provide that Penn Health shall be reimbursed for accrued medical and administrative expenses. (Board Findings based upon review of Contract)

76. Penn Health ignored the clear contractual provisions which limit reimbursable medical and administrative expense under the Contract by relying on an Ernst & Whinney audit of Contract Years One and Two. (Penn Health Exhibit 5)

77. On February 13, 1989, DPW informed Penn Health that the Ernst & Whinney audit would not support a risk-sharing payment because it did not contain the contractually mandated auditor's opinions "as to whether the contractor has complied with the terms and conditions of the Contract." (Penn Health Exhibit 3)

78. The Ernst & Whinney audit overstated losses for Contract Years One and Two because it did not take into account the contractual limitations on medical and administrative expenses. (Penn Health Exhibit 5-6)

79. Penn Health is not due $15,852,854.00 as a risk-sharing adjustment for Contract Years One and Two as the net operating losses set forth in the Ernst & Whinney audit do not take into account the contractually defined limitations on reimbursable medical and administrative expenses. (DPW Exhibit 1 § F.2(c) (Amend. II) & § F.2(d))

80. The Contract states that an audit based on the terms and conditions of the Contract would be used to calculate risk-sharing and provides as follows: "The audits provided for in Section H-12(g) of this Agreement shall serve as the basis for determining profits or losses under the terms of this Section." (DPW Exhibit 1§ F.2(c) (Amend. II) § F.2(d) & § F.2(h))

81. The Ernst & Whinney audit does not contain the contractually mandated opinion that the audit is in agreement with the terms and conditions of the Contract because the GAAP audit performed by Ernst & Whinney did not take into account the specific contractual limitations on reimbursable losses as set forth in the risk-sharing provisions of the Contract. (Penn Health Exhibit 5)

82. The risk-sharing formula contained in Section F.2 of Amendment II of the Contract contains certain limitations which impact the amount of Penn Health's operating loss eligible for risk-sharing reimbursement. (DPW Exhibit 1 (Amend. II) § F.2)

83. Section F.2 of Amendment II of the Contract limits the amount of medical and administrative expenses which are eligible for reimbursement under the risk-sharing adjustment. (DPW Exhibit 1 (Amend. II) § F.2)

84. The terms "medical expense" and "administrative expense" are defined terms as set forth in Forth F.2 of Amendment II to the Contract. (DPW Exhibit 1 § F.2(e) (Amend. II))

85. The risk-sharing provisions which apply to Contract Years One and Two do not make DPW liable for all losses in excess of $2 million, but rather explicitly limit reimbursable losses to "any financial losses, as determined in accordance with this section." (DPW Exhibit 1 § F.2 (Amend. II))

86. The Contract defines "loss" under the risk-sharing provisions as follows: "a loss shall occur when total medical and administrative expenses exceed revenues." (DPW Exhibit 1 § F.2(c) (Amend. II) & § F.2(d))

87. The Contract then provides specific definitions of medical and administrative expenses to be used in determining a financial loss under the risk-sharing provision. (DPW Exhibit 1 (Amend. II) § F.2(e))

88. For purposes of risk-sharing, "[m]edical expenses shall include all payments made by the Contractor for medical services provided under the terms of this Agreement." (DPW Exhibit 1 (Amend II) § F.2(e))

89. For Contract Years One and Two, the term "medical expense" is defined in the Contract as "all payments made by [Penn Health] for medical services provided under the terms of this Agreement." (DPW Exhibit 1 § F.2(e) (Amend. II))

90. The term "medical expense" as set forth in Section F.2 of Amendment II of the Contract clearly sets forth that Penn Health will be reimbursed only for medical claims actually paid during Contract Years One and Two. (DPW Exhibit 1 § F.2(e) (Amend. II))

91. Reimbursable administrative expenses for purposes of the risk-sharing calculations are limited to those administrative expenses "incurred in the administration of the program in accordance with the budget prepared by the Contractor and approved by the Department." (DPW Exhibit 1 (Amend. II) § F.2(f))

92. The only medical and administrative expenses which are eligible for risk-sharing reimbursement are those which fall within the very specific definitions of the Contract. (DPW Exhibit 1 (Amend. II) §§ F.2(d), (e), (f))

93. DPW specifically advised Penn Health that only medical claims that had actually been paid were eligible for reimbursement under the risk-sharing provisions of the Contract. (Penn Health Exhibit 3)

94. Despite the clear wording of the Contract, Penn Health calculated its medical cost expense on an accrual basis. (N.T.L. 440; Penn Health Exhibit 5-6)

95. Richard Link, Senior Vice President, Accounting, and Chief Financial Officer of Maxicare, admitted that "claims paid" and "accrued claims" have different meaning. (N.T.D. 103-104)

96. Richard Link, Senior Vice President, Accounting, and Chief Financial Officer of Maxicare, admitted in testimony before this Board that the phrase "payments made," as used to define reimbursable "medical expenses" under the risk-sharing provisions of the Contract, did not include incurred but not reported ("IBNR") and incurred but not paid claims. (N.T.D. 103-104)

97. The Ernst & Whinney audit specifically notes that incurred-but-not-paid and IBNR claims were included as medical costs: "Estimated claims payable include claims reported as of the balance sheet date and estimates (based upon projection of historical developments) of health care services rendered but not reported." (Penn Health Exhibit 5)

98. Ernst & Whinney's calculation of medical expenses was not limited to medical expenses paid, as specified and in compliance with Section F.2(e) of the Contract, but instead calculated medical expenses on an accrual basis which included claims incurred, but neither reported nor paid during the period of the audit. (Penn Health Exhibit 3; N.T.D. 103, 105)

99. Penn Health's claim for a risk-sharing adjustment for Contract Years One and Two is overstated to the extent that it includes $2,239,000.00 in projected medical costs, including both incurred but not paid claims and IBNR. (Penn Health Exhibit 5, 42)

100. Under the clear contractual language, medical claims incurred in one contract year but paid in another period are chargeable to the year in which the claim was actually paid. (DPW Exhibit 1 § F.2(e) (Amend. II))

101. As of November 30, 1988, approximately nine months after the close of the Second Program Year, Penn Health had actually paid $4,939,000.00 less in medical expenses for Year Two than had been accrued by the auditors. (Penn Health Exhibit 3)

102. In Contract Year Two, however, Penn Health had paid $2.7 million in claims for Year One. (Penn Health Exhibit 40)

103. Under the clear language of the Contract, Penn Health's Year One and Year Two risk sharing claim is therefore overstated by $2,239,000.00 ($4,939,000.00 less $2,700,000.00) because $2,239,000.00 was for accrued rather than paid claims. (DPW Exhibit 1 § F.2 (Amend. II))

104. Penn Health's claim of $15,852,854.00 for risk-sharing under Contract Years One and Two also is overstated in the amount of $2,975,192.00 which amount represents administrative expenses which were not eligible for reimbursement under the risk-sharing provisions. (DPW Exhibit 1 § F.2 (Amend II))

105. Under the risk-sharing provisions of Amendment II of the Contract, "administrative expenses" are defined as expenditures for "salaries, benefits . . . claims processing charges, corporate overhead, and other costs incurred in the administration of the program in accordance with the budget prepared by [Penn Health] and approved by the Department." (DPW Exhibit 1 § F.2(f) (Amend. II) & § F.2(g) (Amend. III & IV); N.T.D. 96)

106. The Contract clearly includes corporate overhead costs as a subcategory of administrative expenses. (DPW Exhibit 1 § F.2(f) (Amend. II) & § F.2(g) (Amend. III & IV)

107. The risk-sharing provisions of Amendment II of the Contract further provides that Penn Health must "obtain the approval of [DPW] prior to implementing any decision which could increase or decrease by more than 10% the per enrollee, per month cost in any category of administrative expense." (DPW Exhibit 1 § F.2(g) (Amend. II) & § F.2(h); N.T.D. 96)

108. Pursuant to Amendment II of the Contract, Penn Health submitted a budget for Contract Year Two to DPW on April 22, 1987. (DPW Exhibit 22-23)

109. Penn Health's budget for Contract Year Two was approved by DPW on July 7, 1987. (DPW Exhibit 24)

110. At the time that DPW approved Penn Health's budget, DPW reminded Penn Health that the risk-sharing provisions "required [DPW] approval of certain changes affecting administrative costs" and that "any payments made in violation of the Department's instructions will not be counted as expenses." (DPW Exhibit 24)

111. Penn Health incurred certain administrative costs in Contract Year Two which exceeded the 110% of approved budget limitation. (Penn Health Exhibit 3)

112. Penn Health exceeded the 110% of approved budget limitation by $2,922,690.00 in Contract Year Two for management information systems (MIS). (Penn Health Exhibit 3)

113. Penn Health never sought, nor did DPW approve, MIS expenditures beyond those approved in the budget for Contract Year Two. (Penn Health Exhibit 3)

114. Pursuant to the risk-sharing provisions of the Contract, Penn Health did seek and obtain DPW approval for other administrative expenditures which exceed 110% of the approved budget item. (N.T.D. 98)

115. For example, Penn Health sought and received DPW approval for expenditures for the Ernst & Whinney audit when the cost of the audit was going to exceed 110% of the budgeted amount. (N.T.D. 98)

116. The Ernst & Whinney audit cannot be used as a baseline to calculate risk-sharing for Contract Years One and Two as it was not prepared in accordance with the Contract. (Penn Health Exhibit 3; N.T.D. 103-105)

117. Penn Health's claim for $15,852,854.00 for risk-sharing for Contract Years One and Two must be reduced by $2,922,690.00, the amount by which Penn Health's costs for management information systems ("MIS") exceeded the 110% of budget limitation specified in the Contract and for which Penn Health neither sought nor obtained DPW approval. (Penn Health Exhibit 3)

118. Penn Health's failure to seek DPW approval of a budget modification for MIS expenses renders any expense in excess of 110% of the approved budget non-reimbursable under the risk-sharing provisions of the Contract. (DPW Exhibit 1 § F.2(g) (Amend. II) & § F.2(h))

119. In a letter dated February 13, 1989, DPW advised Penn Health that its calculation of $15,852,854.00 as due under the risk-sharing provisions for Contract Years One and Two was erroneous and not in compliance with the terms of the Contract. (Penn Health Exhibit 3)

120. In Contract Year Two, Penn Health exceeded 110% of the approved budget for three categories of miscellaneous expenses: dues and subscriptions by $3,960.00; employment ads by $20,707.00, and occupancy by $27,835.00, which items total $52,502.00. (Penn Health Exhibit 3)

121. Penn Health neither sought nor received DPW approval of Penn Health's excess expenditures for dues and subscriptions, employment ads, and occupancy, and such items exceed the approved budget for Contract Year Two by $52,502.00. (Penn Health Exhibit 3)

122. Penn Health admitted that it decided to include certain unallocated charges from Contract Year One in Contract Year Two MIS expenses and did not seek DPW approval for such inclusion. (N.T.L. 138-139)

123. Penn Health's claim for $15,852,854.00 for risk-sharing for Contract Years One and Two also must be reduced in the amount of $52,502.00, which is the amount that Penn Health's claimed miscellaneous administrative expenses exceed the 110% of budget limitation specified in the Contract. (Penn Health Exhibit 3)

124. Penn Health's claim of $15,852,854.00 for risk-sharing payments for Contract Years One and Two is overstated by a total of $5,214,192.00 to the extent that Penn Health is seeking reimbursement for medical costs and expenses which are not reimbursable under the risk-sharing provisions of the Contract. (Total of $2,239,000.00, $2,922,690.00 and $52,502.00 as previously stated in Findings)

125. In January 1989, after Maxicare officials had represented that Maxicare would not use Penn Health's monies for purposes other than the HealthPASS medical assistance payments, and at the same time that providers were complaining about the substantial decreases in claim payments, Penn Health up streamed $6,651,000.00 to Maxicare. (N.T.L. 155-156, 215-216, 530)

126. Penn Health up streamed $6.6 million in Medicaid funds to Maxicare based upon an oral request by Maxicare. (N.T.L. 527-528)

127. The $6.6 million transfer violated the provisions of the Contract which required all Medicaid monies held by Penn Health to be invested in Pennsylvania. (DPW Exhibit 1 §§ F.1 & H.7)

128. Penn Health originally categorized the $6.6 million payment to Maxicare as a loan to an affiliate. (N.T.D. 180, 220; DPW Exhibit 2)

129. In order to try to "legitimize" the transfer and to ensure that Maxicare would not be asked to return the money to Penn Health, the "up streaming" was later categorized by Maxicare's Senior Vice President for Accounting as a "dividend." (N.T.D. 155)

130. The result of the $6.6 million transfer was to reduce Penn Health's retained earnings and cash available to pay health service providers by an equivalent amount. (N.T.L. 220-222)

131. Penn Health ignored the $6.6 million up streamed to Maxicare in January 1989 in calculating its claim against DPW. (Penn Health Exhibit 63)

132. Originally, Penn Health claimed that DPW was obligated to pay an undetermined amount under the risk-sharing provisions for Contract Year Three. (Penn Health Complaint at ¶ 13-15)

133. The risk-sharing formula for Contract Year Three is contained in Amendment III to the Contract. (DPW Exhibit 1 § F.2 (Amend. (III))

134. Under the risk-sharing provisions of the Contract, Penn Health is entitled to a risk-sharing payment for Contract Year Three only if Penn Health suffered operating losses, as defined by the Contract, during the period. (Penn Health Exhibit 2)

135. Penn Health did not suffer operating losses during Contract Year Three. (Penn Health Exhibit 2)

136. Penn Health admitted that it earned a profit for the third program year. (N.T.L. 217-218; DPW Exhibit 3)

137. Penn Health's unaudited financial statement from February 1989 reflects a $4.2 million profit for Contract Year Three. (DPW Exhibit 2; Penn Health Exhibit 6; N.T.L. 184)

138. Penn Health's up streaming of $6.6 million in January 1989 further illustrates that Penn Health did not suffer operating losses in Contract Year Three and is not entitled to a risk-sharing payment. (N.T.L. 1061; Schoen-Githens Dep. 41-42)

139. Pursuant to Section F.3 of the Agreement, DPW as required to adjust, on a quarterly basis, the aggregate capitation payment in accordance with a category mix formula. (DPW Exhibit 1)

140. DPW determined that the amount of the category mix payment owed to Penn Health for the fourth quarter of the Third Program Year was $518,020.58. (Penn Health Exhibit 2, 65; N.T.L. 376; N.T.D. 44, 51)

141. The category mix fee adjustment for the Third Program Year was due by April 15, 1989, 45 days after the February 28, 1989 end of the Third Program Year. (N.T.D. 44, 51)

142. DPW has not paid Penn Health the $518,020.58 category mix payment for the fourth quarter of the Third Program Year. (N.T.L. 376)

143. DPW does not dispute the amount of Penn Health's claim to the category mix payment for the fourth quarter of Year Three of the Contract but does dispute whether it is due by reason of set-off. (Penn Health Exhibit 2; Complaint and Answer)

144. Section F.8 of the Agreement provided for retroactive adjustments in the capitation payments by DPW to Penn Health. The capitation payments to Penn Health were established as a percentage of DPW's projected costs in the fee-for-service program. Retroactive adjustments to the capitation payments were to be made in the event that DPW's actual fee-for-service costs to Medicaid recipients, for those same services provided by Penn Health to HealthPASS enrollees, exceeded DPW's projected fee-for-service cost. (DPW Exhibit 1; N.T.D. 43)

145. Amendment III, Amended Section F.8 to require DPW to make a retroactive capitation payment so that the final capitation amount equaled 92% of DPW's actual fee-for-service cost (the "Adjusted Base") in the event the actual fee-for-service costs exceeded the projected fee-for-service costs. (DPW Exhibit 1, Amendment III, Section F.8; N.T.L. 100, 281-282)

146. For the Third Program Year, running March 1, 1988 through February 28, 1989, DPW initially determined that the amount of the retroactive fee adjustment owed to Penn Health under Amendment III, Section F.8, was $7,973,571.77. (Penn Health Exhibit 2; N.T.L. 102, 283-284)

147. DPW subsequently revised the amount of the retroactive fee adjustment for the Third Program Year to $8,090,045.30. (Penn Health Exhibit 38)

148. The retroactive fee adjustment for the Third Program Year was due by April 15, 1989, 45 days after the February 28, 1989 end of the Third Program Year. (N.T.D. 44)

149. DPW has not paid Penn Health the $8,090,045.30 retroactive capitation fee adjustment payment for the Third Program Year. (Penn Health Exhibit 31; N.T.L. 102; N.T.D. 43)

150. DPW determined that the amount of retroactive fee adjustment due for the Fourth Program Year, running March 1, 1989 through June 30, 1989, was $4,930,376.02. (Penn Health Exhibit 6; N.T.L. 151-152, 376; N.T.D. 44)

151. The retroactive fee adjustment for the Fourth Program Year was due by August 15, 1989, 45 days after the June 30, 1989 end of Penn Health's operation of HealthPASS. (N.T.D 44, lines 23-25)

152. DPW has not paid Penn Health the $4,930,376.02 retroactive capitation fee adjustment payment for the Fourth Program Year. (Penn Health Exhibit 6; N.T.L. 109-110, 153; N.T.D. 45)

153. DPW does not dispute that $8,090,045.00 is the amount of Penn Health's retroactive fee adjustment for Year Three but does dispute whether the amount is due because of set-off. (Penn Health Exhibit 2; Complaint and Answer)

154. DPW does not dispute that the amount adjustment for Year Four of $4,930,376.02 is correct, but does dispute whether it is due by reason of set-off and as no claim for Year Four was pled, that the Statute of Limitations has expired barring any recovery. (Finding of Board from Review of Record; Complaint and Answer)

155. Under Section C.20 of Amendment V, an interest bearing escrow account was established for the Fourth Program Year. During the Fourth Program Year, DPW deposited the monthly capitation payments due to Penn Health under the Agreement into this escrow account (the "Escrow Account"). (DPW Exhibit 1, Amendment V; N.T.L. 45, 109)

156. The funds deposited into the Escrow Account were to be used to pay health care claims submitted for reimbursement to Penn Health for services rendered during the Fourth Program Year. (DPW Exhibit 1; Amendment V, Section C.20)

157. The remaining balance in the Escrow Account after payment of healthcare claims was to be paid to Penn Health. (DPW Exhibit 1, Amendment V, Section C.20)

158. All healthcare claims eligible for reimbursement out of the escrowed funds have been paid and there currently remains approximately $230,000.00 in the Escrow Account. (N.T.L. 109, 111, 296, 1046, 1074; N.T.D. 45)

159. DPW has not released and paid the balance of the escrowed funds to Penn Health. (N.T.L. 111)

160. DPW does not dispute that Penn Health is entitled to any sums remaining in the escrow fund after all claims for Contract Year Four have been settled. (DPW Exhibit 1 §§ F.1(a), F.3 & F.8)

161. Penn Health is claiming $15,852,854.00 in risk-sharing payments, $518,020.58 in category mix payment, $8,090,045.30 in Retroactive Fee Adjustments for the Third Program Year, $4,930,376.02 in Retroactive Fee Adjustments for the Fourth Program Year, and all monies currently remaining in the Escrow Account. The total damages amount claimed by which Penn Health equals $29,391,295.90, plus the amounts remaining in the escrow account. (Board Summary)

162. Penn Health is further claiming 6% prejudgment interest on the approximately $29.3 million of damages in the amount of $13,698,940.00. (N.T.D. 119; Penn Health Exhibit 65)

163. Penn Health admitted in testimony before this Board that its $13,698,940.00 interest claim is based on compound interest. (N.T.D. 120)

164. Compound interest is not recoverable in Pennsylvania as a matter of law. (Pa. Stat. Ann. tit. 41 § 202; DPW Exhibit 65)

165. Because Penn Health relied improperly upon a compound interest caculation in computing its damages, it has failed to present any record evidence supporting the recovery of interest in accord with Pennsylvania law. (N.T.D. 120)

166. Penn Health in its Proposed Findings of Fact filed with the Board reduced its interest claim to $12,302,729.00. (Penn Health Proposed Damages Finding of Fact No. 96)

167. DPW contends no interest is due because of credits or set-offs due DPW reducing Penn Health's claim to below zero. (DPW Proposed Damages Finding of Fact Nos. 470-471)

168. In March 1989, about the time DPW announced that the new Contract to administer the HealthPASS Program would not be awarded to Penn Health, Maxicare and more than 40 affiliated entities filed voluntary petitions for reorganization under Chapter 11 of the Bankruptcy Code. (N.T.L. 180, 183, 531; N.T.D. 307)

169. Maxicare did not include in its bankruptcy filing all of its affiliated entities, however it did include Penn Health. (N.T.D. 356-357)

170. At the time that Penn Health was placed into bankruptcy by Maxicare, Penn Health was a viable, solvent company. (N.T.L. 182, 531, 534-536)

171. The decision to place Penn Health, a viable and solvent company, into bankruptcy was made by Maxicare. (N.T.L. 534; N.T.D. 116)

172. Neither the officers nor directors of Penn Health were consulted by Maxicare prior to its decision to place Penn Health, a solvent subsidiary, into bankruptcy. (N.T.L. 534; N.T.D. 116)

173. At the time that Penn Health was placed into bankruptcy by Maxicare, Penn Health's assets exceeded its liabilities. (N.T.L. 182, 531, 534-536)

174. At the time that Penn Health was placed into bankruptcy by Maxicare, Penn Health was able to satisfy its debts as they came due. (N.T.L. 182, 531, 534-536)

175. At the time that Penn Health was placed into bankruptcy by Maxicare, Penn Health was showing a profit. (N.T.L. 182, 531, 534-536)

176. Penn Health's profitability is evidented at the time of the bankruptcy by seeking to classify the $6.6 million up streamed in January 1989 as a dividend. (N.T.D. 155)

177. Maxicare included Penn Health in the bankruptcy so that Maxicare's creditors would have access to Penn Health's cash surplus. (N.T.D. 177, 215-216, 529-530)

178. When Maxicare decided to place Penn Health in voluntary bankruptcy, no notice was given to DPW, to HealthPASS recipients or providers, or even to Penn Health employees. (N.T.L. 534; N.T.D. 117, 311-312)

179. DPW learned about the bankruptcy filing from newspaper articles as well as from frantic telephone calls from HealthPASS providers, who had apparently read similar articles. (N.T.D. 311; DPW Exhibit 46)

180. As a result of Penn Health's voluntary bankruptcy, all payments to providers for services rendered prior to the bankruptcy were immediately cut-off and would not resume until a bankruptcy plan of reorganization would be approved by the Bankruptcy Court. (N.T.L. 604)

181. At the time of Penn Health's voluntary bankruptcy, hundreds of HealthPASS providers and tens of thousands of individual HealthPASS medical claims had not been paid. (Penn Health Exhibit 69)

182. News of the bankruptcy caused panic in both HealthPASS enrollees and medical providers who were concerned about the availability of services and payment for those services. (N.T.D. 267-270; DPW Exhibit 43, 45)

183. Both DPW and Pennsylvania legislators began receiving reports that HealthPASS providers were not being paid and, as a result, HealthPASS enrollees were not being served. (N.T.D. 267-270)

184. Hospitals, family planning providers, and pharmacists were threatening to close down their programs as they were placed into danger of bankruptcy by Penn Health's voluntary bankruptcy. (N.T.D. 267-270; Penn Health Exhibit 74)

185. Because their pre-bankruptcy claims were not being paid and because they were fearful of not receiving payment for the continued provision of health care services and supplies, HealthPASS providers placed ever-increasing pressure on DPW to satisfy its obligations under the Medicaid program. (N.T.L. 584; N.T.D. 267)

186. On March 17, 1989, the United States Bankruptcy Court for the Central District of California (the "Bankruptcy Court") issued an Order prohibiting, inter alia, any contracting provider from refusing or discontinuing service to Penn Health and prohibiting the Commonwealth of Pennsylvania from taking possession of any of the debtor's property and from seeking to off-set any debt against monies owed to the debtors. (Penn Health Exhibit 76)

187. Providers, who had not been paid for services rendered to the HealthPASS program administered by Penn Health, threatened to refuse to participate in the HealthPASS Contract with the Penn Health successor who was to assume administration of HealthPASS on July 1, 1989. (N.T.D. 318-321)

188. Continued provider participation in the HealthPASS program was essential to DPW's ability to retain the non-replaceable HCFA waiver for the HealthPASS program. (N.T.D. 312-313)

189. The HCFA waiver was important to DPW because an abandonment of the HealthPASS program would disrupt the delivery of medical services to a critical Medicaid population. (N.T.D. 313)

190. The continued operation of HealthPASS was important to DPW because it had historically provided medical cost savings in the Pennsylvania Medicaid program of $20 to $30 million per year. (N.T.L. 588-589; N.T.D. 312-313, 320-321)

191. DPW's Contract with Penn Health was due to expire on June 30, 1989. (N.T.D. 306)

192. The new HealthPASS contractor would assume responsibility for the program on July 1, 1989. (N.T.D. 306-307)

193. In the three months between April 1989 and July 1, 1989, the new contractor was responsible for independently negotiating with, and then contracting with, the Philadelphia-area health care providers who would serve as the provider network for HealthPASS. (N.T.D. 309-310)

194. As late as two weeks before the July 1, 1989 transition date, the new HIO contractor had failed to sign even one hospital to a HealthPASS provider Contract. (N.T.D. 318)

195. News of trouble in HealthPASS spread throughout the recipient community, and began causing serious concern to those who relied on HealthPASS for their medical needs. (N.T.D. 268)

196. Pressured by both the immediate and longer term crisis which would be caused by providers' refusal to participate in the HealthPASS program, in June 1989 DPW conducted a
series of meetings with hospitals in order to determine a viable plan to retain provider participation in HealthPASS. (N.T.L. 584-588; N.T.D. 320)

197. DPW has three primary objectives in attempting to retain provider participation in HealthPASS: (1) To retain the benefits of managed care for the HealthPASS enrollees by preserving the HCFA waiver with its unique provisions no longer available under federal law; (2) To eliminate the risk that providers would refuse to contract with a new contractor under the HealthPASS program; and (3) To ensure uninterruped medical care to HealthPASS enrollees. (N.T.D. 280, 313-315; DPW Exhibit 14 at 2; Penn Health Exhibit 14)

198. In order to retain its unique waiver, DPW had a continuing obligation to demonstrate to HCFA that HealthPASS reduced Medicaid expenditures, while it maintained or improved both the access and quality of medical services to HealthPASS enrollees. (DPW Exhibit 15; 42 U.S.C. § 1396n(b); N.T.D. 318)

199. In their meeting with DPW, hospitals indicated that they required payment for past medical services in order to ease their immediate cash flow problems caused by Penn Health's non-payment and in order to consider contracting with Penn Health's successor as HealthPASS administrator. (N.T.L. 584)

200. The hospitals and other HealthPASS providers believed that DPW was liable for payment for all pre-bankruptcy services provided to HealthPASS enrollees. (DPW Exhibit 42)

201. Under DPW's Contract with Penn Health, Penn Health was obligated to administer the HIO by entering into contracts with health care providers on DPW's behalf for the purpose of providing prepaid managed medical services to Medicaid recipients in the HealthPASS service area. (N.T.L. 564; DPW Exhibit 1 § B.10)

202. In addition to entering a provider Contract with Penn Health, HealthPASS providers were required to be Medicaid participants and to have a direct contract with DPW in order to participate in the HealthPASS program. (N.T.D. 394, 1440, 1445; DPW Exhibit 11)

203. Providers' direct contracts with DPW were separate from the provider contracts with Penn Health. (N.T.D. 394, 1440, 1445; DPW Exhibit 39-41)

204. Providers' direct contracts with DPW require DPW to pay providers for medical services provided under Pennsylvania's Medicaid program:

> [DPW] agrees to reimburse Provider for those allowable medical and related services for those eligible individuals being served in accordance with federal and state Medicaid laws. . . .
>
> (DPW Exhibit 11, ¶ 3; N.T.D. 396, 1445)

205. DPW's obligation to pay, however, was subject to the requirement that the providers first collect payment from other sources for services provided before making a claim against DPW:

> Provider shall identify and make collection from any other parties who may, by insurance contract or otherwise, be liable for all or part of the cost of items or services provided. In such event, the Provider shall reduce its claim or, if such claim has been paid, shall promptly reimburse [DPW] up to the amount paid by [DPW].
>
> (DPW Exhibit 11 at ¶ 9; N.T.D. 435)

206. In response to enrollee and provider complaints, the Pennsylvania House of Representatives' Health & Welfare Committee convened a public hearing on the HealthPASS crisis on June 26, 1989. (N.T.D. 262)

207. At the time of the hearing, the legislature had not yet passed the 1989/1990 fiscal budget and HealthPASS, which was included as the budget appropriation, could have been denied funding from the General Assembly. (N.T.D. 272)

208. The legislators, advised of DPW's decision to provide interim payments to HealthPASS providers, raised no objection; to the contrary, they decided to approve State funding for HealthPASS. (N.T.D. 271-274)

209. As of July 1989, Penn Health had failed to pay claims to HealthPASS providers for pre-bankruptcy services provided to Medicaid beneficiaries under the HealthPASS program. (N.T.L. 584-588)

210. In July 1989, DPW made payments to HealthPASS providers totalling $16.2 million on the pre-bankruptcy claims. (N.T.L. 584-588, 1043-1044)

211. $10,366,033.03 of the total payment was paid to hospital providers, with the remaining $5.9 million paid to physician specialists, pharmacies and other suppliers. (N.T.L. 584-589, 1043-1044; DPW Exhibit 7 at § 2)

212. DPW entered into a separate Contract with each HealthPASS medical provider. (DPW Exhibit 11, 39-41; N.T.L. 495-496; N.T.D. 394-395, 1439-1440)

213. Under its Contracts with the medical providers, DPW agreed to reimburse the provider for Medicaid services if Penn Health did not pay. (DPW Exhibit 40, ¶ 9; N.T.D. 435-436)

214. Pursuant to its contractual obligations and its non-delegable statutory duty, DPW has made certain payments to medical providers who had provided Medicaid services to the HealthPASS program but who had not been paid for such services because of Penn Health's voluntary bankruptcy. (N.T.L. 584-588)

215. To implement HealthPASS, Penn Health contracted with hospitals located within and contiguous to the HealthPASS service area. (DPW Exhibit 1 at § B.3)

216. Each medical provider who contracted with Penn Health was also required to have a direct contract with DPW. (DPW Exhibit 1 at § C.7)

217. The Contract between DPW and each hospital obligates DPW to pay the hospital for services rendered under Pennsylvania's Medicaid program. (DPW Exhibit 41, ¶ 4)

218. Under the HealthPASS hospital provider contracts, hospitals were to be compensated specified dollar amounts for each inpatient and outpatient hospital service provided to HealthPASS enrollees ("Contract rate"). (N.T.D. 399-400)

219. When Penn Health filed its voluntary bankruptcy petition in March 1989, Penn Health ceased making payments to providers. (N.T.D. 172)

220. On July 19, 1989, certain HealthPASS hospital providers commenced an action against DPW in the Board of Claims, Docket No. 1382, seeking to hold DPW liable for pre-bankruptcy services provided to Medicaid participants enrolled in HealthPASS ("DVHC Provider Claim"). (DPW Exhibit 42)

221. In their complaint, the DVHC providers alleged: (1) that DPW is both statutorily and contractually liable to providers for medical services and supplies provided to HealthPASS enrollees; (2) that DPW's non-payment constitutes the breach of its non-delegable duty to administer and operate Pennsylvania's Medicaid program; (3) that hospital providers are third-party beneficiaries of DPW's HealthPASS Contract with Penn Health and that DPW is legally obligated to pay providers in the event that Penn Health defaults; and (4) that Penn Health, as an agent of DPW, obligated DPW, as principal, to perform in the event that Penn Health failed to perform its contractual obligation to pay providers. (DPW Exhibit 42)

222. In their claim against DPW, the DVHC providers sought approximately $32 million, excluding interest, for pre-bankruptcy obligations of Penn health for medical services and supplies provided to HealthPASS enrollees. (DPW Exhibit 42)

223. Each DVHC provider also filed a proof of claim against Penn Health in the United States Bankruptcy Court for the Central District of California, pursuant to the claim filing provisions of the Federal Bankruptcy Code. (N.T.D. 1449)

224. In their combined proofs of claim in the Bankruptcy Court, the DVHC providers sought $31.7 million against Penn Health for unpaid pre-bankruptcy claims for the provision of medical services and supplies to HealthPASS enrollees. (N.T.D. 1451)

225. Through their counsel, the DVHC providers have acknowledged in the record at this proceeding that they are entitled to receive only one recovery despite the fact they have filed claims for the same medical services in the Board of Claims and the Bankruptcy Court. (N.T.D. 1450)

226. Subsequent to filing the proofs of claim with the Bankruptcy Court, the DVHC providers reduced their claim by $2.2 million to a total of $29.5 million. (N.T.D. 1451-1453)

227. The $2.2 million adjustment was caused, in part, by Maxicare's agreement that services provided for the period of March 1, 1989 to March 15, 1989 could be funded from an escrow account established by DPW for services rendered. (N.T.D. 1451-1453)

228. In April 1994, DPW and the DVHC providers settled the DVHC claims for pre-bankruptcy medical services and supplies furnished to HealthPASS enrollees. (DPW Exhibit 7; N.T.D. 1480-1481)

229. The DVHC providers settled their estimated total pre-bankruptcy claim of $29.5 million, before interest, for $23,366,033.33. (DPW Exhibit 7, ¶ 1.6)

230. The DPW settlement of $23,366,033.33 to the DVHC providers was paid in two installments: the $10,366,033.33 previously paid by DPW to the DVHC providers in June 1989, plus an additional payment of $13 million. (DPW Exhibit 7, ¶ 2., ¶ 2.2; N.T.D. 1480)

231. DPW paid the DVHC providers $23,366,033.33 as an aggregate payment to settle the DVHC claims. (N.T.D. 1480)

232. The DVHC itself determined how the $23,366,033.33 was to be allocated among hospitals; DPW played no role in the allocation of the settlement proceeds. (N.T.D. 1480-1481)

233. Penn Health admitted that the $23,366,033.33 was "a compromise by both parties and is not necessarily tied to specific claims." (N.T.D. 538)

234. DPW settled the hospital providers' $29.5 million claim for $23,366,033.33 because DPW had an independent statutory and contractual obligation to pay HealthPASS providers for services rendered toMedicaid enrollees, if those services were not paid by Penn Health. (DPW Exhibit 11, ¶ 9; DPW Exhibit 41, ¶ 4)

235. Under a managed care program such as HealthPASS, hospital providers must satisfy substantial conditions and requirements before their claims are eligible for reimbursement for services rendered. (N.T.L. 1118)

236. Detailed procedures for processing such hospital claims and for the payment of such claims are set forth in the hospital provider agreements and in a detailed hospital manual prepared by Penn Health and the DVHC providers. (N.T.D. 397-399, 407-408)

237. Satisfactory adjudication of medical claims essentially requires the consent of four separate groups: (a) the hospital utilization review department; (b) the hospital's billing department; (c) Penn Health's utilization review department; and (d) Penn Health's billing department. (N.T.L. 1118)

238. Before a claim can be paid, the hospital provider must demonstrate that: (a) the patient was enrolled in the HealthPASS Program at the time services were rendered; (b) any available third-party payer resources have been exhausted; (c) hospital services were authorized by Penn Health prior to the admission, or under emergency circumstances, within a specified period thereafter; (d) that the rates sought were in accordance with the hospital's agreement with Penn Health; (e) that the services rendered were medically necessary; and (f) that the services were appropriately rendered in a hospital setting. (N.T.L. 1079-1084; N.T.D. 171-176)

239. The DVHC providers submitted claims to Penn Health pursuant to the requirements of a Hospital Manual approved by Penn Health and DPW for the HealthPASS program. (N.T.D. 397-399, 407-408; DPW Exhibit 37)

240. The Hospital Manual was developed for the purpose of assuring (1) that HealthPASS patients would receive the appropriate level of care, (2) that HealthPASS providers would be appropriately paid for services provided, and (3) that HealthPASS providers would have the ability to appeal a claim decision in the event that there was a dispute with Penn Health over treatment and payment. (N.T.D. 397-398)

241. The Hospital Manual set forth specific procedures for hospitals to submit a claim to Penn Health and to appeal an adverse payment decision by Penn Health. (N.T.D. 399)

242. Pursuant to the Hospital Manual, when a patient was admitted to a hospital, Penn Health would issue an authorization number. (N.T.D. 636)

243. Receiving an authorization number meant that the hospital was given the "green light" to proceed with treatment of the patient. (N.T.D. 798)

244. If Penn Health subsequently decided that continued treatment or that the scope of treatment was inappropriate, Penn Health was obligated to issue a denial letter to the treating hospital. (N.T.D. 799)

245. Once a hospital received Penn Health's authorization, the hospital could reasonably expect that Penn Health would pay the contract rate for treatment provided unless and until the treatment was denied by Penn Health. (N.T.D. 636, 1221)

246. After providing treatment, the hospital would submit to Penn Health a bill for payment. (N.T.D. 997)

247. If Penn Health denied the claim for lack of authorization, the hospital's utilization review department would receive a denial letter indicating the number of days denied, the reason for the denial and providing an opportunity to appeal. (N.T.D. 997)

248. Receipt of the denial letter formally initiated the appeal process. (N.T.D. 997)

249. As a result, unless a denial letter was received, the hospital would legitimately believe that the claim was approved and would be paid by Penn Health. (N.T.D. 997, 1221)

250. Unless a denial letter was received, a hospital would have no basis to appeal a claim. (N.T.D. 410-411)

251. Through its sole reliance on HAMIS for determining DVHC providers' pre-bankruptcy claims, Penn Health denied a number of claims listed on the DVHC providers' proofs of claim for which hospitals did not receive denial letters and for which hospitals believed that payment had been approved. (N.T.D. 808)

252. When the DVHC providers advised Penn Health that denial letters had not been received, Penn Health responded by requiring the hospital to "prove" that no denial letter was issued in order to consider payment of the claim. (N.T.D. 1166)

253. Penn Health's demand that hospitals prove the non-existence of denial letters in order for claims to be considered was irrational because of the impossibility of proving the non-existence of a letter that Penn Health, itself, could not prove existed. (N.T.D. 1220)

254. Without a denial letter, the hospital had no basis for appealing Penn Health's decision not to pay a claim. (N.T.D. 410-411)

255. Through Penn Health's sole reliance on the HAMIS system for determining whether a pre-bankruptcy claim would be allowed or denied, hospital providers were denied the procedural safeguards, including the opportunity to appeal, which were provided in the Hospital Manual. (N.T.D. 397-399)

256. In addition to the claims denials caused by Penn Health's exclusive reliance on HAMIS and Penn Health's refusal to examine claims documentation in its possession, Penn Health arbitrarily denied and inaccurately processed claim payments to DVHC providers. (N.T.D. 941-943, 652-655, 1090-1093, 1096-1098, 1138-1143)

257. Penn Health denied a number of DVHC provider in-patient claims on the basis that the claims were not supported by an Explanation of Medical Benefits ("EOMB") paid or denied by another provider, e.g. Medicare. (N.T.D. 1096-1098, 1138-1143)

258. DVHC provider witnesses invariably pointed out that the business records produced by the DVHC providers included an EOMB. (N.T.D. 1096-1098, 1138-1143)

259. Penn Health never reviewed its own records, boxed in a Long Beach warehouse, to determine whether or not the claim was supported by an EOMB. (N.T.D. 1096-1098, 1138-1143)

260. The DVHC providers have acknowledged that if this Board credits or off-sets the payments made by DPW in this case, the DVHC providers will release any and all claims of the DVHC providers against Penn Health. (DPW Exhibit 54-55; N.T.L. 9-10)

261. In the California bankruptcy proceedings, this agreement means that the $32 million in DVHC provider proof-of-claim will be withdrawn, and Penn Health's financial obligations to the DVHC providers will disappear. As the DVHC providers' counsel testified at trial: "we will have been paid, Penn Health will owe us nothing and we'll take whatever steps we need to take to be sure that no further payments are made to our clients." (N.T.D. 430-431, 1482-1493)

262. Penn Health asserts that DPW's settlement with the DVHC providers overpaid the DVHC providers $2,234,635.56. (Penn Health Proposed Damages Finding of Fact No. 190)

263. Penn Health bases its assertion that the DVHC providers were overpaid $2,234,635.56 on the information contained in its computer files relating to pre-bankruptcy claims filed by the DVHC providers. (N.T.D. 125-126, 1153-1157; Penn Health Exhibit 68)

264. Penn Health evaluated its pre-bankruptcy obligations to the DVHC providers through the computerized HAMIS System (HealthAmerica Management Information System). (N.T.D. 721, 1124, 1153, 1177)

265. The information on the DVHC providers' pre-petition hospital claims contained in HAMIS was entered by Penn Health employees in a claims processing center located in Nashville, Tennessee. (N.T.D. 186, 1101)

266. Penn Health employees entered the claim information on HAMIS based upon claim forms and supporting documentation submitted by HealthPASS providers. (N.T.D. 1124, 1156-1157)

267. HAMIS did not maintain information on the diagnosis or treatment provided to a patient. (N.T.D. 1123-1124, 1152-1153)

268. HAMIS did not record whether or not Penn Health communicated its approval or denial of a claim to the DVHC provider. (N.T.D. 1123-1124, 1153)

269. HAMIS did not provide information on the existence or status of any dispute concerning an individual claim. (N.T.D. 1123-1124, 1153)

270. Penn Health admitted that the HAMIS system was unreliable and a "disaster" which consistently understated claims. (N.T.D. 1600)

271. Following Penn Health's voluntary bankruptcy, all of the claims filed which supported the DVHC providers' pre-petition claims were boxed up from the Nashville claims processing center and sent to a Long Beach, California warehouse. These documents have not been reviewed by Penn Health or Maxicare in the continuing claims adjudication process. (N.T.D. 1154-1157, 1589)

272. The only information used by Penn Health to evaluate the DVHC providers' pre-petition claims was the information retained on the HAMIS computer system. (N.T.D. 1153-1157)

273. Penn Health relied exclusively on the very limited information in HAMIS even though it possessed backup documentation on each DVHC provider claim which was provided by each DVHC provider at the time the claim was initially submitted to Penn Health. (N.T.D. 1153-1157)

274. Penn Health's justification for relying solely on HAMIS for determining DVHC provider claims was that the task of sorting through boxes of claim documentation, which had been shipped from its Nashville claims processing center to a warehouse in Long Beach, California, would be too cumbersome and inefficient. (N.T.L. 1153-1157)

275. Penn Health relied exclusively on the information in HAMIS for determining the validity of the DVHC providers' pre-petition claims, even though Penn Health admitted that HAMIS experienced a 50% error rate prior to bankruptcy. (N.T.L. 986-987, 1137)

276. Based on the limited information contained in the HAMIS system, Penn Health initially valued the DVHC providers' claims at less than $10 million out of the $29.5 million in claims submitted by the DVHC providers. (N.T.D. 421-422)

277. In March 1991, Penn Health provided the DVHC hospitals with remittance advices which calculated Penn Health's debt to the hospitals at over $12 million. (N.T.D. 421-423)

278. As a result of negotiations between the DVHC hospitals and Penn Health, in November 1991, Penn Health supplied a new set of remittance advices to the hospitals which approved nearly $18 million of the DVHC provider's claims. (N.T.D. 421-423; Penn Health Exhibit 66)

279. Later, at the damages phase of the trial, Penn Health agreed that over $21.4 million in hospital claims were valid. (Penn Health Exhibit 66; DPW Exhibit 54-55; N.T.D. 577-578, 1488-1493, 1601)

280. Since the close of trial, Penn Health has approved an additional $600,000.00 in claims. (Appendix to Penn Health Proposed Damages Findings of Fact at Tab 1; Penn Health Proposed Damages Findings of Fact No. 187)

281. Penn Health has yet to review 12 of the 26 DVHC hospitals for whom patient files were provided at trial. (Appendix to Penn Health Proposed Damages Findings of Fact at Tabs 2-15)

282. Penn Health's inability to identify the DVHC claims arose out of the defective HAMIS system. (N.T.D. 125-126; Penn Health Exhibit 68)

283. The DVHC providers tried on numerous occasions to match the information provided by Penn Health out of the HAMIS system with its proofs of claim filed with the Bankruptcy Court in order to identify claims which would be discharged by the DVHC settlement. (N.T.D. 1492-1493, 1564)

284. The DVHC providers experienced significant problems with matching their claims, submitted on a patient-by-patient basis, with the Penn Health records produced by HAMIS, which is organized only by vendor (physician or provider group). (N.T.D. 1484-1488, 1530-1531)

285. Not until January 1995 did Penn Health produce to the DVHC providers a report which grouped claims according to Penn Health's assigned vendor numbers ("Roll-Up Report"), even though the report had been available to Penn Health at least several years earlier. (N.T.D. 65)

286. With the assistance of the Roll-Up Report, the DVHC providers have stipulated that $21,428,436.99 of claims acknowledged by Penn Health to be due and owing will be satisfied by the DPW settlement. (DPW Exhibit 54-55; N.T.D. 1492, 1598; Penn Health Proposed Damages Finding of Fact No. 186)

287. In addition to the $21.4 million which Penn Health admits is due and owing to DVHC providers for Undisputed Claims, DPW presented evidence to this Board that Penn Health owes DVHC providers $3,974,855.77 for in-patient claims which Penn Health continues to dispute ("Disputed In-Patient Claims"). (DPW Exhibit 65-104)

288. Penn Health now admits that $599,240.52 of the $3,974,855.77 in Disputed In-Patient Claims of the DVHC providers is due and owing. (Penn Health Proposed Damages Finding of Fact No. 187)

289. The DVHC providers' proofs of claim filed in the Penn Health bankruptcy, which total $29.5 million, consist of claims for both in-patient hospital days ("in-patient claims") and for services provided to HealthPASS enrollees on an out-patient basis ("out-patient claims"). (DVHC Hospital Evidence References chart, attached to DPW Damages Brief at Exhibit "A" (providing transcript references for hospital testimony) (N.T.D. 880-890, 892-902, 949-950, 970-971))

290. After Penn Health had provided its version of the November 1991 Remittance Advices ("RAs") to the DVHC providers ("1991 RAs"), the DVHC providers initiated a process to resolve the Disputed In-Patient Claims with Penn Health. (N.T.D. 421-423; Penn Health Exhibit 66)

291. In its 1991 RAs, Penn Health approved only $17,994,253.00 of the $29.5 million in pre-bankruptcy claims submitted by the DVHC providers. (Penn Health Exhibit 66)

292. Penn Health's historical approval rate for claims submitted by HealthPASS hospitals was 85%. (N.T.D. 405-406, 1478)

293. Even prior to its voluntary bankruptcy, however, the DVHC providers had found that obtaining payments from Penn Health to be a long and difficult process. (N.T.D. 413)

294. Claims evaluated by the HAMIS system were incorrectly denied or inaccurately paid by Penn Health nearly 50% of the time. (N.T.L. 986-987, 1137)

295. Penn Health's 85% historical approval rate resulted from the informal process established between HealthPASS hospital providers and Richard Braksator, the Chief Financial Officer of Penn Health, undertaken to correct the errors produced by the HAMIS system. (N.T.D. 405-406)

296. Prior to its voluntary bankruptcy, DVHC providers would routinely have claims which were originally denied by the HAMIS system approved by Richard Braksator, the Chief Financial Officer of Penn Health. (N.T.D. 408-409; N.T.L. 1135-1137)

297. The second review by Richard Braksator of claims originally denied by HAMIS was an integral part of the claims resolution system and resulted in an 85% approval rate, rather than the 50% denial rate produced by the flawed HAMIS system. (N.T.D. 406-409, 986-987)

298. Immediately prior to Penn Health's voluntary bankruptcy filing, claim approval rates dropped from 85% to between 40% to 60%. (N.T.L. 581, 600-601, 893, 1042; N.T.D. 413-414)

299. After receiving the 1991 RAs produced by the flawed HAMIS system, each DVHC provider compiled and provided to Penn Health a list of all outstanding pre-bankruptcy in-patient claims ("DVHC Nutshells"). (DPW Exhibit 6 at Appendix A; N.T.D. 176)

300. Each DVHC Nutshell listed all outstanding in-patient claims of the DVHC provider, sorted the claims alphabetically by patient, and categorized each claim as "undisputed", "disputed", or "unprocessed." (N.T.D. 176, 608)

301. In the DVHC Nutshells, "undisputed" claims were those claims for which Penn Health had agreed in the 1991 RAs to the amount that the provider claimed as due from Penn Health, even though Penn Health had not yet paid the claim. (N.T.D. 608)

302. In the DVHC Nutshells, "disputed" claims were those claims for which Penn Health had not approved the total amount claimed as due by the provider and which the provider asserted were due and owing. (N.T.D. 608)

303. In the DVHC Nutshells, "unprocessed" claims were those claims for which the provider did not receive a response from Penn Health -- either approving or disapproving the claim. (N.T.D. 608)

304. Penn Health responded to the DVHC Nutshells with its own "nutshells" (the "Vanderberg Nutshells"), which were used by Penn Health to advise DVHC providers of Penn Health's evaluation of the filed claims. (N.T.D. 177-178)

305. The Vanderberg Nutshells were merely summaries of information produced by the HAMIS system and did not involve any independent review of the Long Beach, California files. (N.T.D. 1153-1157, 1589)

306. The DVHC providers provided Penn Health with the DVHC Nutshells for the purpose of conducting the full claims file review previously conducted by Richard Braksator, Chief

Financial Officer of Penn Health, prior to Penn Health's voluntary bankruptcy. (N.T.D. 680)

307. Penn Health assured the DVHC providers that if they would provide the DVHC Nutshells, Penn Health would engage in an informal claims resolution process and review additional information provided by the DVHC provider. (N.T.D. 680)

308. For most DVHC providers, Penn Health never reviewed disputed in-patient claims beyond the information contained in its own flawed HAMIS system. (N.T.D. 1153-1157, 1589)

309. Penn Health did engage in a claim-by-claim review of the disputed claims of one DVHC provider, the Hospital of the University of Pennsylvania ("HUP"). (N.T.D. 200-210)

310. Penn Health conducted three claims reviews involving HUP from March 1993 through November 1993. (N.T.D. 200-210)

311. As a result of its review of the HUP claims, Penn Health approved an additional $666,582.32 in claims out of HUP's total disputed claims of $1.5 million. (N.T.D. 203-208)

312. Penn Health's final review of HUP's claims approved nearly $250,000.00 of claims previously denied because it refused to pay neonatal intensive care rates for underweight premature babies. (N.T.D. 251-253)

313. On Penn Health's final review, Penn Health admitted that HUP's claim for sick premature babies should be paid at an intensive care rate, rather than a normal nursery rate, when the babies required neonatal intensive care in order to survive. (N.T.D. 252)

314. In order to expedite Penn Health's review of the DVHC providers' disputed in-patient claims, the DVHC providers attempted to conduct telephone conferences to discuss and resolve all disputed claims. (N.T.D. 773)

315. In August 1993, a telephone conference was conducted between Penn Health and HUP. (N.T.D. 773)

316. During the August 1993 conference call between Penn Health and HUP, Penn Health's claims supervisor advised that she had not reviewed HUP's claims, that she had no claim documentation in the room to discuss with HUP, and that she did not even have a copy of HUP's HealthPASS provider Contract to determine the Contract rate for each service. (N.T.D. 774)

317. Ultimately, Penn Health terminated both the conference calls and the claim-by-claim review of the DVHC providers' disputed in-patient claims. (N.T.D. 1466-1468)

318. Penn Health had access at all times to the claims documentation in its own warehouse in Long Beach, California. (N.T.D. 1154-1157, 1589)

319. In support of their proofs of claim filed with the Bankruptcy Court for medical services, the DVHC providers compiled individual patient files which included all relevant claim information, including the hospital's patient account, utilization review analysis, billing rates and all other payor information. (N.T.D. 596)

320. The DVHC providers' claims files were categorized by provider and alphabetized by patient. (N.T.D. 1462)

321. The DVHC providers' claims files were maintained in the law firm of Dilworth, Paxson, Kalish & Kauffman since 1991. (N.T.D. 1467-1468, 1514, 1601-1602; DPW Exhibit 125)

322. Penn Health stipulated that it had access, at all times, to the claims documentation from the DVHC providers. (DPW Exhibit 125, N.T.D. 1344)

323. In addition, the DVHC providers' counsel offered to copy all of the patient files and send them to Penn Health provided that Penn Health would pay the copy costs. (DPW Exhibit 125)

324. Penn Health never took advantage of the DVHC providers' offer. (N.T.D. 1467-1468, 1514, 1601-1602; DPW Exhibit 125)

325. Penn Health admitted that it did not review the claims information from the DVHC providers despite the fact that is own documentation was inaccessible. (N.T.D. 1153-1157)

326. The very limited review of DVHC provider's disputed in-patient claims resulted in total additional amounts approved by Penn Health from 1991 to 1994 for all DVHC providers of approximately $2.3 million. (N.T.D. 74; Penn Health Exhibit 66)

327. Either through the testimony of a witness representing the individual DVHC provider, or upon stipulation of counsel, DPW offered from 26 DVHC providers the individual patient files supporting the providers' in-patient disputed claims, a DVHC Nutshell which summarized the individual claims filed, and supporting testimony. (DVHC Hospital Evidence References Chart, attached to the DPW Damages Brief at Exhibit A (providing transcript references for hospital testimony); N.T.D. 880-890, 892-902, 949-950, 970-971)

328. The DVHC providers' patient billing files were business records. (N.T.D. 880-920)

329. All information included in the patient files were gathered from the hospital

records prepared and maintained in the ordinary course of business. (N.T.D. 597)

330. The records were prepared by a person with knowledge of, or made from, information transmitted by a person with knowledge of the acts and events which appear on the records. (N.T.D. 598)

331. Once prepared, the records were maintained in the course of each hospital's regularly conducted business activities. (N.T.D. 598)

332. The in-patient claim files of the DVHC providers prove that the DVHC providers delivered services to the HealthPASS enrollees for which Penn Health has not paid and has refused to acknowledge liability in the bankruptcy proceedings. (N.T.D. 880-890, 892-902, 949-950, 970-971)

333. The in-patient claim files of the DVHC providers identify and document the medical services provided to each patient for which Penn Health denies liability. (N.T.D. 880-890, 892-902, 949-950, 970-971)

334. The DVHC Nutshells summarized the pre-bankruptcy in-patient claims presented to Penn Health by each DVHC provider. (N.T.D. 880-890, 892-902, 949-950, 970-971)

335. The DVHC Nutshells were prepared by a competent witness with knowledge to verify the underlying records. (N.T.D. 880-890, 892-902, 949-950, 970-971)

336. The in-patient claims identified in the DVHC Nutshells were categorized as either "undisputed" (meaning Penn Health acknowledged the liability), "disputed" (meaning Penn Health explicitly denied the claim in whole or in part in the 1994 RAs), or "unprocessed" (meaning Penn Health has not acknowledged its receipt of the claim). (N.T.D. 880-890, 892-902, 949-950, 970-971)

337. The DVHC Nutshells and the individual claim files supporting the DVHC Nutshells reflect services provided and billed to Penn Health. (N.T.D. 880-890, 892-902, 949-950, 970-971)

338. The DVHC Nutshells summarize the valid, reimbursable claims for services which were provided by the DVHC providers and which are due and owing from Penn Health. (N.T.D. 880-890, 892-902, 949-950, 970-971)

339. Penn Health did not offer into evidence its business records concerning the disputed in-patient claims, but rather left them boxed and stored in a Long Beach, California warehouse. (N.T.D. 1153-1157)

340. The DVHC Nutshells establish the total amount remaining due and owing from Penn Health to each provider for pre-petition in-patient services in the sum of $3,974,855.77.

341. These Hospital "Nutshells" were revised orally during the Damages Phase trial to reflect late alterations, such as the new approvals listed on Penn Health's November 1994 Remittance Advices. (N.T.D. 615, 676, 694, 730, 753-760, 781, 828-830, 857-858, 891, 907, 950, 957-958, 981-990, 1003, 1004, 1008, 1060-1065, 1078, 1081, 1233-1234, 1238-1239, 1365; DPW Exhibit 56-115)

342. The only evidence produced by Penn Health to support its disapproval of the DVHC provider's in-patient claims were the HAMIS computer screens and the Vanderberg Nutshells. (N.T.D. 1153-1157)

343. Neither the HAMIS screens nor the Vanderberg Nutshells are competent evidence to support Penn Health's disapproval of individual claims since Penn Health failed to present the underlying business records. (N.T.D. 1153-1157)

344. Neither the Vanderberg Nutshells nor the HAMIS computer screens support Penn Health's denial of in-patient claims because they are not supported by the underlying business records. (N.T.D. 1153-1157)

345. Penn Health denied claims in violation of the Hospital Manual which governed the process for submission and adjudication of claims between Penn Health and the DVHC providers. (N.T.D. 1162-1166)

346. DPW's settlement with the DVHC providers is fair and it specifies that the DVHC providers will not be paid twice for the same claim. (DPW Exhibit 7 at 13-14; N.T.D. 1481)

347. In order to ensure that the DVHC providers do not attempt to collect twice for the same claim, the Settlement Agreement provides that the DVHC providers agree to withdraw all claims against Penn Health in both the Board of Claims and the bankruptcy Court for pre-bankruptcy services provided if DPW is permitted a credit or set-off of an amount equal to or greater than the total paid to the DVHC providers. This would amount to a withdrawal of $32 million in claims. (N.T.D. 1482; DPW Exhibit 7, 12-13)

348. DPW's settlement of the DVHC providers' $29.5 million claim for $23.3 million claim is reasonable as applying Penn Health's own admitted historical approval rate of 85% would result in the DVHC providers being paid over $25 million. (N.T.D. 420)

349. DPW's settlement of the DVHC provider's $29.5 million claim for $23.3

million is reasonable as Penn Health's own records now admit liability to DVHC providers for in-patient claims in the amount of $22,027 million, and that Penn Health also owes the DVHC providers for disputed out-patient and in-patient claims. (N.T.D. 416-417, 429-430, 489-490; DPW Exhibit 7)

350. The DPW settlement of the DVHC provider's $29.5 million dollar claim for $23.3 million is reasonable as it appears that Penn Health's actions in disapproving pre-bankruptcy claims submitted by DVHC providers was arbitrary. (N.T.D. 419-420)

351. In June 1990, the HealthPASS Primary Care Physicians ("PCPs") commenced a class action against DPW in the Board of Claims, Docket No. 1433 ("PCP Class"), seeking to hold DPW liable for amounts due the PCPs by Penn Health under the HealthPASS provider Contracts. (See Complaint in Behjat v. Commonwealth, No. 1433 (Pa. Board of Claims, filed May 1, 1990; as Amended February 20, 1991))

352. Similar to the DVHC providers, the PCP Class alleges (1) that DPW is both statutorily and contractually liable to pay the PCPs for the provision of medical services and supplies to HealthPASS enrollees; (2) that DPW's non-payment constitutes the breach of as non-delegable duty to administer and operate Pennsylvania's Medicaid program; (3) that the PCPs are third-party beneficiaries of DPW's HealthPASS Contract with Penn Health and that DPW is legally obligated to pay the PCPs in the event that Penn Health defaults; and (4) that Penn Health is a mere agent of DPW so that DPW, as principal, is obligated to perform under the HealthPASS Contract in the event that its agent does not perform its contractual obligations to pay providers. (See Complaint in Behjat v. Commonwealth, No. 1433 (Pa. Board of Claims, filed May 1, 1990; as Amended February 20, 1991)

353. In its capacity as the HealthPASS HIO, Penn Health was responsible for arranging "through contracts with community providers -- including HMO's, doctors, hospitals and others -- to provide Medicaid services in a given area for a group of recipients." (Penn Health Exhibit 18 at 1 (HCFA's State Medicaid Manual))

354. In order to implement HealthPASS, Penn Health contracted with PCPs who were responsible for acting as "gatekeepers, coordinators and close monitors" of the medical care needed by HealthPASS enrollees. (Penn Health Exhibit 25 at 13 & 15)

355. Each PCP who signed a Contract with Penn Health to provide primary care to HealthPASS enrollees, also had a Contract with DPW. (DPW Exhibit 41; N.T.D. 394-395, 1440)

356. The Contract between DPW and each PCP obligates DPW to pay the provider for services rendered under Pennsylvania's Medicaid Program:

> The DPW agrees to reimburse the Provider for services covered under the Program in accordance with applicable statute and regulations.

(DPW Exhibit 41, ¶ 4)

357. Under the HealthPASS PCP provider Contracts, PCPs were to be compensated by a monthly capitation fee, which is a specified sum paid to a PCP regardless of the number or type of patient visits per month. (Penn Health Exhibit 25 at 13 & 15; N.T.D. 1370)

358. The amount of a particular physician's monthly capitation payments was based on the number, age and category of medical necessity of HealthPASS patients assigned to the physician. (Penn Health Exhibit 25 at 13 & 15)

359. Each monthly capitation payment to a PCP consisted of only 50% of his or her full monthly capitation fee; the balance was held by Penn Health in a "Referral Services Fund" to be used to pay for consultations with medical specialists, laboratory, x-ray and other services authorized by the PCP. (Penn Health Exhibit 25 at 15; N.T.D. 1370-1371)

360. After Penn Health paid the PCP authorized referral services, the physician's balance in the Referral Services Fund, if any, was to be paid to the PCP no later than 120 days after the end of each fiscal year of the HealthPASS Contract. (Penn Health Exhibit 25 at 15)

361. In its claim against DPW, the PCP Class originally sought $3,468,608.00, including interest, for pre-bankruptcy obligations of Penn Health for services provided by the PCP Class to HealthPASS enrollees. (DPW Exhibit 118; N.T.D. 1385)

362. The PCP Class claim of $3,468,608.00, did not include any amounts for the 18 PCPs who opted out of the PCP Class. (N.T.D. 1376-1377; DPW Exhibit 121)

363. As originally calculated, the PCP Class claim against DPW was comprised of the following specific elements: (1) $2,405,038.29 due from the Referral Services Fund; (2) $109,600.00 for payments due PCPs for specialty services; (3) $10,174.12 for checks issued prior to the bankruptcy but on which payment was stopped; and (4) $943,795.63 in interest through September 20, 1995. (DPW Exhibit 118; N.T.D. 1370)

364. In calculating its Referral Services Fund claim of $2,405,038.29, the PCP Class took into consideration several factors including (1) the deletion of claims by PCPs who were entitled to payment from the Referral Services Fund but who opted-out of the PCP Class; (2) the effect of
the DVHC providers' settlement on the Referral Services Fund; and (3) the inclusion of emergency room claims as part of hospital claims in the DVHC providers' settlement. (N.T.D. 1376, 1380-1382; DPW Exhibit 118).

365. Of the PCP's total claim of $2,405,038.29, Penn Health admitted that

$1,281,557.62 is due and owing to the PCP Class from the Referral Services Fund. (Penn Health Proposed Damages Finding of Fact 218)

366. Penn Health calculated that it owed $1,640,663.59 to all PCPs for Referral Services Fund payments for the 1988-1989 Contract year. (DPW Exhibit 120; N.T.D. 530, 1374)

367. Penn Health's calculation of $1,640,663.59, however, assumed that the specialist physicians' fees charged against the Referral Service Fund would, in fact, be paid in the amounts claimed against Penn Health. (DPW Exhibit 120; N.T.D. 1381-1382)

368. The DVHC providers' settlement, however, included payments to both hospitals and specialists affiliated with hospitals. (DPW Exhibit 7; N.T.D. 1381-1382)

369. To the extent that the hospital-affiliated specialists included in the DVHC providers' settlement received less under the settlement than the amount they claimed against Penn Health, the amounts charged against the Referral Services Fund for such specialist services should be reduced. (N.T.D. 1380-1382)

370. The PCP Class calculated the effect of the DVHC providers' settlement on the Referral Services Fund as follows: (1) the DVHC providers originally filed a $31.5 million dollar claim against Penn Health; (2) the $31.5 million dollar claim was settled for $23.3 million; (3) the settlement resulted in DVHC providers' being paid approximately 21% less than their original claims; and (4) the amount owed to the PCPs was then increased by 21% to reflect that the specialists would receive 21% less than the amounts charged against the Referral Services Fund. (N.T.D. 1384; DPW Exhibit 118)

371. In addition, the amount due to the PCP Class from the Referral Services Fund was increased to reflect that certain emergency room charges were included as charges against the Fund which also had to be reduced to reflect the 21% savings resulting from the settlement. (DPW Exhibit 118; N.T.D. 1381-1383)

372. The DVHC providers' settlement, which results in specialty physicians being paid substantially less than what they were entitled to under their Contracts with Penn Health, results in Penn Health owing the PCP Class an additional $867,916.90 in the Referral Services Fund Compensation. (DPW Exhibit 118)

373. The total PCP Referral Services Fund claim of $2,405,038.29 is thus composed of (1) $1,640,663.59 calculated as due and owing by Penn Health, minus (2) $103,542.20 due and owing from the Referral Services Fund to PCPs who opted out of the PCP Class, plus (3) the $867,916.90 arising out of the DVHC providers' settlement. (DPW Exhibit 118-120; N.T.D. 533, 1374-1376)

374. Further, some physicians who contracted with Penn Health to provide PCP

services also provided speciality services to HealthPASS enrollees. (N.T.D. 1377-1379)

375. In addition to amounts due from the Referral Services Fund, the PCP Class originally calculated that the members of the PCP Class who performed specialty services for HealthPASS enrollees were owed $109,600.00. (DPW Exhibit 122; N.T.D. 1379)

376. Adjusted to remove payments due to the DVHC providers, rather than to the PCPs themselves, the specialty services total is revised to $72,483.91.00. (Penn Health Proposed Damages Findings of Fact No. 216)

377. Members of the PCP Class are entitled to $10,174.12 which represents the dollar value of checks issued by Penn Health to PCPs prior to the bankruptcy on which payment was stopped. (DPW Exhibit 123; N.T.D. 1379-1380)

378. From this total, the amounts attributable to the Referral Services Funds of PCPs who participated in the DVHC settlement agreement, i.e. $338,174.68, must be subtracted. (Penn Health Proposed Damages Findings of Fact No. 213)

379. The claim of the PCP Class is entitled to interest calculated at 6% simple interest from the date on which payments were due under the provider Contracts through September 20, 1995. (DPW Exhibit 118; N.T.D. 1378-1384)

380. On September 20, 1995, DPW and counsel for the PCP Class reached a conditional settlement to resolve all PCP Class claims on the following terms: DPW agreed to pay the PCPs $2.1 million in settlement of all claims against DPW, plus certain interest payable from thirty days after the execution of a written settlement agreement, which amount is payable in addition to any other advances which may have been made by DPW to individual providers within the PCP Class. (N.T.D. 1385-1386; PCP Settlement Agreement attached as Exhibit A to *Joint Motion of Plaintiffs and Defendant for Preliminary and Final Approval of Class Action Settlement in Behjat v. Commonwealth*, No. 1433 Pa. Board of Claims, filed January 22, 1996)

381. In accordance with the terms of the Settlement Agreement, the PCP Class agreed to execute a "Release and Covenant Not to Sue," negotiated with DPW, that:

> releases and forever discharges Penn Health Corporation, Maxicare Health Plans, Inc., and each of their successors, assigns, employees, insurers, reinsurers, agents, and attorneys ("Maxicare Releases") from all claims and liability of any kind relating to the HealthPASS program, whether known or unknown, suspected or unsuspected, contingent or non-contingent, and whether or not heretofore asserted, including (but not limited to) and all claims for direct liability, contribution, indemnity, or restitution, under any legal theory,

> however denominated, arising from any cause or conduct at any time before the signing of this Class Release.
>
> ("Release and Covenant Not to Sue" at ¶ 2, attached as Exhibit A to the PCP Settlement Agreement (attached as Exhibit A to *Joint Motion of Plaintiffs and Defendant for Preliminary and Final Approval of Class Action Settlement in* Behjat v. Commonwealth, No. 1433 Pa. Board of Claims, filed January 22, 1996))

382. By its terms, this Release discharges Penn Health and Maxicare from any further obligation to the PCP Class. ("Release and Covenant Not to Sue" at ¶ 2, attached as Exhibit A to the PCP Settlement Agreement (attached as Exhibit A to *Joint Motion of Plaintiffs and Defendant for Preliminary and Final Approval of Class Action Settlement in* Behjat v. Commonwealth, No. 1433 Pa. Board of Claims, filed January 22, 1996)

383. Following an evidentiary class action fairness hearing on Friday, March 29, 1996, the Board approved the PCP Class settlement as fair, reasonable and adequate. Order Approving Class Action Settlement and Discontinuing Proceeding With Prejudice (*Behjat v. Commonwealth*, No. 1433 Pa. Board of Claims, filed March 29, 1996)

384. The Board's Order further ruled that:

> DPW, the Commonwealth of Pennsylvania, Penn Health Corporation, Maxicare Health Plans, Inc., and each of their successors, assigns, employees, insurers, reinsurers, agents, and attorneys are hereby RELEASED and DISCHARGED from all claims and liability of any kind which were or could have been asserted in this litigation, whether known or unknown, suspected or unsuspected, contingent or non-contingent, and whether or not heretofore asserted, including (but not limited to) any claims for direct liability, contribution, indemnity, or restitution,
>
> under any legal theory, however denominated, arising from any cause or conduct at any time before the signing of the Class Release prescribed by the Settlement Agreement.
>
> (Order Approving Class Action Settlement and Discontinuing Proceeding with Prejudice at ¶ 6, in Behjat v. Commonwealth, No. 1433 (Pa. Board of Claims, filed March 29, 1996)

385. By operation of this settlement, the accompanying Release, and the Board's March 29, 1996 Order, DPW has discharged at least $2,149,474.24 in payments that would

otherwise have been due and owing to the PCP Class by Penn Health. (Order Approving Class Action Settlement and Discontinuing Proceeding With Prejudice at ¶ 1, in *Behjat v. Commonwealth*, No. 1433 (Pa. Board of Claims, filed March 29, 1996)

386. DPW's settlement of the PCP's $3,468,608.04 claim for $2.1 million is reasonable given the Board's determination that DPW was in breach of its Contract with the PCPs for services rendered to HealthPASS enrollees. (Order Approving Class Action Settlement and Discontinuing Proceedings With Prejudice at ¶ 1, in *Behjat v. Commonwealth*, No. 1433 (Pa. Board of Claims, filed March 29, 1996)

387. DPW's settlement of the PCPs $3,468,608.04 claim for $2.1 million is reasonable given the Board's determination that DPW was in breach of its contract with the PCPs for services rendered to HealthPASS enrollees. (Order Approving Class Action Settlement and Discontinuing Proceeding With Prejudice at ¶ 1)

388. DPW's settlement of the PCP's $3,468,608.04 claim for $2.1 million is reasonable given the likelihood of the PCPs prevailing on the merits of their claim. (N.T.D. 1385-1386)

389. DPW's settlement of the PCP's $3,468,608.04 claim for $2.1 million is reasonable given that Penn Health calculated its liability to the PCP Class at $1,281,557.62 which amount plus simple interest for six years exceeds the $2.1 million paid by DPW. (Board's Findings observed from Record)

390. DPW's settlement of the PCP's $3,468,608.04 claim for $2.1 million is reasonable given that Penn Health has scheduled liabilities owing to the PCP Class in the Bankruptcy Court in the amount of $1,455,333.00 which amount plus interest exceeds $2.1 million. (N.T.D. 126)

391. The PCPs rendered, to HealthPASS enrollees and Penn Health, at least $2.1 million in medical services for which they have not been paid by Penn Health. (DPW Exhibit 118; N.T.D. 1383)

392. Penn Health owes the PCP Class a minimum of $2.1 million under its HealthPASS provider Contracts with the PCPs for services rendered to HealthPASS enrollees. (DPW Exhibit 118; N.T.D. 1383)

393. In its filing of scheduled liabilities with the Bankruptcy Court, Penn Health acknowledged amounts due and owing to pharmacies and DME suppliers. (DPW Exhibit 53)

394. In September 1995, DPW prepared a comparison of its June 1989 payments to pharmacies and DME suppliers against amounts scheduled by Penn Health with the Bankruptcy Court. (DPW Exhibit 53; N.T.D. 515)

395. DPW's comparison of advance payments to pharmacies and DME suppliers indicated that $759,242.47 of the total amount scheduled by Penn Health has been discharged by DPW's advance to HealthPASS participating pharmacies and DME suppliers. (N.T.D. 515)

396. On February 27, 1991, Penn Health commenced an action against DPW in the Board of Claims, Docket No. 1515, asserting that DPW was in breach of the HealthPASS Contract and seeking $29 million for unpaid HealthPASS claims ("Board Proceedings"). (Penn Health Exhibit 44; Judge Wilson's Finding of Fact No. 7)

397. Prior to filing with the Board of Claims, Penn Health had asserted the same claims against DPW in an adversary proceeding before the Maxicare Bankruptcy Court. ("Bankruptcy Proceeding"; Penn Health Exhibit 44; Judge Wilson Finding of Fact Nos. 2-3)

398. In the Board proceedings, DPW "asserted an off-set against Penn Health's claims before the date Penn Health filed its Counterclaims against DPW in the [bankruptcy court]." (Penn Health Exhibit 44; Judge Wilson's Finding of Fact No. 9)

399. The Bankruptcy Court has abstained from hearing Penn Health's claims in the Bankruptcy Proceedings. (Penn Health Exhibit 44; Judge Wilson's Conclusion of Law No. 1)

400. The Bankruptcy Court has ruled that "The Board is a state forum of appropriate jurisdiction which can enter a final and binding order against DPW in the Penn Health Board Proceedings." (Penn Health Exhibit 44; Judge Wilson's Conclusion of Law 2)

401. The Bankruptcy Court has specifically held that Penn Health's claims against DPW and DPW's claims to credit and/or off-set are to be decided as a matter of state law. (Penn Health Exhibit 44; Judge Wilson's Conclusions of Law No. 1)

402. The Bankruptcy Court has not required this Board to decide Penn Health's claims against DPW and DPW's claim for credit and/or off-set under bankruptcy law, but rather has unequivocally stated that the claims are to be resolved as a matter of state law. (Penn Health Exhibit 44)

403. The Bankruptcy Court expressly denied Penn Health's request that the court "carve out" the DPW set-off claims from the issues on which the court was abstaining. (DPW Exhibit 36 at 72)

404. To the contrary, the Bankruptcy Court has decided to abstain completely, awaiting a decision from this Board on all issues, included DPW's claim of set-off. (N.T.D. 1493-1495)

405. DPW is entitled to credit and/or set-off payments made to HealthPASS

medical providers against any amounts which are due to Penn Health. (Board Findings - Record)

406. DPW has paid HealthPASS providers a total of $26,225,275.50 which DPW can utilize as a credit or set-off of any amount due Penn Health. (Board Findings - Record)

407. DPW is entitled to a credit or set-off in the amount of $759,242.47 against any amounts due and owing to Penn Health by DPW and Penn Health will be relieved of liability for $759,242.47 of its obligations to pharmacies and DME suppliers. (DPW Exhibit 53; N.T.D. 467-469)

408. DPW is entitled to credit or set-off of any amounts which may be due and owing to Penn Health by $2.1 million because Penn Health has been relieved of any liabilities to the PCP Class by the DPW payment. (DPW Exhibit 118; N.T.D. 1383)

409. DPW is entitled to credit or set-off of any amounts which may be due and owing to Penn Health by $23,366,033.22 by reason of payments to DVHC providers and DPW's payment extinguished Penn Health's liability to those providers. (N.T.D. 430-431, 1482-1483; 1491-1492)

410. Penn Health claims interest in the amount of $13,698,940.00 (N.T.D. 119; Penn Health Exhibit 65)

411. Penn Health may not collect interest because the principal amount of its claim is completely off-set by credits or set-offs due to DPW. (Board Finding - Record)

412. Because DPW's payments to the HealthPASS providers are properly deducted from Penn Health's contract damages, the net balance due to Penn Health is less than zero. Consequently, under the "interest on the balance" rule, Penn Health may not recover interest from DPW. (Board Findings - Record)

413. DPW is entitled to credit and/or set-off payments made to HealthPASS medical providers against any amounts which it may owe to Penn Health under Section H.12(h) of the HealthPASS Contract which provides for indemnification of DPW by Penn Health:

> Insurance and Indemnification. . . [Penn Health] shall indemnify, save harmless, and defend [DPW] against all claims which may result from the acts or omissions of [Penn Health], its employees, or agents.
>
> (HealthPASS Contract Section H.12(h))

414. Board's Summary of Damage Findings:

DPW's obligations to Penn Health:

Years I & II Risk Sharing Payments	$15,852,854.00
Less Computer overcharge	2,922,690.00
Less Administrative overage	52,502.00
Less Medical Expensive overage	2,239,000.00
NET	$10,638,662.00
Year III Retroactive Fee Adjustment	$ 8,090,045.00
Year III Category Mix Adjustment	$ 518,021.00
Year IV Retroactive Fee Adjustment	$ 4,930,379.00
TOTAL	**$24,177,107.00**

Credits due DPW:

Payments to DVHC Providers	$23,366,033.00
Payments to PCP Class Members	$ 2,100,000.00
Payments to Pharmacists/DME Suppliers	$ 759,242.47
TOTAL	**$26,225,275.50**

415. As credits exceed obligations, no interest is due. (Board's Findings from Record)

416. As credits exceed obligations, no recovery is due Penn Health. (Board's Findings - Record)

CONCLUSIONS OF LAW

1. The Board of Claims has exclusive jurisdiction over the parties and over the subject matter asserted by the parties pursuant to the Act of May 20, 1937, P.L. 728, as Amended by Act of October 5, 1978, P.L. 1004; 72 P.S. 4651-1, et seq.

2. The Board of Claims has jurisdiction to determine both this breach of contract claim filed by Penn Health Corporation ("Penn Health") against DPW, and DPW's claim for credit and/or set-off against any damages proven by Penn Health. Act of May 20, 1937, P.L. 728, as Amended by Act of October 5, 1978, P.L. 1004; 72 P.S. 4651-1, et seq.

3. Penn Health's claims against DPW under the HealthPASS Contract, as well as DPW's claims for a credit and/or set-off against any damages proven by Penn Health, are subject to Pennsylvania Contract Law.

4. The United States Bankruptcy Court for the Central District of California has ruled that Penn Health's claims against DPW under the HealthPASS Contract, and DPW's claims to a credit and/or set-off against any damages proven by Penn Health, are to be decided as a matter of Pennsylvania state law.

5. The United States Bankruptcy Court for the Central District of California has further ruled that this Board has jurisdiction to enter a final and binding Order as to both Penn Health's claims against DPW under the HealthPASS Contract, and DPW's claim to a credit and/or set-off against any damages proven by Penn Health.

6. To permit this Board to rule upon Penn Health's claims against DPW under the HealthPASS Contract and DPW's claim to a credit and/or set-off against any damages proven by Penn Health, the United States Bankruptcy Court for the Central District of Pennsylvania has formally abstained from any further proceedings on Penn Health's claims against DPW.

7. Penn Health and DPW entered into a Contract relationship by executing two Contracts dated March 1, 1984, both of which fall within the jurisdiction of this Board.

8. Penn Health, pursuant to the Contracts and the activity required of it under the Contracts, is an independent contractor and not an agent of DPW.

9. DPW breached the Contract with Penn Health by failing to make payments to Penn Health as required for in the Contract Agreements.

10. DPW's maximum total obligation to Penn Health under the HealthPASS Contract is $24,177,107.00. This sum consists of contractual obligations for (1) a risk sharing payment for Contract Years One & Two; (2) a Contract Year Three retroactive fee adjustment; and (3) a Contract Year Three Category mix payment and Year Four Retroactive fee adjustment.

11. DPW's contractual obligation to Penn Health under the risk sharing provision of the HealthPASS Contract for Years One and Two is $10,638,662.00.

12. Under the risk-sharing provisions of the HealthPASS Contract for Contract Years One and Two, Penn Health is entitled to reimbursement only for medical expenses it paid during those Contract years.

13. Under the risk-sharing provisions of the HealthPASS Contract for Contract Years One and Two, Penn Health is not entitled to recover for medical claims which it projected or accrued, but which it did not pay, during those Contract years.

14. Penn Health projected or accrued, but did not pay, $2,239,000.00 in Contract Year Two medical expenses, which is not recoverable.

15. Penn Health is not entitled to recover under the risk sharing provisions for Years One and Two for administrative expenses which exceeded 110% of the budget limitation in the Contract and which were not approved by DPW.

16. Penn Health has sought to recover $2,975,192.00 in management information systems, dues and subscriptions, employment ads, and occupancy expenses ($2,922,690.00 in computer charges and $52,502.00 in Administration charges).

17. Based upon the damages evidence presented in this proceeding DPW's obligation to Penn Health for the Year Three retroactive fee adjustment under the HealthPASS Contract is $8,090,662.00.

18. Based upon the damages evidence presented in this proceeding, DPW's obligation to Penn Health under the Year 3 category mix provisions of the HealthPASS Contract is $518,021.00.

19. Although Penn Health failed to timely place a claim for the Year Four retroactive fee adjustment in the amount of $4,930,379.00 and the Statute of Limitations has arguably expired, the Board will recognize the claim for the purposes of this action.

20. Penn Health's Year Four retroactive fee adjustment claim is cognizable, therefore, DPW's total maximum obligation to Penn Health for that adjustment under the HealthPASS Contract is $4,930,379.00.

21. Penn Health admitted claims of $22,027,677.51 due to the DVHC hospital providers for in-patient services provided under the HealthPASS Contract and Penn Health's agreements with these providers.

22. DPW established an additional $3,375,615.25 in valid and reimbursable in-patient claims owed by Penn Health for HealthPASS services provided by the DVHC hospital providers.

23. The nutshell utilized by DPW was a summary of each claim of the 26 hospital members of DVHC and calculated the total amount due to the hospitals. The nutshell claim was properly supported by testimony, stipulations and patient billing information from each hospital rendering the nutshell admissible and reliable.

24. Penn Health's summary referred to as the Vanderberg nutshell was based upon summaries prepared by the supervisor of Claims Examinations for Maxicare and did not utilize documents which were left in Long Beach, California and accordingly the Vanderberg nutshells are entitled to very little weight or consideration by this Board.

25. Penn Health owes a total of at least $25,292.76 to the DVHC hospitals for in-patient pre-bankruptcy services provided to HealthPASS enrollees.

26. Penn Health owes a total of $2,149,474.02 to the PCP class providers for pre-bankruptcy services provided to HealthPASS enrollees.

27. Penn Health admits that it owes $1,281,557.12 to the PCP class providers for physician services provided under the HealthPASS Contract and Penn Health's contracts with HealthPASS providers.

28. DPW established an additional $867,916.90 in valid and reimbursable claims owed by Penn Health for HealthPASS services provided by the PCP class providers.

29. Under the HealthPASS Contract and Penn Health's contracts with HealthPASS providers, Penn Health owes at least $759,242.47 to pharmacists and durable medical equipment suppliers for services and supplies provided to HealthPASS enrollees.

30. In summary, Penn Health owes $28,312,008.35 to the DVHC hospital providers, the PCP class providers, the pharmacies and durable medical equipment suppliers.

31. Pursuant to its contractual relationships with the HealthPASS providers, DPW is obligated to reimburse those providers for all services rendered under the HealthPASS program where Penn Health was unable to meet its obligations under the program.

32. Pursuant to its non-delegable sovereign and statutory duty to provide and maintain the Medicaid Program, DPW is obligated to reimburse the HealthPASS providers for all services rendered under the HealthPASS Program where Penn Health was unable to meet its obligations under the Program.

33. DPW is entitled to set-off amounts it paid to HealthPASS providers as a result of the failure of Penn Health to pay providers.

34. The Operational Agreement between DPW and Penn Health provides that Penn Health "shall indemnify, save harmless and defend [DPW] against all claims which may result from the acts or omissions of the Contractor, its employees, or agents."

35. The HealthPASS providers' claims against DPW resulted directly from Penn Health's act in filing for voluntary bankruptcy and from Penn Health's omission in failing to make payments to the providers.

36. Penn Health may recover only for those damages it actually incurred as the result of any breach of the HealthPASS Contract by DPW.

37. Penn Health may not realize a financial windfall or a double recovery as the result of any breach of the HealthPASS Contract by DPW.

38. Penn Health may not recover for any loss which was avoided as a result of payment made by DPW which satisfied Penn Health's obligations under the HealthPASS program.

39. Under the HealthPASS Contract, Penn Health was contractually obligated to make timely payments to providers for medical services rendered to HealthPASS enrollees.

40. Penn Health breached the HealthPASS Contract when it failed to make timely payments to providers, both before and after its voluntary declaration of bankruptcy.

41. Under the HealthPASS Contract, Penn Health was contractually obligated to remain financially responsible for the HealthPASS services rendered by providers.

42. Penn Health breached the HealthPASS Contract when it voluntarily entered bankruptcy even though it was a viable and solvent organization and fully capable of making timely payments to HealthPASS providers.

43. As a result of Penn Health's breach of the HealthPASS Contract, DPW became obligated to pay HealthPASS providers for services and supplies provided to HealthPASS enrollees.

44. HealthPASS providers are third party beneficiaries of the DPW - Penn Health

HealthPASS Contract.

45. As third party beneficiaries to the DPW-Penn Health HealthPASS Contract, HealthPASS providers are entitled to make a claim directly against DPW for the satisfaction of Penn Health's obligations to providers under the HealthPASS Contract.

46. DPW's payments to HealthPASS providers, as third party beneficiaries under the HealthPASS Contract, will be set-off from DPW's obligations to Penn Health under the HealthPASS Contract.

47. Having provided compensable medical services to HealthPASS enrollees, the providers have asserted valid claims against DPW.

48. Penn Health breached the HealthPASS Contract when it up streamed to its parent, Maxicare, $6,651,000.00 from the funds paid to it by DPW to be used by Penn Health to make timely payments to HealthPASS providers.

49. Under the HealthPASS Contract, Penn Health was required to invest within Pennsylvania all Medicaid monies paid to it by DPW.

50. In settlement with the DVHC hospital providers, DPW has paid $23,366,033.03 to retire at least $25,322,459.99 in HealthPASS obligations owed to the hospital providers by Penn Health.

51. In settlement with the PCP class providers, DPW has paid $2,100,000.00 to retire $2,149,474.02 in HealthPASS obligations owed to the PCP providers by Penn Health.

52. DPW has made unrecovered advance payments to pharmacies and durable medical equipment providers that have discharged at least $759,242.47 in HealthPASS obligations that would have otherwise been owed these providers by Penn Health.

53. DPW's $23,366,033.03 settlement with the DVHC providers, $2,100,000.00 settlement with the PCP class providers, and $759,242.47 payments to the pharmacists and durable medical equipment suppliers were reasonable compromises of valid claims.

54. Under the common law principle of recoupment, equity and good conscience require that Penn Health's damages under the HealthPASS Contract be reduced by all payments made by DPW which satisfied Penn Health's obligations.

55. DPW has made payments to the DVHC hospital providers, the PCP class claimants, and the pharmacies and durable medical equipment suppliers in the amount of $26,225,275.50 that Penn Health would have otherwise been required to pay.

56. Mutual or reciprocal demands existed between the parties; consequently, because DPW had a contractual and statutory obligation to administer the Medicaid Program and the services provided thereunder, and since DPW satisfied Penn Health's debts by making the payments to the HealthPASS providers otherwise owing by Penn Health, DPW is entitled to a common law set-off of the $26,225,275.50 in payments it made to the HealthPASS providers on Penn Health's behalf.

57. Against DPW's total obligations to Penn Health of $24,177,107.00, DPW is entitled to a credit or set-off equal to the $26,225,275.50 in payments made to providers on Penn Health's behalf.

58. If Penn Health were to be entitled to any recovery on the principal amount claimed in this lawsuit, it would be entitled to six-per cent simple interest only.

59. Because the amount of DPW's credit or set-off is greater than DPW's obligations to Penn Health under the HealthPASS Contract, Penn Health is not entitled to a recovery on its breach of contract claim against DPW.

60. Because Penn Health is not entitled to recover on its breach of contract claim against DPW, it is also precluded from recovering any interest on its claim.

DISCUSSION

This litigation centers around a program known as HealthPASS which uses DPW's innovative test program to develop a more effective, patient focused and economical alternative to the Medicaid fee-for-service system.

DPW is designated, by Pennsylvania Statute, to act as the sole responsible agent for the Commonwealth in administering and financing the provision of medical care to low income citizens. See Pa. Stat. Titl. 62 § 201(1). DPW carries out this duty through its participation in the joint federal-state Medicaid Program, and in its creation and implementation of a State Medicaid Plan. By obtaining approval for the State Plan from the Health Care Financing Administration of the United States Department of Health and Human Services ("HCFA"), DPW receives Federal Financial Participation ("FFP") in the form of reimbursement for a percentage of the fees paid to

health care providers rendering services to eligible medical assistance patients. 42 U.S.C. § 1396; 42 C.F.R. § 430.

Traditionally, DPW administered the State Medicaid Program on a "fee-for-service" basis, under which each health care provider would contract directly with DPW, furnish medical services to eligible Medicaid recipients, and then receive compensation directly from DPW for the medical services provided. In certain inner-city regions, however, the fee-for-service system was often not ideal. In some instances, it could effectively relegate patients seeking routine medical care from a primary health care provider to either high volume "Medicaid Mills" or the inefficient use of hospital emergency rooms. HealthPASS offered an innovative alternative.

In an effort to design a superior alternative to the traditional fee-for-service system, officials at DPW in the 1980s created and developed "HealthPASS" as a demonstration Medicaid project. This novel program was crafted to provide improved medical services on a managed-care basis to some 90,000 of Pennsylvania's neediest citizens in designated portions of south, southwest, and west Philadelphia. Under HealthPASS, DPW contracts with a Health Insuring Organization ("HIO") which serves as a conduit through which State payments are channeled to health care providers for furnishing medical services to Medicaid recipients. The HIO must contract with a variety of health care providers, including primary care and specialist physicians, hospitals, pharmacists and other health care providers. In exchange for payments from the HIO, these providers furnish health care services to Medicaid recipients living in the "demonstration areas" in Philadelphia.

HealthPASS is often referred to as a "capitated program" due to the manner in which the HealthPASS HIO contractor was paid by DPW. Unlike the fee-for-service program where

payments to providers were made by the Commonwealth after the services were provided and invoices submitted to DPW, the HealthPASS program called for DPW to make prospective capitation payments to the HIO contractor on a monthly per-recipient basis. Using these monthly per-recipient payments, the HIO contractor would then pay the health care providers for services rendered to HealthPASS patients.

To DPW, HealthPASS presented the opportunity for an extremely valuable health care initiative; if successful, the program would improve the quality, availability and accessibility of care provided to needy patients and, at the same time, produce tax savings for the Commonwealth. HealthPASS permitted patients to select a specific primary care physician, thus encouraging Medicaid recipients to develop and maintain an ongoing relationship with a single doctor, thereby enhancing the focus on prevention and health maintenance, rather than the more costly subsequent treatment of preventable illnesses. This sharpened focus was particularly significant to the HealthPASS recipients in south and west Philadelphia, which were dominated by a largely minority population that suffered from a disproportionately greater percentage of illness, mortality and morbidity. With designated primary care physicians and the contemplated behavioral change from illness treatment to illness prevention, HealthPASS created an effective and palatable alternative to "Medicaid Mills" and unwise routine-care emergency rooms visits.

A further valuable benefit of this primary care system was the tax dollars saved through its implementation. By making capitation payments to the HIO which aggregated to less than the costs of the fee-for-service system, HealthPASS would save the Commonwealth taxpayers twenty-five (25) to thirty (30) million dollars per year.

Before it could implement and operate its HealthPASS program, Pennsylvania was

obligated to first obtain the approval of the federal government's supervising entity, HCFA. A HCFA "waiver" of certain existing Medicaid program requirements was necessary in order for the Commonwealth to receive the federal funding necessary to finance this important demonstration project. DPW applied for the HCFA waiver and, in 1985, the agency granted DPW's request.

Applications for these federal "waivers" were short-lived. Not long after Pennsylvania received its waiver from HCFA, Congress enacted legislation that prohibited the States from creating any additional capitated, managed-care programs like HealthPASS. Consequently, DPW knew well that if its waiver expired or was lost, the Commonwealth would never be in a position to replace it. And if the waiver was lost, the HealthPASS program would be over. Because the waiver was facilitating better health care at lower costs, retaining the waiver was essential to the Commonwealth.

Following a competitive bidding to select the HIO to administer the HealthPASS Program, DPW chose HealthAmerica to develop and operate the demonstration project. HealthAmerica, in turn, created "Penn Health Corporation", as its wholly owned subsidiary, for the sole purpose of developing and then operating HealthPASS. Upon completion of a Developmental Contract, an Operational Contract between DPW and Penn Health went into effect on March 1, 1986. In November 1986, the national health care conglomerate, Maxicare Health Plans, acquired HealthAmerica and became Penn Health's corporate parent.

Under the Operational Contract, Penn Health committed to develop and implement an HIO for Medicaid recipients residing in designated portions of the "Demonstration Area" in south and west Philadelphia. Towards this end, Penn Health agreed to enter into contracts with providers

of health care services in the Philadelphia area -- hospitals, physicians, pharmacists, and others -- in order to ensure that participants in the HealthPASS Program would have access to all medically necessary services. In entering into these contracts with the health care providers, Penn Health was required to contract only with providers who met with DPW approval and executed forms of agreement that had received DPW approval. If DPW terminated a provider from the Medicaid

program during the period when the Penn Health contract was in effect, Penn Health was required, likewise, to terminate its agreement with the provider.

In exchange for receiving monthly capitation payments from DPW, Penn Health agreed under its HIO contract to make timely payments to providers for medical services rendered to HealthPASS patients. In addition, Penn Health agreed to remain "financially responsible (out of the capitation payments described in Section F.1) for the provision, when medically necessary, of sixteen types of service to eligible clients." Thus, the DPW capitation payments to Penn Health were to pay health care providers for delivering medical services and to pay for Penn Health's administrative expenses.

DPW's capitation payments constituted virtually the sole source of Penn Health's revenue which, in turn, would be the source from which the HealthPASS hospitals, physicians, pharmacists and other providers would ultimately be paid. For this reason, the integrity of, and protection of, these State Medicaid payments was of vital importance to the Commonwealth.

Under the traditional fee-for-service system of operating the Medicaid program, DPW had entered into "Provider Agreements" with each of the participating health care providers. These Agreements obligated DPW to pay for covered services rendered to eligible Medicaid recipients.

Similarly, DPW entered into, or kept in force, independent contracts with each of the HealthPASS providers who had also contracted with Penn Health. These DPW-Provider Agreements explicitly assured the providers that DPW would pay for medical assistance services rendered by providers to Medicaid enrollees: "[t]he Department [DPW] agrees to reimburse the Provider for services covered under the [Medical Assistance] Program [i.e. Medicaid Program] in accordance with applicable statutes and regulations." DPW's obligation to pay, however, was subject to the requirement that the providers first seek payment from other sources who are liable for the services provided, before making a claim against DPW.

DPW's obligations under these Provider Agreements included a duty to reimburse health care providers for services they performed in the HealthPASS program. HealthPASS was, and remains, a component of the Commonwealth's Medicaid Program. As noted above, DPW was required to obtain a waiver from HCFA in order to operate HealthPASS as a Medicaid Program for which the Commonwealth could receive federal funding. Because HealthPASS was a qualifying Medicaid Program, the Commonwealth of Pennsylvania had a contractual obligation to ensure that participating hospitals, physicians, pharmacists and other health care providers received the payments they were entitled to for the Medicaid services they provided.

During the summer and fall of l988, in the third year of Penn Health's operation of the HealthPASS Program, officials at DPW began reading media reports recounting the financial difficulties that Penn Health's California parent, Maxicare Health Plans, was encountering. At the same time, HealthPASS providers were experiencing slowdowns in payments due from Penn Health.

In March of 1989, Maxicare filed a voluntary petition for reorganization under Chapter 11 of the Federal Bankruptcy Code in the State of California. Maxicare placed 44 of its

related entities into bankruptcy, including Penn Health. Penn Health did not on its own initiative seek bankruptcy, did not authorize the action nor was even consulted by Maxicare. At the time Penn Health was placed into bankruptcy, it was financially solvent, it was meeting its debts, its assets exceeded liabilities and it was claiming a profit.

DPW learned that one month before the third program year ended and thus a month before the third program year's books could be closed, that Maxicare requested Penn Health to up stream to its parent $6,651,000.00 from the subsidiary's funds. This transfer was made at Maxicare's bequest and was not disclosed to DPW.

This "up streaming" exacerbated DPW's already grave concerns with Penn Health and Maxicare, and for good reason. First, because Penn Health's operations consisted solely of administering the HealthPASS program, this maneuver undoubtedly involved the transfer out-of-State of DPW's Medicaid capitation payments, payments that were appropriated by the Commonwealth for compensation to those who were providing health care services to indigent Philadelphians. Second, because the third program year had yet to close, the actual profit-loss results from the third program year could not be determined with certainty and, thus, Penn Health had no way of confirming what, if any, profit it had earned in 1988-1989. Third, this $6.6 million sum had not left Pennsylvania for a financially solvent destination; instead, these funds had been intentially diverted, with Penn Health's assent and without DPW's knowledge, to Penn Health's financially troubled California parent.

Originally, Penn Health classified this $6.6 million transfer as a "receivable from affiliates." Later, Richard Link, Maxicare's Senior Vice President for Accounting and Penn Health's Treasurer, claimed the "up streaming" was a dividend. Richard Braksator, Penn Health's Chief

Financial Officer, denied that the transfer was a dividend, but testified instead that it merely reflected a cash transaction between the two corporations. Link and Braksator, however, agreed on two points. The distribution came from capitation payments which were then no longer available to pay the health care providers, and Maxicare retained the money for its own purposes. Penn Health "up streamed" these capitation payments, despite its knowledge that it was contractually obligated to pay provider claims from those same Commonwealth funds.

As a consequence of being pulled into Maxicare's Chapter ll filing, Penn Health was barred from making any further payments to health care providers for pre-petition services, that is, for those services the doctors and hospitals had rendered prior to the bankruptcy filing. For large providers and small, this moratorium created enormous cash flow difficulties which prompted urgent calls to DPW for relief.

The new HealthPASS contractor had just been announced in April 1989, and would assume responsibility for the program on July 1, 1989. In the three months between April 1989 and July 1, 1989, the new contractor was responsible for independently negotiating with, and then contracting with, the Philadelphia-area health care providers who would serve as the provider network for HealthPASS.

Confronted by Penn Health's now past-due HealthPASS debts to them, the Philadelphia providers were reluctant to continue their participation in this program. They threatened that, unless the outstanding Penn Health debt was soon paid, they would refuse to renew their contract to participate in the HealthPASS program.

Without provider participation, the federal HCFA waiver that authorized HealthPASS was in jeopardy. Unless DPW could demonstrate to HCFA that the Commonwealth could assemble

the number of participating health care providers necessary to continue under this program to provide access to quality health care while saving tax dollars, the waiver could be lost and, with it, the entire HealthPASS initiative. The loss of the HCFA waiver, and the concomitant forfeiture of the HealthPASS program, would destroy the program's improvements in the quality and accessibility of Medicaid health care and end the important revenue savings the program had realized.

Neither Penn Health nor Maxicare could make the HealthPASS payments under the bankruptcy code, so the providers turned to the Commonwealth. As the governmental sponsor of the program, and in whose name the providers were treating Medicaid patients, the providers demanded that DPW accept responsibility to solve this financial crisis.

To calm the crisis created by Penn Health's bankruptcy, and to quiet the provider threats of both non-treatment of current HealthPASS patients and non-participation with the new HealthPASS administrator, DPW announced its intention to make interim payments, or advances, to certain providers who had furnished services to HealthPASS patients, yet were not paid by Penn Health.

In June 1989, DPW paid certain providers the approximate equivalent of the value of two months' claims in an effort to assist them in paying their own creditors and in obtaining medical supplies. Given the existing time constraints, the payments were calculated roughly, on the basis of estimates generated by using existing Penn Health payment history data. The payments accumulated to approximately $16 million, with approximately $10.3 disbursed to hospital providers and the remainder earmarked for pharmacists and specialists. These payments, however, did not discharge all the DPW allegations to providers.

Nearly one month after DPW advanced the approximately $10.3 million to various hospitals, fifty-three (53) hospital members of the Delaware Valley Hospital Council ("DVHC") filed a lawsuit against DPW with this Board seeking payment for the Medicaid services they had provided to HealthPASS patients, and for which they had not been paid by Penn Health. The hospitals sought approximately $32 million in unpaid pre-petition claims, and alleged that DPW was liable for Penn

Health's debts under theories of, inter alia, breach of the DPW-Provider Agreement and breach of DPW's non-delegable governmental duty to pay for the Medicaid program.

A year later, in June 1990, a group of primary care physicians ("PCPs") filed a class action lawsuit against DPW, ultimately seeking nearly $3.5 million in unpaid pre-petition claims that they alleged Penn Health had failed to satisfy. Like the hospitals, the PCPs believed DPW was liable to them because DPW had contractually agreed to cover the costs of all Medicaid services provided to eligible recipients and because DPW had a non-delegable statutory duty to pay for all costs arising under the Medicaid Program.

In May 1994, DPW reached a settlement with the 53 DVHC hospital claimants. Under the terms of that settlement, the DVHC hospitals agreed to compromise their $32 million in pre-petition HealthPASS claims against DPW for a further payment of $13 million. Combined with the $10,366,033.03 in advance payments made in June 1989, DPW's total payments to the DVHC hospitals totaled $23,366,033.03, more than $8 million less than the DVHC providers had sought in their Complaint.

DPW next resolved the PCP claims by reaching a conditional settlement with the PCP

Class in September 1995. In that settlement, DPW agreed to retire the Class PCPs $3,468,608.04 HealthPASS claims for a one-time payment of $2,100,000.00 million, plus certain modest accumulated post-settlement interest.

Significantly, both settlements directly benefit Penn Health. The DVHC providers have agreed unequivocally before this Board that, if they are permitted to keep the funds DPW has paid to them, they are prepared to release all claims they still maintain against Penn Health and Maxicare. In the California bankruptcy court, this agreement means that the $32 million in DVHC provider proofs-of-claims will be withdrawn, and Penn Health's financial obligations to the DVHC providers will disappear.

As a result of the June 1989 advance payments and the ensuing settlements, the DVHC hospitals and the Class PCP's have been paid to their satisfaction. Penn Health, in turn, will be relieved of any further HealthPASS payment obligations to these providers.

Penn Health claims that it is entitled to damages for DPW's breach of the Operational Contract (the "Contract") in the aggregate amount of $29,391,299.00, plus interest of just under $13 million dollars. Accordingly, Penn Health seeks a total of over $42 million in damages and claims DPW is entitled to no credit for the advances and payments made to the providers on account of Penn Health's debt.

Without considering DPW's claims for credit or off-set, when the components of Penn Health's damage claim are analyzed, it becomes clear that Penn Health has overstated the damages to which it would be entitled to by over $5 million.

Section F of the Contract provides that DPW would compensate Penn Health in two

ways: (1) monthly capitation payments; and (2) certain contractually defined adjustments. Penn Health's claims against DPW arise solely out of the contractual adjustments provisions of the Contract. Specifically, Penn Health claims it is entitled to damages for: (1) a risk-sharing adjustment for Contract Years One and Two; (2) retroactive fee adjustments for Contract Years Three and Four; and (3) a category mix adjustment for Contract Year Three.

The risk-sharing provisions of the Operational Contract, which allocate the risk of HealthPASS operational losses between DPW and Penn Health, are contained in the Second Amendment to the Contract. Under Amendment II, risk-sharing for Contract Years One and Two was to be calculated based on Penn Health's combined results for the two contract years. Specifically, DPW agreed to alleviate the risk assumed by Penn Health by reimbursing Penn Health for any financial losses suffered by Penn Health in excess of $2 million over the two-year period. For purposes of risk-sharing, a loss occurs under the Contract when total medical and administrative expenses exceed revenues.

For Contract Years One and Two, the term "medical expense" is defined as all payments made by Penn Health for medical services provided under the terms of this Agreement. By defining the term in this manner, DPW limited Penn Health's reimbursement to those medical claims actually paid during Contract Years One and Two. Despite this contractual limitation, Penn Health's claim for risk-sharing payment for Contract Years One and Two include both incurred but not paid claims and paid claims.

When words in an agreement are clear and unambiguous, intent is to be discovered only from the express language of the agreement. Steuart v. McChesney, 498 Pa. 45, 444 A.2d 659 (1982). It is not the function of this Board to give a contract a construction that is in conflict with

the accepted and plain meaning of the language used. Steuart v. McChesney, Id. Penn Health contends that it is entitled to claim expenses that are accrued but not paid. The unequivocal and unambiguous language of the agreement in its plain meaning limits reimbursable medical expenses to payments made. Those amounts included in Penn Health's claim that are accrued but not paid therefore must be excluded.

The total amount of the projected, but not paid, medical expenses included in Penn Health's Years One and Two risk-sharing claim is $2,239,000.00. As of November 30, 1988, approximately nine months after the close of the Second Program Year, Penn Health has actually paid $4,939,000.00 less in medical expenses that had been accrued by the auditors. Penn Health had, however, paid $2.7 million in claims for Year One. Under the clear language of the Contract, Penn Health's Year One and Two risk sharing claim is therefore overstated by $2,239,000.00 ($4,939,000.00 less $2,700,000.00).

Under the risk-sharing provisions of Amendment II of the Contract, "administrative expenses" are defined as expenditures for "salaries, benefits . . . claims processing charges, corporate overhead, and other costs incurred in the administration of the program in accordance with the budget prepared by [Penn Health] and approved by the Department."

Pursuant to Amendment II of the Contract, Penn Health submitted a budget on April 22, 1987 for Contract Year Two. Penn Health's budget for Contract Year Two was approved by DPW on July 7, 1987. At the time DPW approved Penn Health's budget, DPW reminded Penn Health that the risk-sharing provisions "required Department approval of certain changes affecting administrative costs." Nevertheless, Penn Health incurred certain administrative costs in Contract Year Two which exceeded the specified 110% of the approved Contract Year Two budget limitation

by $2,922,690.00 for management information systems (MIS). Penn Health never sought, nor did DPW approve, MIS expenditures beyond those approved in the budget, accordingly, Penn Health's claim is overstated in administrative expenses by $2,922,690.00 as it did not get the required approvals.

Penn Health's claim for $15,852,854.00 for risk-sharing for Contract Years One and Two also must also be reduced in the amount of $52,502.00, which is the amount that Penn Health's claimed miscellaneous administrative expenses exceeded the 110% of the budget limitation specified in Section F.2(g) of the Contract. In Contract Year Two, Penn Health exceeded 110% of the approved budget for three categories of miscellaneous expenses: dues and subscriptions by $3,960.00; employment ads by $20,707.00 and occupancy by $27,835.00 which items total $52,502.00.

Penn Health neither sought nor received DPW approval of Penn Health's excess expenditures for dues and subscriptions, employment ads and occupancy, and such items exceed the approved budget for Contract Year Two by $52,50200.

Accordingly, Penn Health's claim of $15,852,854.00 for risk-sharing payments for Contract Years One and Two is overstated by a total of $5,191,000.00 as the claim seeks reimbursement for medical costs and administrative expenses which are not reimbursable under the explicit risk-sharing provisions of the Contract.

Under the Contract, Penn Health was entitled to a retroactive adjustment of the capitation fee payments in the event that DPW's actual fee-for-service costs exceeded its projected fee-for-service costs on which the capitation fee level was based. Penn Health claims that DPW is obligated to pay $8,090,045.00 as a retroactive fee adjustment for Year Three and an additional

$4,930,379.00 for Year Four. DPW does not dispute that $8,090,045.00 is the amount calculated for Penn Health's retroactive fee adjustment for the third operational year. DPW however contends that the claim for Year Four is barred by the failure of Penn Health to plead the same in its February 1991 Complaint. DPW does however admit that the Year Four claim of $4,930,379.00 is correct. This Board believes that the claim was sufficiently put forth and should be considered as DPW was in fact on notice that Penn Health was claiming all sums allegedly due under the contract between the parties. Accordingly, as DPW does not dispute the amount, it will be recognized.

The HealthPASS Contract provides that aggregate capitation payments to Penn Health would be adjusted up or down quarterly based upon a category mix adjustment. The category mix adjustment formula is found at Section F.3 of the Contract and takes into account the actual eligibility categories of HealthPASS enrollees. Penn Health claimed $518,020.00 as a category mix payment due from DPW for the fourth quarter of Year Three of the Contract. DPW does not dispute the amount of Penn Health's claim to the category mix payment for the fourth quarter of Year Three of the Contract.

In summary, the total amount which DPW has failed to pay Penn Health is $24,177,107.00 computed as follows: Years I and II Risk sharing payments of $15,852,854.00 less overcharges of $2,922,690.00, $2,239,000.00 and 52,502.00 for a net of $10,638,662.00; Year III Retroactive fee adjustment $8,090,045.00, Year IV Retroactive fee adjustment $4,930,379.00, Year III category mix adjustment $518,021.00.

DPW however asserts that although payable, no payment is due Penn Health because of credits and set-offs due DPW by reason of payments made to providers that would have been made by Penn Health. DPW claims it is entitled to a credit of set-off against the $24,177,107.00,

payments made by DPW to DVHC Hospitals, PCP Class members, pharmacists and DMR suppliers.

DPW also contends it is entitled to a credit or set-off any amounts which benefit Penn Health because of the DPW payments.

DPW asserts that Penn Health realized a savings as a result of DPW payments and as such these were losses avoided and DPW must be given credit for the savings citing Bellefonte Area School District vs. Lipner, 81 Pa. Cmmwlth. 334, 473 A.2d 741 (1984); Northeastern Vending Company, Inc. vs. P.D.O., Inc., t/a Flood's,. 194 Pa. Super. 200, 606 A.2d 936 (1992). The distinguishing feature in this case, however, is that the claim being asserted is that of DPW on this particular matter and not Penn Health. The purpose of the rule of law announced in these cases is to prevent a windfall to a contractor upon its claim, not to add to a counterclaim or set-off which is a claim unto itself. In fact, it would appear that these cases would not allow DPW to value this savings claim as it would place DPW in a better position than it should be in by claiming amounts it did not expend. Accordingly, DPW's assertion of loss savings will not be recognized.

Credit or set-off for amounts paid by DPW in this case will be permitted under several principles.

DPW entered into provider agreements with each of the DVHC hospitals and PCPs who contracted with Penn Health. Under the DPW-Provider agreements, DPW contractually agreed to reimburse the providers for all services rendered under the Medicaid Program if Penn Health was unable to meet its HealthPASS obligations. Since HealthPASS was indisputably a Medicaid Program, DPW assumed an independent contractual obligation to pay the providers for rendering HealthPASS services.

This Board relied upon these DPW-Provider Agreements when it found, in its Order of December 2, 1994, that a contract existed between DPW and each member of the PCP Class. The Board further concluded that these agreements obligated DPW to reimburse the PCPs for the HealthPASS services rendered to eligible Medicaid patients. As similar contractual language appears in provider agreements between DPW and the DVHC hospitals, there is no question that DPW had a direct contractual obligation to both the PCP's and the DVHC hospital providers to reimburse them for the provision of HealthPASS services in the event Penn Health did not meet its obligations. The fact that the provider agreements with Penn Health state that Penn Health is solely liable for compensation for medical services does not relieve DPW for its agreements to the providers in the event Penn Health did not meet its obligations.

In addition to DPW's direct contractual obligations to the providers, DPW was further obligated to make payments to the providers as a result of its sovereign and statutory duty to administer and operate the Medicaid Program in Pennsylvania.

Federal statutes and regulations mandate that the State designate a single agency to administer or supervise the administration of the State Medicaid Plan. See 42 U.S.C. § 1396a(a)(5); 42 C.F.R. § 431.10(e). Significantly, federal law precludes this designated agency from delegating the administration of the Medicaid Program in order "to ensure that the States will not administer the provisions for services in a way which adversely affects the availability or the quality of the care to be provided" and "to ensure accountability for operation" of the Program. Morgan v. Cohen, 665 F. Supp. 1164, 1177 (E.D. Pa. 1987). See also Fulkerson v. Commissioner, Maine Department of Human Services., 802 F. Supp. 529, 538 (D. Me. 1992); 42 C.F.R. § 431.10(e).

Under Pennsylvania law, DPW is statutorily designated as the sole State agency

responsible for administering the Medicaid Program. Pa. Stat. Ann. titl. 62 § 201(1). DPW is, thus, accountable for the administration, oversight and operation of HealthPASS, a demonstration program created under the umbrella of Pennsylvania's Medicaid Program. When DPW made payments to the providers to calm the crisis created by the Penn Health/Maxicare bankruptcy, it did so pursuant to its statutory obligation to remain accountable for the HealthPASS Program and to ensure its continued existence.

In addition to the statutory obligations, DPW was further obligated as a sovereign to make these payments. The Pennsylvania Supreme Court has repeatedly emphasized that it is the Commonwealth's "obligation", and "the most important function of government", to act to preserve the health, safety and welfare of all of its citizens. The County of Allegheny v. Commonwealth, 507 Pa. 360, 490 A.2d 402 (1985); Commonwealth v. Mikulan, 504 Pa. 244, 470 A.2d 1339, (1983). While the State may delegate specific "health, safety and welfare" functions to other entities, "such delegation of responsibility does not relieve the state of its primary duty to assure the satisfactory discharge of the obligation." County of Allegheny, Id.

Recognizing that it is vested with the primary responsibility to operate the HealthPASS program in Pennsylvania, DPW reacted appropriately when it quelled the health care crisis created by the Penn Health bankruptcy. Once Penn Health defaulted on its payments to the providers, DPW was obligated legally and contractually to ensure that Medicaid recipients continued to receive health care.

The common law doctrine of set-off permits DPW to reduce the contract damages owing to Penn Health by the aggregate amount of DPW's payments to providers in satisfaction of Penn Health's debts to them. A set-off has been defined as a "counter-demand . . . [which] is not

incompatible with the justice of the plaintiff's claim, but seeks to balance in whole or in part by a counter-obligation alleged to be due by the plaintiff to the Defendant." See Beason v. Pierce, 321 Pa. 398-400, 184 A. 650, 651 (1936). Unlike the counterclaim, however, a set-off must be based upon the same transaction underlying the plaintiff's cause of action." Kaiser v. Monitrend Investment Management, Inc., No. 326 M.D. 1995, 1996 WL 89549 at *3 (Pa. Commw. Ct. Jan. 31, 1996). In this regard, it is often said that a set-off is available wherever there are mutual, or reciprocal, demands existing between the same persons. See Dickerson v. Dickersons Overseas Co., 369 Pa. 244, 85 A. 102 (1952).

In this case, DPW is entitled to a set-off against Penn Health for the aggregate amount of DPW's payments to the providers. Since DPW had a contractual and statutory obligation to administer and pay for the Medicaid Program and the services provided thereunder, and since it satisfied Penn Health's debits by making the payments, there were undoubtedly mutual, or reciprocal, demands existing between the parties. Accordingly, DPW is entitled to set-off the payments made to the providers from the monies allegedly due to Penn Health under the Operation Contract.

In addition, the doctrine of subrogation applies to permit DPW to assert a set-off against Penn Health. As the Superior Court recently explained:

> [Subrogation] is a device adopted by equity to compel the ultimate discharge of an obligation by him who in good conscience ought to pay it. . . Where the property of one person is used in discharging an obligation owed by another, under such circumstances that the other would be unjustly enriched by the retention of the benefit thus conferred, the former is entitled to be subrogated to the position of the obligee.

Holloran v. Larrieu, 431 Pa. Super. 558, 560-561, 637 A.2d 317, 318 (1994). Thus,

subrogation "is generally applicable where one party pays out of its own funds a debt or obligation that is primarily payable from the funds of another." Judge v. Allentown & Sacred Health Hosp. Ctr., 90 Pa. Commw. 520, 496 A.2d 92 (1985).

Because DPW paid the providers a debt that was primarily owed by Penn Health, and thereby discharged Penn Health's obligation to the providers, DPW is entitled to be subrogated to the position of the providers. Accordingly, under the subrogation doctrine, DPW is entitled to set-off the aggregate amount of Penn Health's debts which were satisfied upon DPW's payments to the providers.

Not only does the common law set-off doctrine apply in this case, but the doctrine of equitable set-off is also applicable to reduce Penn Health's contract damages in a sum equal to the amount of Penn Health obligations satisfied by the DPW payments. While, as a general matter, a set-off claim involves mutual obligations between the defendant asserting the claim and the plaintiff, the doctrine of equitable set-off expands the reach of common law set-off by permitting a defendant to set-off a plaintiff's claim wherever "circuity of action" can thereby be avoided. Hibert v. Lang, 165 Pa. 439, 442, 30 A. 1004 (1895) (cited approvingly in re: Bank of Pittsburgh Nat'l Ass'n., 324 Pa. 161, 166, 188 A. 200, 202 (1936). As the Court explained in Hibert:

> [A]lthough, in general, in order to support a set-off, there must be cross-demands between the same parties and in the same rights, such as would sustain mutual actions against each other, yet wherever there is the practicability of avoiding circuity of action and needless costs, with safety and convenience to all parties, or where there is a special equity to be subserved, and no equity of third parties to be injured, a set-off will be allowed upon equitable principles.

165 Pa. at 442, 30 A. at 1004. In Hibert, the Court held that it was error for the lower

court to refuse to permit a defendant surety to set-off a judgment of a third party co-surety against the plaintiff. Id. The Court reasoned that the application of set-off principles would promote justice and avoid the circuity of action which would result if the defendant was required to assert a separate contribution claim against the third party, who, in turn, would be entitled to a set-off against the plaintiff. Id.

Here, equity requires that DPW is entitled to a set-off for the payments made to the providers in satisfaction of Penn Health's debt. As in Hibert, granting DPW an equitable set-off here will avoid the inevitable multiplicity of actions that will follow if such relief is denied.

Paragraph H.12.h of the Operational Agreement between DPW and Penn Health provides that Penn Health "shall indemnify, save harmless and defend [DPW] against all claims which may result from the acts or omissions of the Contractor, its employees, or agents." Under Pennsylvania law, an indemnification agreement is valid and permitted as long as the indemnification is stated in clear and unequivocal language. Ruzzi v. Butler Petroleum Co., 527 Pa. 1, 7, 588 A.2d 1, 4 (1991). In the present case, the claims asserted by the DVHC hospitals and the PCPs arose directly as a result of Penn Health's inability to pay these providers for pre-petition debts after the bankruptcy filing.

The contractual indemnification language requires, as a prerequisite, that there be either an "act or an omission by Penn Health that gave rise to the covered claims. It is clear that both an "act" and an "omission" triggers the application of this indemnification provision here. Penn Health's voluntary bankruptcy filing is undoubtedly the act that led directly to the DVHC hospital and PCP lawsuits against DPW. If not for the voluntary bankruptcy, the providers would have

looked directly to Penn Health for any outstanding debts.

Penn Health's "omission" also gave rise to the hospital and PCP suits. Under its contract with the providers, as well as its contract with DPW, Penn Health was obligated to make timely payments to those providers who rendered services to HealthPASS patients. Penn Health's failure to make these payments, as a consequence of the bankruptcy, caused the providers to sue DPW for payment. Had Penn Health continued to make payments to the providers, they would have had no reason to file suit against DPW.

Under the plain reading of the clear and unequivocal language of the indemnification clause, Penn Health is required to indemnify, hold harmless, and defend DPW against the claims asserted by the hospitals and PCPs. Because DPW reasonably settled the DVHC and PCP cases, it is entitled to a judgment in this amount as an off-set to any amount which may be owed to Penn Health. DPW also contends that it is entitled to credit entitlement by application of the doctrine of recoupment. Under the recoupment doctrine:

> "a defendant is entitled to claim by way of deduction, all just allowances or demands, accruing to him in respect of the same transaction that forms the ground of the action. This is not a set-off. . . in the strict sense, because it is not in the nature of a cross demand, but rather it lessens or defeats any recovery by plaintiff. It goes to the existence of the plaintiff's claim, and is limited to the amount thereof. . . . The defense of recoupment, which arises out of the same transaction as plaintiff's claim, survives as long as the cause of action upon the claim exists. **It is a doctrine of an intrinsically defensive nature founded upon an equitable reason, inhering in the same transaction, why the plaintiff's claim in equity and good conscience should be reduced."**

Kaiser v. Monitrend Investments Management, Inc., No. 326 M.D. 1995, 1996 WL 89549 at *3 (Commw. Ct. Jan. 31, 1996) (quoting Household Consumer Discount Co. v.

Vespaziani, 490 Pa. 209, 219, 415 A.2d 689, 694 (1980)); Kline v. Blue Shield of Pennsylvania, 383 Pa. Super. 347, 353, 556 A.2d 1365, 1368 (1989). Because Penn Health's Complaint seeks recovery of payments due for the provision of medical services to HealthPASS patients, and since DPW's claim for recoupment relates directly to payments made to health care providers for the very HealthPASS services upon which Penn Health's Complaint is based, the recoupment doctrine applies. In light of DPW's satisfaction of Penn Health's indebtedness to the providers, it cannot be disputed that Penn Health's claim "in equity and good conscience should be reduced" by the amount of DPW's payment to the providers where justice requires that a defendant counterclaim and should be given credit

against a plaintiff's claim, the doctrine of recoupment will be applied. Stulz v. Boswell, 307 Pa. Super. 515, 453 A.2d 1006 (1982).

In Kline v. Blue Shield of Pennsylvania, Supra., the Court explained recoupment in a situation similar to this case. The Court explained: (at pg. 352 of 307 Pa. Super., and 1368 of 556 A.2d):

> "It is undisputed that [the doctors] owed PBS the sum of $59,947.00 in overcharged fees while PBS was indebted to [the doctors] in the amount of $59,947.00 representing withheld fees. Both debts arose out of the participating doctors' contracts between the parties, and the debts were based upon the payment of fees for medical services rendered to Blue Shield subscribers by [the doctors]. Simply put, [the doctors'] indebtedness to Blue Shield in an amount identical to [Blue Shield's] indebtedness defeats any recovery by [the doctors]. [The doctors] would have this Court award the withheld fees and yet ignore a debt to PBS which they refuse to pay. Neither law nor equity would favor such a result."

Accordingly, it would appear that in the event no other theory would allow DPW to

off-set its payments against the claim of Penn Health, equity and justice would compel that a credit be permitted to DPW pursuant to the doctrine of recoupment.

Partly, DPW agues that it is entitled to claims set-off on the payments made to providers by DPW where payments to "third party beneficiaries." This Board has wide discretion to determining whether the recognition of a third party beneficiary is appropriate. As the central theme of the Operational Contract was the timely payment of health care providers, who were to deliver medical care to HealthPASS patients, and as the purpose of designating Penn Health as an HIO was to allow it to serve as a conduit through which the providers would be reimbursed, the providers are third party beneficiaries of the contract. Guy v. Liederbach, 501 Pa. 47, 459 A.2d 744 (1983).

Accordingly, as DPW payments were paid to the beneficiaries, a set-off for those payments would be in order.

Penn Health argues that DPW should not be entitled to off-set or credit because of the Penn Health bankruptcy and reorganization plan adopted.

It is important to note that the action before this Board is not some unknown, redundant, parallel proceeding that is duplicating efforts taking place before the federal bankruptcy court in California. To the contrary, the bankruptcy court is distinctly aware of this Board's proceeding, and has issued an Order formally abstaining from any resolution of the Penn Health dispute in California until this Board resolves the proceeding now before it.

The bankruptcy judge's rulings on this issue are unmistakable. After briefing and argument on the advisability of concurrent Penn Health proceedings before both the Board of

Claims in Harrisburg and the bankruptcy court in California, the Bankruptcy Judge (Hon. John J. Wilson, B.J.) issued an Order dated November 29, 1993 formally abstaining from further proceedings in California so as to permit this Board to hear and decide the Penn Health dispute. In so ruling, the bankruptcy court concluded, as a matter of law, that the causes of action pending both in California and in the Board of Claims "are based primarily upon state law." As to such claims, the bankruptcy court rules that this Board "is a state forum of appropriate jurisdiction which can enter a final and binding order against DPW in the Penn Health Board Proceedings."

At the hearing before Judge Wilson, counsel for Penn Health sought a clarification that the bankruptcy court was not abstaining on the question of DPW's entitlement to a set-off or credit for all the Commonwealth payments it had made to the HealthPASS providers. Judge Wilson summarily rejected this suggestion:

> [Counsel for Penn Health]: Your Honor, what about the issue of the off-set. You had spoken earlier about possibly carving out the off-set issue.
>
> THE COURT: **I'm not going to carve anything out.** Essentially, I'm saying, you've got nine--you've got ten more months at the Board to resolve Penn Health vs. DPW.

Interestingly, after listening to Penn Health's suggestion that DPW made gratuitous payments to the struggling HealthPASS providers as a "volunteer," Judge Wilson previewed his thoughts for the litigants:

> THE COURT: [DPW's] response [to Penn Health's allegation that the payments to providers were gratuitous] is that sure, they were gratuitous in a certain sense because these are Pennsylvania providers and the debtor went into the tank and wasn't paying the provider for services that it was--that had been--so the debtor didn't pay. Always remember that. **It was the debtor that didn't pay the providers. Your [Penn Health] white gloves are soiled.**

Now the Department is in a bind. They may or may not have some liability to these providers. But they say, we're going to pay the providers. We're going to give them something to ease their financial burden. And we'll off-set that against the debtor at some later date. And we'll look at the records and ultimately determine how much we might owe them.

[Counsel for Penn Health]: Right.

THE COURT: But at least right now, we're going to come up with the $16 million [advances] to sort of keep them from all crowding into the Bankruptcy Court.

[Counsel for Penn Health]: Right.

THE COURT: Which is what it did.

[Counsel for Penn Health]: Yes.

THE COURT: Now, the debtor [Penn Health] comes along and says, oh, those were gratuitous payments. They had no contractual obligation to do that. You don't want to try that part of the lawsuit before me, do you?

[Counsel for Penn Health]: Well --

THE COURT: I know you don't want to try it back there --

[Counsel for Penn Health]: Well--

THE COURT: -- but you're not going to get very much farther with me than you are with that.

[Counsel for Penn Health]: Well, but the --

THE COURT: The ultimate issue is going to be to what extent was DPW liable to the providers. **Whether they paid them prematurely or gratuitously, or what, they at least paid them some money. And that's -- I think, speaks well of the Commonwealth.**

As the Bankruptcy Court's abstention order and Judge Wilson's comments make very

plain, there is no question but that the Bankruptcy Court is anticipating that this Board will resolve the ***Penn Health Corp. v. DPW*** litigation under Pennsylvania law, applying the State's common law to all claims and defenses. In light of the bankruptcy court's comments and its continuing abstention order, no other conclusion is tenable.

The fact that Penn Health has a reorganization plan has no effect upon this Board's ability to grant set-offs or credits as hereinbefore discussed. There is no doubt that the DPW payments benefited Penn Health and will discharge the providers claims against Penn Health. Accordingly, the net result should be no effect upon the plan of reorganization. Most importantly, DPW had no choice but to make the payments to prevent total chaos and failure of the Pennsylvania Medicaid Program. Moreover, set-offs invariably result in creditors being treated differently but such does not mean that granting set-offs are unfair or unjust. Carolco Television Inc. v. National Broadcasting Co, In Re: DeLaurentis Entertainment Group, 963 F.2d 1269 (9th Cir. 1992)

Accordingly, the remaining matters to be addressed are the payments made by DPW, their reasonableness, the amount of credit or set-off due DPW against Penn Health's claim and any interest that may be due.

The claim of the DVHC providers is approximately $32 million dollars. Penn Health contends that it has reviewed their claims and can only approve $21,380,030.52. DPW settled the DVHC claim in total for $23,366,033.03. This Board is of the opinion that the DPW settlement was reasonable and fair.

Either through the testimony of a witness representing the hospitals, or upon stipulation of counsel, DPW offered the following evidence from twenty-six hospital members of the DVHC:

1. The hospital submitted pre-petition in-patient and out-patient

claims to Penn Health for services provided to HealthPASS patients, and Penn Health has failed to pay the hospital for these services;

2. The hospital has identified the medical services provided to each patient for which reimbursement has not been received from Penn Health, and has segregated the pertinent patient billing files;

3. The patient billing files contain documentation reflecting the services provided to each patient;

4. The hospital records, including the patient billing files, were prepared by a person with knowledge of the facts appearing in the records were made at or near the time that the services reflected thereon were provided, and were prepared and maintained in the ordinary course of business of the hospital, which prepares the records as a regular practice;

5. Each of the in-patient claims of the hospital were summarized in a "nutshell" which contains an accurate identification of all in-patient claims submitted by the hospital for reimbursement to Penn Health;

6. The nutshells were prepared by a competent witness with knowledge to verify the underlying records;

7. The in-patient claims identified in the nutshell were categorized as either "undisputed" (meaning Penn Health has acknowledged the debt), "disputed" (meaning Penn Health has explicitly rejected the claim based on information from HAMIS), or "unprocessed" (meaning Penn Health has not even processed the claim);

8. The hospital received authorization from Penn Health, as required under the Hospital Manual, to treat the HealthPASS patient for which each claim was submitted;

9. The Hospital billed Penn Health for the services reflected in each claim;

10. Penn Health has rejected the "disputed" claims and failed to

process the "unprocessed" claims;

11. Each disputed and unprocessed claim was a valid, reimbursable claim for services which was authorized by Penn Health pursuant to the provider contract and the Hospital Manual; and

12. The hospital is owed an aggregate amount from Penn Health, identified specifically for each hospital, for valid claims which Penn Health has either rejected or failed to process.

In addition to the testimony and/or stipulation presented by each of the hospitals, DPW offered into evidence the patient billing files from each of the hospitals supporting each of the claims identified. DPW also introduced into evidence a nutshell for each of the twenty-six hospitals which summarized each claim and calculated the total amount due and owing from Penn Health to the hospitals.

To counter this evidence, Penn Health presented summaries from its HAMIS computerized database but did not provide the Penn Health records which remained in storage in Long Beach, California. In fact, these records were not even consulted when preparing the summaries. The information utilized was strictly the HAMIS information. It is well settled in Pennsylvania that when original documentation evidence is voluminous and detailed so that an examination thereof is impracticable, a summary of such documents is admissible so long as the originals are available for inspection and a competent witness who can verify the documents is available for cross examination. Moreover, it is within the trial court's sound discretion to permit witnesses to testify from such summaries instead of from the original documentary evidence. Royal Pioneer Paper Box Mfg. Co. v. Louis DeJonge & Co., 179 Pa. Super. 155, 115 A. 837 (1955); Keller v. Porta, 172 Pa. Super. 651, 94 A. 140 (1953).

Accordingly, in the opinion of this Board, Penn Health's summaries are entitled to little weight as the documents supporting the summaries were not available for inspection. Further, it appears that the evidence submitted by DPW reveals that the settlement made was reasonable and were obligations due pursuant to the contract between the parties and as such, for the reasons hereinbefore discussed, will be permitted as a credit and set-off against Penn Health's claim.

In addition to the DVHC hospital providers, Penn Health also entered into HealthPASS contracts with primary care physicians (the "PCPs"). The PCPs were the "first-line doctors"- known as "gatekeepers," in HMO parlance. It was these physicians who would provide the primary care to HealthPASS enrollees and who would, when necessary, refer the enrollees to specialty physicians for additional specialized care.

Under the Penn Health contract with PCPs, the PCPs agreed to be compensated by Penn Health on the basis of monthly capitation payments (that is, they would be assigned a monthly payment for each HealthPASS enrollee they were treating). However, the PCPs would only receive 50% of these monthly payments, with the remaining 50% placed by Penn Health into a "Referral Services Fund." Each time a PCP would refer one of his or her patients to a specialist, a portion of the specialist's bill would be deducted from the amounts that were accumulating each month in that PCP's Referral Services Fund. At the close of each fiscal year, Penn Health would compute the total deductions from each PCP's Referral Services Fund and, to the extent there were any monies remaining in the physician's Fund, Penn Health would send a payment to that PCP.

In the class action against DPW which this Board certified, the PCPs alleged that they had not received their respective payments from Penn Health for the Referral Services Fund monies

due and owing as of the conclusion of the March 1988-March 1989 HealthPASS program year. To this total, certain adjustments must be made.

According to Penn Health's computation in 1990, the total amounts due and owing to the PCPs was $1,640,663.59. First, the claims of those eighteen PCPs who elected not to participate in the Behjat class action lawsuit (the "opt-outs") must be subtracted because, as to those PCPs, DPW has not reached a settlement. According to Penn Health, the value of these eighteen claims was $103,542.20.

Second, certain of the class PCPs, who are affiliated with DVHC-member hospitals, have already received their compensation through the DVHC hospital settlement. The value of these claims, $345,795.51, must also be subtracted from the Penn Health debt.

Third, in addition to the Referral Services Fund monies, certain of the PCPs were entitled to other compensation payments from Penn Health for performing non-primary care physician services (e.g., a PCP who also served as a specialist). According to Penn Health, the total value of these additional compensation payment claims was $72,483.91. Certain PCPs who received checks from Penn Health were unable to cash the drafts before Maxicare pulled Penn Health into bankruptcy. As a result, when those PCPs attempted to deposit the Penn Health checks, the checks were dishonored by the banks. The total amount of dishonored PCP checks was $10,174.12. Both these sums must be added.

Fourth, the PCPs noted that DPW has successfully settled with the DVHC hospitals at the compromise figure of $23.3 million which is substantially less than the $32 million in DVHC proofs of claim. This settlement savings had a cost benefit to the PCPs. Because some of the

medical specialists to who the PCPs had referred patients were hospital-affiliated physicians, the DPW settlement with the hospitals meant that those hospital-affiliated physicians were now receiving a lower payment for their services than they would otherwise have expected. Because the specialists' fees were thus being discounted by the DVHC settlement, the PCPs contended that their Referral Services Funds have been overcharged: Penn Health had subtracted from the Funds the full value of the specialists' services, and these subtractions now had to be adjusted to reflect the actual amount of the specialists' services. The total additional required by this calculation is $867,916.90.

In sum, the original Referral Services Fund monies due and owing, less the claims of the class opt-outs, plus the specialists' fees and dishonored check amounts, plus the adjustments required by the DVHC settlement referral savings produces a total of $2,149,474.24. When six-percent legal interest is added to this sum, the total PCP claim as of the September 20, 1995, date of settlement, equals almost $3 million.

In September 1995, DPW and the PCP class reached a conditional settlement to resolve all the class PCP claims for a payment by the Commonwealth of $2,100,000.00.

In accordance with the terms of this Settlement Agreement, the PCP class agreed to execute a "Release And Covenant Not To Sue", negotiated with DPW, that:

> releases and forever discharges Penn Health Corporation, Maxicare Health Plans, Inc., and each of their successors, assigns, employees, insurers, reinsurers, agents, and attorneys ("Maxicare Releases") from all claims and liability of any kind relating to the HealthPASS program, whether known or unknown, suspected or unsuspected, contingent or non-contingent, and whether or not heretofore asserted, including (but not limited to) and all claims for direct liability,

> contribution, indemnity, or restitution, under any legal theory, however denominated, arising from any cause or conduct at any time before the signing of this Class Release.

By its terms, this Release discharges Penn Health and Maxicare from any further obligation to the Class PCPs. Following an evidentiary class action fairness hearing on Friday, March 29, 1996, the Board approved this PCP settlement as fair, reasonable, and adequate. The Board's Order further ruled that:

> DPW, the Commonwealth of Pennsylvania, Penn Health Corporation, Maxicare Health Plans, Inc., and each of their successors, assigns, employees, insurers, reinsurers, agents, and attorneys are hereby RELEASED and DISCHARGED from all claims and liability of any kind which were or could have been asserted in this litigation, whether known or unknown, suspected or unsuspected, contingent or non-contingent, and whether or not heretofore asserted, including (but not limited to) any claims for direct liability, contribution, indemnity, or restitution, under any legal theory, however denominated, arising from any cause or conduct at any time before the signing of the Class Release prescribed by the Settlement Agreement.

The Board is of the opinion that the DPW settlement is fair and reasonable and discharges an obligation arising from the contract between the parties. Accordingly, for the reasons discussed earlier, this settlement amount will also be permitted as a credit and set-off against Penn Health's claim.

In addition to the DVHC hospitals and the PCPs, the HealthPASS program also included pharmacies, apothecaries, drug stores and durable medical equipment suppliers. These suppliers, as well, were denied reimbursement when Penn Health was dragged into Maxicare's bankruptcy. In June 1989, DPW made certain cash advances to these providers in an effort to alleviate the financial crises caused by Maxicare. These cash advances in June 1989, advanced against monies otherwise due and owing by Penn Health to these providers, further reduced Penn

Health's indebtedness under HealthPASS.

Maxicare's schedule of liabilities details its conceded indebtedness to HealthPASS providers, including these pharmacies and durable medical equipment suppliers. From this Penn Health schedule, DPW has identified those pharmacies and suppliers who received June 1989 cash advances from the Commonwealth, as well as the amounts of those cash advances. Certain of those DPW cash advances resulted in a full or partial discharge of Penn Health's obligations to the pharmacies and durable medical equipment suppliers (as those obligations were listed on the Maxicare schedule of liabilities).

The total of Penn Health's scheduled amounts to these providers which have now been discharged by DPW's advance payments in June 1989 is $759,242.47. These funds represent pre-petition HealthPASS debts that would otherwise be payable by Penn Health to the pharmacies and suppliers, but which Penn Health need no longer pay as a result of DPW's cash advances. As such this settlement amount arises from contract claims between the parties and as such, as hereinbefore discussed, DPW is entitled to a credit or set-off of the settlement amount against the Penn Health claim.

In summary, the credits and set-off due DPW is $26,225,275.50 which is a total of the DVHC settlement of $23,366,033.03, PCP settlement of $2,100,000.00 and pharmacists/DME supplier payments of $759,242.47.

The claim of Penn Health as found by this Board to be owing is $24,177,107.00; the DPW set-off and credit arising against this amount is $26,225,275.50. Accordingly, as DPW's credit and set-off is greater than Penn Health's allowed claim, there can be no recovery.

Additionally, while Penn Health is seeking $13 million in interest on its principal

claim, it may not collect interest where the principal amount of its claim is completely off-set by an appropriate credit or reduction. In determining how to calculate prejudgment interest on a breach of contract claim, the Pennsylvania courts follow the methodology of the Restatement (Second) of Contracts § 354, which provides:

> If the breach consists of a failure to pay a definite sum in money or to render a performance with fixed or ascertainable monetary value, interest is recoverable from the time for performance on the amount due less all deductions to which the party in breach is entitled.

Restatement (Second) of Contracts § 354 (emphasis supplied). Burkholder v. Cherry, 414 Pa. Super 432, 607 A.2d 745 (1992). Under this "interest on the balance rule," if an amount due under a contract is reduced by means of a valid deduction, interest is properly allowable only on the balance due. As no balance is due, no interest can be awarded.

ORDER

AND NOW, this 26th day of March, 1997, this Board finds no recovery is due Penn Health Corporation as the claim owing found by this Board of $24,177,107.00 is off-set by credit due the Department of Public Welfare in the amount of $26,225,275.50.

Each party to bear its own costs and attorneys' fees.

BOARD OF CLAIMS

_____
David C. Clipper
Chief Administrative Judge

_____
Louis G. O'Brien, P.E.
Engineer Member

_____
James W. Harris
Citizen Member