PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2007-D1

PROVIDER -
Iowa Lutheran Hospital
Des Moines, Iowa

Provider No.: 16-0024

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Cahaba Government Benefits
Administrator

DATE OF HEARING -
June 12-13, 2003

Cost Reporting Period Ended -
November 21, 1993

CASE NO.: 97-0174

INDEX

ISSUE:

Was the Intermediary's disallowance of the loss on disposal of assets resulting from a merger proper?

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a health care provider.

The Medicare program provides health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with the program's administration. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due providers under Medicare law and interpretative guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20(b) and 413.24(b).

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider, and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

Section 42 U.S.C. §1395x(v)(1)(A) of the Social Security Act (the Act) provides that the "reasonable cost" of any service shall be the actual cost incurred excluding any part of such costs found to be unnecessary in the efficient delivery of needed health services. The implementing regulation at 42 C.F.R. §413.9 states that reasonable cost includes all "necessary and proper" costs incurred in furnishing (healthcare) services, subject to principles relating to specific items of revenue and cost.

Under the Act, a provider is entitled to claim as a reimbursable cost the depreciation (i.e., the loss of value over time) of property, plant and equipment used to provide health care to Medicare patients. An asset's depreciable value is initially set at its "historical cost," generally equal to the purchase price. 42 C.F.R. §413.134(b)(1). To determine annual depreciation, the historical cost is then prorated over the asset's estimated useful life in accordance with an acceptable depreciation method. 42 C.F.R. §413.134(a)(3).

The calculated annual depreciation is only an estimate of the asset's declining value. If an asset is ultimately sold by the provider for less than its undepreciated basis calculated under Medicare (equivalent to the "net book value" and equal to the historical cost minus the depreciation recognized and claimed as allowable costs under the Medicare program,

see 42 C.F.R. §413.134(b)(9)), then a "loss" has occurred, since the sales price was less than the estimated remaining value. In that event, it is assumed that the asset had depreciated more than was originally estimated and, accordingly, the Program provides additional reimbursement to the provider. Conversely, if the asset is sold for more than its undepreciated basis, then a "gain" has occurred, and the Secretary takes back or "recaptures" previously paid reimbursement. 42 C.F.R. §413.134(f)(1).

Where a provider sells several assets for a lump sum sales price, the regulation at 42 C.F.R. §413.134(f)(2)(iv) requires the determination of the gain or loss (depreciation adjustment) for each depreciable asset by allocating the lump sum sales price among all of the assets sold in accordance with the fair market value of each asset as it was used by the provider at the time of sale. An appropriate part of the purchase price is allocated to "all the assets sold" regardless of whether they are depreciable or non-depreciable.

The regulation providing for the recognition of gains and losses was originally implemented to address the disposition of assets through sale, scrapping, trade-in, exchange, donation, demolition, abandonment, condemnation, fire, theft or other casualty. In 1979, CMS extended the depreciation adjustment to "complex financial transactions" not previously addressed in subsection 42 C.F.R. §413.134(f) by including mergers and consolidations. A statutory merger between unrelated parties was treated as a sale of assets that would trigger: (1) the revaluation of assets in accordance with 42 C.F.R. §413.134(g), and (2) the realization of gains and losses under the provisions of 42 C.F.R. §413.134(f). However, a statutory merger between related parties is not a basis for revaluation that would trigger a gain or loss adjustment.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Iowa Lutheran Hospital (Provider) was a general, acute care, not-for-profit hospital located in Des Moines, Iowa. Effective November 22, 1993, the Provider merged with Iowa Methodist Medical Center (Iowa Methodist) pursuant to the laws of the State of Iowa. Iowa Methodist was the surviving corporation and continued to operate as a not-for-profit corporation. Following the effective date of the merger, the Provider submitted a terminating Medicare cost report for the period ended November 21, 1993 to its fiscal intermediary, Blue Cross and Blue Shield of Iowa which later became Wellmark Blue Cross and Blue Shield (Intermediary).[1] Relying on the regulatory provisions of 42 C.F.R. §413.134 et seq., the Provider claimed a loss on the disposal of its assets resulting from the statutory merger. Upon audit of the cost report, the Intermediary disallowed the claimed loss on the basis that the merger was a transaction between related parties, citing Medicare's 42 C.F.R. §413.17 et seq.

The Provider appealed the Intermediary's disallowance to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841. The estimated amount of Medicare reimbursement in controversy is approximately $5,400,000.[2]

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[1] In June of 2000, Cahaba Government Benefits Administrators assumed Wellmark Blue Cross and Blue Shield's fiscal intermediary duties.

The Provider was represented by Robert E. Mazer, Esquire, of Ober, Kaler, Grimes & Shriver. The Intermediary was represented by Bernard M. Talbert, Esquire, Associate Counsel, Blue Cross Blue Shield Association.

BACKGROUND OF THE MERGER:

In February of 1993, the Provider and Iowa Methodist executed a non-binding Memorandum of Understanding, that set forth their intention to merge and the anticipated benefits to be derived from their combination.[3] Each party was represented by legal counsel, and the transaction was contingent upon satisfactory due diligence results. On November 22, 1993, the Provider merged into Iowa Methodist through the simultaneous signing of a Formation Agreement and the filing of the Articles of Merger with the State.[4]

The name of Iowa Methodist, the surviving corporation, was changed to Iowa Health System Hospital Corporation, and the governing board of directors of nineteen members was modified to include eight individuals who had served previously on the Provider's governing board.[5] Similarly, Iowa Methodist's sole member, Iowa Methodist Health System, changed its name to Iowa Health System and remained the sole member of Iowa Health System Hospital Corporation. The post-merger governing board of Iowa Health System had twenty-three individuals, including ten individuals who were previously affiliated with the Provider.[6] Under Iowa law, Iowa Health System Hospital Corporation succeeded to the Provider's assets and liabilities, and the Provider ceased to exist.

PARTIES' CONTENTIONS:

The Intermediary contends that the merger is a related party transaction pursuant to 42 C.F.R. §413.17, because the Provider has the power to significantly influence or direct the actions and policies of Iowa Methodist, the surviving corporation. The Intermediary cites section 1011.1 of Medicare's Provider Reimbursement Manual, Part I (HCFA Pub. 15-1), which states: "[i]f a provider and a supplying organization are not related before the execution of a contract, but common ownership or control is created at the time of execution by any means, the supply contract will be treated as having been made between related organizations." The Intermediary notes that: 1) eight members of the surviving corporation's board of directors had served previously on the Provider's governing board; 2) the Bishop of the religious affiliation of Iowa Lutheran is a voting member of the surviving corporation's board as long as the Provider's religious name is being used; 3) the Provider maintains a financial interest in the surviving corporation's assets through calendar year 2000 should Iowa Methodist dissolve; 4) the Provider's President became the Executive Vice-President of the surviving corporation; and 5) the merger does not appear to be an arm's-length transaction since Iowa Methodist purchased the Provider by

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[2] Provider's Post-Hearing Brief at Exhibit P-43.
[3] Exhibit P-1.
[4] Exhibit P-2.
[5] Exhibit P-3.
[6] Id.

assuming its liabilities totaling $28,092,831 but received $41,093,761 in cash plus all of the Provider's physical assets.[7]

The Intermediary also contends that the loss claimed by the Provider is non-allowable for program reimbursement because the merger with Iowa Methodist was not a bona fide sale.[8] The Intermediary explains that pursuant to 42 C.F.R. §413.134(l)(2)(i), mergers between two or more unrelated corporations, where the merged corporation was a provider, are subject to 42 C.F.R. §413.134(f). This section, entitled Gains and losses on disposal of assets, addresses different ways in which a gain or loss may result from the disposition of depreciable assets. The Intermediary asserts that in order for a merger to qualify for a gain or loss determination, it must be a "bona fide" sale. The Intermediary then argues that this merger was not a bona fide sale because the Provider did not place its assets for sale in the open market to ascertain their worth, and there was no good faith bargaining between the parties to establish the fair market value of the Provider's assets as an ongoing concern. (413.134(b)(2)).

The Provider contends that pursuant to 42 C.F.R. §413.134(l)(2)(i), a statutory merger between unrelated corporations occurs if the parties are unrelated prior to the transaction, as in the instant case. The Provider asserts that its position is supported by section 4502.6 of Medicare's Part A Intermediary Manual (HCFA Pub. 13-4). The manual provides in part, an example of merging entities, unrelated through common ownership or control prior to the merger, that results in a change of ownership determination for Medicare certification purposes and a gain or loss calculation to the seller.[9] The Provider also cites to a letter written on August 24, 1994 by the Director of HCFA's Office of Payment Policy, which indicates that a loss calculation appears appropriate in circumstances such as those of the instant case.[10]

The Provider contends that even if the Intermediary's continuity of control argument were valid (i.e., the Intermediary's reliance upon HCFA Pub. 15-1 §1011.1), it does not exist in the instant case.[11] According to 42 C.F.R. §413.17(b), related party principles apply where there is "common ownership or control" and "control" exists where an "individual or organization" has the power to significantly influence the actions or policies of an organization or institution. In this merger, no single individual previously associated with the Provider has the power to significantly influence the operations of Iowa Methodist. The Intermediary bases its continuity of control argument upon the fact that eleven of the twenty-three members of Iowa Methodist's governing board came from the Provider; however, the Provider maintains that there is no factual or legal basis upon which to aggregate these individuals' voting interests.

The Provider disagrees with the Intermediary's argument that "control" is represented by the fact that Iowa Lutheran's religious order would receive part of Iowa Methodist's

[7] Intermediary's Position Paper at 8.
[8] Intermediary's Supplemental Position Paper at 12.
[9] Exhibit P-18.
[10] Exhibit P-21.
[11] Provider's Post-Hearing Brief at 31.

assets if it were to dissolve between 1993 and 2000. This argument was rejected by the United States District Court in North Iowa Medical Center v. Department of Health and Human Services, No. 00CV70-DEO.[12]

Fnally, the Provider disagrees with the Intermediary's argument that the merger does not meet the requirements of a bona fide sale because reasonable compensation was not given for the Provider's assets. The Provider argues that the transaction was a statutory merger under state law and was not a purchase of assets. The Intermediary relies upon 42 C.F.R. §413.134(l)(2)(i), which subjects mergers involving unrelated parties to the requirements of 42 C.F.R. §413.134(f). However, there is nothing in section (f) that requires mergers to specifically comply with section (f)(2) regarding bona fide sales.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare laws and guidelines, the evidence presented, and the parties' contentions, the Board finds and concludes that the Provider and Iowa Methodist were unrelated parties as that term is defined and applied under the regulatory provisions of 42 C.F.R. §413.17 and 42 C.F.R. §413.134. Accordingly, a revaluation of the assets and a recognition of the loss incurred as a result of the merger is required under the specific and plain meaning of 42 C.F.R. §413.134(l)(2)(i).

The parties agree that the transaction at issue was a statutory merger under Iowa law, and that 42 C.F.R. §413.134, "Depreciation: Allowance for depreciation based on asset costs," is applicable. Section 413.134(l)(2) defines a statutory merger as "a combination of two or more corporations under the corporation laws of the State, with one of the corporations surviving." It is undisputed that Iowa Lutheran Hospital merged into Iowa Methodist Medical Center (which then became known as Iowa Health System Hospital Corporation), with the Iowa Lutheran Hospital entity ceasing to exist. Under the terms of the transaction, Iowa Methodist Medical Center (the surviving corporation) acquired all of the assets and assumed all of the liabilities associated with the operations of the Provider.

Under regulations set forth at 42 C.F.R. §413.134(l)(2), the effect of a statutory merger upon Medicare reimbursement is as follows:

> (i) *Statutory merger between unrelated parties.* If the statutory merger is between two or more corporations that are unrelated (as specified in §413.17), the assets of the merged corporation(s) acquired by the surviving corporation may be revalued in accordance with paragraph (g) of this section. If the merged corporation was a provider before the merger, then it is subject to the provisions of paragraphs (d)(3) and (f) of this section concerning recovery of accelerated depreciation and the realization of gains and losses . . . .

[12] Exhibit P-23 at 11.

> (ii) *Statutory merger between related parties*. If the statutory merger is between two or more related corporations (as specified in §413.17), no revaluation of assets is permitted for the assets acquired by the surviving corporation. . . .

Accordingly, the initial question to be decided by the Board is whether the subject merger was between related or unrelated parties. While it is undisputed that the Provider and Iowa Methodist were unrelated prior to the merger, the Intermediary argues that the phrase "between related parties" requires that the merger transaction be examined for relationships after the transaction as well. The Intermediary refers to the related party regulation at 42 C.F.R. §413.17 which states, in pertinent part:

> (b) *Definitions.* (1) *Related to the provider*. Related to the provider means that the provider to a significant extent is associated or affiliated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.
>
> (2) *Common Ownership*. Common ownership exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider.
>
> (3) *Control*. Control exists if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

In particular, the Intermediary relies on subsection (3) that discusses control. The Intermediary contends that because the board of directors of the new entity was substantially composed of board members of the two merging entities, there is a "continuity of control" that results in the parties being related. The Intermediary contends that this relationship between the old and new entities disqualifies the merger transaction from a revaluation of assets. In support of its position, the Intermediary cites section 1011.1 of Medicare's Provider Reimbursement Manual, Part I (HCFA Pub. 15-1), which states:

> [i]f a provider and a supplying organization are not related before the execution of a contract, but common ownership or control is created at the time of execution by any means, the supply contract will be treated as having been made between related organizations.

The Board finds the plain language of the statutory merger regulation dispositive of the Intermediary's argument. The text at 42 C.F.R. §413.134(l)(2)(i), which states, "if the statutory merger is between two or more corporations that are unrelated . . ." is

unambiguous in its meaning that the related party concept will be applied to the entities that are merging as they existed prior to the transaction.

The Board, therefore, concludes that the plain language of the regulation bars the application of the related party principle to the merging parties' relationship to the surviving entity. The construction of the regulation mandates a determination that only the relationship of the parties participating in the merger before it was completed is relevant to whether the assets would be revalued and a gain or loss recognized. The Board's conclusion is further buttressed by the Secretary's interpretive guidelines published in section 4502.6 of Medicare's Intermediary Manual (HCFA Pub. 13-4), which states, in part: "Medicare program policy permits a revaluation of assets acquired in a statutory merger between unrelated parties, when the surviving corporation is a provider."

Further indication of CMS' interpretation of the statutory merger regulation can be found in two letters written by high level CMS officials. In a letter dated May 11, 1987,[13] the Director of the Division of Payment and Reporting Policy, Office of Reimbursement Policy, responded to an inquiry concerning the application of the gain and loss provisions to mergers or consolidations of not-for-profit hospitals. The letter concluded that a statutory merger between not-for-profit providers gives rise to the revaluation of assets and an adjustment to recognize related gains and losses. The letter also made it clear that, notwithstanding the reference to "capital stock" in the caption of the regulation at 42 C.F.R. §413.134(l), the Agency looked to that regulation for authority in addressing mergers and consolidations of non-stock issuing corporations because the principles involved would be the same. In a letter dated August 24, 1994, the Director, Office of Payment Policy, Bureau of Policy Development, agreed that a consolidation involving non-profit entities required recognition of a gain or loss based on this regulation.[14]

The Board finds that the transaction that resulted in the merger of the Provider into Iowa Health System Hospital Corporation was a transaction under Iowa corporation law. The completed transaction merged one independent hospital corporation, the Provider, into another hospital corporation, Iowa Methodist, with the merged entity ceasing to exist. Contrary to the Intermediary's "continuity of control" assertions, the Board finds that such an interpretation of the related party regulation is not only inconsistent with the regulation governing statutory mergers, but it is in direct opposition to the purpose of corporate mergers. The very nature of a statutory merger as a combination of entities would likely result in some overlap of membership on the board of directors of the merging corporation and the surviving entity, as well as a continuation of other operations and personnel of the merging organization. The fact that this occurs does not disqualify a statutory merger from revaluation and recognition of any gain or loss under 42 C.F.R §413.134(l).

[13] Exhibit P-17.
[14] Exhibit P-21.

The Board finds that the Provider ultimately agreed that the loss calculation should be based upon the proportionate allocation methodology prescribed by 42 C.F.R. §413.134(f)(2)(iv). Pursuant to this methodology, the consideration at issue is allocated among all the assets acquired based upon the relationship of each individual assets fair market value to the total fair market value of all of the assets in aggregate. However, the Board notes a discrepancy between the fair market value of the assets as described in Exhibit P-43 submitted with the Provider's Post-Hearing Brief of $64,949,110 and the amount shown in Exhibit P-41 ($62,700,000), which is the Business Evaluation of the Provider's operation conducted by KPMG Peat Marwick.[15] This discrepancy must be resolved in order to accurately determine the Provider's reimbursable loss.

Finally, the Board finds that the merger results in the Provider's assets being valued at amounts significantly less than their book value, thereby resulting in the loss. However, for accounting purposes, the merger was treated as a pooling of interests and the carrying value of the Provider's assets was not recorded in the financial records of the surviving entity at their written down values. As a result, for areas of the surviving entity that continued to be reimbursed under Medicare's reasonable cost principles, the amount of depreciation allowed by the Medicare program during the years following the merger has been overstated. Accordingly, the allowable loss must be adjusted (reduced) to account for this overstatement.

DECISION AND ORDER :

The Intermediary's adjustment disallowing the Provider's claimed loss on disposal of assets due to a change of ownership resulting from a statutory merger was contrary to the regulatory requirements of 42 C.F.R. §413.134(l)(2)(i) and is reversed. The matter is hereby remanded to the Intermediary for the proper calculation of the loss pursuant to the governing regulations. The Intermediary must reconcile the differences in the fair market value of the Provider's assets discussed above in order to determine the appropriate fair market value of the Provider's assets to be used in its loss calculation. In addition, the Intermediary is directed to adjust the loss computation to account for the overstatement of allowable depreciation expense in the years following the merger.

Board Members Participating:

Suzanne Cochran, Esq.
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West
Yvette C. Hayes

[15] For example, the fair market value of the Provider's land is shown as $10,250,749 in Exhibit P-41 (page 68), and as $7,872,163 in Exhibit P-43. Similarly, the value of the Provider's buildings is shown as $8,525,282 in Exhibit P-41, and as $7,845,156 in Exhibit P-43.

FOR THE BOARD:

DATE: October 6, 2006

Suzanne Cochran, Esq.
Chairman