PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2004-D21

PROVIDER –
Bates Medical Center
Bentonville, Arkansas

Provider No. 04-0048

vs.

INTERMEDIARY –
Blue Cross Blue Shield Association/
Arkansas Blue Cross Blue Shield

DATE OF HEARING -
May 16, 2003 – Live Hearing (Issue 1)
November 19, 2003 – Record Hearing (Issue 2)

Cost Reporting Period Ended
June 30, 1996

CASE NO. 99-1424

INDEX

ISSUE 1- LIVE HEARING HELD MAY 16, 2003:

Was the Intermediary's determination of the loss on disposal of assets proper?

BACKGROUND:

Governing Statutes and Regulations:

This dispute arises out of the Intermediary's failure to reimburse depreciation that the Provider claims is due under the Medicare program (42 U.S.C. §1395 et seq.) on a reasonable cost basis for the 1996 cost year. The Medicare program was established in 1965 under Title XVIII of the Social Security Act (the Act) to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Health Care Financing Administration (HCFA), now the Centers for Medicare and Medicaid Services (CMS), is the operating component of the Department of Health and Human Services charged with administering the Medicare program.

The Secretary's payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under the Medicare law and under interpretative guidelines published by CMS. Id.

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 what proportion of those costs are to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost reports and determines the total amount of Medicare reimbursement due the provider, which it publishes in a notice of program reimbursement (NPR). 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. See 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

Under the Medicare statute, a provider is entitled to claim as a reimbursable cost the depreciation (i.e., the loss of value over time) of the buildings and equipment used to provide health care to Medicare patients. An asset's depreciable value is set initially at its "historical cost," generally equal to the purchase price. 42 C.F.R. §413.134(a)(2)(b)(1). To determine annual depreciation, the historical cost is then prorated over the asset's estimated useful life in accordance with one of several methods. 42 C.F.R. §413.134(a)(3). Providers are then reimbursed on an annual basis for a percentage of the yearly depreciation equal to the percentage of the asset used for the care of Medicare patients.

The calculated annual depreciation is only an estimate of the asset's declining value. If an asset is ultimately disposed of by the provider for less than the net depreciated basis calculated under Medicare (equivalent to the "net book value" and equal to the historical cost minus the depreciation previously paid, see 42 C.F.R. §413.134(b)(9)), then a "loss" has occurred, since the disposal price was less than the estimated remaining value. In

that event, the Secretary assumes that more depreciation had occurred than was originally estimated and accordingly, in the year of disposition, provides additional reimbursement to the provider. Conversely, if the asset is disposed of for more than its depreciated basis, then a "gain" has occurred, and the Secretary takes back or "recaptures" previously paid reimbursement for the cost year in question. 42 C.F.R. §405.415(f)(1).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Bates Medical Center (the Provider) was located in Bentonville, Arkansas and Northwest Medical Center (Northwest) was located in Springdale, Arkansas, approximately 17 miles apart. The Provider was a non-profit entity that operated its facility pursuant to a nominal lease of one dollar per year with the city of Bentonville.[1] The Provider and Northwest entered into an Asset Transfer Assumption and Operating Agreement, dated and effective July 1, 1996.[2] In short, the Provider transferred all of its assets to Northwest in exchange for Northwest's assumption of Bates' liabilities, with Northwest surviving and the Provider ceasing to exist as a corporate entity.

Prior to the asset transfer, the Provider and Northwest were separately incorporated and each had its own board of directors, own management, and own medical staff. There were no common board members or officers between the two entities. The Provider held the Medicare provider number and, pursuant to Medicare regulations, was treated as if it were the owner of the assets in question. This included claiming depreciation on its Medicare cost report and becoming the primary obligor on all hospital bonds.[3]

Prior to the asset transfer, the Provider's financial condition had worsened over time and its leased facility had entered a state of decline.[4] As a result, the Provider began to look for a potential partner for merger, consolidation, or other business combination. After negotiating with a number of entities, the Provider decided to pursue an arrangement with Northwest. The terms were negotiated between the parties and approved by each organization's board of directors. Given the Provider's financial condition, its board of directors concluded that the assumption of its liabilities was a fair "purchase price" for its assets. The Provider asserts that the transfer to Northwest included its rights under the nominal lease with the City of Bentonville.[5] At the time of the transaction, the Provider ceased to exist as a corporate entity and terminated its Medicare provider number.[6] Northwest survived the transaction and began operating the Provider's facility as another campus of Northwest under Northwest's Medicare provider number.[7]

The Provider filed a terminating Medicare cost report, and Medicare recognized the transaction as a change of ownership (CHOW) for purposes of both reimbursement and

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[1] Stip. 14.
[2] Stip. 1, Exhibit P-20.
[3] Stip. 16.
[4] Tr. 89-91.
[5] Tr. 104-110.
[6] Stip. 22.
[7] Stip. 10.

certification.[8] Although the Provider did not originally claim any loss on its terminating Medicare cost report, Northwest hired new auditors in 1997 who recommended amending the Provider's terminating cost report to claim the loss.[9] The Intermediary accepted an amended terminating cost report prior to issuing a Notice of Program Reimbursement (NPR). However, the Intermediary had already informed the Provider that it would not allow the loss, so the loss was included on the amended terminating cost report as a protested item pursuant to CMS Pub. 15-2 §115.[10]

The Provider requested a hearing before the Board and has met the jurisdictional requirements of 42 C.F.R. §§405.1835-1841. The Provider calculated Medicare's share of the loss to be $1,999,443.[11] However, the Intermediary has not audited the amount in question.[12]

The Provider was represented by Irwin Cohen, Esquire, of Fulbright and Jaworski, L.L.P. The Intermediary was represented by Bernard M. Talbert, Esquire, of the Blue Cross Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that its transaction with Northwest was a merger that gave rise to a recognition of a loss on the disposal of assets under the relevant Medicare regulations. The Medicare definition of a merger states:

> A statutory merger is a combination of two or more corporations under the corporation laws of the State, with one of the corporations surviving. The surviving corporation acquires the assets and liabilities of the merged corporation(s).

42 C.F.R. §413.134(l)(2)

The Provider asserts that this is what happened in the case at hand. Northwest and the Provider combined, and as a result, only the Northwest corporate entity survived. All of the Provider's assets were acquired by Northwest, and all of the Provider's liabilities were assumed by Northwest.

The Provider pointed out at the hearing that CMS recognized the transaction as a merger for change of ownership purposes.[13] This was supplemented by a letter from CMS clarifying which entity was the surviving party in the transaction at issue and referring to the combination as a merger.[14]

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[8] Stip. 8 & 10.
[9] Tr. 66.
[10] Stip. 3 & Tr. 66-67.
[11] Stip. 4
[12] Stip. 5.
[13] Tr. 256-257, Stip. 8, & Exhibit P-25.
[14] Exhibit P-27.

As a result, the Provider contends that the Medicare regulation at 42 C.F.R. §413.134(l)(2)(i) provides for the reimbursement effect of a merger as follows:

> 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.

In further support of its position, the Provider cites a 1987 letter from William Goeller, Director, Division of Payment and Reporting Policy at CMS,[15] wherein Mr. Goeller makes it clear that mergers and consolidations among non-profit providers trigger a revaluation of assets. His letter stated in relevant part:

> Notwithstanding the reference to "capital stock" in the caption of regulations section 42 C.F.R. 413.134(k) . . . , we look to that regulation for authority in addressing mergers and consolidations of nonstock issuing corporations because the principles involved would be the same.

Importantly, the letter also notes that: " . . . an adjustment to recognize any gain or loss to the merged/consolidated corporations would be required in accordance with regulations section 42 C.F.R. 413.134(f)."

The Provider asserts that it is undisputed that the parties to the merger were unrelated prior to the merger.[16] While the Intermediary focuses on the "control" aspect of the related party regulation at 42 C.F.R. §413.17, the Provider contends that there is no basis under the related organizations rule to conclude that unrelated parties to a transfer of assets transaction can be considered related parties based on post-merger events. Although the Provider Reimbursement Manual (PRM) sets forth, at length, the rules on related organizations, it does not contain any provision stating that a transfer of assets between unrelated parties can be considered a related-party transaction based on the relationship of the parties after the transaction. There is no discussion whatsoever that "continuity of control," the concept relied on by the Intermediary, between the transferor and transferee can convert unrelated organizations into related parties. To the contrary, the Provider points out that provisions in the Medicare Intermediary Manual on change of ownership focus exclusively on whether the organizations were unrelated prior to the transaction. The provision in CMS Pub. 15-1 §4502.6 requires that the parties be unrelated in order to allow a gain or loss on the sale and a revaluation of the acquired assets. The Manual's example finds that requirement satisfied because the companies involved "were unrelated parties prior to the transactions."

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[15] Exhibit P-16.
[16] Stip. 11.

The Provider also contends that it could never have exercised control over Northwest since it dissolved and ceased to exist as a corporate entity at the time of the merger.[17] Northwest could not have been "controlled" by an entity that did not exist. Further, no "individual" could have controlled Northwest after the merger. After the merger, Northwest's board of directors consisted of 15 voting members, six of which had formerly been members of the Provider's board. Each individual board member had only one vote. Thus, the Provider's former board members could not significantly control the new organization.

The Provider also argues that its merger does not violate the Medicare "bona fide" sale requirements. Existing guidance defining "bona fide" is found in CMS Program Memorandum AB-2087 (January 11, 1989) entitled, Medicare Provider Cost Reports: Recognition of Losses. This memorandum states that:

> . . . "[b]ona fide sale," as used in these sections, means simply that the parties to the sale are not related within the meaning of regulations section 42 CFR 413.17 and PRM section 1000ff.

The Provider again points out that it is undisputed that the parties were unrelated prior to the merger, and the purchase price (i.e., the assumption of liabilities) was negotiated by unrelated parties.[18] Thus, under the definition cited above, the merger meets the Medicare definition of "bona fide."

The Provider states that it held a nominal lease with the city of Bentonville, claimed depreciation on the leased assets under the special provisions of CMS Pub. 15-1 §112 and disposed of its rights to the hospital assets. The Provider contends that it is entitled to claim a loss on disposal of those assets, pursuant to the Medicare regulation at 42 C.F.R. §413.134(f) as a result of its merger with an unrelated entity. The Provider further states that its unrelated merger partner (Northwest) succeeded to the leasehold interests in the hospital's assets.

In support of its position, the Provider cites CMS Pub. 15-1 §112.2 which allows a provider to claim the allowance for depreciation when it leases its facility from a municipality for a nominal amount. The provision states:

> For depreciation cost allowance purposes under the program, the leased asset should be treated as though the lessor and the lessee were one and the same. All the cost principles and reimbursement manual sections on depreciation would be applicable to such assets.

The Provider contends that in the case at hand its merger transaction results in the disposition of depreciable assets with the change of ownership of the leasehold. Northwest, the successor to the Provider's leasehold interests, was treated by the Intermediary as entitled to claim depreciation under the provisions of CMS Pub. 15-1

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[17] Stip. 22.
[18] Stip. 11 & 21.

§112. Accordingly, the Provider asserts that since the gain/loss provisions are merely methods of adjusting depreciation, they are applicable in this situation.

Finally, the Provider points out that since the claimed loss was disallowed in its entirety, the Intermediary has not made a determination as to how to allocate the sales price.[19] The Provider asserts that its loss was calculated in accordance with Generally Accepted Accounting Principles (GAAP). It refutes the Intermediary's argument advanced in a 1994 letter[20] by Mr. Charles Booth, Director of HCFA's Office of Payment Policy, that the allocation of the sales price must be proportionate to the relative fair market value of all of the assets. The Provider claims the Booth letter was never promulgated as official CMS policy, rule or regulation, nor was it consistent with GAAP or any Medicare rule or regulation.

INTERMEDIARY'S CONTENTIONS:

The Intermediary argues that the Provider is not entitled to claim the loss for four principal reasons. First, the Intermediary argues that there exists no regulatory authority for an intermediary to recognize losses arising from mergers. Second, the Intermediary contends that although the Provider and Northwest were unrelated corporations prior to the transaction, the transaction was between related parties because it allowed the Provider to exercise a measure of control over Northwest. Third, the Intermediary concludes that the transaction did not meet the Medicare definition of a "bona fide" sale. Finally, the Intermediary contends that because the Provider was not the owner of the assets and did not dispose of them, it is not entitled to claim the loss.

The Intermediary states that the key regulation governing gains and losses on the disposal of assets (42 C.F.R. §413.134(f)) does not specifically reference the term "merger." Thus, the disposition transaction must meet the test of a bona fide sale, the term used in subsection (f), regardless of how the transaction is characterized or executed. While the Medicare regulations do not specifically define "bona fide sale," the Intermediary contends that the nature of the transaction was not intended to result in a bona fide sale between disinterested parties negotiating at arm's length.

The Intermediary points out that it is in complete disagreement over the essence of the asset transfer. While the Provider characterized the deal as a merger, the Intermediary believes this to be inaccurate. First, there was never an appraisal commissioned to determine what a sale might yield.[21] Second, the Provider relinquished its assets for one third of their book value, which is the antithesis of a bona fide sale transaction.[22] The Intermediary further contends that its position is supported by the Provider's financial statements, which described the transaction as a "pooling of interests."[23] This argues against the Provider's contention that its assets were sold via a "merger" with Northwest.

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[19] Stip. 5.
[20] Exhibit P-26.
[21] Stip. 24.
[22] Intermediary Post-Hearing Brief at 16.
[23] Exhibit I-19.

Given the nature of the transaction, the Intermediary contends that it is more appropriately defined as a reorganization. The Provider's Asset Transfer Assumption and Operating Agreement identifies the motivation and execution of the coming together of the Provider and Northwest as two independent hospitals who made a decision that their respective interests could be served by joining together under one parent. As such, the Intermediary points to the CMS Administrator's decision in Cardinal Cushing Goddard Memorial Hospital v. Blue Cross Blue Shield Association/Associated Hospital Services of Maine, PRRB Dec. No. 2003D-6, November 27, 2002, Medicare & Medicaid Guide (CCH) ¶ 80,950 rev'd. CMS Administrator, January 29, 2003. In that case, a similarly structured combination was viewed as a reorganization under §4502.10 of HCFA Pub 13-4 and a revaluation of the assets and the concomitent loss was not permitted.

Finally, the Intermediary argues that because the Provider was not the owner of the assets and did not dispose of them, it is not entitled to claim the loss. The assets which made up the loss claim were owned by the City of Bentonville and leased to the Provider for an annual amount of $1.00. As an element of closing the transfer agreement, a new lease was executed between Bentonville and the new Northwest on similar terms. Legal title to all depreciable assets remained with the City.

The Intermediary contends that the regulation at 42 C.F.R. §413.134 does not provide that the substitution of a lessee can be considered to be a revaluation/gain/loss transaction. Nor can the assumption of lease rights be deemed to be a consolidation or merger under 42 C.F.R. §413.134(l). More specifically, the surrender of lease rights is not a covered disposition under 42 C.F.R. §413.134(f).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

At the hearing, the Provider characterized its transaction with the Northwest Health System as a merger. However, the Asset Transfer Assumption and Operating Agreement (the document reciting the agreement between the parties) dated July 1, 1996 refers to the transaction as a consolidation. The Agreement states in part:

> The consolidation of the Companies is to be accomplished by the transfer of the assets of Bates to Northwest, the assumption by Northwest of the liabilities of Bates, the restructuring of Northwest's Board of Directors and bylaws and by establishing operating and governance procedures for the combined entity ("New Northwest") (the "Consolidation"). As a result of the consolidation as provided in this Agreement, Northwest Medical Center and Bates Medical Center ("the Hospitals") will be operated as separate campuses in a system (the "System") owned and operated by New Northwest.[24]

[24] Exhibit P-20 at 8.

At the conclusion of the Board hearing, the Chairperson requested that the Provider include, along with its post-hearing brief, a copy of the Arkansas merger statute, articles of merger filed, or similar documents that may have been required under the statute for statutory merger. The Provider responded by stating that Arkansas statutes do permit non-profits to merge, as per Ark. Code Ann. 4-28-301 et seq.; Ark. Code Ann. 4-33-1101 et seq. The Provider acknowledged that the Bates/Northwest combination was not technically structured under these specific provisions, but it claimed that the transaction was, nonetheless, a combination under the corporation laws of the State, with one of the corporations surviving.[25] Based on this information, the Board does not believe that the Provider's characterization of the transaction as a merger is dispositive.

The Board concludes that whether a particular transaction is deemed to be a merger, consolidation, or sale of assets, Medicare regulations provide for a revaluation of assets and a calculation of gain or loss. However, the Board finds that the key issue in this case is whether or not the depreciable assets or the lease thereof were a part of the transaction with Northwest. It is undisputed that the Provider did not own the hospital property/equipment with which it conducted the business of Bates Medical Center. The Provider leased those assets from the City of Bentonville. The Provider did not have the ability to either sell, transfer, or assign the assets under the lease agreement. Upon the transaction with Northwest, the Provider's lease with the City of Bentonville terminated and testimony indicated that the City of Bentonville entered into a new lease agreement with Northwest.

A review of the Medicare regulation at 42 C.F.R. §413.134 et seq. did not reveal any instances where the relinquishment of lease rights could be reviewed as a disposition giving rise to a revaluation calculation. Thus, the Board concludes that a triggering event which could give rise to a gain/loss calculation did not take place. Finally, the Board concludes that since the Provider was not the owner of the assets in issue here and the lease rights were not assigned, the assets in question must be excluded from any gain/loss calculation relative to the transaction at issue.

DECISION AND ORDER:

The Provider did not have ownership of the assets in question. The Intermediary's determination not to allow a loss on the disposition of those assets resulting from the Provider's transaction with Northwest is affirmed.

ISSUE: 2 – HEARING ON RECORD HELD NOVEMBER 19, 2003

Was the Intermediary correct in reclassifying wellness program costs from the administrative and general cost center to a non-reimbursable cost center?

[25] Provider Post-Hearing Brief at 8.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Bates Medical Center (Provider) is a non-profit entity located in Bentonville, Arkansas. During the cost report period under appeal, the Provider operated a community wellness program entitled "Excelle and Seniors." Services included nutritional counseling and providing health activities and information to members of the community. The Intermediary determined that the costs incurred were not related to patient care and established a non-reimbursable cost center on the Medicare cost report to accumulate the cost of the program. This is similar to prior year findings which were never contested by the Provider.

The Provider filed a timely appeal to the Provider Reimbursement Review Board (Board) and has met the jurisdictional requirements set forth in 42 C.F.R. §§405.1835-.1841. The Medicare reimbursement impact of the Intermediary's adjustments is approximately $9,000.

The Provider was represented by Irwin Cohen, Esquire, of Fullbright and Jaworski, L.L.P. The Intermediary was represented by Bernard M. Talbert, Esquire, of the Blue Cross Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that its programs were intended to present a positive image to the public by promoting preventive health goals and safe, healthy behavior. As such, it believes that the costs incurred would be allowable under 42 C.F.R. §§413.9(b)(2) and 413.9(c)(3), which permit costs that are directly or indirectly related to patient care. CMS Pub. 15-1 §2136.1 also allows costs that are concerned with presentation of a good public image and that are directly or indirectly related to patient care.

The Provider also points to the Board's decision in Mother Frances Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Texas, PRRB Dec. No. 97-D92, August 7, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,566, Rev'd. CMS Admin., October 14, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,941, in which the Board held that the primary purpose of the activity should dictate its allowability. The Board also stated that the public expects providers to participate in health awareness and prevention activities, and that these have become "common and accepted occurrences in the field of the providers' activities" and should be reimbursed pursuant to 42 C.F.R. §413.9(b)(2).

Further, the Provider states that it is not in agreement with the Intermediary's position that even if the costs are allowable, they must be offset by the revenues received from these programs. The Provider contends that the Intermediary has offered no regulation or manual citation that supports the revenue offset theory.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that there is a fine line between an intent to increase patient utilization and an intent only to educate the public. Generally, the distinction should be guided by what is reasonable and what is a common and accepted occurrence in the industry. In the instant case, the Intermediary contends that the Provider's programs go beyond the scope of what is related to patient care and that they are aimed at increasing patient utilization.

The Intermediary also points out that, in the case of Mother Francis, the CMS Administrator reversed the Board's decision, agreeing with the intermediary that the costs of the provider's programs were not related to patient care. Instead, they were determined to be designed and administered to benefit the community at large. The provider in that case, incurred costs to perform screening tests, distribute health literature and promote health maintenance activities, much like the Provider in this case.

The Intermediary also asserts that the Provider has not contested the creation of a non-reimbursable cost center in prior years. Nor has the Provider addressed the issue of the significant amount of revenue generated by the Excelle and Seniors program. Thus, the Intermediary contends that even if the costs were deemed to be allowable, the revenue must be offset against allowable costs.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board finds that the record in this case contains no documentation supporting the Provider's argument that the costs at issue are allowable program expenditures. Specifically, the record does not contain copies of the various programs developed by Excelle & Seniors, Inc. Without this information, it is impossible for the Board to determine if the costs in question were intended to educate the public or if they were related to patient care.

The Board concludes that the Provider was not in compliance with the Medicare regulation at 42 C.F.R. §413.24, Adequate Cost Data and Cost Finding. That regulation states in part:

> (a) *Principle.* Providers receiving payment on the basis of reimbursable cost must provide adequate cost data. . . .
>
> *****
>
> (c) *Adequacy of cost information.* Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended. . . .

DECISION AND ORDER:

The Provider did not present adequate documentation to support its position. The Intermediary's adjustment is affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Martin W. Hoover, Jr., Esquire
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, C.P.A.

DATE: May 6, 2004

FOR THE BOARD

Suzanne Cochran
Chairman