PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2004-D36

PROVIDER –
Germantown Hospital and Medical Center

Provider No. 39-0088

vs.

INTERMEDIARY –
Mutual of Omaha Insurance Company

DATE OF HEARING –
October 22, 2003 Live Hearing

Cost Reporting Periods Ended
August 31, 1997

CASE NO. 00-0386

INDEX

ISSUE:

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

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Germantown Hospital and Medical Center (Provider), a Medicare certified provider of services, merged into Germantown Hospital and Community Health Services (GHCHS) and claimed a loss on the disposal of its depreciable assets resulting from the merger. Mutual of Omaha Insurance Company (Intermediary) audited the Provider's cost report and disallowed the loss. The Provider appealed the disallowance to the Provider Reimbursement Review Board (Board) pursuant to 42 C.F.R. §§405.1835-405.1841 and met the jurisdictional requirements of those regulations. The amount of Medicare funds in controversy is approximately $4.8 million.[1]

STATUTORY AND REGULATORY BACKGROUND:

The Medicare program was established in 1965 under Title XVIII of the Social Security Act (Act) to provide health insurance to aged and disabled persons. 42 U.S.C. §§1395-1395cc. The Secretary of the Department of Health and Human Services (Secretary) is authorized to promulgate regulations prescribing the health care services covered by the program and the methods of determining payments for those services. The Centers for Medicare and 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 has entered into contracts with insurance companies known as fiscal intermediaries to maintain the program's payment and audit functions. Intermediaries determine payment amounts due providers of health care services (e.g., hospitals, skilled nursing facilities, and home health agencies) under Medicare law, as well as regulations and interpretative guidelines issued by CMS.

In general, each provider submits a cost report to its intermediary at the close of its12-month accounting period. This report shows the costs the provider incurred during the period and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The intermediary reviews the provider's cost report and determines the total amount of Medicare reimbursement due the provider. This determination is conveyed to the provider in a Notice of Program Reimbursement (NPR). 42 C.F.R § 405.1803. A provider dissatisfied with the intermediary's determination may file an appeal with the Board, which is an independent forum established by Congress to help resolve payment disputes between providers of health care services and the program. 42 U.S.C. §1395oo; 42 C.F.R. §405.1835.

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[1] Intermediary Position Paper at 1.

Under the Medicare statute in effect during the fiscal year at issue, a provider was entitled to claim as reimbursable cost the depreciation (i.e., the loss of value over time) of buildings and equipment used to provide health care to Medicare patients. Regulations provided that an asset's depreciable value was set initially at its "historical cost," generally equal to the purchase price. 42 C.F.R. §413.134(a)(2). To determine annual depreciation, the historical cost was then prorated over the asset's estimated useful life. 42 C.F.R. §413.134(a)(3). Providers were then reimbursed on an annual basis for a percentage of the yearly depreciation equal to the percentage the asset was used for the care of Medicare patients.[2]

Because the calculated annual depreciation was only an estimate, the regulation at 42 C.F.R. §413.134(f) provided for the determination of a depreciation adjustment where a provider incurred a gain or loss on the disposition of a depreciable asset.[3] If an asset was disposed of for less than the depreciated basis calculated under Medicare (net book value), then a "loss" had occurred because the consideration received for the asset was less than the estimated remaining value. In the event of a loss, the Medicare program assumed that more depreciation occurred than was originally estimated, and the provider received additional reimbursement in the form of a depreciation adjustment. Conversely, if a provider received consideration for a disposed asset that was greater than the depreciated basis, then a "gain" had occurred, and the Medicare program recaptured its share of previously reimbursed depreciation paid to the provider.

In 1979, CMS extended the depreciation adjustment to "complex financial transactions" not previously addressed in 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 would not trigger a gain or loss adjustment.

Medicare's rules regarding "relatedness," 42 C.F.R. §413.17, state 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 the 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.

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[2] The Medicare Act has been amended to change the method of payment for capital assets.

[3] A depreciation adjustment for a gain or loss was removed from the program's regulations effective December 1, 1997.

(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.

BACKGROUND OF THE MERGER AND MEDICARE LOSS:

The Provider had experienced a decline in patient admissions and had operated at a loss in each of its fiscal years ended June 30, 1995 and 1996.[4] To help preserve its service to the community, the Provider sought proposals from several health care systems in an attempt to change its organizational control (merge with another organization) or sell its facility.[5] In response, the Provider received three proposals and ultimately decided that Albert Einstein Healthcare Network (AEHN) had made the best offer.[6] On February 28, 1997, the Provider and AEHN signed a non-binding Letter of Intent agreeing on the terms of a proposed acquisition. In effect, AEHN would acquire the Germantown Medical Center Foundation (Foundation) with all its affiliates, which included the Provider. In part, the agreement explained that the transaction would be structured to result in a newly created corporation that would own and operate the Foundation.[7]

On May 30, 1997, the Foundation and AEHN entered into a Definitive Agreement,[8] and on September 1, 1997, the Foundation merged into Germantown Hospital and Community Health Services (GHCHS), a corporation newly created by AEHN to accommodate the planned merger. AEHN was the sole corporate member of GHCHS; however, once the merger had been completed, GHCHS had a 40-member Board of Directors that included 6 individuals who were previously members of the Provider's Board, and AEHN's 127 member Board included 7 individuals who had been members of the Provider's Board.

The loss claimed is the difference between the net book value of the Provider's assets at the time of the merger and the Provider's liabilities that were assumed by AEHN in exchange for those assets. However, it is noted that under the terms of the merger agreement, AEHN would commit $6 million during a 5-year period to help assure the community's continued access to GHCHS.[9]

STIPULATION OF THE PARTIES

The parties stipulated as follows:

1. Effective September 1, 1997, Germantown Hospital and Medical Center and its sole corporate member Germantown Medical Center Foundation statutorily merged into

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4 Transcript (Tr.) at 75. Exhibits P-4 and P-7.
5 Tr. at 93. Exhibit P-14.
6 Provider's Post Hearing Brief at 4, 5.
7 Exhibit P-21.
8 Exhibit P-24.
9 Provider's Post Hearing Brief at 5. Exhibit P-24 at 13.

Germantown Hospital and Community Health Services, whose sole corporate member was Albert Einstein Healthcare Network. The transaction was a statutory merger under Pennsylvania law and Medicare regulations.

2. As a result of the statutory merger, Germantown Hospital and Medical Center ceased to exist. All of its assets, liabilities and obligations passed by operation of law to Germantown Hospital and Community Health Services, the surviving corporation.

3. At all times prior to September 1, 1997, Germantown Hospital and Medical Center and Germantown Hospital and Community Health Services were not subject to common ownership. Prior to September 1, 1997, there were no common board members, no common officers and no common ownership of each other's assets. Each of these entities were organized as separate not-for-profit corporations.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of Medicare law and guidelines, parties' contentions, and evidence presented, finds and concludes that the Provider is entitled to claim a loss on the disposal of depreciable assets stemming from its merger with GHCHS.

The Intermediary presents three (3) arguments supporting its position that the Provider's loss should not be allowed for purposes of program reimbursement. First, the Intermediary asserts that the Provider and GHCHS/AEHN were related parties prior to the merger. This relationship would bar the Provider's claim to the loss pursuant to 42 C.F.R. §413.17. Second, the Intermediary claims that the Provider and GHCHS became related parties as a result of the merger itself. This relationship, according to the Intermediary, would bar the Provider's claim to the loss pursuant to program instructions contained in Medicare's Provider Reimbursement Manual, Part I (HCFA Pub.15-1) §1011.1 entitled Contracts Creating Relationships. And third, the Intermediary argues that, even if the parties were found to be unrelated, the Provider's loss would still be unallowable because the merger was not a bona fide transaction pursuant to 42 C.F.R. §413.134(f)(2). Notwithstanding these arguments, the Intermediary asserts that if the Board finds the Provider's loss to be an allowable program cost, it must be recalculated to address several concerns.

The Board finds that there is no evidence in the record to support the argument that common ownership existed among the parties prior to the merger or that any level of control existed between them at that time. The Intermediary's assertion that control is represented by pre-merger discussions and written agreements (specifically the non-binding Letter of Intent and the more comprehensive Definitive Agreement) is unwarranted. A review of these documents shows that the parties gave consideration to such matters as the Medicare reimbursement consequences of the merger, specifically at issue here, as well as other matters such as the assumption of liabilities as consideration for the transfer of the Provider's assets and the composition of the Board of Directors and officers of the surviving entities after the merger. However, the Board finds that these are precisely the

types of issues one would expect to be raised during the negotiation and structuring stages of any merger of this type. No evidence was presented showing that GHCHS or its parent corporation conducted any business of any type prior to the effective date of the merger.

The Intermediary's second argument is based upon some of the Provider's Board of Directors and officers becoming members and officers of GHCHS after the merger, as well as members of AEHN's board. The Intermediary asserts that this "continuity of control" makes the subject merger a related party transaction pursuant to HCFA Pub. 15-1 §1011.1, which states in part:

> If 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.

However, the plain language of the merger regulation is dispositive of this argument. 42 C.F.R. §413.134(1)(2)(i) states in part:

> 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.

The Board, therefore, concludes that the plain language of the regulation bars application of the related party principle to the merging parties' relationship after the merger. The evolution and construction of the regulation reflects the Secretary's deliberate rejection of the position proposed by the Intermediary and a determination that only the relationship of the merging parties before the merger is relevant to whether assets would be revalued. The Board's conclusion is buttressed by the Secretary's interpretive guidelines at HCFA Pub. 13-4 §4502.6, which state 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."

Regarding the continuity of control issue, the Board is not persuaded by the Intermediary's argument that the Provider controlled the post-merger entity because some of its pre-merger directors were on the surviving entity's board and some of its pre-merger managers continued to be employed by the surviving entity. The Board finds that the evidence shows that the powers of the surviving entity's board are severely limited, as the controlling powers appear to vest in AEHN. This position is supported by the Board's decision in North Iowa Medical Center v. Blue Cross and Blue Shield Association, PRRB Dec. No. 2000-D52, May 2000, Medicare and Medicaid Guide (CCH) ¶ 80,442, where the Board held that even though the directors had influence, the "degree" to which that influence exists is less than is needed to "direct" the actions of the corporation. That concept was upheld in North Iowa Medical Center v. Department of Health and Human Services, 196 F. Supp. 2d 785 (N.D. Iowa 2002).

For the same reasons, the Intermediary's argument that the transaction fails the traditional tests of "bona fide" and "arm's length" is also without merit. With respect to the concept of a bona fide sale, 42 C.F.R. §413.134(f)(1) and (2), the Board notes that the Provider determined on its own initiative that it should seek affiliation with a larger health system. The record indicates the Provider requested proposals, which could involve a change in its control or sale of its assets, from Allegheny Health Education and Research Foundation, Temple University Health System, Primary Health Systems, Jefferson Health System, University of Pennsylvania, and AEHN. Ultimately, an agreement with AEHN was pursued, and the parties developed the Letter of Intent to merge followed by their Definitive Agreement. These documents included all the terms of the planned merger and covered items such as obtaining regulatory approvals, opinions of counsel, approvals from lenders, as well as all other elements of due diligence. The Board finds that these actions are consistent with the concept of arm's length, bona fide negotiations.

The Intermediary further argues that, even if the Board concludes that the loss is allowable, the Provider's claimed amount of Medicare reimbursement is incorrect. The Intermediary asserts that the Provider has not appropriately documented the Medicare utilization rate (Medicare Average Percentage) of 31.59 percent used to determine Medicare's share of the loss; that the $6 million AEHN agreed to commit to GHCHS for community access should be added to the consideration otherwise at issue; that the endowment funds which had benefited the Provider are clearly assets that should receive an allocation of consideration; and, that the intangible assets should not receive an allocation of consideration.[10]

The Board finds as follows:

An average utilization rate should not be used to determine Medicare's share of the subject loss. Medicare's share should be determined for each applicable cost reporting period in accordance with program instructions at HCFA Pub. 15-1 §132.

The $6 million AEHN agreed to commit to GHCHS for community access should not be included in the consideration used to compute the Provider's loss. The Definitive Agreement indicates that the commitment would only be realized upon the effective date of the merger, at which time the Provider would cease to exist. Therefore, this commitment is an investment that AEHN is making in itself. While the Provider may have been encouraged to see this commitment in the merger agreement, there is no evidence it had any recourse in the event AEHN reneged.

The endowment funds are not included in the Provider's loss calculation; however, the present day value of the annual income generated from those funds for the Provider's benefit must be included. The endowment funds themselves are not recognized as an asset since the Provider is not the "legal owner" of the principal amount, but is rather the "beneficial owner" of specified portions of the income generated from those funds. The

[10] Intermediary's Position Paper at 24. Exhibit P-34. Exhibit I-3 at 4.

Provider cannot sell or mortgage the endowments, nor does it have unfettered use of the income they generate since some of the funds are restricted. Since the Provider does not have open access to the funds' principal, neither the market nor the face value of the endowments is indicative of their value to the Provider. Although the record indicates that the Provider may, in instances, borrow monies from certain of the endowments, the evidence indicates that such access is extremely limited.

The disputed intangibles are comprised of medical records valued by the Provider at $4,615,000, radiology film valued at $260,000, medical library and related materials valued at $356,000, and an assembled workforce valued at $3,310,000. Of these items, the medical library and its related materials are tangible assets. Therefore, the value of the medical library will be reflected as an asset in the Provider's loss calculation and will receive an allocation of consideration. The value of the other items, however, will not be included in the loss calculation.

The Board finds that medical records, radiology film, and assembled workforce do not meet the definition of intangible assets presented by the Financial Accounting Standards Board (FASB) Statement 141, Business Combinations, Paragraph 39. FASB requires that intangible assets, which did not arise from contractual rights, shall be recognized as assets apart from goodwill only if they are capable of being separated from "the acquired entity" and sold, transferred, licensed, rented or exchanged, which is not the circumstance with these items. Notably, FASB specifically states: " [f]or purposes of this Statement, an assembled workforce shall not be recognized as an intangible asset apart from goodwill."

DECISION AND ORDER:

The Intermediary's adjustment disallowing the Provider's loss on the disposal of its depreciable assets was improper and is reversed. This case is remanded to the Intermediary to recalculate the Provider's loss in accordance with HCFA Pub. 15-1 §132, and to determine Medicare's share of the loss for each applicable cost reporting period. In addition, the Intermediary will ensure that: the $6 million commitment made by AEHN to community access is not included as consideration in the loss calculation; that the endowment funds are not represented as an asset in the loss calculation but that the present day value of their income is included as an asset; and, that the value of the Provider's medical library and related materials is reflected as an asset in the loss calculation while the value of medical records, radiology film, and assembled workforce is excluded from the loss calculation.

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