PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2008-D15

PROVIDER –
Allentown Osteopathic Medical Center
Allentown, PA

Provider No.: 39-0242

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
Veritus Medicare Services (n/k/a
Highmark Medicare Services)

DATES OF HEARINGS –
January 18, 2007 and January 19, 2007

Cost Reporting Period Ended -
December 31, 1996

CASE NO.: 00-1182

INDEX

ISSUE:

Whether the Intermediary's denial of the loss on disposal of assets claimed by Allentown Osteopathic Medical Center (AOMC) was proper?

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. 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 administering the Medicare program. 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 the providers under Medicare law and under interpretive 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 issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

Under the Social Security Act (Act) in effect during the year in issue, a provider was entitled to claim as a reimbursable cost the depreciation (i.e., the loss of value overtime) 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). 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.[1]

Because the calculated annual depreciation was only an estimate of the asset's declining value, 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.[2] 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

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

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

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 depreciation 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 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.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Allentown Osteopathic Medical Center (AOMC) was a non-profit, general acute care hospital located in Allentown, Pennsylvania. Effective January 1, 1997, the Provider merged into an unrelated entity, St. Luke's Hospital (St. Luke's). The Provider submitted its final Medicare cost report for the period ended December 31, 1996, on which it claimed a loss on statutory merger.

Upon audit of the Provider's cost report, Veritus Medicare Services (Intermediary) disallowed the loss claiming that the statutory merger from which the loss arose did not meet the requirements of a bona fide sale.

The disallowance of the loss was reflected in a NPR dated August 6, 1999.[3] On January 21, 2000, the Provider timely filed its request for hearing with the Board pursuant to 42 C.F.R. §§405.1835-1841 challenging the disallowance of the loss claim. The Provider met the jurisdictional requirements set forth in those regulations. The amount of Medicare program funds in controversy is approximately $2.9 million.[4] The Provider was represented by Leslie Demaree Goldsmith, Esquire, of Ober Kaler, Grimes & Shriver. The Intermediary was represented by Bernard M. Talbert, Esquire of Blue Cross Blue Shield Association.

STIPULATIONS OF THE PARTIES:

The parties have stipulated that the merger of the Provider into St. Luke's was a statutory merger under Pennsylvania law and Medicare regulations. As a result good title to all of the Provider's assets passed by operation of law to St. Luke's. St. Luke's became legally responsible for all of the Provider's debts and liabilities, both known and unknown. The statutory merger was a bona fide transaction and complied with all applicable legal and regulatory requirements, and the transaction was not between related parties.[5]

PROVIDER'S CONTENTIONS:

Market Conditions

The Lehigh Valley market place in the early 1990's became increasingly competitive with the growth of managed care and the development of health systems. As a small community osteopathic hospital in the Lehigh Valley, the Provider was excluded from managed care contracts, and doctors could not send their patients to the Provider because the managed care plans refused to pay for hospital services furnished by the Provider.[6]

The Provider had a 9.16% decline in its admissions from 1993 to 1995.[7] In 1995, it had the smallest share of the market for hospital services. The Provider had occupancy rates of 48.6% and 42.3% of its licensed beds in 1995 and 1996,[8] respectively, as compared to other Pennsylvania Region 7 hospitals of similar size that experienced occupancy rates of 66.1% and 64.0%[9] during the same periods. As a result, the Provider was experiencing losses of about $1 million a year.[10] In its fiscal year ended June 30, 1996, the last full fiscal year prior to the merger, the Provider lost $1.3 million.[11]

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[3] See, Intermediary Exhibit I-4
[4] See, Provider Exhibit P-93, p. 5.
[5] See, Provider Exhibit P-96.
[6] Transcript (Tr.) at 64-65.
[7] Tr. at 85-87; Exhibit P-71.
[8] See, Provider Exhibit P-74, p.85
[9] See, Provider's Post Hearing Brief at 2.
[10] Tr. at 101.
[11] Tr. at 102-03; Provider Exhibit P-15.

Condition of Physical Plant

Two of the buildings at the Provider comprising the hospital exceeded 25-30 years of age. Because there had been a plan to relocate the hospital, adequate money had not been reinvested into the physical plant, and the majority of the buildings and programs required substantial improvements.[12] The mechanical, electrical and plumbing systems needed replacement.[13] The facility had significant violations of the building code, the most significant of which was the sprinkler system, for which the Provider was granted an extension for a period of time.[14] An upgrade to the telephone system and computer systems was also required.[15] Asbestos was known to exist in the West Wing, and was subsequently found in other parts of the complex.[16] The buildings also were not in compliance with the Americans With Disabilities Act (ADA). Although the buildings were grandfathered, i.e., deemed not in violation because they pre-dated the ADA, any significant renovations or new construction required for the hospital's long-term survival would result in the buildings having to comply with ADA requirements and with current building codes.[17]

Provider's Strategic Plan

The Provider began its strategic planning process in 1993 by engaging KPMG, Peat Marwick to evaluate whether the Provider could afford to borrow sufficient funds to build a brand new hospital at a suburban site and to evaluate other alternatives. KPMG's evaluation was that the Provider could not carry the debt necessary to build a new hospital.[18] Subsequently, the Provider engaged Chi Systems, Inc. (Chi) to assist it in strategic planning. Chi presented a report to the Board of Directors in February 1995 identifying five "strategic imperatives" for the Provider. These imperatives were:

1. To affiliate with a leading health care delivery system in Lehigh Valley.
2. To obtain sufficient capital to address resource needs for medical staff, facility upgrades, information systems and program development.
3. To support medical staff development and promote greater physician-hospital integration.
4. To become well-positioned for managed care contracting.
5. To review, enhance and modify existing programs and expand non-acute services.[19]

The report concluded that retaining independence was not a viable option, and that to gain access to the necessary capital needed to address the facility's needs, the Provider needed a tight affiliation with another entity.[20]

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[12] Tr. at 197-200, 203.
[13] Tr. at 203; Provider Exhibits P-6, pp. 23-24, P-73, p. 13.
[14] Tr. at 242-43.
[15] Tr. at 218-24; Provider Exhibits P-3, p. 5, P-9.
[16] Tr. at 204; Provider Exhibits P-73, p. 14.
[17] Tr. at 205-07; Provider Exhibit P-73, p. 14.
[18] Tr. at 59-62.
[19] Tr. at 62-70; Provider Exhibit P-3.

In response, the Provider's Board established an Affiliation Task Force and began the process of examining potential affiliation partners. The Provider was willing to engage in conversations with any interested party,[21] agreed to supply other hospitals with financial information,[22] and engaged KPMG to assist in negotiations with potential partners.[23] The Provider first explored an alliance with the Hospital of the University of Pennsylvania (HUP), but HUP was not interested.[24] The Provider then investigated affiliations with the obvious choices of Sacred Heart Hospital, Lehigh Valley Hospital and St. Luke's Hospital,[25] as well as with Graduate Health System and Alleghany System.[26] Meetings were held with all five of these entities. All of these were non-profit entities, as there were no for-profit health systems in Pennsylvania at that time with which the Provider could investigate an affiliation or other transaction.[27]

Complicating the search for an affiliation partner was the fact that the Provider's medical staff had "veto power" over any corporate restructuring.[28] The medical staff wanted to continue to provide acute care at the existing facility and, as long as that alternative was a possibility, it would not have approved anything less than an entity coming in with substantial capital to keep the Provider operating as an acute care hospital.[29]

On December 11, 1995, the Provider's governing board agreed to begin negotiations with St. Luke's. St. Luke's was chosen for several reasons. It was one of only two of the five possible partners that was willing to invest in upgrading AOMC's facilities. Of those two, St. Luke's was the only local system and was very strong. In addition, St. Luke's had an interest in merging with the Provider because St. Luke's needed a foothold in the Allentown market.[30] St. Luke's, thus, was the entity with which the Provider could strike the best deal.[31]

The Provider entered into a Merger Agreement with St. Luke's dated October 16, 1996.[32] Under its terms, the Provider would merge into, and become part of, St. Luke's. St. Luke's agreed to maintain and operate acute inpatient services at the Provider's campus for a minimum of two years after the merger, unless an operating loss of $75,000 or more per month for six months, or a cumulative loss of $500,000 for any rolling six-month period, was incurred. After the two-year period, inpatient services would continue unless a cumulative operating surplus, on the six-month rolling basis, was not maintained. In addition, St. Luke's agreed to invest in the Provider's campus plant, equipment, programs

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[20] Id.
[21] Tr. at 81; Provider Exhibit P-4, p. 14.
[22] Tr. at 81; Provider Exhibit P-4, p. 16.
[23] Tr. at 83-84.
[24] Tr. at 76-77.
[25] Tr. at 77-80.
[26] Tr. at 83.
[27] Tr. at 100, 114.
[28] Tr. at 73-74, 98-100; Provider Exhibits P-4, p. 4, P-70, p. 3.
[29] Tr. at 99.
[30] Tr. at 94-97.
[31] Tr. at 97-98.
[32] See, Provider Exhibit P-1.

and services, although it would not agree to a specific amount.[33] St. Luke's would continue to recognize osteopathic medical philosophy, training programs and accreditations. The Provider's Board of Trustees would serve as an "other body" under Pennsylvania Law, in an advisory capacity.[34]

The merger was effective on January 1, 1997.[35] On that date, the Provider merged into St. Luke's and ceased to exist as a separate entity.

Recognition of the Loss

The Provider contends that the requirements for recognition of a loss on statutory merger have been satisfied. The transaction on which the Provider incurred a loss was a statutory merger between unrelated parties, requiring recognition of the loss. The parties have stipulated that, prior to the transaction, AOMC and St. Luke's were not subject to common control or common ownership, and that following the merger, St. Luke's, including the assets formerly owned by AOMC, was not subject to the control or significant influence of any individual(s) or organization that had been able to control or significantly influence AOMC prior to the merger. Neither side had control or influence over the other prior to the date of the merger.

The Medicare regulations require that a gain or loss be recognized when, as here, a statutory merger takes place between unrelated corporations. CHOW Manual §4502.1(c) defines "corporation" to include both proprietary and non-stock entities.[36]

The disallowance of the Provider's loss cannot be sustained based on the Intermediary's determination that consideration was unreasonable. Since the loss resulted from a statutory merger, the requirements related to purchase and sale of assets are irrelevant to recognition of that loss. The Intermediary must bear the burden of demonstrating that bona fide sale requirements are applicable, and that those requirements were not satisfied. The Intermediary has not satisfied that burden.

All testimony established that a statutory merger is fundamentally different from a sale of assets – bona fide or otherwise.[37] Accordingly, the Intermediary applied bona fide sale requirements to a different type of transaction. As of the date of the loss and the audit determination, there was no Medicare policy that required statutory mergers between unrelated entities to satisfy the requirements for a bona fide sale.[38]

The Provider contends that its calculation of the loss at Exhibit P-93, p. 5 of which Medicare's share is $2,865,338, should be accepted. This was calculated by allocating the consideration (liabilities assumed) among all the assets transferred, using the

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[33] Tr. at 119-21.
[34] Tr. at 186-88.
[35] See, Provider Exhibit P-17.
[36] See, Exhibit P-77.
[37] Tr. at 162-64.
[38] Tr. at 353-54; Tr.

"proportionate allocation" methodology, under which the consideration is allocated proportionately among all assets that were transferred based on the net book value of the assets.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its position is supported by the CMS Administrator's reviews of past Board decisions and reinforced by recent Federal District Court decisions. The Intermediary argues that:

- The purpose of recognizing a loss (or gain) on disposition of depreciable assets is to correct the depreciation estimate and recognize the true cost to the Medicare program of the use of depreciable assets in caring for Medicare beneficiaries.

- The only transaction that corrects the depreciation within the regulations at 42 C.F.R. §413.134 is a bona fide sale under 42 C.F.R. §413.134(f)(2).

- A transfer of assets through the execution of a statutory merger may have the bona fide sale behavior objectives in which the negotiations produce a reasonable determination of the fair market value of the assets sold. On the other hand, a merger deal may be done for "bona fide" reasons, but a sale between a buyer and seller is the opposite of the participant's objective.

- Providers that have claimed losses on mergers or consolidation have argued that identification of the transaction as a statutory merger or a consolidation between unrelated parties ends the discussion and a loss is reimbursed. Determining the loss is then a function of a formulistic debate over how to allocate the liabilities transferred in the merger to all the assets transferred. The more solvent the merging party, the larger the loss.

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 as follows. The parties have stipulated that the Provider, AOMC and St. Luke's were unrelated parties as that term is defined in the regulatory provisions of 42 C.F.R. §413.17. Accordingly, the Board finds that a revaluation of the assets and a recognition of the loss incurred as a result of the merger of these unrelated parties 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 Pennsylvania 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 the Provider merged into St. Luke's and ceased to exist. Under the terms of the transaction, St. Luke's (the surviving

corporation) acquired all the assets and assumed all 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. . . .

The Board finds the plain language of the statutory merger regulation dispositive. 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 finds that because there is a specific regulation that controls the recognition of a loss on the merger transaction at issue in this case, 42 C.F.R. §413.134(l), the merger is not required to meet the bona fides of sales transactions addressed in 42 C.F.R. §413.134(f)(2). The Board is aware that a subsection of the regulation on mergers refers to capital stock and may be interpreted as applying only to stock transactions. However, CMS has interpreted the regulation to apply to non-profit transactions as well. CMS' Director of the Division of Payment and Reporting Policy, Office of Reimbursement Policy, stated in a 1987 letter that the regulation applied to non-profits. In addition, the October 2000 "Clarification of the Application of the Regulations at 42 C.F.R. §413.134(1) to Mergers and Consolidations Involving Non-profit Providers," CMS Program Memorandum, Transmittal A-00-76, states that the regulation applies to non-profits; however, it asserts that "special considerations" apply.

The Provider and Intermediary agreed that if the Board allowed the loss, 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 asset's fair market value to the total fair market value of all of the assets in the aggregate.

The Board concludes that evidence of a changing healthcare environment and lack of a market for provider facilities is persuasive that the Provider incurred a genuine financial loss. That evidence also supports the Provider's position that the process of finding a suitable merger partner requires arm's length evaluation and bargaining similar to that in a traditional sale, although the Board believes it may be more imprecise in producing fair

market value. The Medicare Manual supports this view. HCFA Pub. 13-4 §4508.11 incorporates as part of the Manual, Accounting Board Opinion No. 16, "Business Combinations." "Medicare program policy places reliance on the generally accepted accounting principles as expressed in . . . APB No. 16 in the revaluation of assets and gain/loss computation processes for Medicare reimbursement purposes."[39] APB No. 16 contains a comprehensive discussion of the advantages and disadvantages and the practical difficulties of treating a combination as a purchase. Paragraph 19, entitled "A bargained transaction," states that proponents of the purchase method recognize a business combination as " . . . a significant economic event that results from bargaining between independent parties. Each party bargains on the basis of his assessment of the current status and future prospects of each constituent as a separate enterprise and as a contributor to the proposed combined enterprise. The agreed terms of combination recognize primarily the bargained values and only secondarily the costs of assets and liabilities carried by the constituents . . ." The Board concludes that the assumption of liabilities through a merger transaction is persuasive evidence of acquisition costs.[40] Liabilities assumed in a merger also may, but do not necessarily, equate to fair market value.

The Board finds that the "Booth pro-rata method," calculated by the Provider, requires review and audit by the Intermediary. The Board, therefore, remands this case to the Intermediary to perform the necessary audit procedures to ensure the accuracy and appropriateness of the loss calculation to include a review of the documentation related to the $177,984 liability due to St. Luke's –Bethlehem/Quakerstown that was excluded from the consideration. See page 27 of the Provider's post-hearing brief for a description. The explanation is insufficient to determine if the liabilities addressed should have been considered part of the consideration used in the loss calculation. The Board also requires the Intermediary to determine the Provider's actual Medicare utilization that should be used to determine Medicare's share of the loss.

In computing the Provider's loss, the Board finds, as it has in similar cases, that the amount of the allowable loss should be reduced by the depreciation expense that would have been claimed on the merged assets by the surviving corporation. This adjustment, commonly referred to as the "DEFRA adjustment," is necessary because the merger transaction was treated as a pooling of interests for accounting purposes, and the value of the assets transferred to St. Luke's in the merger was not written down. As a result, St. Luke's continued to claim depreciation for these assets at their carrying value on the Provider's books at the date of the transaction without considering the decline in their value as evidenced by the loss.

The Provider argues in its footnote 17 on page 27 of its Post-Hearing Brief that while it agrees that the DEFRA adjustment is appropriate if the loss is allowed, the years to which

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[39] The Manual cautions, though, that in certain areas, Medicare policy deviates from that in generally accepted accounting principles.

[40] Acceptance of the amount of liabilities assumed as the acquisition cost is the position taken by HCFA's Director of the Division of Payment and reporting Policy, Office of Reimbursement Policy, in a 1987 letter. Provider Supplemental Exhibit D.

the adjustment would be applied are after the year in issue and, therefore, are not before the Board. Consequently, the Board may not properly reduce the loss on statutory merger incurred by (the Provider) during the fiscal year ended December 31, 1996 by any excess depreciation that St. Luke's may have received in subsequent years."[41] The Board disagrees, and finds authority for its decision to require the DEFRA adjustment in Bethesda Hospital Association v. Bowen, 108 S. Ct. 1255 (1988), where the U.S. Supreme Court held that the Board may go beyond issues directly before it if the Board deems it necessary. The Board finds that commensurate with allowance of the loss, the DEFRA adjustment must also be made in order to prevent the Medicare program from paying excess depreciation cost.

DECISION AND ORDER:

The Provider's claimed loss on disposal of depreciable assets as a result of the merger is allowable under 42 C.F.R. §413.134(l)(2)(i) subject to the Intermediary review and audit of the Provider's "Booth method" allocation of consideration relating to the merger and the application of the DEFRA adjustment. The Intermediary's denial of the loss resulting from the merger is reversed.

BOARD MEMBERS PARTICPATING:

Suzanne Cochran, Esquire
Elaine Crews Powell, CPA
Anjali Mulchandani-West, CPA
Yvette C. Hayes

FOR THE BOARD:

Suzanne Cochran
Chairperson

DATE: January 24, 2008

[41] See, Provider Post Hearing Brief at 27.