

PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2003-D64

PROVIDER –

St. Joseph Medical Center
Wichita, Kansas

Provider No. 17-0087

LIVE HEARING -
April 30, 2002

Cost Reporting Period Ended
September 30, 1995

vs.

INTERMEDIARY – Blue Cross and
Blue Shield Association/Blue Cross and
Blue Shield of Kansas

CASE NO. 98-2851

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ISSUE:

Was the Intermediary's determination of loss on consolidation proper?

BACKGROUND:Governing Statues and Regulations:

This dispute arises out of the Intermediary's failure to reimburse the Provider for depreciation expense Provider claims is due under the Medicare program of the Social Security Act, 42 U.S.C. §§ 1395 *et seq.*, for the 1995 cost year. The amount in contention relates to a claimed loss on the disposal of assets when two hospitals consolidated (St. Joseph Medical Center ("Provider or St. Joseph")) and St. Francis Regional Medical Center ("St. Francis")), resulting in the creation of a new entity, Via Christi Regional Medical Center ("Via Christi").

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 et. seq. The Health Care Financing Administration ("HCFA") (now Centers for Medicare and Medicaid Services ("CMS")) is the operating component of the Department of Health and Human Services ("HHS") 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 which portion of these costs are to be allocated to Medicare. 42 C.F.R. § 413.20. The fiscal intermediary audits the cost reports period and determines the total amount of Medicare reimbursement due the provider. It then issues a notice of program reimbursement ("NPR") that sets forth the individual expenses allowed and disallowed by the Intermediary. 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.

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 building 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). To determine annual depreciation, the historical cost is prorated over the asset's estimated useful life. 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 the asset is 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 sold by the provider for less than the 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 sales price was less than the estimated remaining value. In that event, the Secretary assumes that more depreciation has occurred than was originally estimated and accordingly provides additional reimbursement to the provider. Conversely, if the asset is sold for more than its depreciated basis, then a "gain" has occurred, and the Secretary takes back or "recaptures" previously paid reimbursement. 42 C.F.R. § 405.415(f)(1).

The Provider contends that its consolidation into Via Christi is a transaction that, like a sale, resulted in a disposition of assets and gives rise to a loss in which Medicare must share in order to fully reimburse the reasonable costs of providing Medicare services. The Provider alleges that the Intermediary's determination denying the loss on disposition of assets in connection with the consolidation of the new facility was, therefore, incorrect.

Statement of Factual and Procedural History:

Prior to the consolidation, the Provider was a non-profit corporation operating a 600-bed acute care hospital located in Wichita, Kansas.¹ The Provider's sole member was CSJ Health System of Wichita, Inc. ("CSJ"). CSJ's sole member and religious sponsor was Sisters of St. Joseph of Wichita. A nineteen person Board governed the Provider.² Members of the Board were appointed by CSJ.³

The Provider and St. Francis entered into a Master Plan of Consolidation on September 28, 1995.⁴ Effective October 1, 1995, the Provider and St. Francis consolidated under the applicable Kansas statute, resulting in the creation of Via Christi.⁵ As a result of the consolidation, all the assets, rights, liabilities, obligations and contingent liabilities of the Provider and St. Francis passed under operation of law to the new entity, Via Christi.⁶ The Provider and St. Francis ceased to exist at the same time that Via Christi was created.⁷ One day later, CSJ, the Provider's sole member, consolidated with St. Francis's sole member, St. Francis Ministry Corporation ("Ministry Corporation"), to create Via Christi Health System, Inc. ("VCHS").⁸

¹ See Tr. 77 and 156.

² See Tr. 161-162.

³ See Tr. 78-79.

⁴ See Provider's Exhibit P-49.

⁵ See Provider's Position Paper at Provider's Exhibit P-1.

⁶ See Tr. 85-86, 134 and 145-146.

⁷ See Tr. 83-86, 103-105 and 148-149.

⁸ See Tr. 80 and 100, and Provider's Exhibit P-50.

Upon completion of the consolidation resulting in creation of Via Christi, seven individuals who had been members of the Provider's governing Board became members of Via Christi's twenty-three person Board of Directors.⁹

In completing its Medicare terminating cost report, the Provider claimed reimbursement for the loss resulting from the consolidation transaction that was attributable to assets for which Medicare had recognized depreciation allowances. In computing the final loss, the Provider assigned \$12,111,468 of consideration to its property, plant and equipment "PP&E". Of that amount, \$10,978,392 was assigned to assets for which Medicare had recognized depreciation. The Medicare book value of those depreciable assets was \$47,758,076.¹⁰ The Provider claimed reimbursement for Medicare's share of the \$36,779,684 loss. The Intermediary disallowed the loss, claiming that it resulted from a transaction among related organizations because there was a "continuity of control" between the non-surviving entities and the new consolidated entity.¹¹

The parties stipulated that the transaction from which the loss arose was a consolidation under Kansas law.¹² They also stipulated that the Provider and St. Francis, the two consolidating entities, were not subject to common control or common ownership prior to consummation of the consolidation, including, but not limited to, when the terms of the transaction were negotiated and when the transaction documents were executed.¹³

The Provider's cost report was audited by Blue Cross and Blue Shield of Kansas ("Intermediary"). The Intermediary issued an NPR on January 14, 1998 and a revised NPR on January 21, 1998. On June 12, 1998, the Provider appealed the Intermediary's adjustment to the Board pursuant to 42 C.F.R. §§ 405.1835–405.1841, and met the jurisdictional requirements of those regulations. The amount of Medicare reimbursement in controversy is approximately \$9,700,000.

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

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's disallowance of its loss claim is premised on Medicare policies that were developed after the transaction in issue here. In 1994, HCFA created a workgroup to review Medicare authorities addressing change of ownership transactions ("CHOW Workgroup") and to recommend changes.¹⁴ On September 30, 1996, one year after the Provider's loss, the CHOW Workgroup provided HCFA with proposed Medicare regulatory

⁹ See Tr. 162-165 and 203-204.

¹⁰ See Provider's Exhibits P-52 and P-115.

¹¹ See Provider's Exhibit P-3.

¹² See Provider's Exhibit P-115, Stipulation dated April 26, 2002, paragraph 1.

¹³ See Provider's Exhibit P-115, Stipulation dated April 26, 2002, paragraph 2.

¹⁴ See Provider's Position Paper at Provider's Exhibit P-60.

revisions that would define “bona fide sale” to require “reasonable consideration” and would require disallowance of losses when there was “continuity of control,” e.g., where the consolidated entity’s governing board included significant representation from the consolidating entities’ boards.¹⁵ In disallowing Provider’s loss, the Intermediary included the proposed Medicare regulatory revisions in its audit work papers, they were quoted verbatim in the audit adjustment report, and were conceded to have been part of the Intermediary’s “thought process.”¹⁶ Provider asserts that this resulted in disallowance of the Provider’s loss even though all applicable requirements were satisfied.

The Provider contends that Medicare authorities in effect at the time of the consolidation require recognition of its loss because it resulted from a consolidation between unrelated parties. The Intermediary stipulated that the transaction was a consolidation under Kansas law and that the two consolidating entities were not subject to common control or ownership at the time of the transaction.¹⁷ Medicare regulations provide that a “consolidation between unrelated parties” occurs if the consolidation is between two or more corporations that are unrelated.¹⁸ The regulatory preamble confirms that the related party determination is based solely on the consolidating entities’ relationship at the time of the transaction.¹⁹ HCFA has stated consistently that if consolidating entities are not subject to common control or ownership, then any loss on the transaction is recognized.²⁰ For example, HCFA’s Director, Office of Payment Policy, Bureau of Policy Development advised an accountant in 1994 that a consolidation appeared to be governed by the regulation addressing consolidations between unrelated parties “requiring a determination of gain or loss” even though each consolidating hospital would appoint one-half of the consolidated entity’s board.²¹ The Provider asserts that the Intermediary acknowledged in testimony at the hearing that the HCFA Director was correct.²² Similarly, HCFA Pub. 15-1 § 4502.7 instructs intermediaries to recognize a gain or loss when consolidating entities were unrelated prior to the transaction. The Provider’s position that the consolidating entities’ relationship prior to the transaction is determinative is supported by administrative and judicial case law.²³ The Provider argues that the only documents supporting the

¹⁵ Id.

¹⁶ See Provider’s Position Paper at Provider’s Exhibits P-8, P-97; Intermediary’s Exhibit I-6; and Tr. 566-68.

¹⁷ See Provider’s Position Paper at Provider’s Exhibit P-115.

¹⁸ 42 C.F.R. § 413.134(1)(3)(i). See Provider’s Position Paper at Provider’s Exhibit P-4.

¹⁹ Final Rule, 44 Fed. Reg. 6912, 6913 (Feb. 5, 1979). See Provider’s Position Paper at Provider’s Exhibit P-13.

²⁰ Id. See Provider’s Position Paper at Provider’s Exhibits P-6, P-54 and P-56.

²¹ See Provider’s Exhibit P-56.

²² See Tr. 545 and 552.

²³ See Monsour Med. Ctr. v. Heckler, 806 F.2d 1185 (3d Cir. 1986), cert. denied, 482 U.S. 905 (1987) (Provider’s Exhibit P-10); Buckingham Valley Ctr. v. Aetna Life and Cas. Co., PRRB Dec. No. 90-D13, [1990 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 38,369 (Jan. 3, 1990), aff’d, HCFA Adm’r Dec., [1990 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 38,459 (Mar. 28, 1990), aff’d sub nom. Nursing Ctr. of Buckingham and Hampden v. Shalala, 990 F.2d 645 (D.C. Cir. 1993), (Provider’s Exhibit P-11).

Intermediary's theory that the Provider and Via Christi were related parties because of "continuity of control" were documents prepared after the Provider's loss. They included a proposed regulatory revision on which the Intermediary could not properly rely.²⁴

The Provider further asserts that, even if continuity of control were a valid concept, it was improperly applied by the Intermediary. Under the regulations, control exists "if an individual or an organization" has the power to influence or direct an organization.²⁵ Examples in the HCFA manual demonstrate that a 30% voting interest is insufficient to confer significant control.²⁶ No individual controlled five percent of Via Christi's governing board. Even collectively, the seven Via Christi board members who had served on the Provider's board could not significantly influence or direct Via Christi. Provider also challenges what it characterizes as the Intermediary's belated attempt to rely on the continuing role of the ultimate sponsors of the Provider (Sisters of St. Joseph) and Via Christi (Sisters of the Sorrowful Mother and Sisters of St. Joseph), because Sisters of St. Joseph could not significantly influence the Provider before the transaction or afterwards.²⁷

The Provider contends that the disallowance of its loss cannot be sustained based on the Intermediary's argument that the transaction was not a bona fide sale. It argues that consolidations are not required to satisfy requirements for bona fide sales of assets²⁸ but, even if those requirements were applicable, they were satisfied. "Bona fide sale" means a "sale made by a seller in good faith, for valuable consideration, and without notice of a defect in title or any other reason not to hold the sale."²⁹ Blue Cross Blue Shield Association has found this to be a reliable and acceptable definition in the absence of a specific Medicare definition.³⁰ It has also been adopted substantially by the Board.³¹ The Acting Director of HCFA's Bureau of Eligibility, Reimbursement and Coverage has stated that "bona fide sale means simply that the parties to the sale are not related . . ."³² It has been stipulated that the consolidating parties were unrelated and the Intermediary's witness could not deny that \$11 million was valuable consideration for the Provider's depreciable

²⁴ See Harrisburg Hosp. v. Shalala, 48 F.Supp.2d 467 (M.D. Pa. 1999), (Provider's Exhibit P-9).

²⁵ See Provider's Position Paper, 42 C.F.R. § 413.17(b)(3) at Provider's Exhibit P-18.

²⁶ See Provider's Position Paper at Provider's Exhibit P-19.

²⁷ Tr. 102 and 130-31.

²⁸ See Provider's Position Paper at Provider's Exhibits P-6, P-54 and P-56.

²⁹ See Provider's Position Paper, BLACK'S LAW DICTIONARY (7th Ed. 1999) at Provider's Exhibit P-75.

³⁰ See Edgecombe Gen. Hosp. v. Blue Cross Blue Shield Ass'n/Blue Cross and Blue Shield of North Carolina, PRRB Dec. No. 93-D87, [1993-2 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 41,704 (Sept. 9, 1993) ("Edgecombe") Provider's Position Paper at Exhibit P-107.

³¹ See Ashland Reg'l Med. Ctr. v. Blue Cross and Blue Shield Ass'n, PRRB Hearing Dec. No. 98-D32, [1998-1 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 46,109 (Feb. 27, 1998) ("Ashland") (Exhibit P-108).

³² See Provider's Position Paper at Provider's Exhibit P-55.

assets.³³ Additionally, the Intermediary's assertion that consideration was inadequate was based solely on the assets' book values and fails to recognize that Via Christi assumed the Provider's risk related to contingent liabilities such as from obligated group borrowings.³⁴ The Provider points out that if loss of equity precluded loss recognition, there could be no recognition of loss on any consolidation or merger contrary to the regulation. Finally, the Board and HCFA Administrator have recognized losses where amounts received for depreciable assets were asserted to be inadequate.³⁵

The Provider also claims that the Intermediary's reliance on financial statements is misplaced. Medicare follows Generally Accepted Accounting Principles ("GAAP") only when Medicare does not have prescribed methods of dealing with a financial item.³⁶ The Intermediary's determination is contrary to the Deficit Reduction Act of 1984, which required the HHS Secretary to adopt recapture (and loss) regulations that provide for the calculation of gains and losses "as provided under the regulations in effect on June 1, 1984." The Intermediary's action reflects an unlawful retroactive application of a new rule developed in violation of procedural safeguards.³⁷

INTERMEDIARY'S CONTENTIONS:

The Intermediary describes the "factual heart" of the Provider's argument as follows: The Provider exchanged (in round numbers) \$114 million in assets for the assumption of \$26 million in liabilities for a loss of \$88 million. Prorating the liabilities to the assets reflected a loss of \$36.8 million on the PP&E depreciable assets with an allocation of \$9 million to the Medicare Program. The Provider then argues that payment of the loss is necessary to "true up" depreciation or fairly compensate it for the actual reduction in value of the assets from the time of acquisition to the time of consolidation.

That outcome, according to the Intermediary, is totally inconsistent with the private and public posture of the participants, their financial reports, and it makes no

³³ Tr. 614-615.

³⁴ See Intermediary's Position Paper at Intermediary's Exhibits I-18 at 17-18 and I-21 at 14-16.

³⁵ See Ashland; Lac Qui Parle Hosp. of Madison, Inc. v. Blue Cross and Blue Shield Ass'n/Blue Cross and Blue Shield of Minn., PRRB Dec. No. 95-D37, [1995-1 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 43,269 (May 10, 1995); Provider's Exhibit 108 and Edgecombe, Provider's Exhibit P-107.

³⁶ Tr. 533-535 and 538; see also Medicare Intermediary Manual § 4500, Provider's Position Paper at Exhibits P-54 and Exhibit P-56.

³⁷ See Provider's Position Paper, Pub. L. No. 98-369, § 2314, 98 Stat. 494, 1079 (1984), Provider's Exhibit P-15; H.R. Conf. Rept. 98,861 at 1338 (1984), Provider's Exhibit P-16; 5 U.S.C.A. § 553 (West 1996), Provider's Exhibit P-83; and See Monmouth Medical Center v. Thompson, 257 F.3d 807,814 (D.C. Cir. 2001). See also, 42 U.S.C.A. § 1395hh(a)(2) (West 1996) Provider's Exhibit P-83; 5 U.S.C.A. § 552 (West 1996); 5 U.S.C.A. § 801 (West Supp. 2001) Provider's Exhibit P-83; Bowen v. Georgetown Univ. Hosp., 488 U.S. 204, 206-07, (1988) Provider's (Exhibit P-84).

business sense. The Intermediary also insists that neither Medicare regulations nor provider reimbursement manual provisions support that outcome.

The Intermediary acknowledges that the Medicare Program had recognized gains and losses and a corresponding revaluation of assets in transactions that were undisputedly “bona fide asset sales” between unrelated buyers and sellers as the terms were commonly understood. However, the Medicare Program had taken the position that sales of stock followed by mergers of the buying and selling corporate entities were not asset sales. The Intermediary believes that the purpose of the proposed addition of §413.139(l), the regulation in issue here, was to incorporate that policy into the depreciation regulation. The emphasis in the preamble was on asset sales executed as mergers. According to the Intermediary, consolidations presented themselves only as an afterthought. It points out that the context of the regulation change discussion was with the bona fide sale starting point. The requirement that a transaction that would result in a gain/loss to a buyer and revaluation to a seller must be a bona fide sale, regardless of how it is consummated is, therefore, supported by the regulation.

The Intermediary argues that if we accept the Provider’s position, then we must also accept the following position: The Medicare Program was very concerned that, in a transaction that was an asset sale, the parties bargain adversely to identify fair market value of the assets and that any gain/loss recognition and revaluation must be based on fair market value. There was absolutely no such concern, however, when a change of ownership transaction was executed as a merger or consolidation. CMS Pub. 13-4 §4502.7 does not support the argument that defining a transaction as a consolidation between unrelated parties is sufficient in itself, to support the loss. The entire CHOW Manual sections on different forms of asset transfers use buyer/seller language.

The Intermediary also argues that the appealing Provider is claiming a loss on a related party transaction in that there was “continuity of control” between the consolidating entities and the new consolidated entity. The Provider’s sponsoring order is one of two corporate members of the acute care hospital’s parent. Also, the Board of the newly created corporation, that was the execution vehicle for the consolidation, had substantial representation from the Provider’s pre-consolidation Board of Directors and the board of its partner.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the Medicare law and guidelines, parties’ contentions and evidence presented, finds and concludes that the Providers 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 assets and recognition of the loss incurred as a result of the consolidation is required under the specific and plain meaning of the regulation at 42 C.F.R. § 413.134(1)(3)(i).

The parties agree that the transaction at issue was a consolidation under Kansas law, and that the regulation at 42 C.F.R. § 413.134, “Depreciation: Allowance for Depreciation Based on Asset Costs,” is applicable.³⁸ Section 413.134(1)(3) defines a consolidation as “the combination of two or more corporations resulting in the creation of a new corporate entity.” The record in the instant case is undisputed that in October of 1995 Via Christi was formed through the consolidation of two hospitals into one new entity, with the two pre-existing entities ceasing to exist. Under the terms of the transaction, Via Christi acquired all of the assets and assumed all of the liabilities associated with the operation of the Provider and St. Francis.

The Medicare regulation at 42 C.F.R. § 413.134(1)(3) provides for the reimbursement effect of a consolidation as follows. It states in part,

If at least one of the original corporations is a provider, the effect of a consolidation upon Medicare reimbursement for the provider is as follows:

(i) Consolidation between unrelated parties. If the consolidation is between two or more corporations that are unrelated (as specified in § 413.17), the assets of the provider corporation(s) may be revalued in accordance with paragraph (g) of this section.

(ii) Consolidation between related parties. If the consolidation is between two or more related corporations (as specified in § 413.17), no revaluation of provider assets is permitted.

The initial question to be decided by the Board is whether the consolidation was between unrelated parties. While it is undisputed that the Provider and St. Francis were unrelated to each other prior to the consolidation, the Intermediary argues that consolidation transaction must also be examined for relationships after the transaction. The Intermediary refers to the related party regulation at 42 C.F.R. § 413.17 which states, in pertinent part:

³⁸ While the Board is aware that the regulation on consolidations may be interpreted as applying only to stock transactions, CMS interprets the regulation to apply to non-profit transactions as well. HCFA’s 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. See Provider’s Position Paper at Provider’s Exhibit P-6. 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,” HCFA Program Transmittal A-00-76, states that the regulation applies to non-profits; however, “special considerations” apply. See Intermediary’s Position Paper at Intermediary’s Exhibit I-16.

(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.

(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.

Relying on subsection (3) that discusses control, the Intermediary contends that because the board of trustees of the subsequently formed Via Christi was composed principally of former members of the board of trustees of the individual hospitals, that creates a related party relationship that disqualifies the consolidation transaction under the applicable regulation. According to the Intermediary's interpretation, if a consolidated corporation is substantially controlled by members of the board of the entities that formed the new corporation, there is a "continuity of control" that establishes a relationship between the consolidating corporations and the new corporation. In support of the doctrine, the Intermediary relies on the October 19, 2000 HCFA publication entitled "Clarification of the Application of the Regulations at 42 C.F.R. § 413.134(1) to Mergers and Consolidations Involving Non-profit Providers."³⁹ The October 2000 "Clarification" states, in part:

Whether the constituent corporations in a merger or consolidation are or are not related is irrelevant; rather, the focus of the inquiry should be whether significant ownership or control exists between a corporation that transfers assets and the corporation that receives them.

The Board finds the plain language of the consolidation regulation dispositive of the Intermediary's argument. The text at 42 C.F.R. § 413.134(1)(3)(i) specifically states "if the consolidation is between two or more corporations that are unrelated. . ." This language is crystal clear that the related party concept will be applied to the entities that are consolidating.

Until 1977, the regulation on depreciation did not specifically include consolidations, although it did cover other types of transactions. In 1977, the Secretary proposed

³⁹ See Intermediary's Position Paper at Intermediary's Exhibit I-16.

adding a section on mergers and consolidations. The proposed section (1) to the regulation provided in relevant part:

[t]he consolidation of two or more providers resulting in the creation of a new corporate entity, is treated as a transaction between related parties (see § 405.427). No revaluation of assets is permitted for those assets acquired by the surviving corporation. . . .

42 Fed. Reg. 17486 (April 1, 1977).

The regulation, as finally published in 1979, abandoned the blanket rule of treating all consolidations as related party transactions and instead adopted the current version. In addition, the preface to the final rule conclusively resolves whether the language “between related parties” was intended to apply to the consolidating entities’ relationship with the new entity. The comment states that “assets may be revalued if two or more unrelated corporations consolidate to form a new corporation. . . .” 44 Fed. Reg. 6912, 6913 (Feb. 5, 1979).

Accordingly, it is the Board’s conclusion that the plain language of the regulation bars the application of the related party principle to the consolidating parties’ relationship to the new entity. The evolution and construction of the regulation reflects the Secretary’s deliberate rejection of the position proposed by the Intermediary and mandates a determination that only the relationship of the consolidating parties before the consolidation is relevant to whether the assets would be revalued. The Board’s conclusion is further buttressed by the Agency’s interpretive guidelines published in the Medicare Intermediary Manual long before the October, 2000 “Clarification” cited above. CMS Pub. 13-4 § 4502.7⁴⁰ states, in part: “Medicare program policy permits a revaluation of assets affected by corporate consolidations between unrelated parties.”

Further indication of the Agency’s interpretation of the consolidation regulation can be found in the form of two letters that presented written interpretations from high level Agency officials. In a letter dated May 11, 1987,⁴¹ HCFA’s 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 consolidation of not-for-profit hospitals. The conclusion of this letter was that a consolidation among not-for-profit providers gives rise to the revaluation of assets. The letter also made it clear that, notwithstanding the reference to “capital stock” in the caption of the regulation, 42 C.F.R. § 413.134(k),⁴² the Agency looked to that regulation for authority in addressing mergers and

⁴⁰ See Provider’s Position Paper at Provider’s Exhibit P-5.

⁴¹ See Provider’s Position Paper at Provider’s Exhibit P-6.

⁴² The letter actually references subsection (k) but it is the caption on subsection (l) that says: “Transactions (lowercase) involving a provider’s capital stock.”

consolidations of non-stock issuing corporations because the principles involved would be the same.

The Board finds that the transaction that resulted in the formation of Via Christi was a bona fide transaction under Kansas corporation law. The completed transaction consolidated two independent hospital corporations into one new entity, with the two pre-existing entities ceasing to exist. Contrary to the "continuity of control" doctrine embodied in the HCFA Program Transmittal A-00-76, dated October 19, 2000, the Board finds that such an interpretation of the related party regulation is not only inconsistent with the regulation governing consolidations, but it also ignores the very nature of a consolidation. A combination of entities would likely result in some overlap of membership on the boards of trustees of the consolidating corporations and the new entity, as well as a continuation of other operations and personnel of the old organization. The fact that this occurs does not disqualify a consolidation from revaluation under 42 C.F.R. § 413.134(1). It is implicit in the evolution of the regulation that the Secretary considered these factors but rejected them from the determination of whether a revaluation to the new entity was permissible.

With respect to the Intermediary's argument that the relationship between the Provider, St. Francis and Via Christi does not meet the traditional test of "bona fide" and "arm's length" bargaining, the Board finds that the application of such criteria also fails to consider the distinctive features of a consolidation transaction. By definition, Via Christi is nothing more than a combination of the two hospitals. That concept simply forecloses the type of bargaining between the pre and post transaction entities the Intermediary contends is necessary. Requiring "bargaining" between the old and new entity to be "arm's length" would effectively nullify the regulation's directive to permit revaluation where unrelated parties consolidate. The Intermediary's imposition of additional requirements is not supported by the plain meaning of the consolidation regulation and the Agency's own previous interpretation set forth in the manual instructions and informal written advice.

The Board acknowledges the CMS Administrator's reversal of the Board majority's decision in Cardinal Cushing Hospital/Goddard Memorial Hospital v. Blue Cross and Blue Shield Association/Associated Hospital Services of Maine, ("Cushing/Goddard")⁴³ involving virtually identical circumstances. Based upon his review of the related party regulations, 42 C.F.R. § 413.17 and HCFA Ruling 80-4, the Administrator concluded that the record contains compelling evidence on the relatedness of the consolidating corporations and the newly established corporation.

The Board agrees with the Administrator that if a consolidation is viewed only in light of the related party regulations and guidelines, a consolidation appears to be a

⁴³ Cardinal Cushing Hospital/ Goddard Memorial Hospital v. Blue Cross and Blue Shield Association/Associated Hospital Services of Maine, PRRB Dec. No. 2003-D6, November 27, 2002, Medicare and Medicaid Guide (CCH) ¶80,950, rev'd, CMS Administrator, January 29, 2003, unreported.

related party transaction in that the consolidating parties create their successor and determine how it will operate, at least initially.⁴⁴ We also agree that the “continuity of control” concept discussed in HCFA Program Transmittal A-00-76 dated October 19, 2000, is fairly encompassed in the related party rules as they existed prior to the issuance of the Program Memorandum to Medicare Intermediaries. Whether or not “continuity of control” is a new concept is irrelevant. Since the issue under appeal concerns the recognition of losses on the transfer of assets resulting from a consolidation, the Board cannot limit its review only to the related party rules, but it must also view the transaction in light of the specific consolidation regulations at 42 C.F.R. § 413.134(1)(3).

The Board found in Cushing/Goddard,⁴⁵ as it does in the instant case, that the explicit language in the consolidation regulation severely limits the application of the related party regulations to consolidations. The Board also found that the related party principles, if applied as the Intermediary and Administrator assert, would emasculate the consolidation regulations. The Board finds nothing in the Administrator’s reversal of Cushing/Goddard that reconciles these competing principles expressed in the two regulations. For example, the Administrator’s decision cites Internal Revenue Service (“IRS”) precedent for the proposition that a consolidation is merely a reorganization and, thus, a gain or loss is not recognized for IRS purposes.⁴⁶ The Administrator’s decision does not address what characteristics convert a consolidation, executed strictly according to state law and precisely fitting the Medicare regulations description of consolidation, into a mere reorganization. The Board observes that all consolidations and mergers are to a large extent a form of reorganization as that term is commonly used.⁴⁷ The Agency was undoubtedly aware of the nature of these transactions as reorganizations when the regulations and guidelines were developed. The Agency, nevertheless, distinguished transactions that would result in a depreciation adjustment only by whether the constituent corporations were related. The Board finds that limited distinction is significant and binding as to whether the Provider is entitled to a revaluation of its depreciable assets.

⁴⁴ As discussed infra the writers of the original proposed regulation took the same view but that position was reversed through the rulemaking process.

⁴⁵ See also the Board’s decisions in AHS 96 Related Organization Costs Group Appeal v. Blue Cross and Blue Shield Association/Riverbend Government Benefits Administrator, PRRB Dec. No. 2003-D34, June 27, 2003 rev’d CMS Administrator, Aug. 20, 2003, unreported and Meridian Hospitals Corporation Group Appeal v. Blue Cross and Blue Shield Association/ Riverbend Government Benefits Administrator, August 20, 2003, unreported.

⁴⁶ Administrator’s Cushing/Goddard Decision. The Administrator acknowledges that Medicare reimbursement rules often diverge from IRS rules and Medicare policy is not bound by IRS’ policy.

⁴⁷ The Administrator’s Cushing/Goddard Decision, at footnote 11 points out that Massachusetts State law recognizes mergers and consolidations as forms of reorganizations.

The Provider contends it also qualifies for Medicare reimbursement of the loss commensurate with the revaluation, claiming that it is a required second step in the process of adjusting depreciation. The Intermediary contends, however, that the gain or loss recognition is not required even if revaluation is appropriate. Accordingly, the Board is confronted with two rules of construction which, in this case, will produce opposite results.

The Provider argues that a well established rule of construction applies. The consolidation regulation, subsection (1), must be viewed in the context of the entire regulation on depreciation, 42 C.F.R. § 413.134. Subsection (f), which deals with gains and losses, is also a part of the same regulation and an integral part of the greater reimbursement scheme on depreciation. It provides that “[i]f a disposal of a depreciable asset results in a gain or loss, an adjustment is necessary in the provider’s allowable cost.”

The Intermediary argues that its position is supported by an equally well established construction rule. The applicable regulation, 42 C.F.R. § 413.134(1), includes statutory mergers as well as consolidations. The language applicable to revaluation for both mergers and consolidations between unrelated parties is virtually identical. But, in sharp contrast to the consolidation part of the rule, the regulation on mergers goes on to provide expressly for a gain or loss to be calculated under subsection (f). The specific inclusion of gain or loss recognition in one section, but silence in a companion section, evidences an intent not to permit recognition of the gain or loss.

Since both interpretations are plausible, the Board must look to the Agency’s interpretation of the regulation for guidance. The Agency’s guidelines specific to consolidations were published in April, 1987 in the manual instructions on Change of Ownership. CMS Pub. 13-4 §§ 4500-4509. Under “General,” the Agency describes the rapidly changing healthcare delivery system over two decades resulting in restructuring of provider facilities. It states in part:

[t]hese sections present a set of working guidelines based on existing Medicare law, regulations and implementing general instructions for use by the Medicare fiscal intermediaries and by health care providers on the reimbursement implications of various types of changes of provider ownership (CHOW) transactions. . . .

The provisions of CMS Pub. 13-4 § 4502.7, entitled “Consolidation,” states “[a] consolidation is similar to a statutory merger, except that a new corporation is created . . .” This section furnishes the following example and reimbursement effect:

Corporation A, the provider, and Corporation B (a non-provider) combine to form Corporation C, a new corporate provider entity. By law, Corporations A and B

cease to exist. Corporations A and B were unrelated parties prior to the consolidation. . . .

* * * *

A gain /loss to the seller (Corporation A) and a revaluation of assets to the new provider (Corporation C) are computed.

(emphasis added).

The Board finds this specific statement of Medicare policy to be consistent with a reasonable, albeit not exclusive, interpretation of the regulation. This formal pronouncement of the Agency was issued to the intermediaries in 1987 with the intent of providing specific guidance as to their treatment of consolidations among unrelated parties.

In addition, two informal letters from high level Agency officials confirmed the Agency's view in 1987 and 1994 that recognition of a gain or loss on consolidation is required.⁴⁸

It is the Board's conclusion that the manual instructions, together with the history of the regulation's adoption and the Agency's consistent interpretations up until the time of the transaction at issue in this case fully resolve the question of whether a gain or loss is to be allowed. The acceptance of the doctrine that a consolidation transaction should result in a revaluation of the assets without a depreciation adjustment (gain/loss calculation) would render the regulatory provision a nullity and would contradict the symmetry of the regulatory scheme set forth under the Medicare program's allowance for depreciation.

While it is the Board's conclusion that the Provider qualifies for a loss on disposition of assets, there is no clear application of this directive to consolidations in either the Medicare regulations or manual instructions. The regulation at 42 C.F.R. § 413.134(1)(3)(i) instructs that the assets are to be revalued in accordance with subsection (g) entitled "Establishment of cost basis on purchase of facility as an ongoing operation." Subsection (g) does not specifically address the allocation of acquisition costs in a consolidation; however, it does address the typical bona fide sale situation. Subparagraph (3) which is pertinent to transactions after July, 1984⁴⁹ states the following:

⁴⁸ See Provider's Position Paper at Provider's Exhibits P-6 and P-56.

⁴⁹ The Deficit Reduction Act of 1984 changed the reimbursement effect of some CHOW transaction effective July 18, 1984. The practical effect is that Medicare would no longer allow a "write up" from the historical cost basis of acquired assets; however, a "write down" could occur.

(3) *Assets acquired by hospitals and SNFs on or after July 18, 1984 and not subject to an enforceable agreement entered into before that date.* Subject to paragraphs (b)(1)(ii)(B) through (G) and (b)(1)(iii) of this section, historical cost may not exceed the lowest of the following:

- (i) The allowable acquisition cost of the asset to the owner of record as of July 18, 1984 (or, in the case of an asset not in existence as of July 18, 1984, the first owner of record.);
- (ii) The acquisition cost to the new owner; or
- (iii) The fair market value of the asset on the date of acquisition.

42 C.F.R. § 413.134(g)(3).

Fair market value is defined as:

The price that the asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition. Usually the fair market price is the price that bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition.

42 C.F.R. § 413.134(b)(2).

The Provider argues that the liabilities assumed by Via Christi for the two hospitals' assets establish the consideration that is to be used as the acquisition cost. The Provider further contends that the acquisition cost resulted from arm's-length bargaining among unrelated consolidating parties, and thus, approximates the fair market value of the transaction. Accordingly, the Provider concludes that the revaluation of the assets and calculation of the loss is purely a function of allocating the consideration (liabilities assumed) among all of the assets acquired.⁵⁰

⁵⁰ 42 C.F.R. § 413.134(f)(2)(iv) provides that: “[i]f a provider sells more than one asset for a lump sum sale price, the gain or loss on the sale of each depreciable asset must be determined by allocating the lump sum sales price among all 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.” This provision also authorizes an appraisal if there is insufficient evidence of the fair market value.

In contrast, the Intermediary relies on the October, 2000 “Clarification” and cites the lack of motivation to maximize the sales price of depreciable assets to support denying reimbursement of the loss claimed by the Provider. The gain/loss regulation was not amended when the additional sections on consolidation and merger were added. The old sections clearly contemplate that an “acquisition cost” will have been determined through bona fide, arm’s length bargaining typical of a sale that is likely to produce fair market value.

A fundamental principle of Medicare reimbursement requires that the cost of covered services be reasonable and necessary. Reimbursement consequences of any transaction must ultimately be tested in light of this principle. The treatment of this transaction as a sale that would trigger a gain or loss calculation is especially perplexing because the providers, though consolidated under a new corporate structure, continued providing the same services using the same facilities and, to a great extent, using the same personnel.⁵¹ The Board is troubled that, if this transaction had been structured as a sale with the old providers creating their own buyer and dictating the terms, a loss would not have been recognized because it would have been treated as being between related parties. Related party rules and regulations prohibit “self-dealing” to obtain reimbursement from the Medicare program. The writers of the consolidation regulation failed to provider any reconciliation among the various regulations that may apply to these type transactions. The Agency must, therefore, accept some responsibility for this quagmire.

The Board acknowledges that there was no “disposition” of assets as that term is used in the regulation on gains and losses. However, the Board has previously concluded that the consolidation regulation, as written, insulates the application of the principles concerning “bona fide” and “arm’s length bargaining” to the relationship between the consolidating hospitals and their successor. Given the regulation’s explicit limitation on the application of the related party principle and the Agency’s long-standing interpretation that the regulation applies to non-stock company transactions, the Board finds no authority in the regulation or the guidelines in effect at the time of the transaction to permit motivations unique to non-profits to be a determining factor in the reimbursement treatment.

Pursuant to long-standing Medicare reimbursement policy, the ultimate goal of reimbursing depreciation is to compensate the provider for the actual consumption of its assets in providing care to Medicare patients. When ownership of depreciable assets changes, consumption is measured by changes in fair market value, typically reflected in the consideration paid for those assets. Assumption of debt is a well recognized component of consideration. In a consolidation, however, the terms are dictated by operation of law and there is typically no “consideration” other than the

⁵¹ Lack of disposition was also a factor in the Administrator’s Cushing/Goddard Decision “[n]o substantial change has been affected (sic) either in the nature or substance of the taxpayer’s capital position . . .”

amount of liability assumed.⁵² The Provider submitted the testimony of two ex-HCFA officials, both of whom were represented as having an integral role in the policy development of the consolidation regulations and guidelines. Despite intensive questioning by the Board and the Intermediary, neither was able to articulate how the financing of a consolidation under the state law formula of transferring all assets and liabilities produces a better gauge of consumption of depreciable assets for Medicare services than the estimate under straight line depreciation.⁵³ The Board is likewise unable to discern such rationale. Regardless of what the Agency's rationale may have been,⁵⁴ the Board is, nevertheless, bound by the regulation's directive to adjust depreciation when unrelated Medicare providers engage in a consolidation.⁵⁵

The Board concludes that evidence of a changing healthcare environment, combined with the lack of a market for provider facilities, is persuasive that the Provider incurred a genuine economic loss of value of their depreciable assets. The HHS Inspector General's 1996 report also supports the view that hospital facilities were losing value.⁵⁶

The Board further concludes that the process of finding a suitable consolidation partner requires arm's length evaluation and bargaining similar to that in a traditional sale, although the Board believes it may be imprecise in producing fair market value. The Medicare Intermediary Manual supports this view. CMS Pub. 13-4 § 4508.11 incorporates, as part of the Manual, Accounting Principles 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

⁵² The Board notes that the greater the difference between the book value of assets and the liabilities assumed, the more difficult the application of typical allocation methodologies become. To illustrate, Corporation A and B consolidate to form Corporation C. A has been prosperous, has high utilization, good revenues, assets with a book value of \$200 million and liabilities of \$150 million. B has foundered, occupancy has dropped precipitously, it has missed debt payments and is considering closing. It has assets with a book value of \$200 million but it has liabilities of \$225 million. Applying the Provider's position would result (assuming 100% Medicare utilization) in Medicare paying for a higher loss on the well run, prosperous Corporation A and recouping a gain on the poor performing Corporation B.

⁵³ Tr. 275:17-280:9 and 440:1-455:16

⁵⁴ Provider's witness, formerly a HCFA official, testified that the policy brought millions of dollars in gains to Medicare up until the early 1990s when a reduction in Medicare payments and the growth in managed care made medical facilities less valuable. Although there is no independent verification in the record of gains being recaptured on consolidations, the Intermediary did not controvert the testimony. See eg., Tr. 428:3-8.

⁵⁵ The Board also notes the Intermediary's and Administrator's arguments that the Providers made no effort to maximize the "sales price" of the assets by offering them on the open market. The Board finds nothing in the regulations to suggest that a provider must choose a transaction form that maximizes the benefit to Medicare provided the prudent buyer concept is followed. The evidence here is that the transaction and the parties to it were chosen based on numerous permissible factors.

⁵⁶ See Provider Exhibit P-103.

Medicare reimbursement purposes.” *Id.*⁵⁷ 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 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. . . .”

Despite the lack of nexus between liabilities assumed and fair market value, using liabilities assumed as the acquisition cost is supported by the 1987 letter written by HCFA’s Director of the Division of Payment and Reporting Policy, Office of Reimbursement Policy. It stated:

In a situation where the surviving/new corporation assumes liability for outstanding debt of the merged/consolidated corporations, the assumed debt would be viewed as consideration given. Thus, in a merger or consolidation of nonstock, nonprofit corporations in which the surviving or new corporation assumes debt of the merged or consolidated corporations, the basis of the assets in the hands of the surviving or new corporation would be the lesser of the allowable acquisition cost of the assets to the owner of record as of July 18, 1984 (gross book value), or the acquisition cost of the assets (amount of the assumed debt) to the new owner (the surviving or new corporation). In addition, 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). For purposes of calculating the gain or loss, the amount of the assumed debt would be used as the amount received for the assets, notwithstanding any limitation on depreciable basis imposed on the surviving/new corporation.⁵⁸

In a letter dated August 24, 1994,⁵⁹ HCFA’s Director, Office of Payment Policy, Bureau of Policy Development, agreed that a consolidation as defined in 42 C.F.R. § 413.134(1)(3)(i) required a determination of a gain or loss under 42 C.F.R.

⁵⁷ The Manual cautions, though, that in certain areas, Medicare policy deviates from that in generally accepted accounting principles.

⁵⁸ See Provider’s Position Paper at Provider’s Exhibit P-6.

⁵⁹ See Provider’s Position Paper at Provider’s Exhibit P-56.

§ 413.134(f). With respect to the apportionment of the sale price, the letter stated the following:

Within the context of Medicare payment policy, generally accepted accounting principles (GAAP) are recognized only when a particular situation is not addressed in the regulations. Because the allocation of purchase price is addressed in both a regulation and in the instructions, GAAP (APB-16) would not apply. The regulations at 42 C.F.R. § 413.134(f) (2) (iv) and § 104.14 of the Provider Reimbursement Manual, require that when more than one asset is sold for a lump sum sales price, the gain or loss on the sale of each depreciable asset must be determined by allocating the lump sum sales price among all the assets sold in accordance with the relative fair market value of each asset. The allocation must be to all assets and must be proportionate to their relative fair market value. In the situation you described, since the sales price was a lump sum and the fair market value exceeds the sales price, the sales price must be apportioned among all the assets transferred proportionate to their relative fair market value.

(emphasis in original).

The Board concludes that the assumption of liabilities through a consolidation transaction is persuasive evidence of acquisition costs. Liabilities assumed in a consolidation also may, but do not necessarily, equate to fair market value.

With respect to the calculation of the loss resulting from this consolidation, the Intermediary has consistently maintained that the loss claimed by the Provider should not be recognized. Consequently the Intermediary's audit determinations have not addressed the methodologies associated with the calculation of the loss. Because the Intermediary posed the issue as "all or nothing," the Provider did not present any meaningful discussion in their briefs, exhibits or testimony about the methodology for computing a loss in the case of a consolidation.⁶⁰

In evaluating the calculation of the loss, the Board has considered various allocation methodologies, the applicable governing authorities, and the evidence presented. It is the Board's conclusion that the acquisition cost, i.e., the amount of assumed liabilities must be prorated among the Provider's assets transferred using the proportionate value method set forth in 42 C.F.R. §413.134(f)(2)(iv). The manual provisions at CMS Pub. 13-4 § 4506, entitled "Revaluation of Assets and Gain/Loss

⁶⁰ The Intermediary's stipulated that it did not contest the "approach used" for computation as reflected in Provider's Exhibit 52. See Provider's Exhibit P-115 stipulations dated April 26, 2002, paragraph 3.

Computation," provide further guidelines for applying the allocation procedures under this methodology. Because neither party has fully addressed the calculation aspect, the Board remands this matter to the Intermediary for the proper calculation of the loss pursuant to the governing regulatory and manual provisions.

DECISION AND ORDER:

The Intermediary's adjustments disallowing the Provider's claimed loss on disposal of assets due to a change of ownership resulting from a consolidation were contrary to the regulatory requirements of 42 C.F.R. § 413.134(1)(3)(i) and are reversed. The matter is hereby remanded to the Intermediary for the proper calculation of the loss pursuant to the governing regulatory and manual provisions.

BOARD MEMBERS PARTICIPATING:

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

DATE: September 29, 2003

FOR THE BOARD:

Suzanne Cochran
Chairman