PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2004-D14

PROVIDER –
Moore Regional Hospital, Inc.
Pinehurst, North Carolina

Provider No. 34-0115

vs.

INTERMEDIARY –
Blue Cross Blue Shield Association/
Palmetto Government Benefits
Administrators

DATE OF HEARING -
Live Hearing
May 7-8, 2003

Cost Reporting Period Ended
October 31, 1995

CASE NO. 98-1861

INDEX

ISSUE:

Was the Intermediary's determination disallowing the loss incurred on change of ownership proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Moore Regional Hospital, Inc., ("Provider"), a Medicare certified provider of services, and Montgomery Memorial Hospital ("MMH"), merged into a new corporation named FirstHealth of the Carolinas, Inc. ("FirstHealth") and claimed a loss on the disposal of its depreciable assets resulting from the merger. Blue Cross and Blue Shield of North Carolina ("Intermediary") audited the Provider's cost report and disallowed the loss.[1] The Provider timely appealed the Intermediary's 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 $5.8 million.[2]

The Provider was represented by Robert E. Mazer, Esq., of Ober, Kaler, Grimes & Shriver. The Intermediary was represented by Eileen Bradley, Esq., Associate Counsel, Blue Cross Blue Shield Association.

Medicare Statutory and Regulatory Background:

The Medicare program was established in 1965 under Title XVIII of the Social Security Act (the "Act") to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Secretary of the Department of Health and Human Services is authorized to promulgate regulations prescribing the methods of determining Medicare payments and items to be included. The Centers for Medicare and Medicaid Services ("CMS") is the operating component of the Department of Health and Human Services ("DHHS") charged with the administration of the Medicare program.[3] 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 interpretative guidelines published by CMS. Id.

Under the Medicare statute, during the fiscal year in issue, a provider was entitled to claim as a 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 is set initially at its "historical cost," generally equal to the purchase price. 42 C.F.R. §413.134(a)(2)(b)(1). To determine annual depreciation, the historical cost was then prorated over the asset's estimated useful life.

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[1] Palmetto Government Benefits Administrators replaced Blue Cross and Blue Shield of North Carolina as the responsible intermediary.

[2] Provider's Supplemental Position Paper at 5. Intermediary's Position Paper at 1 and 4. Provider's Post Hearing Brief at 59.

[3] CMS was formerly the Health Care Financing Administration ("HCFA").

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.[4]

Because the calculated annual depreciation is 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.[5] 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.

The regulation providing for gain or loss originally dealt with disposition of assets through sale, scrapping, trade-in, exchange, demolition, abandonment, condemnation, fire, theft or other casualty. In 1979, CMS extended the depreciation adjustment to "complex financial transactions" not previously addressed in subsection 42 C.F.R. § 413.134(f) by including mergers and consolidations. A statutory merger between unrelated parties was treated as a sale of assets that would trigger: (1) the revaluation of assets in accordance with 42 C.F.R. §413.134(g), and (2) the realization of gains and losses under the provisions of 42 C.F.R. §413.134(f). However, a statutory merger between related parties would not trigger a gain or loss adjustment. Likewise, a consolidation between two or more corporations that were unrelated resulted in a depreciation adjustment. No revaluation was allowed if related corporations consolidated. 42 C.F.R. §413.134(e)

Background of the Merger and Medicare Claimed Loss:

During the early part of 1995, the Provider and MMH began to discuss the benefits of combining their two facilities. The Provider's witness testified that it was important that the transaction not appear as an acquisition or takeover of one by the other. Rather, the hospitals wanted to become part of an overall new entity. Tr. 98:6-17-138:9. North Carolina law did not permit the two hospitals to consolidate into a new corporation that would come into existence only upon consummation of the transaction. It did allow for a statutory merger of one or more existing corporations into another existing corporation, however. The Provider and MMH, therefore, decided to create the new entity into which they would merge. Together they drafted a Merger Statement addressing such factors as their strategic fit, an overview of a merger, organizational structures, etc.[6] On July 12, 1995, representatives of the Provider and MMH signed a Letter of Agreement and a

[4] The Medicare Act has been amended to change the method of payment for capital assets.
[5] A depreciation adjustment for a gain or loss was removed from the program's regulations effective December 1, 1997.
[6] Exhibit P-1.

document entitled "Principles of Merger," which contained more details about the construct of the merger.[7]

The Provider directed its attorney to assist it in the transaction to incorporate the new company, Moore Regional Hospital Acquisition Corporation. The attorney became the sole director. Two days later, the attorney amended the Articles of Incorporation to change the name of the corporation to FirstHealth of the Carolinas, Inc. On September 26, 1995, the attorney adopted bylaws for FirstHealth which included the appointment of a Board of Directors to replace himself as the sole director. On November 1, the Provider and MMH merged into FirstHealth, making FirstHealth the only surviving entity.

The loss claimed was calculated to be 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 FirstHealth in exchange for those assets. The Medicare portion of the loss, as computed by the Provider, was approximately $5.8 million.[8]

Parties' Contentions:

The Intermediary determined that the loss was unallowable for Medicare reimbursement because, among other reasons, it resulted from a related party transaction. It relies on 42 C.F.R. § 413.17, which provides that parties are related where there is common ownership or control. The regulations further provide that control exists if an individual or organization has the ability, either directly or indirectly, to significantly influence the actions or policies of an organization. The Intermediary raises several bases for finding that the parties were related, only one of which is relevant to the Board's finding. The Intermediary asserts that the Provider created a related party relationship when it assumed the financial responsibility, leadership and related support to establish a corporation into which it would merge.

The Provider responds that there was no related party relationship between what it believes are the only relevant parties to the transaction: the Provider and MMH. It argues that FirstHealth should not be considered because it was merely a "shell" until the merger when the Provider and MMH ceased to exist.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

There is no dispute that the transfer of the Provider's assets and liabilities to FirstHealth was the result of a "statutory merger" executed in accordance with state law. Medicare regulations regarding losses stemming from a statutory merger are found at 42 C.F.R. §413.134(l)(2). In pertinent part, these regulations state:

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[7] Exhibit P-2. Provider's Post Hearing Brief at 3. Intermediary's Post Hearing Brief at 11.

[8] Provider's Supplemental Position Paper at 10. Provider's Post Hearing Brief at 59.

> (2) *Statutory merger*. A statutory merger is a combination of two or more corporations under the corporation laws of the State, with one of the corporations surviving.
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> (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). . . may be revalued. . . . 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. . . .
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> (ii) *Statutory merger between related parties*. If the statutory merger is between two or more related corporations (as specified in §413.17), no revaluation of assets is permitted for those assets acquired by the surviving corporation. . . .

42 C.F.R. § 413.134(l)(2)(i) and (ii).

Accordingly, the key issue to be decided in this case is whether the merger was a related party transaction or, in other words, whether there was any common ownership or control among the merging parties pursuant to 42 C.F.R. § 413.17. The relevant provisions of that regulation state:

> (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.
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> * * * *
>
> (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.

The Board finds that the Provider and FirstHealth were related parties and that the Intermediary's denial of the loss was proper. This conclusion is based upon the undisputed evidence that the Provider created and controlled FirstHealth prior to the effective date of the merger. The record shows that the Provider engaged an attorney to serve as its "counsel on the transaction."[9] This attorney, while under the direction and employ of the Provider, established FirstHealth with Provider funds, and was appointed as the new corporation's sole director. Thereafter, on September 26, 1995, the attorney adopted amended and restated bylaws for FirstHealth, authorized a fifteen (15) member Board of Directors, and appointed fourteen (14) members to that board.[10] Notably, the

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[9] Tr. May 7 at 103 and 178. Exhibit I-2 at 25.

[10] Exhibit P-3.

Board of Directors of FirstHealth as of September 27, 1995, prior to the effective date of the merger, consisted of five (5) members of the Provider's existing Board in addition to seven (7) other members who were nominated by the Provider.[11] Prior to the merger, eighty percent (80%) of FirstHealth's board was comprised of the Provider's representatives. The Provider's dealings with FirstHealth were, in essence, doing business with itself. The Provider's own witnesses admitted as much:

> Q. Are you saying that Moore Regional Hospital and FirstHealth are one and the same essentially?
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> A. At that time, sure. Of course they were.

Tr. May 7 at 227.

> Q. November 1, whenever the merger was. You have got to have a merging partner prior to the merger. Right? It is not like a consolidation whereas two disappear and evolve into another.
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> A. Right. It is where one disappears into another.
>
> Q. Right. How could they not be related?
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> A. If you look at them [the Provider and FirstHealth] on a day, or a month, or three months, well, of course they were related. Moore's lawyer wrote it all, but that is not in my view realistic to look at it.

Tr. May 8 at 138.

The Board disagrees with the Provider's argument that relatedness between itself and FirstHealth is irrelevant because FirstHealth was nothing more than a non-operating "shell corporation" prior to the effective date of the merger. The Provider asserts that the Board has previously relied on the notion of a "shell corporation" to find that the parties were not related by control, citing North Iowa Medical Center v. Blue Cross and Blue Shield Association, PRRB Dec. No. 2000-D52, May 2, 2000, Medicare & Medicaid Guide (CCH) ¶ 80,442, rev. CMS Administrator, June 28, 2000. North Iowa and St. Joseph were unrelated parties. They originally contemplated a consolidation but settled on St. Joseph's outright purchase of North Iowa's assets. St. Joseph created a new nonprofit corporation to hold the assets it purchased from North Iowa and eventually sold its own assets to the new corporation as well. When North Iowa claimed a loss on the sale, the Intermediary argued that North Iowa significantly controlled the new corporation and was thus a related party disqualified from recognition of the loss.

The Provider relies on the Board's comment that the new corporation created by St. Joseph to hold the North Iowa assets purchased was a "shell" with no operations or physical assets prior to the purchase. It asserts that the same circumstances are present

[11] Exhibit I-12 at 5. Tr. May 7, at 223.

here and should result in the Board treating Moore and Montgomery as the only parties to the transaction, effectively ignoring FirstHealth as merely a shell corporation.

The Provider overlooks the context. The Board's "shell" comment was in response to the Intermediary's argument that North Iowa was, in fact, actually exerting control over the new corporation created by St. Joseph. The Board observed that, as a "shell," there were no activities or assets over which North Iowa, with only a Class B membership, could have asserted control.

It is also significant that the North Iowa case involves only the treatment of North Iowa's loss. Had the new corporation's creator, St. Joseph, been claiming a loss on its eventual sale to the new corporation, St. Joseph's position would be parallel to the Provider's position in this case. The Provider, the creator of FirstHealth, orchestrated and financed FirstHealth's activities and staffing prior to the merger. The Provider, therefore, merged into an organization over which it had control and is not entitled to reimbursement treatment as an unrelated party.

Even if the concept of a non-operating shell corporation had application to the circumstances, the Board finds that FirstHealth, prior to the effective date of the merger, was a viable operating entity. For example, FirstHealth's Board of Directors met on September 27, 1995[12] and designated depositories for the corporation's funds and approved the pertinent Plan of Merger, which included the adoption of bylaws and appointment of officers. It even acquired Montgomery County Primary Care Group, which had been a subsidiary of MMH, and approved the assumption of the Provider's bond obligations as well as those of MMH, all prior to the merger.

The Board also disagrees with other arguments presented by the Provider to show that FirstHealth's existence prior to the effective date of the merger did not create a related party situation. The Provider cites the Medicare State Operations Manual as saying: "[i]n general, the key date regarding a newly-formed corporation is not the incorporation date (the date the corporation came into legal existence), but the date a provider was conveyed to the new corporation." These manual instructions are inapplicable to the instant case in that they apply to the effective date of a provider's qualification for certification in Medicare, not when a corporation became a viable entity under a state's corporation laws.

The Provider also argues that case law addressing "two-step transactions" supports its position that the organization of FirstHealth prior to the merger is irrelevant to a related party determination. The Provider asserts that various courts reviewing these transactions have held that where the parties were unrelated prior to commencement of the change of ownership transaction, the fact that relatedness may occur prior to its completion does not bar asset revaluation and concomitant recognition of gain or loss.[13] These cases pertained

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[12] Exhibit I-13 at 40.

[13] See e.g., See e.g., Humana v. Heckler, 758 F.2d 696, 705, Medicare and Medicaid Guide (CCH) ¶ 34,572 at 9827-9829, *cert. denied*, 474 U.S. 1055 (1996); PIA-Asheville, Inc. v. Bowen, 850 F.2d 739, Medicare and Medicaid Guide (CCH) ¶ 37,162 (D.C. Cir. 1988); Pacific Coast Medical Enterprises v.

to one corporation acquiring another through the purchase of stock. Then, either concurrently with the stock purchase or shortly thereafter, the acquiring corporation dissolved the acquired corporation and thereby directly acquired the assets. These cases are unlike the instant case in that the acquiring corporation was unrelated to the corporation that was being acquired. The fact that the asset acquisition was accomplished in two steps did not deprive the transactions being between unrelated parties.

As the Provider acknowledges, other options were available to the Provider and MMH that would have allowed them to join operations (perhaps establishing an allowable Medicare loss) without having to form FirstHealth. For example, either party could have merged into the other or there could have been a sale and purchase by one of the corporations of the other's assets. This type of arrangement conflicted with the Provider's and MMH's desire to avoid a public image by one corporation taking over the other. The Provider cannot have it both ways. It chose a statutory merger with a corporation it created and to which it is, therefore, related. It must also accept the reimbursement consequences dictated by the regulation

Finally, the Provider argues that, had it not been for North Carolina state law, the Provider and MMH could have consolidated rather than merged. Under a consolidation FirstHealth would not have come into existence until the transaction's consummation, and Medicare rules would have required recognition of the subject loss.[14] However, the fact remains that a statutory merger did occur, and the Board is bound by 42 C.F.R. §413.134(l)(2)(i) and (ii) quoted previously which established the reimbursement consequences of a merger.

DECISION AND ORDER:

The Intermediary properly denied the Provider's claim to be reimbursed for a loss on the disposal of its depreciable assets resulting from a change of ownership (CHOW). The statutory merger effectuating the CHOW was a related party transaction. The Intermediary's adjustment is affirmed.

Harris, 633 F.2d 123, 132-136 Medicare and Medicaid Guide (CCH) ¶ 30,414 (9th Cir. 1980); and, West Seattle General Hospital v. United States, 674 F.2d 899, 902-03, Medicare and Medicaid Guide (CCH), ¶ 31,874 at 9337-38 (Ct. Cl. 1982).

[14] As the Provider points out, the Board has found that where the transaction is structured as a consolidation (the surviving corporation comes into existence at the moment the combining corporations cease to exist), the regulations specifically permit recognition of a loss despite the consolidation parties having established their successor. See Board's decisions in 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 , and AHS 96 Related Organization Cost Group Appeal v. Blue Cross and Blue Shield Association/ Riverbend Government Benefits Administrator, PRRB Dec. No. 2003-D34, June 27, 2003, Medicare and Medicaid Guide (CCH) ¶81,020 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, PRRB Dec. No. 2003-D35, July 2, 2003, Medicare and Medicaid Guide (CCH) ¶81,021, rev'd, CMS Administrator, August 20, 2003, unreported.

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DATE: April 15, 2004

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