PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2006-D23

PROVIDER -
UPMC - St. Margaret Hospital
Pittsburgh, Pennsylvania

Provider No.: 39-0102

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Veritus Medicare Services

DATE OF HEARING -
June 6, 2005

Cost Reporting Period Ended -
February 28, 1997

CASE NO.: 00-2689

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ISSUE:

Whether the Intermediary's audit adjustments to the Medicare cost report that disallowed the loss on disposal of depreciable assets due to the facility's change of ownership (CHOW) were 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. §1395(h), 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 proportion 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 Medicare statute in effect during the fiscal year at issue, a provider was entitled to claim as reimbursable cost for its outpatient population the depreciation (i.e., the systematic amortization of cost over time) of buildings and equipment used to provide health care to Medicare patients. Regulations provided that an asset's depreciable value was set initially at its "historical cost," generally equal to the purchase price. 42 C.F.R. §413.134(a)(2). To determine annual depreciation, the historical cost was then prorated over the asset's estimated useful life. 42 C.F.R. §413.134(a)(3). Providers were then reimbursed on an annual basis for a percentage of the yearly depreciation equal to the percentage the asset was used for the care of Medicare patients.[1]

Because the calculated annual depreciation was only an estimate, the regulation at 42 C.F.R. §413.134(f) provided for the determination of a depreciation adjustment where a provider incurred a gain or loss on the disposition of a depreciable asset.[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 consideration received for the asset was

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[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.

less than the estimated remaining value. In the event of a loss, the Medicare program assumed that more depreciation occurred than was originally estimated, and the provider received additional reimbursement in the form of a depreciation adjustment. Conversely, if a provider received consideration for a disposed asset that was greater than the depreciated basis, then a "gain" had occurred, and the Medicare program recaptured its share of previously reimbursed depreciation paid to the provider.

In 1979, CMS extended the depreciation adjustment to "complex financial transactions" not previously addressed in 42 C.F.R. §413.134(f) by including mergers and consolidations. A statutory merger between unrelated parties was treated as a sale of assets that would trigger: (1) the revaluation of assets in accordance with 42 C.F.R. §413.134(g), and (2) the realization of gains and losses under the provisions of 42 C.F.R. §413.134(f). However, a statutory merger between related parties would not trigger a gain or loss adjustment.

Medicare's rules regarding "relatedness," 42 C.F.R. §413.17, state in pertinent part:

> (b) *Definitions.* (1) *Related to the provider*. Related to the provider means that the provider to a significant extent is associated or affiliated with or has 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:

On June 3, 2005 UPMC St. Margaret (Provider) and Blue Cross Blue Shield Association/Veritus Medicare Services (Intermediary) jointly stipulated to the following facts relevant to this decision:

1. On November 4, 1996 and at all times through and including February 28, 1997, St. Margaret Memorial Hospital (SMMH) was a Pennsylvania nonprofit corporation and a duly licensed general hospital located in Allegheny County, Pennsylvania, its sole corporate member was St. Margaret Health Systems, Inc. (SMHS).

2. On November 4, 1996 and at all times therafter, the University of Pittsburgh Medical Center System (UPMCS) was a Pennsylvania nonprofit corporation situated in Pittsburgh, Allegheny County, Pennsylvania and the parent and

corporate member of a major academic center and integrated health care system headquartered in the City of Pittsburgh, Pennsylvania, Allegheny County.

3. On November 4, 1996, officers of St. Margaret Hospital and UPMCS co-signed a letter described in its paragraph 16 as a non-binding Letter of Intent. A true and correct copy of this letter is marked as Intermediary Exhibit 22, pages 4 to 11 (Letter of Intent).

4. Without limiting the opportunity of the Provider or Intermediary to further analyze the Letter of Intent, the parties agree it outlined a process of proposed integration of St. Margaret Hospital with the UPMCS system. Paragraph 17 set forth suggested target dates for an execution of a more definitive agreement and also a closing date.

5. On January 10, 1997, a Pennsylvania nonprofit corporation named University of Pittsburgh Medical Center, St. Margaret (UPMC St. Margaret) was incorporated, but it was not operational until March 1, 1997. At the time of incorporation and at all times through the Merger Date (defined below), UPMCS was the sole corporate member of UPMC St. Margaret. The only incorporator was an officer of St. Margaret Hospital.

6. On February 3, 1997, UPMCS and SMMH executed the MERGER and AFFILIATION AGREEMENT (Agreement), a true and correct copy of which is marked as Exhibit H in the Provider's Position Paper.

7. Without limiting the opportunity of the Parties to analyze the document further, the Parties agree that the Agreement:

    A. Contemplated the statutory merger of SMHS and SMMH into UPMC St. Margaret, said merger to occur on the Merger Date which was defined as 11:59 p.m. on February 28, 1997 (Merger Date).

    B. Identified UPMCS as the sole corporate member of UPMC St. Margaret (paragraph 3.2a).

    C. Set forth the reserved powers of UPMCS with regard to UPMC St. Margaret (Article X).

    D. Established a 5-year integration period (paragraph 10.1 and 10.2).

    E. Established the procedure for appointment of the Board of Directors of UPMC St. Margaret, defined the powers of that Board (paragraph 10.3), and identified its executives and the process for termination and replacement of executives.

8. At all times prior to February 28, 1997, St. Margaret Hospital and UPMC had no common board member and officers and had no common ownership interest in each other.

9. While UPMC St. Margaret was incorporated on January 10, 1997, its officers and directors selected pursuant to the procedures in the Agreement did not take those positions and did not exercise corporate governance power until the Merger Date. However, the President of St. Margaret Hospital who was designated as President of UPMC St Margaret signed the new Medicare Participation Agreement on its behalf prior to the Merger date.

10. SMMH, prior to the Merger Date, was an approved provider participating in the Medicare and Medicaid programs and was in compliance with the conditions of participation in those programs and the provider contracts with these programs.

11. UPMC St. Margaret became a Medicare provider on the Merger Date pursuant to procedures and notices required by 42 C.F.R. §489.18(c).

12. Following the closing on the Merger Date, UPMC St. Margaret succeeded by operation of law to and assumed all rights and obligations of SMHS and SMMH under the Non-Profit Corporation Law of Pennsylvania.

13. On the Merger Date, the assets, liabilities, reserves and accounts of each of SMHS were taken upon the books of UPMC St. Margaret at the amounts they were being carried on the books of SMMH immediately prior to the closing, subject to any adjustments which were required in accordance with generally accepted accounting principles giving effect to the Merger Date.

14. Of the (12) UPMC St. Margaret Board members who initially comprised the Board following the merger, seven (7) had been on either the Board of SMHS or SMMH.

15. All Officers and directors of the newly created entity owed a fiduciary duty to the new entity, UPMC St. Margaret.

16. All actions taken pursuant to the Agreement were done pursuant to Pennsylvania law.

On its filed Medicare cost report for the period ended February 28, 1997, St. Margaret Memorial Hospital claimed a loss of $13,244,231 resulting from the statutory merger of SMHS and SMMH into UPMC St. Margaret. The Intermediary denied the loss, and the Provider appealed this determination to the Board. The Provider's filing meets the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841. The Provider was represented by Samuel W. Braver, Esquire, of Buchanan Ingersoll, P.C. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law, regulations, program instructions, evidence, parties' contentions and post-hearing briefs, finds and concludes that the Provider is entitled to claim a loss on disposal as a result of the statutory merger of SMMH and SMHS into UPMC St. Margaret. There are two fundamental arguments offered by the Intermediary in its denial of the above loss. First, that the parties, through various actions before and after the merger, retained significant control of the merged corporations as defined in 42 C.F.R. §413.17. Specifically, the Intermediary argues that affiliating parties negotiated the terms and structure of the corporation that would take the assets and liabilities of the loss-claiming hospital. Furthermore, there was a carry forward of top executives and board members that preserved the influence of the new corporation's creators. Second, the transfer of assets to the merged entity (UPMC St. Margaret) was not a bona fide, arms-length transaction between two non-related, independent parties where the purchase price was negotiated in any fashion resembling open market buyer/seller behavior.[3] The Intermediary supports these positions with relevant CMS Administrator reversals of Board decisions in which the Board permitted similar losses on mergers or consolidations. The Board will address each of these arguments.

The Board finds that the merger at issue was a statutory merger under Pennsylvania state law. The Medicare regulation at 42 C.F.R. §413.134(k)(2)(i) provides for the reimbursement effect of a merger as follows:

> If the statutory merger is between two or more corporations that are unrelated (as specified in §413.17), the assets of the merged corporation(s) acquired by the surviving corporation may be revalued in accordance with paragraph (g) of this section. If the merged corporation was a provider before the merger, then it is subject to the provisions of paragraphs (d)(3) and (f) of this section concerning recovery of accelerated depreciation and the realization of gains and losses.

The first question to be decided by the Board is, therefore, whether the merger was between unrelated parties. While it undisputed that SMHS/SMMH and UPMC were unrelated prior to the merger, the Intermediary argues that the transaction to be scrutinized here is the relationship between SMHS/SMMH and UPMC St. Margaret (rather than the relationship between SMHS/SMMH and UPMC) and concludes that these parties were, in fact, related prior to the merger. The Intermediary argues further that the phrase "between related parties" requires that the merger transaction be examined for relationships after the transaction as well. It directs us to the related party regulation at 42 C.F.R. §413.17 set forth previously on pages 4 and 5 of this decision.

In particular, the Intermediary relies on subsection (3) that discusses control. It contends that because there was, in fact, a carry forward of board members pre and post affiliation,

[3] Intermediary's Supplemental Position Paper, pages 3 and 4.

a carry forward of executives, and other factors in the structure of the surviving entity which preserve the influence of the creators, there is a "continuity of control" that results in the parties being related. The Intermediary contends that this relationship between the old and new entities disqualifies the transaction from revaluation of assets. In support, the Intermediary cites the August 7, 2001 CMS publication entitled: "Clarification of the Application of the Regulations at 42 C.F.R. §413.134(1) to Mergers and Consolidation involving Non-profit Providers." The August 2001 "clarification" states, in part:

> [W]hether 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 merger regulation to be dispositive of the Intermediary's argument. As stated in 42 C.F.R. §413.134(k)(2)(i), "If the statutory merger is between two or more corporations that are unrelated (as specified in §413.17), the assets of the merged corporation(s) acquired by the surviving corporation may be revalued in accordance with paragraph (g) of this section." The Board concludes that the regulation precludes the application of the related party principle to the merging parties' relationship after the merger. The evolution and construction of the regulation reflects the Secretary's deliberate rejection of the position proposed by the Intermediary and a determination that only the relationship of the merging parties before the merger is relevant to whether assets would be revalued.

The Board's conclusion is further buttressed by the Secretary's interpretive guidelines published long before the August, 2001 "clarification," which evolved four years after the fiscal year in issue. With regard to mergers, CMS Pub. 13-4 §4502.6 states, in part: "Medicare program policy permits a revaluation of assets affected by corporate mergers between unrelated parties."

The Intermediary argues that St. Margaret Hospital was related to UPMC St. Margaret before the merger. UPMCS chose to create its new subsidiary, UPMC St. Margaret. UPMC lawyers drew up the incorporation documents of UPMC St. Margaret and UPMC paid the incorporation fees. Furthermore, the only incorporator of UPMC St. Margaret was an officer of SMHS/SMMH, and it was the officers who signed the new Medicare participation agreement rather than an officer of UPMC. Finally, the Intermediary argues that other than UPMC creating another subsidiary for itself, it did not change. The only entities that merged into UPMC St. Margaret were SMHS/SMMH, the provider entity which is claiming a loss on this merger transaction. These facts, the Intermediary argues, are proof that a related party relationship existed prior to the merger.

The Board observes that in a merger, the surviving entity must be in existence prior to the merger. Further, the signing of the Merger and Affiliation Agreement and the Medicare agreement was necessary to assure the continuity required to complete and execute the

merger. Various documentation to effectuate the merger does not, in itself, create a related party transaction.

The Intermediary also points out that this case illustrates control as defined in 42 C.F.R. §413.17 because of the five-year transition period where SMHS retained significant powers on the Board of Directors of the surviving corporation (UPMC - St. Margaret). The Board finds that the very nature of a merger would likely result in some overlap of board members of the merging corporation and the surviving entity as well as a continuation of other operations and personnel of the old organizations. 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 owner was permissible.

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 bona fides of sales transactions addressed in 42 C.F.R. §413.134(f)(2). However, the Board observes that while it is aware that the regulation on mergers may be interpreted as applying only to stock transactions, the Agency 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. 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, it asserts that "special considerations" apply.

The Board acknowledges that there was no "disposition" of assets as that term is used in the regulation on gains and losses and that the Providers, through merger under a new corporate structure, continued to provide substantially the same services using essentially the same facilities and personnel. However, given the regulation's explicit limitation on the application of the related party principle and the Agency's longstanding 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.

Regarding the calculation of the loss, the Board finds, as it has consistently done in the various cases that it has reviewed, that it should be based on 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 Computation" provide further guidelines for applying the allocation procedures for this methodology. The Board observes that the Provider submitted a calculation using this method (Booth Method) as part of its post-hearing submissions. (See Provider Exhibit P-10A). This computation also followed previous Board decisions in that it removed an allocation of the consideration to intangibles and gave effect to the impact of the DEFRA adjustment.

The Board remands this calculation to the Intermediary for further review, analysis and verification of amounts included in the calculation. The Board observes that the Provider

used average utilization to establish the amount of the loss allocable to Medicare. The Intermediary should have access to actual utilization data which should be used to recompute the loss.

DECISION AND ORDER:

The loss resulting from the statutory merger is allowable under Medicare regulations. The case is remanded to the Intermediary to review the Provider's calculation using the proportionate value method as addressed in 42 C.F.R. §413.134(f)(2)(iv). The Intermediary's adjustments are reversed.

BOARD MEMBERS PARTICIPATING:

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

FOR THE BOARD:

DATE: May 26, 2006

Suzanne Cochran
Chairperson