PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2010-D12

PROVIDER - Ober Kaler 2005 & 2006 Illinois Provider Tax Groups; Southern Illinois Hospital Services 2005 & 2006 Illinois Provider Tax Groups; Memorial Health System 2005 Illinois Provider Tax Group; Blessing Health System 2005 Illinois Provider Tax Group

Provider Nos.: Various - See Appendix I

vs.

INTERMEDIARY –
BlueCross BlueShield Association/ National Government Services

DATE OF HEARING -
November 21, 2008

Cost Reporting Periods Ended - Various - See Appendix I

CASE NOs: 06-2136G; 07-2590G; 08-2765GC; 08-2961GC; 08-2963GC; 08-2964GC

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ISSUE:

Whether the Intermediary's disallowance of the Illinois property tax assessment was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of Medicare services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§ 413.20 and 413.24.

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §§405.1835-405.1837.

Medicare reasonable cost reimbursement is governed by 42 U.S.C. §1395x(v)(1)(A). In part, the statute provides that the ―reasonable cost of any service shall be the actual cost incurred excluding any part of such costs found to be unnecessary in the efficient delivery of needed health services. The implementing regulation at 42 C.F.R. §413.9 provides that reasonable cost includes all ―necessary and proper costs incurred in furnishing healthcare services, subject to principles relating to specific items of revenue and cost.

Consistent with the above statutory and regulatory provisions, CMS Pub. 15-1 Medicare Provider Reimbursement Manual ("PRM") § 2122 contains provisions regarding when taxes paid by a provider are considered allowable reasonable costs under Medicare. The relevant PRM provisions are as follows:

> **PRM § 2122.1 - The General Rule**
>
> The general rule is that taxes assessed against the provider, in accordance with the levying enactments of the several States and lower levels of government and for which the provider is liable for payment, are allowable costs. Tax expense should not include fines

and penalties.

Whenever exemptions to taxes are legally available, the provider is expected to take advantage of them. If the provider does not take advantage of available exemptions, the expenses incurred for such taxes are not recognized as allowable costs under the program.

PRM § 2122.2 – Taxes Not Allowable as Costs

Certain taxes which are levied on providers are not allowable costs. These taxes are:

A. Federal income and excess profit taxes, including any interest or penalties paid thereon (see § l2l7).

B. State or local income and excess profit taxes (see § l2l7).

C. Taxes in connection with financing, refinancing, or refunding operations, such as taxes on the issuance of bonds, property transfers, issuance or transfer of stocks, etc. Generally, these costs are either amortized over the life of the securities or depreciated over the life of the asset. They are not, however, recognized as tax expense.

D. Taxes from which exemptions are available to the provider.

E. Special assessments on land which represent capital improvements such as sewers, water, and pavements should be capitalized and depreciated over their estimated useful lives.

F. Taxes on property which is not used in the rendition of covered services.

G. Taxes, such as sales taxes, levied against the patient and collected and remitted by the provider.

H. Self-employment (FICA) taxes applicable to individual proprietors, partners, members of a joint venture, etc.

The Medicare principles of reasonable cost reimbursement provide that refunds of previous payments must be deducted from a provider's costs associated with such payments. The Medicare regulation at 42 C.F.R. § 413.98(a) provides that "discounts and allowances received on purchases of goods or services are reductions of the costs to which they relate. Similarly, refunds of previous expense payments are reductions of the related expense." The term "refunds" is defined under the regulation as "amounts paid back or a credit allowed on account of an overcollection." 42 C.F.R. § 413.98(b)(3).

The PRM § 802.31 defines "refunds" as "amounts paid back by the vendor, generally in recognition of damaged shipments, overpayments, or returned purchases." The PRM §804 provides that "discounts, allowances, refunds, and rebates are not to be considered a form of income. Rather, they should be used to reduce the specific costs to which they apply in the accounting period in which the purchase occurs."

The Medicaid statute and regulation permits the states to impose taxes on classes of health care providers of services. 42 U.S.C. § 1396a(a)(2); 42 C.F.R. §433.50. The states can then use those tax revenues to pay for medical services to Medicaid enrollees, and are permitted to claim Federal Matching Assistance Payments ("FMAP") for those Medicaid expenditures. 42 U.S.C. §1396b(w); 42 C.F.R. §433.68. In order for such Medicaid expenditures to be available for FMAP, the taxes that generate the revenues must meet certain requirements and conditions. Specifically, the health care related taxes must be both "broad-based" and "uniform" as those terms are defined. Id. The term "broad-based" tax means that it is imposed "with respect to all items or services in the class [of health care provider] furnished by all non-Federal, nonpublic providers in the State." 42 U.S.C. §1396b(w)(3)(B)(i); 42 C.F.R. §433.68(c). A tax is considered to be imposed uniformly if, generally, "the amount of the tax imposed is the same for every provider providing items or services within the class" or, if it is based on the number of beds (licensed or otherwise) of the provider, "the amount of the tax is the same for each bed of each provider of such items or services in the class." 42 U.S.C. §1396b(w)(3)(C)(i); 42 C.F.R. §433.68(d). If providers are reimbursed, or "held harmless," for the amount of the tax, then the use of the tax revenue to pay for Medicaid services is not eligible for FMAP. 42 U.S.C. §1396b(w)(4); 42 C.F.R. §433.68(f).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The Providers are located in the State of Illinois.[1] During the cost report periods on appeal, the Providers were subject to and paid hospital tax assessments levied by the State of Illinois. Illinois Public Aid Code, Ch. 305 Illinois Compiled Statutes (ILCS) §5 (2004).[2] The assessment was a tax on hospitals of $84.19 per occupied bed day. 305 ILCS §5/5A-2(a). Certain government-operated hospitals, public hospitals, psychiatric and rehabilitation hospitals and long-term hospitals were exempted from paying the tax. 305 ILCS §5/5A-3. If a hospital failed to pay the full amount when an installment payment was due, the State was authorized to impose a penalty assessment equal to 5% of the unpaid portion at the end of each 30-day period it remained unpaid. 305 ILCS at §5/5A-4(c).

Proceeds from the tax assessment were paid into the Illinois Hospital Provider Fund. 305 ILCS §5/5A-6. The "Hospital Provider Fund" is statutorily authorized to disburse monies for various programs including: to make payments under the Children's Health Insurance Program Act, to pay administrative costs incurred in administering the program, and to reimburse money erroneously collected from hospitals. 305 ILCS § 5/5A-8(b). Some of the expenditures of the Hospital Provider Fund were made to hospitals as "hospital access improvement payments" under the Medicaid program. 305 ILCS §5/5A-12. These payments were made on a quarterly basis and utilized to make payment adjustments to hospitals based on an individual hospital's Medicaid utilization, including a high volume adjustment payment, a Medicaid inpatient utilization rate adjustment, a psychiatric base rate adjustment, a supplemental tertiary care adjustment payment, a Medicaid outpatient utilization rate adjustment, a state outpatient service adjustment payment, a rural hospital outpatient adjustment, and a merged/closed hospital

[1] See Appendix I for the listing of Providers.

[2] See Provider Position Paper Case No. 06-2136G Exhibit P-19 and Intermediary Position Paper Exhibit I-2. The parties have stipulated that the position papers filed in Case No. 06-2136G serve as the lead position paper in the six cases consolidated in this decision.

adjustment.

After enactment of the Hospital Assessment Program, Illinois submitted two state plan amendment (SPA) requests to CMS for approval of adjustments to the Medicaid inpatient and outpatient payment.[3] Illinois also requested that CMS grant a waiver of the broad-based regulatory requirement under 42 C.F.R. §433.68(e) because some classes of hospitals were exempt from paying the tax.[4] Upon review of the SPAs, CMS requested the State remove the conditional language from the proposed SPAs indicating that the enhanced Medicaid payments for hospital services were conditioned on CMS's approval of the Illinois provider tax waiver request[5]. CMS noted that if the proposed enhanced Medicaid payments were truly necessary, Illinois would fund them absent any conditions. The State responded by removing the conditional language from the proposed SPAs.[6] CMS approved Illinois' SPAs for the period May 9, 2004 through June 30, 2005[7] and granted the State's waiver request.

Subsequently, the Providers claimed on their cost reports the amount of hospital tax assessments that were levied by the State. The fiscal intermediary, National Government Services, LLC (Intermediary) disallowed all or a portion of the provider tax assessments. The Providers timely filed appeals to challenge the Intermediary's disallowances and satisfied the jurisdictional requirements for a hearing before the Provider Reimbursement Review Board (Board). 42 C.F.R. §§405.1835 – 405.1841. The Provider was represented by Carel T. Hedlund, Esquire of Ober, Kaler, Grimes & Shriver, P.C. The Intermediary was represented by James R. Grimes, Esquire of Blue Cross BlueShield Association.

PARTIES' STIPULATIONS:

The parties submitted stipulations [8] which include the following:

1. The following cases all involve the Intermediary's disallowance of the Illinois provider tax assessments relating to the tax program that was in effect from May 9, 2004 through June 30, 2005, and there are no substantive differences among the cases:

    - 07-2590G Ober Kaler 2006 Illinois Provider Tax Group Appeal
    - 08-2765GC Southern IL Hospital Services 2006 Illinois Provider Tax
    - 08-2961GC Southern Illinois Hospital Services 2005 Illinois Provider Tax Group
    - 08-2963GC Memorial Health System 2005 Illinois Provider Tax Group
    - 08-2964GC Blessing Health System 2005 Illinois Provider Tax Group

[3] See Providers' Exhibit P-21.
[4] See Providers' Exhibit P-22.
[5] See, Providers' Exhibit P-23 at 2, item no. 2; Exhibit P-49 at 2, item no.3.
[6] See Providers' Exhibit P-24 at 4, Question/Response no.2; Exhibit P-50 at 5-6, Question/Response no.3.
[7] See Providers' Exhibit P-25.
[8] The Parties have submitted two documents containing the stipulations. The first document is entitled, "Stipulation of the Parties." The second document is entitled, "Second Stipulation of the Parties" submitted by facsimile dated November 20, 2008.

2. The position paper filed in Case No. 06-2136G will serve as the position paper in the five appeals in paragraph 1.

3. The five appeals in paragraph 1 may be heard concurrently with Case No. 06-2136G on November 21, 2008, and the decision of the Board to be issued pursuant to the hearing will apply to all the cases.

4. The Illinois State Plan Amendments TN 04-01 and TN 04-02 were approved by the Centers for Medicare and Medicaid Services (CMS), Center for Medicaid and State Operations, for Federal matching funds under sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act (the Act) (42 U.S.C. §§1396a(a)(2), 1396a(a)(13), 1396a(a)(30), 1396b(a) and 1396r-4) and implementing regulations.

5. CMS did not determine that there was "in effect a hold harmless provision" under section 1903(w)(4) of the Act (42 U.S.C. §1396b(w)(4)) with respect to the provider assessment tax at issue in this appeal.

6. The issue in this case is: Whether the Intermediary's disallowance of the Illinois provider tax assessment was proper.

PROVIDERS' CONTENTIONS:

The Providers contend the tax assessment meets the definition of an allowable cost under the Medicare statute, regulations and policy manuals. First, the tax assessments were mandated by state law and the hospitals were subject to fines and penalties if they failed to pay the taxes.[9] Second, the provider tax assessments meet the specific requirements for allowable taxes for Medicare reimbursement as set forth in the general rule at PRM § 2122.1. The tax assessment was levied by the State of Illinois and the hospitals were liable for its payment.[10] There are no fines or penalties included in the tax assessment expense being claimed by the hospitals, or any exemptions from the tax assessment available to the hospitals in this appeal.[11] In addition, the Illinois assessment is not among the taxes that CMS has said fail to qualify as allowable costs in PRM § 2122.2. The wording of the PRM section is all-inclusive, meaning that if a tax is not on this list, then it is allowable.[12]

The Providers assert that the Medicaid payments to the hospitals were not refunds of the Providers' tax assessment. The Providers contend that the payments do not meet the regulatory definition of refunds, defined at 42 C.F.R. §413.98(b)(3) as "amounts paid back or a credit on account of an overcollection," because there was no overcollection of the tax assessments by the State.[13] Likewise, the Providers argue that the Medicaid amounts paid do not qualify as a refund

[9] Transcript (Tr.). at 59-60; 137-39; Providers' Post-Hearing Brief at 10.
[10] Tr. at 18; 59-60; 139-41; Providers' Post Hearing Brief at 10.
[11] Tr. at 139-41; Providers' Post Hearing Brief at 11.
[12] Tr. at 145-48; Providers' Post Hearing Brief at 11; *See Regions Hosp. v. Blue Cross and Blue Shield Ass'n/Noridian Gov't Servs.*, PRRB Hearing Dec. No. 2000-D64, [2000-2 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 80,510 (June 22, 2000).
[13] Tr. at 19-20; Providers' Post-Hearing Brief at 12.

as defined by the PRM.[14] Specifically, PRM §802.31 defines refunds as an amount paid back by a vendor; however, in these cases, the State is not a vendor, but rather the hospitals are vendors to the State. Also, PRM §804 states that a refund must reduce a provider's expense and relate to that reduced expense. The Providers assert that regardless of the Medicaid payment received, their obligation to pay the State tax assessment was never reduced from the amount the Providers were originally assessed. This is because each Provider was still required to pay the full provider tax assessment. Most importantly, at the hearing the Intermediary's counsel conceded that the Medicaid payments do not fall within the regulatory and manual definitions of refunds or rebates.[15]

The Providers further contend that the Medicaid payments do not constitute a refund of the tax assessment considering the undisputed fact that CMS determined the Illinois provider tax program was not a "hold harmless" arrangement and that CMS approved the SPAs.[16] As testified by the expert witness, the hold harmless test is synonymous with whether the Medicaid payments to the hospitals are a refund or repayment of the provider tax.[17] Therefore CMS' determination of a "no hold harmless arrangement" establishes that the tax assessment was a permissible legal tax and that the Medicaid payments were not a refund of the taxes. Next, CMS' approval of the SPAs and its payment of the federal matching share for the Medicaid payment establishes that the payments to the hospitals were for services to Medicaid beneficiaries and not for reimbursement of the tax assessment. This is because the Medicaid statute mandates that Medicaid payments to hospitals can only be for covered services to Medicaid enrollees.[18] The Providers maintain that the Intermediary is precluded from reducing the taxes by the Medicaid payments received by the hospitals, when CMS has so clearly reviewed, approved and accepted the methodology and authorized the Medicaid payments.[19]

The Providers acknowledge that prior to CMS' approval of the SPAs, Illinois agreed to remove from the SPAs the language that conditioned the Medicaid payments on approval of the tax waiver request.[20] CMS was apparently concerned with how the State proposed to fund these payments if CMS did not approve the tax waiver request. The Providers note that by removing this conditional language from the SPAs, there was no longer a link between the payment rate increase and the provider tax for purposes of CMS' approval. That was because the State would need to come up with funds from other sources to make the higher Medicaid payments in the event CMS disapproved the tax waiver request. The Providers contend that this "delinking" further demonstrates the Medicaid payments to the hospitals were not refunds, as the payments

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[14] Tr. at 164-67; Providers' Post-Hearing Brief at 12 and 13.
[15] Tr. at 29-30.
[16] Second Stipulation of the Parties 1 and 2.
[17] Tr. at 52; 100-03; Providers' Exhibit P-41 at 6.
[18] Providers' Post Hearing Brief at 18 n. 4 citing §1903(a)(1) of the Social Security Act (42 U.S.C. §1396b(a)(1)) which states, "(a) From the sums appropriated therefore, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1966—(1) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b), subject to subsections (g) and (j) of this section and subsection 1923(f)) of the total amount expended during such quarter as medical assistance under the State plan."
[19] Providers' Post-Hearing Brief at 16.
[20] Exhibit P-23 at 2 no. 2; and Exhibit P-49 at 2 no. 3.

would have been made in any event. In response to the Board's inquiry, the Providers acknowledged that the conditional language was never removed from the state statute. The Providers assert that since CMS only required the language be removed from the SPAs and ultimately approved the tax waiver, there was no need to amend the statute to further "delink" the Medicaid payments from the provider taxes.[21]

The Providers assert that the Medicaid payments to the hospitals did not operate as a return or guarantee of any portion of the tax assessments, as there was no correlation between the Medicaid payments received by and the amount of taxes paid by the Providers. This is because the payments to the hospitals were based on each hospital's individual Medicaid utilization, whereas the tax was assessed based on an uniform rate of $84.19 per occupied bed day for all hospitals.[22]

The Providers observe that the Medicare program has allowed reimbursement of Medicaid provider taxes in other situations without requiring that the Medicaid revenues funded by those taxes be offset against the tax expense. Indeed, the Provider noted that the other Medicare Intermediary (Mutual of Omaha) that serves hospitals in Illinois has not offset the Medicaid payments and instead allowed the full amount of the tax assessments as an allowable cost.[23] Additionally, the Medicare program has recognized comparable tax assessments as allowable costs without requiring offset of payments received by the hospitals.[24] Specifically, CMS did not require that the uncompensated care pool (UCP) payments received by the hospitals from the State of Massachusetts be offset against the UCP tax assessments in determining how much was allowable, and the hospitals claimed and were reimbursed the full amount of the UCP tax assessments.

The Providers further assert the Office of Inspector General (OIG) report on the Missouri Provider Tax Program[25] supports their position that the provider tax assessment should not be offset by the amount of the Medicaid payments received by the hospitals. The Providers note the OIG report required offset of the funds hospitals received from a redistribution pool set up by the hospital association; but did not require offset of payments that the hospitals received directly from the Missouri Medicaid program. Consequently, since the Providers received the Medicaid payments directly from the State, no offset is required.[26]

The Providers note the Board has issued several decisions upholding the allowability of provider taxes used to create a revenue pool for indigent medical care.[27] In all these cases, the Board

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[21] Tr. at 69; 95-98; 115-17; 122-24; Providers' Post-Hearing Brief at 16 n. 3.
[22] Providers' Exhibit P-24 at 6-8; Providers Post-Hearing Brief at 15.
[23] Tr. at 91; 167-68; 195-96; Providers' Post-Hearing Brief at 19.
[24] Tr. at 151-155; Exhibit P-27; Providers' Post-Hearing Brief at 20-21.
[25] Intermediary's Exhibit I-5, Department of Health and Human Services Office of Inspector General, *Review of the Classification of Missouri Provider Tax Refunds on Hospitals' Medicare Cost Reports* A-07-02-04006 (May 2004).
[26] Tr. at 79-83; 173-75; Providers' Post-Hearing Brief at 31.
[27] *See St. Joseph Hosp. v. Blue Cross and Blue Shield Ass'n/Blue Cross and Blue Shield of Minn.*, PRRB Hearing Dec. No. 2000-D47, [2000-1 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 80,438 (Apr. 20, 2000); *Bethesda Lutheran Med. Ctr. v. Blue Cross and Blue Shield Ass'n/Blue Cross and Blue Shield of Minn.*, PRRB Hearing Dec. No. 2000-D48, [2000-1 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 80,439 (Apr. 20,

concluded the taxes met the requirements of 42 C.F.R. §413.9, and they were therefore an allowable Medicare cost. There was no requirement that the amounts received by the hospitals from the State for caring for uninsured individuals had to be offset against the amount of the tax assessments.[28] The Providers reference another Board decision, *Guam Memorial Hospital.*[29] In *Guam,* the Board took the position that the hospital had incurred an expense that had to be reimbursed, even though the legislature had expressly appropriated funds earmarked for the payment of the taxes. Of significance, the Providers note the CMS Administrator declined to review these cases, thereby making them the final decisions of the agency. The Providers urge that the Board should follow the precedent set in those cases, and find that the Providers did incur the costs associated with the State tax assessments and that the Medicaid payments to the Providers did not reduce that obligation.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that while the Providers incurred a tax expense, the allowable cost was the tax less the amount refunded by the state in the form of access improvement payments.[30] The adjustment therefore reduced the amount of the tax, but did not affect the Medicaid revenue.

In support of its position, the Intermediary referred to the Illinois Statute 305 ILCS §5A-4,[31] which conditioned the Providers' payment of the tax assessment on CMS' approval of the tax arrangement for federal Medicaid matching funds and actual payment of the access improvement payments. Based on the statutory language, the Intermediary maintains the tax was collected only after the Providers had received the payments the tax was designed to fund. The Intermediary argues that the Providers had no obligation for the tax amount because the Providers had already been paid by the State for amounts that exceeded that tax liability, and their obligation to pay the tax was tied to the receipt of those access improvement payments.[32]

The Intermediary recognizes that the State removed the conditional language from the SPAs, which in effect "delinked' the increased Medicaid payments from the provider tax amounts.[33] The Intermediary contends however that the conditional language was never removed from the statute, thereby making the Providers' obligation to pay the tax conditional on receipt of the increased Medicaid payments.[34]

The Intermediary contends that based on the statutory provisions, the Providers were paid the increased Medicaid payments before incurring the tax expense. For example, a letter issued by

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2000); *Divine Redeemer Hosp. v. Blue Cross and Blue Shield Ass'n/Blue Cross and Blue Shield of Minn.*, PRRB Hearing Dec. No. 2000-D49, [2000-1 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 80,440 (Apr. 20, 2000); *Regions Hosp. v. Blue Cross and Blue Shield Ass'n/Noridian Gov't Servs.*, PRRB Hearing Dec. No. 2000-D64, [2000-2 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 80,510 (June 22, 2000).

[28] Tr. at 155-58.

[29] Tr. at 110-12, 170-73; *Guam Mem'l Hosp. Auth. v. BlueCross BlueShield Ass'n/United Gov't Servs.*, PRRB Hearing Dec. No. 2007-D60, [2007-2 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 81,771 (Aug. 9, 2007).

[30] Tr. at 25-27; Intermediary's Post-Hearing Summary at 2.

[31] Exhibit P-19.

[32] Tr. at 27.

[33] Tr. at 67 -68, Exhibit P-23 and P-24, Intermediary's Post-Hearing Summary at 2.

[34] Exhibit I-7.

the Illinois Department of Public Aid informs a Provider the amount of access improvement payments it would receive for fiscal years 2004 and 2005, and that such payments should be received on or before March 4, 2005.[35] The Provider's tax payment however was not due until March 11, 2005 for fiscal year 2004 and April 19, 2005 for fiscal year 2005.[36] The Intermediary asserts that this arrangement amounts to a refund, since the vast majority of the Providers in the State received more in increased Medicaid payments than they actually paid in tax. Therefore, since all or some of the portion of the tax was refunded to the Providers as part of the transaction, the tax expense should be reduced by the amount of the refund.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and guidelines, the parties' contentions and evidence submitted, the Board finds and concludes that the State of Illinois hospital tax assessment is an allowable cost.

The hospital tax assessment meets the statutory and regulatory requirements of 42 U.S.C. §1395x(v)(1)(A) and 42 C.F.R. §413.9, respectively as an allowable cost. It is a proper and necessary expense, which is related to patient care. The tax meets the requirements of PRM §2122.1 and §2122.2. The tax was enacted by the State of Illinois for which the Provider was liable to pay. Additionally, the tax is not included as a non-allowable type of tax nor does it fall within the scope of any excluded tax listed in the manual section.

The tax assessment also meets the statutory and regulatory requirements as a permissible tax under the Medicaid program. 42 U.S.C. §1396b(w)(4) and 42 C.F.R. §433.68. The tax was imposed uniformly on all the Providers, at a rate of $84.19 per occupied bed day. CMS granted the Providers' request for waiver from the broad-based requirement. Most importantly, and as stipulated by the parties, CMS did not determine that there was "in effect a hold harmless provision" with respect to the provider assessment tax at issue.[37]

The Intermediary contends that since all or some of the portion of the tax was refunded to the Providers as part of the increased Medicaid payments, the tax expense should be reduced by the amount of the refund.[38] The Board finds the Intermediary's contention unpersuasive. First, the Medicaid payments do not fall within the regulatory or manual definitions of refunds or rebates. 42 C.F.R. §413.98 and PRM §§802.31, 802.41 and 804. Indeed, at the hearing Intermediary's counsel conceded this point. The record also does not support a finding that the Providers overpaid their tax assessments and received a credit for the overpayment.[39]

Second, the mere timing of Providers' receipt of their Medicaid payments and their obligation to pay the tax assessment does not substantiate that the Providers had received a refund. The Medicaid statute at 42 U.S.C. §1396b(w)(4) allows the states to use permissible provider taxes to fund Medicaid payments. As explained by the expert witness, it was not uncommon for large

[35] Exhibit P-52; Intermediary Post-Hearing Summary at 3.
[36] Exhibit P-53; Intermediary Post-Hearing Summary at 3.
[37] Stipulation 5, Tr. at 15-18.
[38] Tr. at 29, Intermediary's Final Position Paper at 4, Intermediary's Post-Hearing Summary at 2.
[39] Tr. at 29-30.

lump sum Medicaid payments to be made to hospitals because of delays in the SPA approval process or based on the structure of such payments, i.e. monthly or quarterly payments.[40]

Third, a review of the Illinois statute establishes that the Medicaid payments are not refunds of the tax assessments.[41] Based on the statute at 305 ILCS §5/5A-12, the payments to the hospitals were based on each hospital's individual Medicaid utilization, including a high volume adjustment payment, a Medicaid inpatient utilization rate adjustment, a psychiatric base rate adjustment, a supplemental tertiary care adjustment payment, a Medicaid outpatient utilization rate adjustment, a state outpatient service adjustment payment, a rural hospital outpatient adjustment, and a merged/closed hospital adjustment. By comparison, under 305 ILCS §5/5A-2 the tax assessment the Providers were obligated to pay were based on an uniform rate of $84.19 per occupied bed day for all hospitals. There was no correlation between the Medicaid payments received by and the amount of taxes paid by the Providers. Consequently, Medicaid payments to the hospitals did not operate as a refund of any portion of the tax assessments.

Fourth, as stipulated by the parties, CMS approved the SPAs and paid the federal matching share of the Medicaid payments to the hospitals.[42] By virtue of its approval, CMS established that the payments to the hospitals were for services to Medicaid beneficiaries and not for reimbursement of the tax assessment. This is because the Medicaid statute at 42 U.S.C. § 1396b(a)(1) authorizes Medicaid payments for covered services to Medicaid enrollees. As such, these payments are not in the nature of "tax refunds."

The Board notes that prior to CMS' approval of the SPAs, Illinois agreed to remove language that conditioned the Medicaid payments on approval of the tax waiver request.[43] By removing that language, there was no longer a link between the payment rate increase and the provider tax assessment, because in the event CMS disapproved the tax waiver request, the State would have had to utilize funds from other sources to make the higher Medicaid payments.

The Intermediary advised that although the conditional language was removed from the SPAs, the language still remained in the statutory provision 305 ILCS §5/5A-4; [44] thereby establishing a link between the increased Medicaid payments and the tax assessment. The Board acknowledges that CMS required the conditional language only be removed from the SPAs and not from the statute.[45] Additionally, since CMS ultimately approved the tax waiver request, there was no need to amend the statute to further "delink" the Medicaid payments from the provider taxes.[46] Moreover, despite the conditional language remaining in the statute, it is undisputed that CMS' did not determine that the Illinois provider tax program constituted a "hold harmless" arrangement in which the hospitals would get a return of all or part of their provider tax assessments.[47] Thus, the tax assessment was a permissible, legal tax and the Medicaid payments were not a refund of those taxes.

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[40] Tr. at 85-86; 120-24
[41] Providers' Exhibit P-19 at 17.
[42] Stipulation No. 4.
[43] Exhibit P-24 at 4 Question/Response no.2; Exhibit P-50 at 5-6 Question/Response no.3.
[44] Exhibit I-7.
[45] Exhibit P-23 at 2 no. 2; and Exhibit P-49 at 2 no. 3.
[46] Tr. 69; 95-98; 115-17; 122-24. Providers' Post-Hearing Brief at 16 fn 3.
[47] Stipulation 5.

DECISION AND ORDER:

The State of Illinois hospital tax assessment is an allowable cost, under the Medicare law, regulations and program instructions. The Intermediary's adjustment is reversed.

Board Members Participating:

Suzanne Cochran, Esquire
Yvette C. Hayes
Michael D. Richards, C.P.A.
Keith E. Braganza, C.P.A.
John Gary Bowers, C.P.A.

FOR THE BOARD:

Suzanne Cochran, Esq.
Chairperson

DATE: January 29, 2010

APPENDIX I

PROVIDER NAME	PROVIDER NOS.	COST REPORTING PERIODS ENDED
Blessing Hospital	14-0015, 14-S015, 14-T015, 14-5643, 14-7031, 14-1501, 14-3422, 14-2301, 14-3529, 26-3503	09/30/05
Shelby Memorial Hospital	14-0019, 14-5565, 14-7622, 14-U019, 14-3446	08/31/05
Passavant Memorial Area Hospital	14-0058, 14-5951	09/30/05
Richland Memorial Hospital	14-0147, 14-5580, 14-7187, 14-S147, 14-U147, 14-1542	09/30/05
Memorial Medical Center	14-0148, 14-S148, 14-T148, 14-2315	09/30/05
Sarah Bush Lincoln Health Center	14-0189, 14-S189, 14-3978, 14-3998, 14-3435	06/30/05
Methodist Medical Center	14-0209, 14-S209, 14-T209, 14-1537, 14-2334, 14-5763, 14-7259	12/31/05

PROVIDER NAME	PROVIDER NOS.	COST REPORTING PERIODS ENDED
Memorial Hospital Association	14-1305, 14-Z305, 14-3405, 14-3456	06/30/05
Community Memorial Hospital	14-1306, 14-3427, 14-Z306	06/30/05
Mendota Community Hospital	14-1310, 14-Z310, 14-7616	03/31/05
Illini Community Hospital	14-1315, 14-Z315	09/30/05
Hoopeston Community Memorial Hospital	14-1316, 14-Z316, 14-3448, 14-5470	09/30/05
Gibson Area Hospital and Health Services	14-1317, 14-Z317, 14-5979, 14-7507, 14-3408, 14-3440	09/30/05
Community Medical Center of Western Ill., Inc.	14-1318, 14-5528, 14-7627, 14-Z318 14-3461	03/31/05
Paris Community Hospital	14-1320, 14-Z320, 14-3431, 14-3987, 14-3989	12/31/05
Abraham Lincoln Memorial Hospital	14-1322, 14-Z322	09/30/05
Ferrell Hospital	14-1324, 14-Z324	03/31/05
Kewanee Hospital	14-1325, 14-Z325, 14-3445, 14-7418, 14-1557	09/30/05

PROVIDER NAME	PROVIDER NOS.	COST REPORTING PERIODS ENDED
Hardin County General Hospital	14-1328, 14-Z328	03/31/05
Hillsboro Area Hospital	14-1332, 14-Z332, 14-5305, 14-7648	06/30/05
Saint Joseph Memorial Hospital	14-1334, 14-Z334,	03/31/05
Saint Joseph Hospital (Highland)	14-1336, 14-Z336, 14-5554	06/30/05
Taylorville Memorial Hospital	14-1339, 14-5339, 14-Z339, 14-7252, 14-1555	09/30/05
Valley West Community Hospital	14-1340	04/30/05
Pana Community Hospital	14-1341, 14-Z341, 14-7299, 14-1575	12/31/05