PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

2014-D8

PROVIDER -
Dana Farber Cancer Institute
Boston, Massachusetts

Provider No.: 22-0162

vs.

INTERMEDIARY –
BlueCross BlueShield Association/NHIC Corp. c/o National Government Services, Inc. and Cahaba Safeguard Administrators, LLC

DATE OF HEARING -
June 12, 2013

Cost Reporting Periods Ended -
2004 - 2008

CASE NOs: 07-1797; 08-1631; 11-0211; 11-0596; 11-0609

INDEX

ISSUE:

Whether the Medicare Administrative Contractor erred in disallowing certain of the costs associated with Dana Farber Cancer Institute's (the "Provider") state provider tax expense in the Provider's Fiscal Year 2004 through Fiscal Year 2008 cost reporting periods.[1]

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

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

The Medicare program was established under Title XVIII of the Social Security Act, as amended ("Act"), to provide health insurance to eligible individuals. Title XVIII of the Act was codified at 42 U.S.C. Chapter 7, Subchapter XVIII. 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 to insurance companies known as fiscal intermediaries ("FIs") and Medicare administrative contractors ("MACs"). FIs and MACs[2] determine payment amounts due providers under Medicare law and under interpretative guidelines published by CMS.[3]

Providers are required to submit cost reports annually, with reporting periods based on the provider's accounting period. A cost report shows the costs incurred during the relevant fiscal year and the portion of those costs allocated to the Medicare program.[4] 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").[5] 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 receipt of the NPR.[6]

The Medicare program reimburses participating cancer centers for the reasonable cost of providing services to beneficiaries. The statutory provisions addressing Medicare reasonable cost reimbursement are located in 42 U.S.C. § 1395x(v)(1)(A). In pertinent part, the statute provides as follows:

> The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in

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[1] Transcript, ("Tr") at 6. The hearing conducted on June 12, 2013 was limited to fiscal years ("FY") 2007 and 2008 (Case Nos. 11-0596 and 11-0609 respectively). Subsequent to the hearing, the parties and the Board agreed to consolidate FYs 2004, 2005, and 2006 (Case Nos. 07-1797, 08-1631 and 11-0211 respectively) into this hearing.
[2] FIs and MACs are hereinafter referred to as intermediaries.
[3] *See* 42 U.S.C. §§ 1395h, 1395kk-1; 42 C.F.R. §§ 413.20, 413.24.
[4] *See* 42 C.F.R. § 413.20.
[5] *See* 42 C.F.R. § 405.1803.
[6] *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835-405.1837.

> determining such costs for various types or classes of institutions, agencies, and services....

The regulations implementing this statutory provision are located at 42 C.F.R. § 413.9, "Cost related to patient care", and state in pertinent part:

> (a) *Principle*. All payments to providers of services must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs incurred in furnishing the services, subject to principles relating to specific items of revenue and cost....
> (b) *Definitions*-(1) *Reasonable cost*. Reasonable cost of any services must be determined in accordance with regulations establishing the method or methods to be used, and the items to be included. The regulations in this part take into account both direct and indirect costs of providers of services. The objective is that under the methods of determining costs, the costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program...
> (2) *Necessary and proper costs*. Necessary and proper costs are costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. They are usually costs that are common and accepted occurrences in the field of the provider's activity.
> (c) *Application*. (1) It is the intent of Medicare that payments to providers of services should be fair to the providers, to the contributors to the Medicare trust funds, and to other patients.
> (2) The costs of providers' services vary from one provider to another and the variations generally reflect differences in scope of services and intensity of care. The provision in Medicare for payment of reasonable cost of services is intended to meet the actual costs, however widely they may vary from one institution to another. This is subject to a limitation if a particular institution's costs are found to be substantially out of line with other institutions in the same area that are similar in size, scope of services, utilization, and other relevant factors.
> (3) The determination of reasonable cost of services must be based on cost related to the care of Medicare beneficiaries. Reasonable cost includes all necessary and proper expenses incurred in furnishing services....The reasonable cost basis of reimbursement contemplates that the providers of services would be reimbursed the *actual costs* of providing quality care however widely the actual costs may vary from provider to provider and from time to time for the same provider.

In making a determination as to what constitutes a reasonable cost, the regulations at 42 C.F.R. § 413.98 provide for reductions due to purchase discounts, allowances and refunds of expenses. The regulations in effect during the cost reporting periods at issue state in pertinent part:

> (a) *Principle*. 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....
> (b) (3) *Refunds.* Refunds are amounts paid back or a credit allowed on account of an overcollection.
> (c) *Normal accounting treatment-Reduction of costs.* All discounts, allowances, and refunds of expenses are reductions in the cost of goods or services purchased and are not income. If they are received in the same accounting period in which the purchases were made or expenses were incurred, they will reduce the purchases or expenses of that period. However, if they are received in a later accounting period, they will reduce the comparable purchases or expenses in the period in which they are received.

And finally, additional guidance exists in the instructions located in the Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1") relating to reasonable cost and the allowability of tax costs. In particular, PRM 15-1 § 800 addresses the application of the principle of reasonable cost with regard to purchase discounts, allowances and refunds in pertinent part as follows:

> 800. PRINCIPLE
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> Purchase discounts, allowances, and refunds are reductions of the cost of whatever was purchased. Similarly, refunds of previous expense payments are reductions of the related expense.
>
> 802.31 Refunds. - Refunds are amounts paid back by the vendor generally in recognition of damaged shipments, overpayments, or returned purchases. Refunds of container deposits are not purchase refunds under this definition.
>
> 802.41 Rebates. - Rebates represent refunds of a part of the cost of goods or services....
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> 804. ACCOUNTING TREATMENT
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> Discounts, allowances, refunds, and rebates are not to be considered a form of income but rather a reduction of the specific costs to which they apply in the accounting period in which the purchase occurs. The true cost of goods and services is the net amount actually paid for the goods or services.

> Where the purchase occurs in one accounting period and the related allowance or refund is not received until a subsequent period, where possible, an accrual in the initial period should be made of the amount, if it is significant, and cost correspondingly reduced. However, if this cannot be readily accomplished, the amounts reduce comparable expenses in the period in which they are received.

PRM 15-1 § 2302 defines various terms related to providers receiving payment on the basis of reimbursable cost. Those include:

> 2302.5 Applicable Credits. – Those receipts or types of transactions which offset or reduce expense items that are allocable to cost centers as direct or indirect costs. Typical examples of such transactions are: purchase discounts, rebates, or allowances; recoveries or indemnities on losses; sales of scrap or incidental services; adjustments of overpayments or erroneous charges; and other income items which serve to reduce costs.

PRM 15-1 § 2122 contains provisions regarding when taxes paid by a provider are considered allowable reasonable costs under Medicare. The relevant provisions in effect during the cost reporting periods at issue are as follows:

> 2122.1 - General Rule
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> 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. *Taxes are allowable costs to the extent they are actually incurred and related to the care of beneficiaries.*
>
> 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.
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> 2122.2 - Taxes Not Allowable as Costs
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> Certain taxes which are levied on providers are not allowable costs. These taxes include:
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> A. Federal income and excess profit taxes, including any interest or penalties paid thereon (see § 1217).
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> B. State or local income and excess profit taxes (see § 1217).

> 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.
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> D. Taxes from which exemptions are available to the provider.
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> 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.
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> 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.[7]

In addition, PRM 15-1 § 2122 was revised in December 2011[8] in accordance with the clarification contained in the FY 2011 Inpatient Prospective Payment System ("IPPS") Final Rule published on August 16, 2010,[9] as follows:

> 2122.7 – Review of Reasonable Costs, Including Taxes
>
> In general, reasonable costs claimed by a provider, including taxes, must actually be incurred. While a tax may fall under a category that is generally accepted as an allowable Medicare cost, the provider may only treat the net tax expense as the reasonable cost actually incurred for Medicare payment purposes. The net tax expense is the tax paid by the provider, reduced by payments the provider received that are associated with the assessed tax. Contractors will continue to determine whether taxes and other expenses are allowable based on reasonable cost principles set forth in the Medicare statute and regulations.

The Medicaid statute and regulations permit the states to impose taxes on classes of health care

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[7] (Emphasis added.)

[8] PRM 15-1, Transmittal 448 (Dec. 2011) (stating that "Section 2122 is revised in accordance with the FY 2011 IPPS Final Rule, published on August 16, 2010, which clarified policy with respect to the treatment of the taxes incurred by providers and reported on the Medicare cost report" and that "[t]his clarification is consistent with the current and longstanding statutory, regulatory, and policy provisions").

[9] 75 Fed. Reg. 50042, 50362, 50634 (Aug. 16, 2010) (excerpt included as Provider Exhibit P-11 (Case No. 11-0609)).

providers of services.[10] 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.[11] 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. The term "broad-based" tax means that it is imposed "at least with respect to all items or services in the class or providers of such items or services furnished by all non-Federal, non-public providers in the State . . ."[12] 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"[13] 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."[14] 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.[15]

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The Provider is located in the Commonwealth of Massachusetts and has a fiscal year ending on September 30th. This appeal involves the Provider's fiscal years (FYs) for 2004 through 2008.

During the fiscal years at issue, the Provider was subject to and paid hospital tax assessments levied by the Commonwealth of Massachusetts. Under the statute and regulations in effect during these periods, acute care hospitals were subject to an assessment based on their proportion of private sector charges in relation to all Massachusetts acute care hospitals' private sector charges ("the Tax"). For an individual acute care hospital, the Tax was, by statute equal to the product of: (a) the ratio of the acute care hospital's private sector charges to all Massachusetts acute care hospitals' private sector charges; and (b) $160,000,000.[16] Certain government-operated hospitals, public hospitals, psychiatric and rehabilitation hospitals and long-term care hospitals were exempted from paying the Tax.

The fiscal intermediaries, National Government Services, LLC and Cahaba Safeguard Administrators, LLC ("Intermediary") made adjustments to net the payments received from the Uncompensated Care Trust Fund/ Health Safety Net Trust Fund[17] against the Provider tax assessments, thereby effectively disallowing a portion of the Provider tax assessments. The Provider timely filed appeals to challenge the Intermediary's disallowances and satisfied the jurisdictional requirements for a hearing before the Board as noted at 42 C.F.R. §§ 405.1835 – 405.1841.

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[10] *See* 42 U.S.C. § 1396a(a)(2); 42 C.F.R. § 433.50.
[11] *See* 42 U.S.C. § 1396b(w); 42 C.F.R. § 433.68.
[12] *See* 42 U.S.C. § 1396b(w)(3)(B)(i); 42 C.F.R. § 433.68(c).
[13] *See* 42 U.S.C. §1396b(w)(3)(C)(i)(I).
[14] *See* 42 U.S.C. § 1396b(w)(3)(C)(i)(II); 42 C.F.R. § 433.68(d).
[15] *See* 42 U.S.C. § 1396b(w)(4); 42 C.F.R. § 433.68(f).
[16] *See* Mass. Gen. Laws Ann. ch. 118G, § 18(e) (West 2012) (copy included at Provider Exhibit P-40 (Case No. 11-0596)).
[17] *See* Stipulations 7 and 8.

The Provider was represented by Deborah Kantar Gardner, Esq., and Elizabeth Dewar, Esq., of Ropes & Gray, LLP. The Intermediary was represented by Brendan G. Stuhan, Esq., of the Blue Cross and Blue Shield Association.

PARTIES' STIPULATIONS:

For each of the relevant fiscal years, the Provider and the Intermediary stipulated to certain facts.[18] The following is an amalgamation of pertinent facts taken from these stipualtions:

1. The Provider is a non-profit Comprehensive Cancer Center designated by the National Cancer Institute and affiliated with Harvard Medical School. As a dedicated cancer center, it is exempt from Medicare's prospective payment system.

2. Under the Massachusetts statute and regulations in effect during the Provider's fiscal years under appeal, acute care hospitals in Massachusetts were subject to a tax assessment based on their proportion of private-sector charges in relation to all Massachusetts acute care hospitals' private-sector charges (hereinafter, "the Tax" or the Provider's "Tax expense").

3. During each fiscal year under appeal, the Provider was an acute care hospital subject to the Tax.

4. The Massachusetts Division of Health Care Finance and Policy (the "Division"), which administered the Tax, estimated providers' Tax liability prior to the start of the fiscal year. The Division produced statements on a monthly basis which set forth the providers' Tax liability. During the fiscal year, providers made monthly interim payments of their Tax liability as estimated by the Division.

5. Because the Massachusetts statutory formula for determining the amount of each provider's Tax liability depended upon each hospital's share of total private-sector charges for all acute care hospitals in Massachusetts during that fiscal year, a change to any hospital's private-sector charges would affect each hospital's own Tax liability. Accordingly, the Division calculated a "final settlement" of all providers' Tax liability for a given year once the data on private charges for that year was collected.

6. Under the assessment formula as calculated in the final settlements issued to the Provider by the Division, the Provider's final tax liability for each of the fiscal years under appeal was as follows: FY 2004 - $3,772,105 ($3,388,925 in monthly payments plus a final settlement amount of $383,180); FY 2005 - $4,024,846 ($3,904,216 in monthly payments plus a final settlement amount of $120,630); FY 2006 - $4,941,109 ($4,634,228 in monthly payments plus a final settlement amount of $306,881); FY 2007 - $5,245,830 ($4,935,961 in monthly payments plus a final settlement amount of $309,868); FY 2008 - $5,418,349 ($4,943,775 in monthly

[18] Provider's Post Hearing Brief and Exhibits at Exhibit P-69(Case No. 07-1797), Exhibit P-70 (Case No. 08-1631), Exhibit P-71(Case No. 11-0211); Stipulation of Facts (Case No. 11-0596); Stipulation of Facts (Case No. 11-0609).

payments plus a final settlement amount of $474,574).

7. The revenues from the Tax, together with revenues from surcharge payors, and state appropriations of federal and other monies from the state's funds comprised the Uncompensated Care Trust Fund[19] ("UCTF") (FY 2004 through FY 2007) and the Health Safety Net Trust Fund[20] ("HSNTF") (FY 2008).

8. Massachusetts law required the Division to make payments from the funds it collected from the Tax on acute care hospitals, the statutory surcharge, annual appropriations, and compliance actions to reimburse acute care hospitals for otherwise unreimbursed care they provided to certain qualifying under or uninsured low-income patients.[21] For fiscal years 2004 through 2006, the governing statute mandated basing these payments on "the product of allowable actual free care charges, adjusted for any audit findings, multiplied by [the hospital's] final cost-to-charge ratio."[22]

9. The Provider received payments from the UCTF/HSNTF in each fiscal year under appeal as follows: FY 2004 - $1,714,683; FY 2005 - $1,967,728; FY 2006 - $1,664,912; FY 2007 - $2,479,708; and FY 2008 - $1,174,335.

10. The final allowable Tax expense as calculated by the Intermediary for each fiscal year in this appeal was as follows: FY 2004 - $2,057,422 (initial Provider claim of $3,388,925 less Intermediary adjustment of $1,331,503); FY 2005 - $2,057,118 (initial Provider claim of $1,936,487 plus Intermediary adjustments totaling $120,631); FY 2006 - $3,276,197 (initial Provider claim of $2,969,316 plus Intermediary adjustment of $306,881); FY 2007 - $2,766,122 (initial Provider claim of $2,456,253 plus Intermediary adjustment of $309,869); and FY 2008 - $4,221,013 (initial Provider claim of $3,769,439 plus Intermediary adjustment of $451,574). For FY 2008, the Intermediary erred, however, in its calculation of the Provider's net tax expense because it increased the Provider's allowable Tax expense only by $451,574 rather than by $474,574. The Intermediary thus improperly calculated the net Tax expense with the result that it disallowed an additional net Tax amount of $23,000.[23]

11. In each fiscal year under appeal, the Intermediary adjusted the Provider's Tax expense to reflect the Provider's final tax liability net of its reimbursement from the UCTF/HSNTF.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary erred in disallowing a portion of the Provider's

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[19] *See* Mass. Gen. Laws Ann. ch. 118G, § 18(b) and (d) (West 2012).
[20] *See* Mass. Gen. Laws Ann. ch. 118G, § 36(b) (West 2011) (copy included at Provider Exhibit P-41 (Case No. 11-0596)).
[21] *See* Mass. Gen. Laws Ann. ch. 118G, § 18(h) (West 2012).
[22] *Id.*
[23] *See* Stipulation of Facts at ¶ 16 (Case No. 11-0609).

expense incurred in paying Massachusetts' tax on acute care hospitals' private sector charges. It argues that the Intermediary wrongly concluded that Medicaid Disproportionate Share Hospital reimbursements the Provider received to compensate its cost of furnishing health care to certain low-income patients in Massachusetts instead served to make the Provider whole or partly whole for the costs of the Tax.[24]

The Provider contends that the full amount of the tax assessment meets the definition of an allowable cost under the Medicare statute, regulations and policy manuals. It argues that it is undisputed that the Tax assessment meets the specific requirements for allowable taxes for Medicare reimbursement as set forth in the general rule at PRM 15-1 § 2122.1. It contends that it "actually incurred" the full amount of the tax assessment. Payment of the tax was mandated by state law and was a cost of doing business as an acute care hospital in Massachusetts.[25]

In addition to incurring the cost of paying the Tax, the Provider also incurred costs in furnishing care to low-income uninsured and under-insured patients. The Medicaid payments the Provider received from the UCP/HSNTF were based on the Provider's cost of furnishing that care and never exceeded the amount of those costs. Accordingly, the Provider's Medicaid payments did not lessen the tax liability incurred by the Provider, rather they served to reduce the cost of furnishing care to uninsured and under-insured patients.[26]

The Provider disputes the Intermediary's contention that the Medicaid payments it received from the UCP/HSNTF were refunds of the Provider's tax assessment. The Provider contends that the payments do not meet the regulatory definition of refunds as defined at 42 C.F.R. § 413.98(b)(3) as "amounts paid back or a credit allowed on account of an overcollection", because there was no overcollection of the Tax assessments by the Commonwealth. In fact, the Provider owed additional Tax at the end of each fiscal year since its estimated Tax payments throughout each year were less than its total final liability for the year.[27]

The Provider notes that some providers, such as community health centers, received Medicaid payments from the UCP/HSNTF yet did not pay the Tax, meaning that the payments could not represent a refund of Tax. Additionally, under both State law and the terms of the Massachusetts Medicaid plan, the UCP/HSNTF was permitted to make these Medicaid payments only for health care services; using the funds as a Tax refund would violate the law.[28]

The Provider also disputes the Intermediary's contention that the Medicaid payments it received from the UCP/HSNTF must be offset against the Provider's tax expense because the payments were "associated" with the tax. The Provider argues that there is no meaningful match between the payments, which were meant to reimburse the cost of providing care to low-income patients, and the Tax expense. In addition, the Provider argues that the payments received are not of the

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[24] *See* Provider's Post-Hearing Brief at 1.
[25] *See id.* at 19-20.
[26] *See id.* at 20-25.
[27] *See id.* at 24-26.
[28] *See id.* at 26-27.

kind that concerned CMS in the 2011 IPPS Final Rule, which instead related to payments intended to make a provider whole for a tax expense.[29]

The Provider further contends that Medicare's longstanding policy and practice has been to allow the full amount of provider taxes, and that CMS' treatment of the Massachusetts provider Tax has accorded with that longstanding policy and practice until now. By approving the tax as a permissible health care tax included in the Medicaid State Plan, CMS has already determined that the tax was intended to fund payments for health care services for Medicaid beneficiaries and did not have impermissible "hold harmless" features. In particular, the provider asserts that certain guidance from the Intermediary and CMS officials makes clear that it was CMS' position to allow the Tax without offset for Massachusetts hospitals.[30]

Lastly, the Provider contends that CMS' clarification regarding taxes in the FY 2011 IPPS final rule is fully consistent with allowing the total amount of the Provider's tax assessments. In the alternative, to the extent that this clarification and CMS' "associated with" language might be interpreted to require netting of payments against a tax expense without regard to the fact that the tax cost is actually incurred, that interpretation cannot apply to the determination of the Provider's FY 04 – FY 08 reimbursements because it constitutes a retroactive substantive change; it effects a substantive change in policy without the requisite notice and comment period; and it violates the Medicare statute.[31]

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that although the taxes that the Provider paid into the UCP and HSNTF were allowable, the payments into these pooled funds must be offset by the amounts that the Provider received from these pooled funds. The Intermediary contends that the Provider's true cost of the tax is the net of the amounts that were paid into and received from the pooled funds. Massachusetts set up the tax in a way that the state effectively overcollects the tax from providers because it does not know in advance how much uncompensated care will be provided, then refunds to providers portions of the tax based on the proportionate amount of care that they provided. The Intermediary contends that the payments from the pooled funds effectively act as refunds, and 42 C.F.R. § 413.98 dictates that refunds be offset against costs.[32]

The Intermediary contends that CMS has clarified in PRM 15-1 § 2122.7 that providers may only claim the net tax expense actually paid as allowable costs where providers received payments that are associated with the tax. The Intermediary contends that the tax payments that the Provider made went into pooled funds designated for the payment of uncompensated care and that the payments that the Provider received came from those same pooled funds to pay the Provider for the cost of uncompensated care, thus there is a clear association. Additionally, the Intermediary notes that the State itself clearly associates the tax payments with the payments received from the pooled funds when it publishes the annual reports on the operation of the pooled funds as it discloses information regarding assessments to the fund, payments from the

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[29] *See id.* at 31-34.
[30] *See id.* at 34-36; Provider Exhibits P42, P43 (Case No. 11-0596).
[31] *See* Provider's Post-Hearing Brief at 40-44.
[32] Intermediary's Post Hearing Brief at 5-7.

fund, and net payments to/from the fund itemized by provider.[33]

Lastly, the Intermediary contends that the Seventh Circuit Court of Appeals and the Eighth Circuit Court of Appeals have both held that fiscal intermediaries properly offset payments to providers from pooled funds against payments providers made into pooled funds.[34] The Intermediary asserts that since all courts that have addressed this issue have come to the same conclusion, it was reasonable for the Intermediary to do so here.[35]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and regulations, the parties' contentions and the evidence submitted, the Board finds and concludes that the Intermediary's adjustments were proper.

While the Parties' agree that the provider Tax assessment is an allowable tax under the Medicare program, the issue in these appeals involves the proper treatment of the UCP/HSNTF payments made to the Provider for purposes of Medicare reimbursement under reasonable cost principles. The Board finds that the payments made to the Provider from the UCP/HSNTF were properly treated as refunds of the Massachusetts Provider Tax and properly offset against the allowable Tax expense in the cost reporting periods in which the Tax was incurred.

The Board finds that the reasonable cost reimbursement provision in the Medicare statute at 42 U.S.C. § 1395x(v)(1)(A) and the regulations at 42 C.F.R. § 413.9 implementing this provision control in these appeals. The statute provides, in part, that the "reasonable cost of any services shall be the cost *actually incurred*, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services."[36] Likewise, the regulations state, in pertinent part, that "the reasonable cost basis of reimbursement contemplates that the providers of services would be reimbursed the *actual costs* of providing quality care however widely the costs may vary from provider to provider and from time to time for the same provider."[37] Consistent with these statutory and regulatory provisions, PRM 15-1 § 2122.1 specifies that "[t]axes are allowable costs to the extent they are *actually incurred* and related to the care of beneficiaries."[38] In determining the cost "actually incurred" or "true cost," 42 C.F.R. § 413.98 and PRM 15-1 §§ 800 and 804 require that a provider's costs be offset to account for the receipt of refunds, rebates, credits or other discounts by offsetting the costs to which they relate. In particular, PRM 15-1 § 800 specifies that "refunds of previous expense payments are reductions of the related expense."

The Board finds that the Tax liability paid to the UCP/HSNTF by each provider and the uncompensated care payments made from the UCP/HSNTF to each provider are inextricably linked. First, the Board notes that the UCP/HSNTF is set up solely to pay for uncompensated care and the Tax is used solely for the UCP/HSNTF. As part of its mission, the UCP/HSNTF

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[33] Intermediary's Post Hearing Brief at 8-9.
[34] *See Kindred Hosps. East, LLC v. Sebelius*, 694 F.3d 924 (8th Cir. 2012); *Abraham Lincoln Mem. Hosp. v. Sebelius*, 698 F.3d 536 (7th Cir. 2012).
[35] Intermediary's Post Hearing Brief at 10-12.
[36] (Emphasis added.)
[37] 42 C.F.R. § 413.9(c)(3) (emphasis added).
[38] (Emphasis added.)

can conduct certain demonstration programs related to uncompensated care and, during most of the years at issue, was allowed to spend only $6 million each year for this purpose. Specifically, the purpose for these demonstration programs is to determine whether there are any more efficient ways to provide care to uninsured individuals and to do so in a way that would cost less.[39] This interrelated and dependent nature between the Tax liability and uncompensated care payments is further highlighted by the following facts: (1) all acute care hospitals in Massachusetts are required to pay the Tax;[40] (2) the uncompensated care payments are made to partially compensate a provider for the underlying care (as opposed to guaranteeing the provider compensation of their full cost in providing the uncompensated care);[41] and (3) the extent to which an uncompensated care payment covers the cost of the underlying care may vary from year to year depending on funding.[42]

The methodology utilized by the State to collect the Tax supports the interrelated and dependent nature between the Tax liability and uncompensated care payments and supports the finding that the net amount of the Tax represents the allowable cost in these appeals. The sequence of events in this regard is as follows:

1. The State notifies each provider in advance of a particular month of its Tax liability due to the UCP/HSNTF for that month as well as the payment being made from UCP/HSNTF for that same month to the hospital for uncompensated care.

2. Each provider deposits the "net" amount due to the UCP/HSNTF into its designated bank account based on this notice.

3. The State deposits the uncompensated care payment due to each provider into its designated bank account.

4. The State sweeps the designated bank account for each provider's tax liability to the UCP/HSNTF.[43]

For example, under this sequence of events, if a provider is notified in advance for a particular month that its Tax liability will be $20 and the uncompensated care payment will be $5, then that provider need only deposit $15 into its designated account to cover the tax liability because the $5 payment for uncompensated care will be deposited into that account prior to it being swept for the Tax liability. Thus, through these mechanics, the actual cost incurred by the Provider in this scenario is the net amount due to the UCP/HSNTF.[44]

As the Tax that the Provider pays to the UCP/HSNTF is inextricably linked to the uncompensated care payments that it receives from the UCP/HSNTF, the Board finds that the uncompensated care payments act as a refund to reduce cost (*i.e.*, the Tax) under 42 U.S.C.

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[39] *See* Mass. Gen. Laws Ann. ch. 118G, § 36(b) (West 2011) (copy included at Provider Exhibit P-41 (Case No. 11-0596)); Tr. at 213-214.
[40] *See* Mass. Gen. Laws. Ann. ch. 118G, § 18A(b) (West 2012); Tr. at 220-221.
[41] *See* Tr. at 222-223.
[42] *See id.* at 222-223.
[43] *See* Provider's Revised Final Position Paper, Provider Exhibit P-5 (Case No. 11-0609); Tr. at 213-220.
[44] Provider's Revised Final Position Paper, Provider Exhibit P-4 (Case No. 11-0596).

§ 1395x(v)(1)(A) and 42 C.F.R. § 413.9. Further, this treatment is consistent with the principles for accounting of refunds described in 42 C.F.R. § 413.98 and PRM 15-1 §§ 800 and 804. As such, the cost of the Tax liability "actually incurred" by the Provider is the Tax payments paid to the UCP/HSNTF during the relevant fiscal year reduced by the uncompensated care payments made to the Provider from UCP/HSNTF during that same fiscal year.

The Board recognizes that the Provider has asserted that certain guidance from the Intermediary and CMS officials makes clear that it was CMS' position to allow the Tax without offset for Massachusetts hospitals.[45] The Board's review of this documentation shows that, while the Intermediary may have stated to Massachusetts hospitals that "the allowable cost *should* represent the *gross* amount you paid to the UCP,"[46] the CMS officials *only* affirmed to the Intermediary that the Tax was allowable under the Medicare program and did not address whether the *gross* amount of the Tax was allowable or whether the Tax should be offset by any uncompensated care payments.[47] As a result, the Board concludes that, while CMS has had a longstanding policy of allowing the Tax, it did not have a longstanding policy of allowing Massachusetts providers to claim the Tax without offsetting uncompensated care payments.

The Board finds that the decision of the Seventh Circuit in *Abraham Lincoln Memorial Hospital v. Sebelius*[48] provides a comprehensive analysis of the interpretation and application of the controlling statutory and regulatory provisions at issue in these appeals -- 42 U.S.C. § 1395x(v)(1)(A) and 42 C.F.R. § 413.9 respectively. In that case, the Illinois Department of Public Aid collected the tax assessments and deposited the assessments in a Hospital Provider Fund. Like the UCP and HSNTF, the Hospital Provider Fund in Illinois was comprised of the tax assessments and other funds, including federal matching funds and money from another fund in the state treasury. As in the case with the UCP and the HSNTF, the hospitals that paid money into the Hospital Provider Fund received payments back from the fund as additional Medicaid payments.[49]

The Seventh Circuit found that the Administrator's decision to treat the access payments as refunds and offset the access payments against the tax assessments was in keeping with the statutes and regulations. The Seventh Circuit rejected the provider's argument that the access payments were not based on the amount of the tax assessments and, thus, could not have constituted refunds. The Seventh Circuit also found that there was substantial evidence that the access payments were linked to the tax assessments, including the fact that the access payments were disbursed out of the same fund into which the tax assessments were paid. The Seventh

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[45] *See id.* at 34-36; Provider Exhibits P42, P43 (Case No. 11-0596).

[46] Provider Exhibit P-43 at 1 (Case No. 11-0596) (emphasis added). The Board also notes that the Intermediary statement to Massachusetts hospitals did not discuss or refer to uncompensated care payments made from the UCF to Massachusetts hospitals.

[47] *See id.* at 8 (stating that "I advised [the Intermediary representative] to write to you and request a policy interpretation regarding the allowability of the Massachusetts Uncompensated Care Pool (UCP) tax assessment under section 2122 of the Provider Reimbursement Manual"); *id.* at 7 (stating that "the taxes are assessed on providers and seem to meet the general rule of allowability of sec 2122.1 of the PRM" and that the CMS official "was in agreement with the [Boston Regional Office], and intermediary that these taxes would be allowable"). Further, it is unclear from the record what materials and information CMS Central had when it reviewed the allowability of the Tax under the Medicare program.

[48] 698 F.3d 536 (7th Cir. 2012).

[49] *See id.* at 549-551.

Circuit emphasized that the key to determining the costs that the provider actually incurred was the "real net economic impact" of the payments. Because the real net economic impact of the access payments that the provider received was to reduce the full cost of the tax assessments that the provider paid, the Seventh Circuit affirmed the District Court's "thoughtful and carefully drafted opinion" affirming the Administrator's decision that required tax payments to be offset by payments received from the funds into which the taxes were paid.[50]

DECISION AND ORDER:

The Intermediary properly offset the payments that the Provider received from the UCP/HSNTF against the Tax payments that the Provider made to the UCP/HSNTF for the fiscal years at issue in these appeals. The Intermediary's adjustments are affirmed with the exception of FY 2008. The calculation of the Provider's net tax expense for FY 2008 is remanded back to the Intermediary to correct the error in the original calculation as noted above in Item #10 of the Section entitled Parties' Stipulations.

Board Members Participating:

Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD:

Michael W. Harty
Chairman

MAY 28 2014

[50] *See id.* at 551-553.