CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Kindred Hospital - Kansas City **Kindred Hospital - St. Louis**	**Provider Cost Reimbursement Determination for Cost Reporting Periods Ended: 08/31/00, 08/31/01 08/31/02, 08/31/03**
Provider **vs.**	
Wisconsin Physician Services (formerly Mutual of Omaha)	**Review of: PRRB Dec. No. 2009-D42 Dated: September 29, 2009**
Intermediary	

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in §1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). The parties were notified of the Administrator's intention to review the Board's decision. Comments were received from the Intermediary requesting reversal of the Board's decision. Comments were also received from the Provider requesting affirmation of the Board's decision.[1] Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue is whether the Intermediary's adjustments treating the Management Services Corporation (MSC) pool payments the Providers received as provider refunds, which were offset against the allowable provider tax expense, were proper.

The Board held that the Intermediary's decision to treat payments the Providers received from the MSC pool as provider tax refunds, and offset such payments

[1] The Center for Medicare Management submitted untimely Comments after the prescribed commenting period, and thus, those comments were not considered.

against allowable FRA tax expense, was inconsistent with the facts, Medicare laws, and program guidance. The Board reversed the Intermediary's adjustments.

The Board found that the MSC pool payments are not refunds of the Federal Reimbursement Allowance Program (FRA) tax since the only way under State law to change the amount of FRA tax assessed on a hospital is for the hospital to petition the State before the tax is due.

The Board stated that payments from the MSC pool are not "refunds of previous expense payments" as contemplated under the regulation at 42 C.F.R. §413.98(a) ("Refunds of previous expense payments are reductions of the related expense.") The Board points out that the creation of the FRA tax and the MSC pooling arrangement at approximately the same time does not necessarily support the conclusion reached by the Intermediary or the Office of the Inspector General that an MSC pool payment constitutes a tax refund that should be used to offset the FRA tax.

The Board found that payments from the MSC pool does not qualify as a tax refund because the Missouri Hospital Association (MHA) and MSC are private entities. According to the Board, a tax refund may only be issued by a governmental authority or its representative and neither MHA, nor MSC, is a governmental authority or representative of such.

The Board found that the MSC pool payments are not credits or returns. In making this argument, the Board states that MSC pool payments are part of a funding mechanism for the state-wide care provided to Medicaid and uninsured patients. Hence, such payments to hospitals into the MSC pool do not constitute an allowable expense. Therefore the hospitals that receive payments from the MSC pool cannot result in the reduction of that expense, since MSC pool payments cannot be an income which serves to reduce costs.

Instead, the Board found that payments from the MSC pool are properly characterized as "other revenue" or as donations for financial accounting and Medicare cost reporting purposes. The Board stated that "other revenue" is derived from "services other than providing health care services or coverage to patients, residents or enrollees." Therefore, since only "other income items which serve to reduce costs" qualify as applicable credits, and not "all other income", such as the non cost-reducing revenue at issue qualify as credits, give-backs or returns, the MSC pool payments in this case do not offset FRA tax expenses.

SUMMARY OF COMMENTS

Providers Comments

The Providers requested affirmation of the Board's decision. The Providers stated that the Board correctly held that MSC pool payments are not refunds of the FRA tax. The Providers asserted that Missouri Statute 208.461(1) provides no provision authorizing a refund of FRA taxes, except under limited circumstances not involved here. Therefore, payments from the MSC pools are not "refunds of previous expense payments" as contemplated under 42 C.F.R. §413.98(a), and the FRA tax and the pooling arrangement are independent of one another. MSC pool payments are derived from private contracts and hospitals may voluntarily choose to participate in the MSC pooling arrangement.

The Providers stated that MSC pool payments are not credits, give-backs or returns, as contemplated under PRM §2302.5 because only "other income items which reduce costs" qualify as an applicable credit, not all other income items as asserted by the Intermediary. Since the MSC pool payments are part of a funding mechanism for state-wide care provided to Medicaid and uninsured patients, a hospital's payment to the MSC pool could not constitute an expense, and another hospital's receipt of a payment from the MSC pool could not result in the reduction of an expense. Therefore, a payment from the MSC pool cannot be an income item which serves to reduce costs.

According to the Providers, a payment from the MSC pool is properly characterized as "other revenue" for financial accounting and Medicare cost reporting purposes. These payments are unrelated to, and should not be used as an offset to, the FRA tax expense.

Intermediary Comments

The Intermediary requested reversal of the Board's decision. The Intermediary argued that the MSC pool payments serve to reduce the FRA tax burden. Therefore, the Intermediary's adjustments made to offset the FRA tax expense were appropriate. According to the Intermediary, the statute defines reasonable costs as: "the cost actually incurred" and the regulations allow for reductions of expenses when related funds are received. Furthermore, the manual instruction allows the offset of an expense by the receipt of "other income" items which serve to reduce costs.

The Intermediary pointed to the Office of the Inspector General's (OIG) report, dated May 6, 2004, which concluded that the MSC pool payments should be offset against

the FRA tax expense because the pool was established to mitigate the provider tax imposed by the State.

The Intermediary stated that the purpose of the MSC pool is for "enhancing the ability of Missouri hospitals to provide health care services to beneficiaries of the Missouri Medicaid Program and to the uninsured." However, it is the FRA tax itself which results in increased Medicaid funding, which enhances Medicaid beneficiaries. The MSC pool is simply a redistribution system that does not restrict how the funds may be used. The redistribution formula considers the FRA tax to determine which hospitals contribute funds to the pool, as well as the hospitals which receive funds from the pool. The OIG report concluded that the contributions to the pool were not "unconditional." Thus, the contributions cannot be considered to be donations.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

Section 1861(v)(1)(A) of the Social Security Act establishes that Medicare pays for the reasonable cost of furnishing covered services to program beneficiaries, subject to certain limitations. This section of the Act also defines reasonable cost as "the cost actually incurred, excluding there from any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." The Act further authorizes the Secretary to promulgate regulations establishing the methods to be used and the items to be included in determining such costs. Consistent with the statute, the regulation at 42 C.F.R. §413.9 states that 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. The implementing regulation at 42 C.F.R. §413.9(a) provides that "reasonable costs" includes "all necessary and proper costs incurred in furnishing the services subject to principles relating to specific items of revenue and cost."

In determining what constitutes a reasonable cost, 42 C.F.R. §413.98 provides for reductions due to purchase discounts, allowances and refunds of various expenses:

> (a) 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.
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> (b)(3) Refunds are amounts paid back or a credit allowed on account of an over collection.
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> (c) All discounts, allowances and refunds of expenses are reductions in the costs 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.

Providing additional guidance about purchase discounts, allowances, and refunds, the CMS Provider Reimbursement Manual (PRM) 15-1, Section 2302.5 defines "Applicable Credits," that offset or reduce expense items listed on a cost report as follows:

> 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.[2]

[2] The Administrator notes that the term "other income" is generally defined as income activities that are not undertaken in the ordinary course of a firm's business, while the term "other revenue" is generally defined as revenue from sources other than regular sources. Hence, the use of the term "other income" or "other revenue" appears interchangeable. See also Transcript of Oral Hearing (Tr.) at 173. (Provider Witness: "A. Well since the payments from the pool which is coming from the MSC cannot be identified with an individual patient and an individual service provided they really can't be designated as patients services and really related to other revenue or other income.")

This particular case involves the Providers' Medicare cost report treatment of the payments they received from a privately-administered pooling arrangement in which certain Missouri hospitals participated.

In 1992, the MHA created a voluntary Medicaid pool arrangement on behalf of Missouri hospitals that chose to participate. The pooling arrangement provided for the distribution of funds among participating hospitals with the purpose of enhancing the ability of Missouri hospitals to provide health care services to patients who are uninsured and to Medicaid beneficiaries. The hospitals first paid the FRA tax directly to the State by check or requested that the tax be deducted from their Medicaid reimbursement.

Under the MHA's pooling arrangement, the MSC was authorized by participating hospitals to endorse and deposit the checks issued by the State to the respective hospitals into separate bank accounts maintained by each participating hospital and such funds were in turn transferred to an MSC bank account (the MSC pool).[3] Generally the State payments included Medicaid DSH (add-on) payments in addition to payments for Medicaid claims.[4] The MSC then reallocated this revenue to hospitals participating in the pool pursuant to an agreed-upon payment methodology. According to the agreement, each hospital received a net payment from MSC equal to their Medicaid claims net payment (after reduction for FRA assessment payment) and including any uninsured add-on payment and upper payment limit payment, i.e., Medicaid DSH payment) less the MSC's administrative fee and contributions for scholarship and poison control network, plus an adjustment for participation in the pool (either a payment received from the pool, or a deduction for the amount of the Medicaid revenue paid into the pool).[5] This payment detail, which, inter alia, showed the FRA assessment, were included on monthly account statements issued by MSC to each participating hospital.[6]

While the FRA State tax is mandatory, the MSC pooling arrangement is voluntary and not all hospitals participate. Participating hospitals sign a private contract that authorizes MSC to accept and deposit a hospital's State payment contributions on behalf of the hospitals and to redistribute such voluntary payments to other

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[3] See, Agreement between the Providers and MHA, Providers' Final Position Paper at Exhibit, P-16, No.13.

[4] See, e.g., Intermediary Exhibits I-13, I-14, I-15 (Intermediary Workpapers and MSC remittance advices)

[5] See, e.g., Provider Exhibit P-14-2 Schedule A Calculation Worksheet at 00138.

[6] See, e.g., Intermediary Exhibits I-13, I-14, I-15 (MSC remittance advices)

participating hospitals pursuant to a pre-established methodology. The Providers' Agreement with MHA[7] explains how the pool funds are created, stating:

> Hospital authorizes MSC, as agent, to withhold certain funds received by MSC from Hospital that have been paid to Hospital by the program for the purpose of redistributing said funds or a portion thereof to other hospitals to enhance such hospitals' ability to provide health care to Medicaid beneficiaries and the uninsured. This amount is separate and apart from amounts withheld pursuant to paragraph 2.c. of this Agreement. Such separate funds managed on behalf of Hospital are not the property of MSC in accordance with this Agreement and will be consolidated with like funds from other hospitals. Such consolidation of funds will constitute the Pool.

The Providers in this case are Medicare-certified long-term acute care hospitals located in the State of Missouri that were subject to the FRA tax and have been participants in the MSC pooling arrangement. The Providers entered into separate contracts with MSC for this purpose. The Providers have received regular statements from the MSC listing their payments to, and from, the MSC pool. On their Medicare cost reports, the Providers reported both their FRA tax payments and the payments they received from the MSC pool. The Providers respectively claimed the amount of provider FRA tax each hospital paid to the State as an allowable expense on their cost reports. The Providers listed payments received from the MSC pool as Medicaid revenue on their cost reports by reporting MSC pool payments as a reduction of their Medicaid contractual allowance adjustment.

The Providers' appeals cover fiscal years ending (FYE) from 2000 to 2003. The Intermediary audited the Provider's [Kindred Hospital – Kansas City] FYE August 31, 2000 cost report, and issued an NPR, dated September 19, 2003. On the original NPR, the Intermediary made no adjustments with regard to FRA tax expense, or the pool payments.

On May 6, 2004, the OIG released a report on its review of 17 Missouri hospitals that purportedly received the largest MSC pool payments from the Missouri Hospital Association or MHA.[8] The OIG found that 15 of the 17 hospitals recorded the pool payments as Medicaid revenue, rather than as a reduction of the FRA tax expense. The OIG concluded that CMS should instruct the Intermediary to reopen these

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[7] See, Providers' Final Position Paper at Exhibit P-16, No. 3.

[8] See "Review of the Classification of Missouri Provider Tax Refunds on Hospitals' Medicare Cost Reports," May 2004, A-07-02-04006 (the "OIG Report").

hospitals' cost reports and make adjustments to reclassify the pool payments as tax refunds, to be offset against the FRA tax expense.

At the instruction of CMS, and pursuant to the OIG report, the Intermediary reopened the Provider's [Kindred – Kansas City] FYE August 31, 2000 cost report, and issued a revised NPR dated September 15, 2004. Adjustment No. 4 to the revised NPR disallowed $1,714,610 "to reflect the non allowable FRA tax." Adjustment No. 5 to the revised NPR disallowed $2,267 in expenses claimed related to the administration of the Association's pool. The Intermediary issued a second revised NPR for the same cost report, dated October 21, 2004. Adjustment No. 4 to the second NPR allowed $570,033 to "correct the allowable expense for FRA tax for previous excess revenue offset." The Provider determined that these adjustments have a total Medicare reimbursement impact of $484,728, the amount at issue in appeal PRRB No. 05-0717. For FYEs 2001 through 2003, at the instruction of CMS, and pursuant to the OIG report, the Intermediary audited additional cost reports of the Providers and issued several NPRs. As with the Provider's NPR for FYE August 31, 2000, these NPRs offsetting the FRA tax expense by the amount of pool payments received to decrease FRA tax.

After consideration of the law, regulations, policy guidelines and the administrative record, the Administrator finds that the Intermediary correctly treated the MSC pool payments the Providers received as a reduction of the costs of the FRA tax and properly offset such payments against the allowable FRA tax expenses.

The history of the Missouri FRA program shows that the State and the Missouri Hospital Association originally proposed, in 1990, a voluntary contribution program. Under this proposal, hospitals would be compensated for some of the uncompensated care costs with the understanding that hospitals would contribute some of the funds back to the State to be used to pay the State share of the uncompensated care payments necessary to draw matching Federal dollars and underwrite some of the State's costs of operating the basic Medicaid program. The "FRA Briefing Book"[9] explained that: "Under the voluntary contribution program, there were no losers. All hospitals received payments in excess of their contribution."

However, in 1992, the Federal government enacted "The Medicaid Voluntary Contribution and Provider- Specific Tax Amendments of 1991" (Pub. Law 102-234). The Public Law 102-234 required the phasing out of the Voluntary Contribution program and established alternative criteria for Medicaid provider assessment or tax programs. As a result, the State of Missouri enacted the Federal Reimbursement Allowance (FRA) law, which in complying with the Federal law, imposed a

[9] Provider Exhibit P-14-4.

uniformed and broad based tax. This tax did not rely heavily on disproportionate share hospitals contributions and was originally based on patient days, which was later based on operating revenue. Moreover, because of these changes, the State concluded that all hospitals would receive disproportionate share payments. As the FRA Briefing Book explained:

> The [DSH] payments were based on a hospital's Medicaid contractual adjustment and 15 percent of a hospital's Medicare contractual adjustment. The inclusion of 15 percent of the Medicare contractual adjustment allowed the payments to hospitals to be structured in such a way that extreme variation in payments could be avoided. **MHA's objective in reviewing the [DSH] payment was to have this component of the FRA payment system offset the FRA assessment.** **** *Under the provisions of Public Law 102-234 some hospitals became "losers", meaning that their FRA disproportionate share payments did not exceed their FRA assessments.*

The MHA thus initiated the "Hold Harmless" pool, an arrangement that saw further increased participants due to the Omnibus Budget Reconciliation Act of (OBRA) 1993 attempts to contain the growth of the Medicaid program. These provisions limited the Medicaid disproportionate share payments to no more than the costs of serving Medicaid patients and the costs of the uninsured, thus requiring the State's removal of the 15 percent of the Medicaid contractual adjustment in the formula for determining State of Missouri "FRA-based [DSH] payments. When the 15 percent of Medicaid contractual adjustment was removed from the [DSH] payment, it was no longer possible to avoid wide variations in payments among hospitals….. Under OBRA '93 the number of losers increased and the amount of losses increased."[10] Correspondingly, the number of hospitals that volunteered to join the pooling arrangement significantly increased. The Missouri Hospital Association explained:

> The enactment of Public Law 102-234 created a dilemma for Missouri's hospitals. The law's requirement of a broad-based and

[10] The FRA Briefing Book at 00165 The FRA Briefing Book also showed the "Impact on the FRA on the State Medicaid Appropriations: FY 1996" showing hospital DSH payments of $360 million and Hospitals tax payment of $316 million (which allows Federal matching of $475 million). Id. 00165. See also Provider Exhibit P-1 showing "How FRA Works" State fiscal year 2002, showing Hospital Assessments of $463 million, $678 million of Federal matching with the resultant expenditures of a total of $1,112 million including $311 million for DSH, $249 million for direct payments, $311 million for hospital care, $181 million for managed care, $57 million for 1115 waiver.

> uniform assessment forced some hospitals to pay a tax substantially in excess of any benefit they would derive from the program. A review of the federal law led to the conclusion that hospitals could engage in a pooling arrangement to mitigate the impact of a broad-based, uniform assessment. Under the pooling arrangement, funds are withheld from hospitals that are winners under the program. Winners are defined as hospitals with certain designated Medicaid payments in excess of their FRA assessments. The withheld funds are transferred to the hospitals that are losers. Losers are defined as hospitals with an FRA assessment in excess of their designated Medicaid payments. This pooling arrangement is voluntary, and not all hospitals participate.
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> In July 1996, because of concerns of the Health Care Financing Administration about the uniformity of the tax, the DSS converted the FRA based on patient days to an assessment based on net-patient service revenue minus Medicaid net patient-service revenue. With this change in taxing methodology, the number of hospitals paid from the pool increased from 51 to 71. (The 71 hospitals include those that received a pool payment to cover their nursing home assessment.) In SFY 1999, the state began to include Medicaid net patient revenue and other revenue in its assessment calculation. In SFY 2004, 79 hospitals received payments from the pool.[11]

In sum, under the FRA program, the State assessed a provider tax for use in the Medicaid financing formula, which allowed the State to increase matching Federal funding and provide higher reimbursement to Medicaid providers. The MHA, long a partner with the State in developing sources of revenue for providing uncompensated and Medicaid care, created the redistribution arrangement on behalf of the Providers to mitigate the impact of the provider tax.[12] As a result of the FRA tax assessment program and changes in the Federal law which affected the Medicaid DSH formula and the State's ability to directly mitigate the tax burden, certain Missouri hospitals elected to participate in the redistribution arrangement managed by the Missouri Hospital Association. This pool arrangement allowed for a distribution of the increased funding that occurred as a result of the FRA tax based on the provider's tax burden. The pooling arrangement created a redistribution methodology under which payment in excess of a hospital's FRA tax assessment would be redistributed to those

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[11] See Intermediary Exhibit I-4, "Missouri Hospital Association-FRA History and Background."

[12] See, Intermediary Final Position Paper at 7.

Missouri providers that did not receive Medicaid reimbursement in excess of their FRA tax assessment.

The objective for establishing the system that returned funds to the providers was to "offset" or ease the severity of the FRA tax assessment and diminish the effects of changes in law that resulted in wide disparity in the impact of the tax, an objective, which, in practice, was achieved. This objective, in practice, can be seen in the computation formula of the remittance advices which shows the FRA obligation of the respective participant and the amount of its Medicaid DSH add-on payment. The pool payment is shown when the tax burden was not sufficiently eased by the DSH payment for that period.[13] The remittance advices show the pool participation payment was linked to the amount of the FRA tax assessed on the individual hospital and the amount of its Medicaid DSH payment. The MHA/MSC remittance advices recorded the Medicaid add-on (DSH) payment, the FRA tax withheld, and the pool payment to the provider for that period.[14] The pool contributors and pool receivers were directly linked to, and determined by, the amount of the tax assessment and the amount of the DSH payment.[15]

Generally, the providers that received a payment from the pool were assessed a FRA tax that exceeded the Medicaid add-on (DSH) payment amount. Those providers with a tax assessment amount less than the Medicaid add-on payment amounts were not adversely affected by the hospital provider tax and were not awarded an additional payment from the pool.[16] Thus, for providers receiving a payment from the pool, these payments were specifically designed to reduce the tax assessment burden determined by the State.

Based on the foregoing, the Administrator finds that the record shows an integral nexus and link between the FRA tax assessment program and the pooling arrangement payments. As the history of the FRA program shows, the State and the

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[13] See, e.g., Intermediary Exhibits I-13, I-14, I-15 (MSC remittance advices), Intermediary Exhibit I-17. Attachment 1.

[14] See Id. As noted above in Provider Exhibit P-1, the total amount of DSH payment expenditures by the State was less than the amount of the FRA assessments. Thus, it is reasonable that the pool participation payment to an individual hospital may not result in a dollar for dollar recovery of the tax burden incurred, but rather reduce the tax burden.

[15] See, also e.g. Provider Final Position Paper, at 10. ("The reasons the hospitals needed to join in this voluntary association was that the State's distribution mechanism of the additional Medicaid funds realized from the FRA tax assessment and the resulting Federal match was not equitable to all hospitals.")

[16] See, e.g., Intermediary Exhibits I-13, I-14, I-15 (MSC remittance advices), Intermediary Exhibit I-17-Attachment 1.

Missouri Hospital Association were long partners in working together to seek financing for Medicaid and uncompensated care individuals. Because of Federal law changes, the State's Medicaid DSH payment to a respective provider could no longer be guaranteed to directly track a provider's FRA assessment. The FRA tax amount was assessed broadly based on all revenue (both operating and other) and unrelated to the Medicaid DSH payment. No longer did the FRA tax assessment weigh more heavily on the hospitals receiving significant DSH payments therefore causing the MHA's establishment of the pool to accomplish what State law no longer could. But for the FRA tax assessment and the Federal limitations placed on such tax funds and Federal limitations placed on the mitigation of the burden by DSH payments, the pooling arrangement at issue in this case would not have been created by the Missouri Hospital Association. Likewise, the record shows that the FRA tax assessments and the payments of funds derived directly and indirectly from that tax through the DSH payments drove the pools payment methodology.

Therefore, the Administrator finds that payment from the pool must be used to offset the tax assessment. The reasonable cost rules require that a provider be reimbursed the costs actually incurred. In this case, the actual costs incurred are properly determined with respect to the tax assessments once the related pool payment is recognized and offset. Similarly, the regulation at 42 C.F.R. §413.98(a)[2003] states that refunds of previous expense payments (such as FRA taxes) are reductions (offsets) of the related expense, just as other income (the pool payment) should be used to reduce the related cost (the FRA tax assessment) under §2302.5 of the PRM.. A reduction to the amount "paid from the pool" is required under reasonable cost principles which allows only the costs actually incurred under §2302.4 of the PRM as the "other income" received from the pool was because of the FRA tax assessment.[17]

In addition, contrary to the Providers' assertion, the payments to the pool cannot be considered donations or unrestricted grants from one hospital to another hospital. The Administrator finds inter alia, that the contribution was not unconditional and, thus, cannot be considered a donation. The record shows that the pool itself, not the individual hospital, calculated the contribution amount based on a formula. The contributions by the hospitals were driven or conditioned by the underlying mechanism whereby the hospital was assured that it would have some relief overall from the FRA tax assessments if needed. Overall, the pool also ensured cooperative

[17] As stated previously, "For services reimbursed on the basis of actual cost, the Medicare program's clear intent is to pay the "net cost of covered services." Inherent in the definition of "net costs" is the concept that expenses must be reduced by any related income earned … form cannot prevail over substance…." See, Montefiore Medical Center (New York, N.Y.) v. BlueCross BlueShield Association/Empire Medicare Services, PRRB Hearing, Dec. No 2006-D29; Intermediary Exhibit I-7.

compliance and agreement with the tax assessment that allowed for the matching Federal funds benefits and increased Medicaid payments overall. Thus, the payment to the pool cannot be considered unconditional and, hence, a donation.

Further, the OIG Report released May 6, 2004, also found that other funds paid from the pool as the "pool redistribution amounts" also known as "payment from the pool" were not included in the IRS Form 1099 released annually by the Missouri Medicaid Department of Social Services. The Administrator finds that, while treated as Medicaid revenue by the Providers, there was no evidence that the pool payment was shown as Medicaid revenue through the IRS Form 1099 reporting process. This is further cumulative evidence that the "payment from the pool" was not Medicaid operating revenue as originally claimed and, but rather a payment to offset the burden of the FRA tax and, consequently, a payment that reduced the costs incurred from the tax under reasonable cost rules and principles.[18]

In sum, the Administrator finds that the Intermediary properly revised the Providers' Medicare cost reports to identify improper classification of payments and ensure the integrity of the Medicare Trust Fund by treating the Providers' MSC pool payments as offsets against the Providers' allowable tax expense.[19]

[18] The Administrator notes that the Board found, based on the OIG Report, that CMS determined after ten years of review, that the arrangement under Medicaid rules did not violate the hold harmless provision of 42 CFR 433.68(f). However, the OIG Report stated that: "CMS and the State ultimately arrived at a compromise for Medicaid purposes in December 2002. As part of the agreement, the State agreed to change its financing formula." Thus, while not having a conclusive bearing on this case, it would not be accurate to state based on the OIG Report summary, that CMS concluded that the arrangement did not violate the Medicaid hold harmless rule.

[19] The Administrator notes that such offsets should only include positive pool payments from the fund to the Providers and not pool contributions. See Tr. at 80-84.

DECISION

The decision of the Board is reversed in accordance with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 11/20/09

/s/
Michelle Snyder
Acting Deputy Administrator
Centers for Medicare & Medicaid Services