CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Ober Kaler 2005 & 2006 Illinois 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 Tax Group **Providers** **vs.** **BlueCross BlueShield Association/ National Government Services** **Intermediary**	**Provider Cost Reimbursement Determination for Various Cost Reporting Periods** **Review of:** **PRRB Dec. No. 2010-D12** **Dated: January 29, 2010**

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. The Center for Medicare Management (CMM) also submitted comments requesting that the Board's decision be reversed. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue is whether the Intermediary's disallowance of the Illinois property tax assessment was proper.

The Board reversed the Intermediary's adjustment and found that the State of Illinois hospital tax assessment is an allowable cost, under the Medicare law, regulations and program instructions. The Board held that the tax is not included as a non-allowable type of tax nor does it fall within the scope of any excluded tax. The Board stated

that the tax assessment also meets the requirements as a permissible tax under Medicare and was imposed uniformly on all of the Providers. The Board found that the portion of the tax that was refunded to the Provider as part of the increased Medicaid payments should not go toward reducing the Providers' overall tax expense since Medicaid payments do not fall within the definitions of refunds or rebates.

SUMMARY OF COMMENTS

The Intermediary submitted comments, requesting reversal of the Board's decision. The Intermediary maintained that Medicare regulations require that providers are to be paid based on the actual costs of developing and maintaining patient care operations in the facility. The Intermediary stated that while the Providers incurred a tax expense, the actual cost was the tax less the amount refunded by the State in the form of access improvement payments. Accordingly, the Board's decision should be reversed.

The Providers commented, requesting affirmation of the Board's decision. The Providers maintained that the taxes at issue meet all of the Medicare requirements to be an allowable cost. The additional Medicaid payments received by the Providers under the Illinois program cannot be considered as "refunds of expenses" under the regulations. The Medicare program does not have the authority to recharacterize legitimate Medicaid payments made to the Providers by the State for which the Federal government paid its matching share. The Intermediary erred, in concluding that the payment of the taxes close in time to the receipt of the Medicaid payments meant that the Providers did not actually incur the tax expense.

Further, the Providers claimed that offsetting Medicaid payments received from States against provider taxes is contrary to Medicare policy. The Providers noted a recent agency review of a provider tax program in another State which involved a “redistribution pool” demonstrates CMS’ position that for purpose of determining Medicare allowable costs, Medicaid payments received directly from the State should not be offset against permissible provider taxes. The Providers pointed out that in that other State, after receiving their Medicaid payments some of the hospitals put a portion of their Medicaid payments into a “pool” set by the State hospital association for redistribution. The Providers noted that the Office of the Inspector General criticized the “redistribution pool” and indicated that any amounts hospital received from the pool should be offset against the amount of provider tax claimed by those hospitals. However, neither before, nor after, the OIG report did the intermediary offset Medicaid payments received directly from the State against the amount of the provider tax claimed. In a prior case involving that same State, the Administrator similarly held that a redistribution pool was not Medicaid operating revenue, but

rather was a non-Medicaid payment which offset the burden of the provider tax and should be used to reduce the tax expense.

Moreover, the Providers argued that their situation is critically different from that of the State in two key aspects. First, in contrast to the other State, it is undisputed that the payments that the Intermediary offset against the provider tax expense were the actual Medicaid revenues received by the hospitals directly from the State Medicaid program to pay for services provided to Medicaid enrollees. Secondly, the redistribution pool in the other State was not part of any Medicaid State Plan Amendment (SPA) approved by CMS. In their case, CMS explicitly determined in the course of reviewing the State Plan that the Medicaid funds received by the Providers under the SPA were not hold harmless payments that reduced the amount of the provider taxes paid. Thus, the Administrator should affirm the Board's decision. The Providers claimed that affirmation of the Board's decision would be consistent with other similar decision in other Board cases involving State provider taxes.

CMM submitted comments requesting that the Board's decision be reversed. The Intermediary found that the State assessment tax was allowable under the principles of reimbursement describe in the Medicare statute and regulation. However, the intermediary disallowed or reduced all or a portion of the allowable cost by the amounts received from the Funds. The Providers contended that all of the costs associated with the tax are reimbursable without reducing such costs by the payment from the Fund. CMM disagreed with the Provider's contention.

CMM stated that the Board decision stated that the State tax assessment was an allowable cost. CMM agreed that the State of Illinois tax assessment is an allowable cost; however, the taxes must be reduced by an amount received from the Fund. Although the payments received from the Fund may not meet the general definition of a refund, the treatment of these payments from the Fund on the Medicare cost report should be analogous to a reduction of an expense. CMM noted that applicable statute and regulations include two principles that help guide the determination of which expenses may be considered allowable under Medicare. First, costs must be related to the care of Medicare beneficiaries and second, costs must actually be incurred. CMM also pointed out that the regulation at 42 C.F.R. 413.98(d) provides that the "true cost of goods or services is the net amount actually paid for them." Thus, CMM reasoned that the Providers' net expense was the tax that the Providers paid into the Fund reduced by the payment of the Providers received from the Fund.

In addition, CMM maintained that the Board incorrectly used section 2122.1 of the Provider Reimbursement Manual to support that all taxes assessed on a provider by the State are allowable and that section 2122.1 provides an exhaustive list of the unallowable taxes. CMM noted that this section of the PRM was written and last

updated in 1979 when States typically raised revenue only from income, sales, and property taxes and does not reflect changes over time in the type and structure of provider taxes levied by State. Thus, providers cannot assume that any tax no on the list is allowable regardless of whether it comports with broader reasonable cost principles.

Finally, CMM argued that the provision in the Medicaid statute and regulations are not applicable to the determination of whether the State tax is an allowable cost under the Medicare program.

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 regulation at 42 C.F.R. 413.9, "Cost related to patient care," states that:

> (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 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. The regulation states that:

> (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.
> ****
> (b)(3) Refunds are amounts paid back or a credit allowed on account of an over collection.
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> (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.

The Provider Reimbursement Manual provides guidance and agency interpretation of its policies. Section 800, *et. seq.*, (Rev. 45 Nov. 1971) of the Provider Reimbursement Manual further discusses the application of the reasonable cost principles with regard to purchase discounts, allowances and refund. Section 800 states that:

> 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.
> 802.3l 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.
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> 802.4l Rebates--represent refunds of a part of the cost of goods or services…
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> 804. Accounting Treatment. 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.*
> *Where the purchase occurs in one accounting period and the related allowance or refund is not received until the 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, such amounts may be used to reduce comparable 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.

Regarding the allowability of tax costs, Section 2122 of the Provider Reimbursement Manual[1] states that:

> 2122.1 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.
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> 2122.2 Taxes Not Allowable as Costs.--Certain taxes which are levied on providers are not allowable costs. These taxes are:
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> A. Federal income and excess profit taxes, including any interest or penalties paid thereon (see § 1217).
> 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.
> 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 Providers are located in the State of Illinois. During the cost reporting periods on appeal, the Providers were subject to and paid hospital tax assessments levied by

[1] (Rev. 215, Jan. 1979) The original provision for section 2121.1 and 2121.2 was issued Sept. 1969.

the State of Illinois.[2] The assessment was a tax on hospitals of $84.19 per occupied bed day.[3] Certain government-operated hospitals, public hospitals, psychiatric rehabilitation hospitals and long-term hospitals were exempted from paying the tax. [4] 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 percent of the unpaid portion at the end of each 30-day period it remained unpaid.[5] The tax assessments were paid into the Illinois Hospital Provider Fund.[6] The "Hospital Provider Fund" is statutorily authorized to disburse monies for various programs. The Providers acknowledged that:

> The "Hospital Provider Fund" is statutorily authorized to disburse monies for a variety of purposes, not simply for Medicaid payments to hospital providers. For example, the hospital provider fund is also used to make payments under the children's health insurance program act and to pay administrative costs incurred in administering the program, 5/5A-8(b). Some of the expenditures of the hospital provider fund are made as "hospital access improvement payments.[7]

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 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.[8] Illinois also requested that CMS grant a waiver of the broad-based regulatory requirement under 42 C.F.R. §433.68(e)

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[2] Illinois Public Aid Code, Ch. 305 Illinois Compiled Statutes (ILCS) §5 (2004). See, Provider Position Paper Case No. 06-213G, 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.

[3] 305 ILCS §5/5A-2(a).

[4] 305 ILCS §5/5A-3.

[5] 305ILCS at §5/5A-4(c).

[6] 305 ILCS §5/5A-6.

[7] Provider's Final Position Paper at 7. 305 ILCS §5/5A-9(b). 305 ILCS §5/5A-12

[8] See, Providers' Exhibit P-21.

because some classes of hospitals were exempt from paying the tax.[9] 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.[10] CMS noted that if the proposed enhanced Medicaid payments were truly necessary, Illinois would fund them absent any conditions. CMS also requested explanation with respect to the requested amendment as to why providers with lower Medicaid utilization rates receive higher payments than providers with higher Medicaid utilization rates.[11] The State responded that the "goal of the Illinois hospitals service amendment is to ensure that hospitals in rural suburban areas of the State which have traditionally had low Medicaid, but are located where there has been the greatest increase in recent enrollment growth are able to continue to service Medicaid patients. Simply put we must increase payment amounts to these hospitals to allow them to maintain and expand services to the growing Medicaid population in these areas…" The State further noted that: "Like many other States, Illinois hospital reimbursement system has historically directed more dollars to hospitals serving higher proportion of Medicaid patients. This produces substantial variability in the percentage of a hospital's costs in treating Medicaid patients that are actually covered by Medicaid payments to that hospital…The State proposed solution to the crisis in Illinois is to reimburse significantly more dollars to low utilization Medicaid hospitals by amending the payment methodology for both inpatient and outpatient hospital services."[12] The State claimed that while CMS has questioned the economy and efficiency of the methodology "those concerns do not…establish a direct relationship (correlation) between the tax and the method of payment provided." The State responded by removing the conditional language from the proposed SPAs.[13] CMS approved Illinois' SPAs[14] and granted the State's waiver request.

In this case the record shows that, for most Providers, the provider assessment tax was included in the first cost reporting period that ending after January 1, 2005. The Intermediary pointed out that the first and second installments of the provider assessments were due on March 11, 2005, and the third installment was due on April 19, 2005. The installment payments involved in this case related to fiscal years 2004 and 2005. The Intermeidary disallowed all or a portion of the provider tax assessments by offsetting the amounts received from the Hospital Provider Access

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[9] See, Providers' Exhibit P-22.
[10] See, Providers' Exhibit P-23 at 2, Item No. 2; Exhibit P-49 at 2, Item No. 3.
[11] Provider Exhibit P-23.
[12] Provider Exhibit P-23.
[13] See, Providers' Exhibit P-24 at 4, Question/Response No. 2; Exhibit P-50 at 5-6, Question/Response No. 3.
[14] See, Providers' Exhibit P-25.

Fund. However, the Intermediary noted that: "since receipt of the refund may in some cases have occurred in a subsequent fiscal year for the payment of the assessment, [in those instances] the intermediary did not allow the expenses as opposed to offsetting the refund."[15]

After consideration of the law, regulations, policy guidelines and evidence contained within the administrative record, the Administrator finds that the assessment payments to the Providers from the Fund are properly treated as refunds of the State tax and properly offset against the allowable State tax expenses in the cost reporting period in which the tax was incurred.[16] While the hospital tax assessment is an allowed tax, the issue in this case involves the proper treatment of the Fund payments made to the Providers for purposes of the Medicare reimbursement under reasonable cost principles.[17]

Under the Illinois Medicaid Tax Assessment, the State assessed a provider tax for use in the Medicaid financing formula, which allowed the State to maximize Federal funding and provide higher reimbursement to Medicaid providers. The State of Illinois' intent to link the hospitals' respective payments of the tax with the State's receipt of Federal matching funds, and hence, the State's ability, *inter alia*, to pay the hospital access payment refund to the hospital was evident in the Illinois Statute.[18] The Illinois Statute at 305 ILCS 23§5A-4 contained the hospital's conditional obligation to pay the provider assessment tax contingent upon CMS' approval of the

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[15] Intermediary Final Position Paper at 4.

[16] In certain cost years the Intermediary disallowed the tax, as the refund, occurred in the subsequent period. Technically, the Intermediary should have allowed the tax, but offset it, to the extent possible, with the payments received from the Fund. See section 804. In the infrequent cases where the payment was not received in the same cost reporting period, the payments were made relatively close in time to that period when measured by date for filing cost reports (and also already anticipated as coming). Thus, the payment received in the subsequent period should be offset against the related assessment tax in the period the assessment was incurred.

[17] The Providers in this case are made up of providers that either continued to be paid under reasonable costs for these cost years for certain services or were paid reasonable costs for certain pass through items (i.e., critical access hospitals, sole community hospitals, rural hospital, inpatient psychiatric hospitals, rural health clinics.)

[18] It is unclear as to the action the Board expected CMS to take with regard to the State's continuation of the language in the Illinois Statute. CMS approved the SPA only after the language was removed from the SPA, an action which was under CMS' scope of authority.

tax arrangement for Federal Medicaid matching funds. To make the tax assessment and fund payments beneficial to the State, it was necessary to have the SPA approved and the State to receive matching Federal funds for its Medicaid program. Under the statute a provider had no obligation to pay the tax until the Fund payments financed by the tax were approved to receive matching funds for the State Medicaid program. The record demonstrates a close and related timing of the Provider tax and the Fund payment as evident, inter alia, in a letter from the State informing the provider of the timing of its payment and of the tax payment for fiscal years 2004 and 2005. The letter stated that the payments should be received by the provider on or before March 4, 2005.[19] A subsequent letter written to the same provider indicated that the provider's tax payment was not due until March 11, 2005 for the 2004 tax payment and April 19, 2005 for the tax covering the 2005 fiscal year.[20] Consequently, the State statute, communications with Provider and the timing of the tax assessment and fund payments demonstrate that the tax assessments and the Fund payments were inextricably interrelated. That is, but for the tax assessment there would have been no Fund payment and likewise without the Fund payment there would have been no tax assessment. Finally, if the State would not have benefitted from increased Federal funding neither the tax, nor the Fund would have been established. Thus, the Administrator find that the Provider assessment tax and the Fund payment were inextricably linked for purposes of determining the total amount of necessary and reasonable Medicare expenses.

Contrary to the Board finding, the Administrator also finds that, whether the tax meets the required Medicaid "hold harmless" provision is not pertinent to whether the related refund should be offset under Medicare principles to determine the total amount of necessary and reasonable tax expenses. The guiding principle in this case is the reasonable cost rules at section 1861(v)(1)(A) of the Act and the regulation at 42 CFR 413.9. The Medicare reasonable costs determination is controlled by section 1861 of the Act program and is not controlled by the Medicaid "hold harmless" provision. The two programs are authorized by different provisions of the Social Security Act and financed under different mechanisms. Most notably, for the most part the reasonable cost payment is made from the Medicare Trust Fund, while Medicaid is a joint State and Federal program and financed under, *inter alia*, both State and federal appropriations with its own separate and distinct rules.[21] Consequently the Medicaid determination regarding the validity of State's hospital tax program for purposes of Federal contributions, is not controlling over the

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[19] See, Provider Exhibit P-52 and P-53.

[20] Id.

[21] This is not to say certain terminology is not used consistently throughout the two provisions. But a Medicaid hold harmless determination is not a Medicare reasonable cost determination.

Medicare program's determination of reasonable and necessary tax expense for purposes of payment under Medicare.

Further, regardless of how the Fund payment is characterized, the Administrator finds that it must be used to offset the tax under Medicare reasonable cost rules. Section 1861(v)(1)(A) of the Act and the regulation at 42 CFR 413.9 requires providers of services to beneficiaries to be reimbursed the reasonable costs of those services. Reasonable costs are defined, in part, as the cost actually "incurred," excluding costs found to be unnecessary in the efficient delivery of needed health services. The tax expense actually incurred by the Providers in this case is the tax expense offset by the Fund payment. To treat the Fund payment otherwise and allow the provider tax without recognition of the refund as an offset, would also violate the regulations general prescription that the payments be fair to the provider, *to the contributors of the Trust Fund* and to other patients.[22]

This treatment is also analogous and supported by the regulation at 42 C.F.R. §413.98 which states that refunds of previous expense payments (such as State taxes paid by the Providers) are reduction (offsets) of the related expense. Under the regulations at 42 C.F.R. 413.98(c), the State's Medicaid assessment refund must reduce the related expense. Almost all of the participating Illinois hospitals received a refund greater than the amount of their contributed assessment. Therefore, it is only reasonable that the "refund" should be used to reduce allowable expenses for Medicare cost reimbursement purposes. The reduction of the tax assessment by the redistribution/refund received most accurately captures the costs actually "incurred" for purposes of Medicare reimbursement.[23]

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[22] While not determinative as to how Medicare should treat those refunds or payments, the record does not clearly demonstrate that these funds were "Medicaid funds." The payment was made out of the "Hospital Provider Fund." The Hospital Provider Fund does not appear on its face to be synonymous with the State "Medicaid Trust Fund." For example, pursuant to Sec. 5A-8(b)(7) the use of the term "Hospital Provider Fund" does not appear to be interchangeable with "Medicaid Trust Fund" as funds are transferred from the "Hospital Provider Fund" to the "Medicaid Trust Fund." As noted in 5/5A-12 the majority of the Hospital Provider Fund is made for "hospital access improvement payment." That is, the funds at issue are not disbursed from the "Medicaid Trust Fund", but rather the "Hospital Provider Fund." See e.g. Provider Final Position Paper at 9.

[23] See e.g. Sta-Home Health Agency v. Shalala, 1983 WL 475516 S.D. Miss. (1983) (where Administrator held that donations by employees were amounts paid back and, thus, should be deducted from the salary costs. The court noted: "As indicated by the above, PRM provision limiting reimbursement to incurred cost and required by 42 USC 1395f(b) and 1395x(v) has been the consistent policy of the Medicare policy.");

Finally, the Administrator finds that, as the issue is not the allowability of the tax, but rather the treatment of the assessment payment as an offset against the tax in determining the reasonably, necessary and actual tax expense. Thus, section 2122.1 is not determinative of the issue raised in this case.[24] Section 2122.1 of the Provider Reimbursement Manual (PRM) is also not an exhaustive list of the unallowable taxes under Medicare. The policy in this section of the PRM was originally written in 1969 and not substantially revised since. The Manual reflects an environment when States typically raised revenue only from income, sales, and property taxes, and did not use methods to enhance federal revenue with provider taxes. The list of unallowable

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54 Fed. Reg. 5946 5955 (Feb. 7, 1989) ("The proposal is consistent with the statute and with our regulations concerning cost related to patient care (§ 413.). Under section 1814(b) of the Act, we may not pay more than the reasonable cost of services (under the cost reimbursement system). Section 1861(v)(1)(A) of the Act defines reasonable cost as the cost of services actually incurred by providers in furnishing patient care excluding unnecessary costs. For example, if a provider receives a rebate or discount from a supplier of goods or services, we reimburse the actual costs, net of the discount (see § 413.89) Another example would be that if a provider claims reimbursement for interest expense, generally it must reduce that amount by any investment income (§ 413.153). This provision has been upheld in court as a reasonable way to determine the "net cost" of a provider's borrowing. Similarly, if an employee, including a physician, is compensated for services to the provider and, as a condition of employment, is required to return to the provider part of the payment received for services to individual patients in the provider, this payment serves to reduce the provider's actual incurred costs for compensation. Thus, in determining reasonable costs, we base reimbursement on the net or actual compensation costs incurred." See also Montefiore Medical Center (New York, N.Y.) v. BlueCross BlueShield Association/Empire Medicare Services, PRRB Hearing, Dec. No. 2006-D29 ("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.")

[24] However, an analogy section 2121.G of the Manual is instructive. Paragraph G provides that: "Taxes, such as sales taxes, levied against the patient and collected and remitted by the provider" are not allowable. In this case, it is the State that collects and in turn pays out the money to the providers. However, in both instances, it results in the provider incurring no expense. To find otherwise does elevate form over substance and in both instances the "collection" of the tax and the payment of the tax may not be with the exact same dollar but the link is sure and results in no incurred expense.

taxes does not reflect changes over time in the type and structure of provider taxes levied by the States. Therefore, it is improper to assume that any tax not specifically on the list is allowable or any portion thereof regardless of whether or not it comports with broader reasonable cost principles. The Manual must be read consistent with the statutory authority upon which it is based.

In sum, the Administrator finds that the tax is properly offset with the Fund payment amounts received by the respective Providers from the related hospital access improvement payments. The allowable tax is properly calculated as being the amount of the State imposed tax less the amount refunded by the State of Illinois in the form of the hospital access improvement payments.

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: 3/30/10

/s/
Marilyn Tavenner
Principal Deputy Administrator
Centers for Medicare & Medicaid Services