PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2022-D18

PROVIDERS –
Inland Hospital
Maine Coast Memorial Hospital
Franklin Memorial Hospital

Provider Nos.: 20-0041
20-0050
20-0037

vs.

MEDICARE CONTRACTOR –
National Government Services, Inc.

HEARING DATE –
August 28, 2019

Cost Reporting Periods Ended –
September 29, 2012, June 30, 2012 &
June 30, 2012

CASE NOs. – 15-1708
15-1709
15-1688

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ISSUE STATEMENT

Whether the Medicare Contractor's adjustment for fiscal year ("FY") 2012, which reduced the Providers' allowable Medicare reasonable costs by offsetting a portion of the Providers' Medicaid payments against the Providers' Maine Hospital Tax expense, was proper?[1]

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that, for each of the Providers, the Medicare Contractor properly offset the Supplemental Pool payments that the Provider received from the Maine Medicaid program during FY 2012 against the Maine Hospital Tax assessments that the Providers paid during FY 2012.

INTRODUCTION

Inland Hospital, Maine Coast Memorial Hospital, and Franklin Memorial Hospital (hereinafter "Providers") are *acute care, non-critical access hospitals* located in Waterville, Ellsworth, and Farmington, Maine respectively.[2] The Medicare contractor[3] assigned to each of them is National Government Services, Inc. (the "Medicare Contractor").[4]

Each of the Providers was subject to and paid a hospital assessment tax levied by the State of Maine's Medicaid program ("MaineCare") for FY 2012. The issue in this appeal is that each of the Providers dispute the Medicare Contractor's adjustments to reduce each Provider's tax assessment expense by payments received from MaineCare for FY 2012.

The Providers timely appealed the issue to the Board, and met the jurisdictional requirements for a hearing. The Board conducted a live consolidated hearing on August 28, 2019. The Providers were represented by William H. Stiles, Esq. of Verrill Dana, LLP. The Medicare Contractor was represented by Joseph J. Bauers, Esq. of Federal Specialized Services.

STATEMENT OF FACTS

A. STATE TAXES ELIGIBLE FOR FMAP

The Federal Medicaid statute and regulations permit states to impose taxes on various classes of health care providers of services without a reduction to Federal financial participation ("FFP") in

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[1] Hearing Transcript ("Tr.") at 6.

[2] *See* MAC Consolidated Final Position Paper, 2-4 (June 26, 2019). The Providers are not related.

[3] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate.

[4] National Government Services, Inc. is the Medicare Administrative Contractor ("Medicare Contractor") assigned to these providers. National Government Services contracted with Cahaba Safeguard Administrators, LLC to perform the audit work. *See* MAC Consolidated Final Position Paper Exhibit C-1 at 1, 3, 5. All of the Medicare Contractor exhibits referenced throughout this decision are from its Consolidated Final Position Paper unless otherwise noted.

the form of Federal matching assistance payments ("FMAP").[5] As long as the taxes assessed and collected meet certain Federal requirements and conditions, the states can use the tax revenues collected to pay for medical services to Medicaid enrollees, and are permitted to claim FMAP for those Medicaid expenditures.[6] 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.[7] The term "broad-based" tax means that it is imposed "on at least all health care items or services in the class or providers of such items or services furnished by all non-Federal, non-public providers in the State[.]"[8] 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 the FMAP.[9]

B. MAINE MEDICAID PROGRAM

The Maine Department of Health and Human Services ("Maine DHHS") is the single state agency authorized to administer the Maine Medicaid program, known as MaineCare.[10] The Maine DHHS submitted, and CMS approved,[11] revisions to Maine's Medicaid State Plan that were effective on or before July 1, 2011 and, as such, were in effect for the fiscal years at issue in this appeal.[12]

Historically, MaineCare paid acute care non-critical access hospitals on a modified Medicare reasonable cost basis.[13] However, effective July 1, 2011, Maine DHHS adopted, and CMS approved, a State Plan Amendment to MaineCare, which was effective for the cost years at issue in this appeal. This amendment included "an increase of $7.4 million in the supplemental payment pool."[14] Under the State Plan Amendment, Maine DHHS' obligation to acute care non-critical access hospitals, such as the Providers, consisted of Medicaid payments to cover:

1. Inpatient services;
2. Outpatient services;
3. Inpatient capital costs;
4. Hospital based physician costs;
5. Graduate medical education costs;
6. Disproportionate share payments (for eligible hospitals) ("DSH payments"); and
7. Supplemental pool reimbursements referred to as supplemental pool payments ("SPA").[15]

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[5] 42 U.S.C. § 1396b(a), (w). *See also* 42 C.F.R. § 433.50 (copy at Exhibit C-12).
[6] 42 C.F.R. § 433.68 (2015) (copy at Exhibit C-13).
[7] 42 C.F.R. § 433.68(b).
[8] 42 C.F.R. § 433.68(c).
[9] 42 C.F.R. § 433.68(b)(3), (f).
[10] *See* Exhibit P-3; Tr. at 16; Providers' Consolidated Final Position Paper, 4 (May 29, 2019).
[11] *See* 42 U.S.C. § 1396a (process for State plan approval); 42 C.F.R. Part 430, Subpart B (entitled "State Plans").
[12] The change in MaineCare occurred on July 1, 2011. *See* Provider's Second Revised Consolidated ("PRC") Exhibit P-4 at 1-2; PRC Exhibit P-3 at 2 (Memorandum from MaineCare Servs, Maine DHHS, to Interested Parties (Sept. 23, 2011)). The determinations that were appealed confirm that the fiscal year at issue for both Maine Coast Memorial Hospital and Franklin Memorial Hospital began on July 1, 2011 and the fiscal year at issue for Inland Hospital on September 25, 2011. Exhibit C-1 at 1, 3, 5.
[13] *See* PRC Exhibit P-3 at 1 (referring to eliminating hospital specific rates as part of converting to the DRG method).
[14] PRC Exhibit P-4 (copy of CMS approval letter dated Sept. 6, 2011).
[15] MaineCare Benefits Manual ("MCBM"), Ch. III, §§ 45.03-1, 45.07 (Sept. 28, 2011) (copy at PRC Exhibit P-3).

In this regard, the MaineCare amendment also implemented a *DRG-based* inpatient payment system, as well as modifications to the SPA.[16]

Under the new reimbursement methodology, Maine acute care hospitals, including the Providers, were each paid an identical, predetermined amount for similarly grouped inpatient services *(i.e.*, the DRG), subject to hospital specific amounts for capital and graduate medical education costs.[17] Because this MaineCare DRG-based inpatient hospital payment methodology applied *uniformly* statewide, it does not take into account the additional costs associated with a specific hospital's treatment of low income patients. Rather, MaineCare makes separate DSH payments to qualifying acute care hospitals from a pool of set funds ($200,000 for each State fiscal year) that is apportioned between those hospitals based on a set methodology taking into account MaineCare (*i.e.,* Medicaid) inpatient utilization.[18]

As a part of the new reimbursement methodology described above, Maine DHHS adopted, and CMS approved, a revised Supplemental Pool.[19] This revised Supplemental Pool resulted in ***additional*** MaineCare reimbursement for hospital services allocated based upon a hospital's relative share of MaineCare (*i.e.,* Medicaid) inpatient utilization statewide.[20] For acute care hospitals, such as the Providers, the Supplemental Pool is allocated based upon two specific MaineCare inpatient utilization metrics: (1) MaineCare inpatient discharges, and (2) MaineCare inpatient days.[21] Fifty (50) percent of the Supplemental Pool is allocated based upon a hospital's relative share of MaineCare inpatient discharges statewide, and the other fifty (50) percent is allocated based upon that hospital's relative share of MaineCare inpatient days statewide.[22] SPAs are not subject to "cost settlement" and funds are distributed semi-annually in even distributions in November and May.[23]

The State of Maine annually imposes a tax equal to "2.23% of the hospital's net operating revenue"[24] on all acute care, non-critical access hospitals in Maine. The Board will refer to this as the "Maine Hospital Tax." For the individual cases in this consolidated decision, the relevant Maine state fiscal year ("MSFY") is MSFY 2012 and the Maine Hospital Tax assessed for MSFY 2012 was based on each Provider's net operating revenue for its fiscal year ending in 2008.[25] Further, for MSFY 2012, each acute care, non-critical access hospital was required to

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[16] PRC Exhibit P-4; MCBM, Ch. III, § 45.03-1(A). *See also* PRC Exhibit P-3 at 1 (MaineCare memorandum stating that "[t]he distribution methodology for the supplemental pool for non-critical access hospitals was changed to reflect the elimination of hospital specific discharge rates as part of the conversion to DRG methodology.").
[17] MCBM, Ch. III, § 45, Appendix DRG-Based Payment Methodology.
[18] MCBM, Ch. III, § 45.12-3(B) (specifying that 50 percent of the DSH pool for eligible acute care hospitals is distributed based on relative share of MaineCare days of all eligible acute care hospitals and that the remaining 50 percent is apportioned based on a specified standard deviation related DSH allocation methodology).
[19] *Id.*
[20] *Id.* MCBM, Ch. III, § 45.07.
[21] *Id.*
[22] *Id.*
[23] *Id.*
[24] 36 M.R.S. § 2892. Maine Hospital Tax law is located at 36 M.R.S. Pt. 4, Ch. 377 and, therein, § 2892 mandates this hospital tax assessment (copy at PRC Exhibit P-5).
[25] *Id.*; Exhibit C-3 at 5, 21.

"submit to the assessor a [tax] return" and pay one half of the total tax due by November 15, 2011 and the remaining half by May 15, 2012.[26]

Hospital payments of the Maine Hospital Tax are initially deposited into the "General Fund suspense account" and, by the end of each month, these deposits are then transferred to the "Medical Care – Payments to Providers Other Special Revenue Funds account in the [Maine DHHS]."[27] The distribution of the funds for the Supplemental Pool appears to then be made from that account[28] and is based upon the individual hospital's Medicaid utilization as compared to all Maine hospitals.[29]

The Medicare Contractor made adjustments to net the payments received from MaineCare against the Providers' 2012 tax assessments paid, thereby effectively disallowing a portion of the hospitals' provider tax assessments.[30] The below Table shows in Columns 2 and 3 the total Maine Hospital Tax assessed for MSFY 2012 on each of the Providers and the total SPA payments issued to each of the Providers for MSFY 2012:

Provider	**MSFY 2012 Maine Hosp. Tax**	**MSFY 2012 SPA Pymts.**[31]	**FY 2012 Outpt. Reimb. Assoc. With Hosp. Tax**
Inland Hospital	$1,105,047	$ 616,582	$128,364[32]
Maine Coast Memorial Hospital	$1,760,134	$1,220,484	$161,524[33]
Franklin Memorial Hospital	$1,707,808	$1,493,472	$0[34]

In addition, the Maine hospital tax is included on the MaineCare Medicaid cost report and, as a result of how the tax is treated on the cost report, a portion of a hospital's Medicaid outpatient reimbursement is attributable to the reported hospital tax.[35] Column 4 of the Table reflects the additional Medicaid outpatient reimbursement that the Medicare Contractor determined for each Provider is attributable to the hospital tax.[36] The hospitals paid their Maine Hospital Tax to

[26] 36 M.R.S. § 2893(2); PRC Exhibit P-7A-C (copy of each of the Providers' 2012 tax return and the payments made for the tax due on November 15, 2011 and May 15, 2012).
[27] 36 M.R.S. § 2893(3).
[28] *See* Maine State Legislature, State of Maine Compendium of State Fiscal Information Through Fiscal Year Ending June 30, 2017, 10 (Jan. 2018) (copy at PRC Exhibit P-14).
[29] MCBM, Ch. III, § 45.07.
[30] Exhibit C-3 (copy of the Medicare Contractor's audit work papers detailing the adjustments).
[31] Tr at 42.
[32] Exhibit C-3 at 3.
[33] Tr. at 42. Total tax payment is the Supplemental Pool plus the outpatient payment. For Maine Coast, the calculation was as follows: $1,382,008 minus the supplemental pool payment of $1,220,484 to get the outpatient payment of $161,524.
[34] There is no calculation of the outpatient reimbursement by the Medicare Contractor in the record for Franklin Memorial Hospital. *See* Exhibit C-3 at 18-23; Tr. at 42-43; 121.
[35] *See* PRC Exhibit P-8 at 2 (Letter from Maine DHHS (Sept. 9, 2012) stating: "The mechanics of the settlement calculation result in the pool payment being considered part of the total reimbursement for patient care services. The pool payments are also included in all Upper Payment Limit (UPL) calculations the Department submits to CMS in offering assurance that Medicaid payments to the hospitals do not exceed what Medicare would pay."); Tr. at 121-22.
[36] Tr. at 122; 150-152.

DHHS, and concurrently received their payment from DHHS for the distribution owed from the Supplemental Pool.[37]

C. MEDICARE PROGRAM

During the time period at issue, all three hospitals in this appeal participated in the Medicare demonstration program known as the Rural Community Hospital Demonstration Program ("RCH Demonstration Program").[38] Section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 initially established the RCH Demonstration Program for five (5) years[39] and § 410A of the Patient Protection and Affordable Care Act extended it for an additional five-year period.[40] A hospital participating in the RCH Demonstration Program is paid for inpatient hospital services furnished to Medicare beneficiaries on a reasonable cost basis in the first cost reporting period on or after implementation of the program.[41] For subsequent cost reporting periods, the hospital is paid the lesser amount of the reasonable cost or the previous year's amount updated by the inpatient prospective payment update factor for that particular cost reporting period.[42] For the fiscal years under appeal, all the Providers were paid based on a reasonable cost basis.

The statutory provisions addressing Medicare reasonable cost reimbursement are located in 42 U.S.C. § 1395x(v)(l)(A). In pertinent part, the statute provides:

> 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 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

[37] *See* Exhibit C-3 (includes copies of the correspondence from Maine confirming the timing of Maine Hospital Tax assessments and SPA distributions). *See also* MAC Post Hearing Brief, 7-8 (Nov. 20, 2019).
[38] MAC Consolidated Final Position Paper at 2-4; Provider's Final Position Paper at 4.
[39] Pub. L. No. 108-173, § 410A(a), 117 Stat. 2066, 2272 (2003).
[40] §§ 3123, 10313, 124 Stat. 119, 423, 943 (2010).
[41] Pub. L. No. 108-173, § 410A(b)(1)(A), 117 Stat. at 2272.
[42] *Id.* at § 410A(b)(1)(B), 117 Stat. at 2272.

> 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*[43] 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 (2012) provide for reductions due to purchase discounts, allowances and refunds of expenses. The regulations in effect during the cost reporting periods at issue, in pertinent part, state:

> *(a) Principle.* Discounts and allowances received on purchases of goods or services are reductions of the costs to which they relate.

[43] (Emphasis added.)

> 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.

Finally, instructions located in the Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1") provide additional guidance regarding reasonable cost. In particular, §§ 800 and 804 address the application of the reasonable cost principle to purchase discounts, allowances and refunds:

> 800. PRINCIPLE
> 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. . . .
>
> 804. ACCOUNTING TREATMENT
> 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. In this context, it defines the term "applicable credits":

> 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 provides Medicare guidance on the circumstances under which taxes paid by a provider are considered allowable reasonable costs. The general principles governing this guidance are set forth in § 2122.1 and examples of taxes that are not allowable are listed in § 2122.2:

> 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. *Taxes are allowable costs* ***to the extent*** *they are actually incurred* ***and*** *related [sic* relate] *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.
>
> 2122.2 Taxes Not Allowable as Costs.--Certain taxes which are levied on providers are ***not*** allowable costs. These taxes include:
>
> 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.[44]

In December 2011, CMS made the following clarification to PRM 15-1 § 2122[45] in accordance with the clarification to CMS policy contained in the FY 2011 Inpatient Prospective Payment System ("IPPS") Final Rule published on August 16, 2010 ("FY 2011 IPPS Final Rule")[46]:

> 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.[47]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The Providers offer several arguments to support its position that the Medicare Contractor improperly offset payments from the Supplemental Pool against the tax the Providers paid. First, the Providers claim that the relevant law, regulations and manual provisions do not support the offset of the Supplemental Pool Revenue.[48] Second, they argue that, contrary to the Medicare Contractor's position, the Maine Hospital Tax is not inextricably linked to the Supplemental

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[44] (Bold and italics emphasis added.)

[45] 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.") (*available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R448PR1.pdf).

[46] 75 Fed. Reg. 50042, 50362-64 (Aug. 16, 2010).

[47] (Bold and italics emphasis added.)

[48] Providers' Consolidated Final Position Paper at 8-19.

Pool.[49] Third, they assert that the CMS policy clarification in the FY 2011 IPPS Final Rule was not an interpretation of previous law, but rather was a substantive change in how provider taxes were treated and should have gone through notice and comment rulemaking.[50] In support of its position that this change should have gone through notice and comment rulemaking, the Providers point to the alleged facts that CMS had not made an adjustment to offset the Maine Hospital Tax prior to 2012 and was not willing to offset the Maine Hospital Tax subsequent to 2012.[51]

The Medicare Contractor contends that, although the taxes that the Providers paid into the MaineCare fund were allowable, such payments into the fund must be offset by the amounts that the Providers received back from that fund. The Medicare Contractor contends that this resulting ***net*** amount is the cost which was "actually incurred" by the Providers. Accordingly, the Medicare Contractor determined the "net cost" by reducing the gross tax liability by the SPA payments issued to the Providers.[52]

The key inquiry in these appeals is whether the full or gross amount of the Maine Hospital Tax paid by the Providers was "actually incurred" by the hospitals, as that term is understood in the governing Medicare regulations and guidance. The Board finds that the reasonable cost reimbursement provision in the Medicare statute at 42 U.S.C. § 1395x(v)(1)(A), and the regulation at 42 C.F.R. § 413.9 implementing this provision, are the controlling authorities in these appeals. This statutory provision states, in relevant 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."[53] Likewise, the regulation states, 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 actual costs may vary from provider to provider and from time to time for the same provider."[54]

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."[55] 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."

Facts strikingly similar to those in the instant appeals have been litigated before. In the court cases, *Abraham Lincoln Memorial Hospital v. Sebelius* ("*Abraham Lincoln*")[56] and *Dana Farber Cancer Institute v. Hargan* ("*Dana Farber*"),[57] the facts differ slightly from this appeal, but the

[49] Providers' Consolidated Post-Hearing Brief, 13-15 (Nov. 20, 2019)
[50] Providers' Consolidated Responsive Brief, 13 (July 29, 2019).
[51] Providers' Consolidated Final Position Paper at 29.
[52] *See* MAC Consolidated Final Position Paper at 6.
[53] 42 U.S.C. § 1395x(v)(1)(A) (emphasis added).
[54] 42 C.F.R. § 413.9(c)(3) (Emphasis added).
[55] (Emphasis added.)
[56] *Abraham Lincoln Mem'l. Hosp. v. Sebelius*, 698 F.3d 536 (7th Cir. 2012) (copy at Exhibit C-14).
[57] *Dana-Farber Cancer Inst. v. Hargan*, 878 F.3d 336 (D.C. Cir. 2017) (copy at Exhibit Ex. C-15).

underlying concept is the same. In *Abraham Lincoln*, the U.S. Court of Appeals for the Seventh Circuit ("Seventh Circuit") found that "the full Tax Assessment was not an *incurred cost* as the Illinois statute made clear that no installment of the Tax Assessment was 'due and payable' until the Hospital actually received the Access Payments. So . . . Access Payments were to be made on or before June 15, 2004, and the Tax Assessment was due three days later on June 18, 2004."[58] Similarly, in *Dana-Farber*,[59] the U.S. Court of Appeals for the D.C. Circuit ("D.C. Circuit") found that, if the provider's uncompensated care payment was less than its tax liability, the provider was only required to put the difference between the tax liability and the uncompensated care payment in its designated account prior to it being swept by the state for payment.

In both these provider tax scenarios, the Circuit Courts found that the tax liabilities paid and payments received from the state Medicaid programs were sufficiently related to each other to require offset. As the Seventh Circuit noted in *Abraham Lincoln*:

> To borrow an example from the Fifth Circuit, this is akin to arguing that if a thermometer manufacturer sold the Hospitals a thermometer for $100 and then, pursuant to a separate agreement, voluntarily gave the Hospitals $75 of that money back, the hospitals would be able to be reimbursed $100 by the Medicare program, without any offset, because the $75 was not directly computed off of the $100 purchase price.[60]

The Seventh Circuit continued:

> In concluding that the Access Payments were properly treated as refunds of the Tax Assessments and should be offset against the Tax Assessments because they were ***inextricably linked***, the Administrator relied on the language of the Legislation, ***communications between providers and the State***, and the ***timing of the Tax Assessments and the Access Payments***.[61]

In *Dana Farber*, the D.C. Circuit agreed:

> Nowhere did the Board's decision state a payment must be inextricably linked to a cost in order to constitute a refund. Instead, the Board reasoned that because it found that the payments and tax were ***inextricably linked*** and that the payments reduced the cost of Dana-Farber's tax liability, the payments "act as a refund to reduce cost[s] (*i.e.*, the Tax) under 42 U.S.C § 1395x(v)(1)(A) and 42 C.F.R. § 413.9." This interpretation is consistent with the regulatory requirements that refunds must be related to and reduce an expense.[62]

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[58] *Abraham Lincoln*, 698 F.3d at 549 (citation omitted)(emphasis added).
[59] *See Dana Farber*, 878 F.3d at 341.
[60] *Abraham Lincoln*, 698 F.3d at 550 (citation omitted).
[61] *Id.* (emphasis added).
[62] *Dana Farber*, 878 F.3d at 343 (citation omitted) (emphasis added).

In this appeal, the Providers were notified of both their tax liability and their MaineCare Reimbursement in the same letter. Furthermore, both the payment and reimbursement occur concurrently on the same date.

In all three cases before the Board, the Providers are paying a provider tax (*i.e.*, the Maine Hospital Tax) which appears eligible for FMAP (*i.e.*, federally matched dollars).[63] Based upon the facts, regulatory guidance, and case law, the Board finds the Maine Hospital Tax is inextricably linked to the Medical Care – Payments to Providers Other Special Revenue Fund. This link necessitates an offset of these funds received against the Maine Hospital Taxes paid. Specifically, 36 M.R.S. § 2893(3) states:

> All revenues received by the assessor under this chapter must be credited to a General Fund suspense account. No later than the last day of each month, the State Controller shall transfer all revenues received by the assessor during the month under section 2892 to the *Medical Care Payments to Providers Other Special Revenue Funds* accounts in the Department of Health and Human Services.[64]

The Providers' post hearing submissions consist of the Providers' Consolidated Post-Hearing Brief and PRC Exhibits P-14 to P-22. The Providers assert, in their post-hearing submissions, that the "Medical Care Payments to Providers Other Special Revenue Funds accounts" identified in 36 M.R.S. § 2893(3) is the "Other Special Revenue Funds" account designated for or linked to the MaineCare program known as "Medical Care – Payment to Providers 0147." As set forth below, the Providers have ***not*** presented sufficient evidence to definitively reach this conclusion and, regardless, it is not consequential to the Board's decision.

The Providers note in their Consolidated Post-Hearing Brief that the "Other Special Revenue Funds" appropriated by Maine to "Medical Care – Payment to Providers 0147" was $145,651,782 but states, in error, that it was only for 2012 when it was *for the biennium,* 2011-2012.[65] The Providers further allege, in their Consolidated Post-Hearing Brief, that "[t]he Compendium [*i.e.*, State of Maine Compendium of State Fiscal Information Through Fiscal Year Ending June 30, 2017 at PRC Exhibit P-14] identifies other sources of appropriations to 'Other Special Revenue' ***within*** the "Medical Care – Payments to Providers 0147" budget item."[66] The Provider then gives the following examples in support of this assertion:

> For example, the Compendium explains that "[s]ervice provider tax revenues from the above listed items 7-9 and 11 accrue to Other Special Revenue Funds accounts in the Department of

[63] *See* PRC Exhibit P-8.
[64] 36 M.R.S. § 2893(3) (emphasis added).
[65] Providers' Consolidated Post-Hearing Brief at 8 (citing PRC Exhibit P-19 at 728; PRC Exhibit P-14 at 26). The Providers incorrectly suggest that $145 million in "Other Special Revenue Funds" associated with "Medical Care – Payment to Providers 0147" was for FY 2012 only. *See, e.g.,* Providers' Consolidated Post-Hearing Brief at 8. However, it is clear that it covers a "biennium," namely 2011 through 2012.
[66] *Id.* at 9 (emphasis added.)

> Health and Human Services and are used to fund MaineCare services, with a part of the proceeds of the tax used to replace General Fund appropriations for these purposes." [**PRC**] **Exhibit P-14, p. 9-10.** The graph indicates that $34,829,087 of Service Provider Taxes were appropriated to Other Special Revenue. **Id.** Other sources include expenditures charged to earned federal ([**PRC**] **Exhibit P-17, p. 2 /**[**PRC**] **Exhibit P-19, p. 705 of 1216)**, school-based services expenditures under new payment procedures ([**PRC**] **Exhibit P-17, p. 2)**, Healthy Maine Prescription rebates ([**PRC**] **Exhibit P-17, p. 2)**, Dirigo Health Fund revenues transferred from the state share of MaineCare costs of the Dirigo Health program ([**PRC**] **Exhibit P-17, p. 2/** [**PRC**] **Exhibit P-19, p. 704 of 1216)**, and one-time transfers ([**PRC**] **Exhibit P-17, p. 714 of 1216)**, among others. In fact, the State of Maine has even dedicated proceeds from a revenue bond related to a liquor sales contracts "to be used for payments to health care providers (primarily hospitals) for services provided under the MaineCare program prior to December 1, 2012. [**PRC**] **Exhibit P-14, p. 14.**[67]

The Providers then conclude that the above information "shows that various sources of revenue (*beyond the Maine Hospital Tax*) are appropriated to 'Medicare Care – Payments to Provider 0147' as 'Other Special Revenue.'"[68] However, close examination of the above information demonstrates that the Providers allegation is untrue and is based on the misconception that ***any*** identified "Other Special Revenue" must be placed in the "Medical Care – Payments to Provider 0147" account. First, PRC Exhibit P-14 makes it is clear that "Other Special Revenue Funds receive their revenues *from segregated or dedicated sources*," and "are expended *by category for* ***specific*** *purposes*."[69] Second, PRC Exhibit P-17, which is a summary document for MaineCare, demonstrates that:

1. MaineCare had in the aggregate over $221 million in "Other Special Revenue (OSR) Funds" for FY 2012 along and over $419 million for the 2011 to 2012 ***biennium***.[70]

2. The net $221 million in OSR Funds were not just for the 0147 program but for all MaineCare program and MaineCare-related programs *with OSR Funds dedicated or linked to them.* MaineCare programs beyond 0147 include: "0960, 0148, 0705, 0978, 0987, Z006, 0731, 0732, 0844, 0948 (MaineCare seed only), Z042, 0733, 0734, Z159, Z160 and Z171" and the related programs of "0202, Z015, Z008, Z009"[71]

3. PRA Exhibit P-17 lists the following OSR Funds existing in 2011 and 2012 but did not state to which MaineCare programs each was designated or linked:

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[67] *Id.* (emphasis in original.)
[68] (Emphasis added.)
[69] PRC Exhibit P-14 at 3 (emphasis added).
[70] PRC Exhibit P-17 at 1.
[71] *Id.* at 2, n.3.

- Beginning in 2003 - NF and ICFs/MR taxes ***and*** in in [*sic*] 2004, ***a new hospital tax*** that was subsequently rebased in 2009, 2011, and 2014;
- Beginning in 2004 – the PNMI service provider tax, expanded in 2006 to include community support services and MR day habilitation, residential training and personal support services. Provider tax funded expenditures include both increased payments to providers and MaineCare program spending previously paid for with General Fund;
- Beginning in 2005, Dirigo Health Fund revenue transferred for the state share of MaineCare costs of the Dirigo Health program; and MaineCare prescription drug rebates that had previously been accounted for in the General Fund;
- Beginning in 2011, expenditures charged to Earned Federal Revenue;
- Beginning in 2012, school-based services expenditures under new payment procedures; and
- For 2014 only includes $183.5 million in settlement payments to hospitals authorized under PL 2013, c. 269.

The first bullet above lists a hospital tax that appears to be the Maine Hospital Tax at issue in this case but it neither references the authorizing statute nor indicates the OSR Funds account to which the taxes were designated. Third, the Provider's post-hearing exhibits establish the following facts:

1. Maine DHHS (including but not limited to MaineCare) had over $460 million in the aggregate for "Other Special Revenue Funds" for the 2011 to 2012 ***biennium***[72]

2. These appropriations are then broken out into separate accounts such as the "Medical Care – Payments to Providers 0147" having an "Other Special Revenue Funds" totaling 145,651,782.[73]

3. For example, the following MaineCare programs appear to have dedicated OSR Funds: 0148[74], 0705[75], 0978[76], Z006.[77]

[72] PRC Exhibit P-19 details "total appropriations and allocations" for the *biennium* 2011 to 2012 for Maine DHHS "Other Special Revenue Funds" of $61,736,566 (*id*. at 4, 565) and $399,286,023 (*id*. at 4, 802).
[73] *Id*. at 728.
[74] *Id*. at 733.
[75] *Id*. at 525.
[76] *Id*. at 556.
[77] *Id*. at 502-503.

Notwithstanding the above, the record is clear that, for FY 2012, the Maine Hospital Taxes collected a total of $80,909,981 and 100 percent of $80,909,981 collected for FY 2012 was placed in "Other Special Revenue Funds" account[78] which 36 M.R.S. § 2893(3) identifies as "the *Medical Care Payments to Providers Other Special Revenue Funds* accounts in the [Maine] Department of Health and Human Services." The total amount allocated for Supplemental Pool payments for 2012 for acute care, non-critical access hospitals totaled $51,847,218[79] and for acute care, critical access hospitals totaled $4,000,000[80] which, in the aggregate, is clearly less that the total Maine Hospital Tax collected for 2012.

Similarly, the record is also clear that the Maine Hospital Taxes were part of the pool from which the federally-matched non-patient-specific Medicaid payments at issue were made to Maine hospitals.[81] Evidence of the association between the Maine Hospital Tax and the MaineCare outpatient reimbursement increase and Supplemental Pool payments is borne out both in how Maine DHHS communicated with the hospital community about them as well as how the Providers themselves understood them. The Tax Expense Audit Workpapers found at Exhibit C-3 contain copies of form letters from Maine DHHS issued to Inland Hospital and to Franklin Memorial Hospital regarding impending Maine Care Hospital Tax assessments and Supplemental Pool payments.[82] The following form letter that ***Maine DHHS*** issued to Inland Hospital on October 21, 2011 highlights the language of each of these letters:

> The hospital tax due to the State of Maine from your hospital for the State Fiscal Year 2012 will be paid in two installments. The amount of the first installment due from your hospital is $[*amount omitted*] and is ***due on November 15, 2011***. The tax is based on calendar year 2008 audited financial statements.
>
> Your tax payment should be in the form of a check, payable to "Treasurer State of Maine" and should be delivered directly to Maine Revenue Services. You should have received further information and the tax return to use from Maine Revenue Services.
>
> You may pick up a check for the amount owed to your hospital at the Department of Health and Human Services at 442 Civic Center Drive, Conference Room 1A, Augusta from 11:30 AM until 3:00 PM on November 15, 2011. The first installment owed to your hospital is $[*amount omitted*].[83]

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[78] PRC Exhibit P-14 at 26 (table showing $80,909,981 was collected for 2012, that $0 was placed in the general fund, and $80,909,981 was placed in the Other Special Revenue Funds).
[79] PRC Exhibit P-3 at 17.
[80] *Id.* at 13.
[81] *See* Tr. at 120, 180, 189.
[82] Exhibit C-3 at 1, 5, 20-21.
[83] *Id.* at 1.

Thus, each of these form letters lists both the Maine Hospital Tax due and the Supplemental Pool amount owed to the Provider from MaineCare. Relative to the fiscal years at issue, the biannual due dates for both the payment of the Maine Hospital Tax assessment and issuance of the Supplemental Pool amounts is the same – November 15, 2011 and May 15, 2012.[84] The Board agrees with the Medicare Contractor's conclusion that, if the Maine Hospital Tax assessments and Supplemental Pool payment were not associated and intertwined, then Maine DHHS would not be referring to both in the ***same*** form letter and the due date for the Main Hospital Tax assessment would not be the ***same*** day as the distribution of the Supplemental Pool amounts owed to the Providers. Indeed, it is apparent that the Providers recognized the association between the Maine Hospital Tax and the Supplemental Pool payments as each of the Providers referred to their Maine Hospital Tax payment as a "tax match" or "T&M" or "tax/match" payment on the invoice description for the tax payments.[85]

While the Maine Hospital Tax is paid to an agency other than the one that administers the Maine Medicaid program, the Board finds that this fails to establish that these funds are not interrelated. The Maine Hospital Tax is initially paid into the General Fund and, at the end of the same month, is transferred to the Medical Care - Payments to Providers Other Special Revenue Fund. The Providers' argument tries to deflect from the reality that the Providers' Maine Hospital Tax payment resulted in more state funds being federally matched resulting in higher rates of reimbursement being paid to Maine acute care hospitals.

As a result of these findings, the Board must necessarily reject the Providers' arguments that: (1) neither the plain language of the federal provider tax statute nor the implementing regulation requires an offset to the Maine Hospital Taxes they paid in these cases; (2) the Maine Hospital Tax is not a purchase of goods and services and, therefore, is not subject to reduction from a "discount" or "allowance" received; and (3) the Secretary's interpretation of his own regulations is not to be accorded deference if it is inconsistent with the plain language of the regulation. Nothing in the record leads the Board to a different conclusion than that reached by the Seventh and D.C. Circuit Courts on this, essentially, identical issue.

Finally, the Providers assert that the Medicare Contractor's treatment of the Maine Hospital Tax both prior to and subsequent to FY 2012 confirms that the tax is allowable, in full, without offset.[86] First, the Providers allege that, in years *prior to* FY 2012, the Medicare Contractor allowed the *full* Maine Hospital Tax. Similarly, the Providers further allege that, for FY 2013, the Medicare Contractor proposed adjustments to offset the Providers' Maine Hospital Tax; however, prior to the issuance of the FY 2013 NPR, removed the adjustments to the Maine Hospital Tax and issued a notice of reopening which reserved the right to revise the NPR at a

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[84] 36 M.R.S. § 2893(2).

[85] PRC Exhibit P-7, Tab A at 2 ("tax match"); PRC Exhibit P-7, Tab B at 2-3 ("T&M"); PRC Exhibit P-7, Tab C at 2-3 ("tax/match").

[86] Providers' Consolidated Final Position Paper at 8 (stating: "The Maine hospital Tax satisfies the criteria specified for a permissible health care related tax set forth in 42 U.S.C. 1396b(w). This is evidenced by CMS' approval of the SPA, as well as the fact the CMS has not reduced the amount of the FFP paid to the MaineCare program. 42 U.S.C. § 1396b(w)(1)(A). Furthermore, the MAC has consistently allowed the Maine Hospital Tax as an allowable Medicare cost, and has never before offset any MaineCare reimbursement against the tax.").

later date, once they received definitive direction from CMS.[87] In November 2018, the Medicare Contractor then allegedly issued a letter to all Maine Hospitals, including the Providers, closing the notices of reopening that had been issued for the Maine Hospital Tax for FY 2013 (as well as any subsequent years), explaining that no further direction from CMS has been received on how to address the provider tax.[88]

The Providers assert that it was not until the December 2011 revision of PRM 15-1 § 2122 that the Medicare Contractor started to offset the Maine Hospital Tax with revenue received from the Supplemental Pool for FY 2012. The Providers cite this to support its contention that PRM 15-1 § 2122 and the related CMS policy clarification in the FY 2011 IPPS Final Rule were not clarifications of the applicable law.[89]

The Board disagrees with the Providers' arguments here, and finds instead that, in the FY 2011 IPPS Final Rule, the Secretary clearly articulates and explains why the clarification to existing policy is not a change in policy. Moreover, the Secretary specifically notified the provider community that revisions would be made to PRM 15-1 § 2122 to reflect this clarification and, to this end, the December 2011 revisions included revisions to PRM 15-1 § 2122.7. In support of its finding, the Board cites the following statements in the preamble to the FY 2011 IPPS Final Rule:

> In the FY 2011 IPPS/LTCH PPS proposed rule (75 FR 24019), we stated that we have learned that there is some confusion relating to the determination of whether a tax is an allowable cost. We believe that much of this confusion has arisen because it may be possible to read sections 2122.1 and 2122.2 of the PRM–1 as permitting all taxes assessed on a provider by a State that are not specifically listed in section 2122.2 to be treated as allowable costs. Section 2122 of the PRM–1 was last updated in 1979 when States typically raised revenue only from income, sales, and property taxes. The list in section 2212.2 is incomplete now, as it does not reflect the variety of provider taxes imposed by States. *In addition, we are concerned that, even if a particular tax may be an allowable cost that is related to the care of Medicare beneficiaries, providers may not, in fact, ''incur'' the entire amount of these assessed taxes. For example, in accordance with the Medicaid statute and regulations, some States levy tax assessments on hospitals. The assessed taxes may be paid by the hospitals into a fund that includes all taxes paid, all Federal matching monies, and any penalties for nonpayment. The State is then authorized to disburse monies from the fund to the hospitals. We believe that these types of subsequent disbursements to providers are associated with the assessed taxes and may, in fact, offset some, if not all, of the taxes originally paid by the hospitals.*

[87] *Id.* at 2-3.
[88] *Id.* at 3-4.
[89] *Id.* at 37-42.

> We believe that the treatment of these types of payments on the Medicare cost report should be analogous to the adjustments described at § 413.98 of the regulations. Specifically, § 413.98(d) provides that the ''true cost of the goods or services is the net amount actually paid for them.'' Section 413.98 specifically addresses the purchase of goods and services and reflects the statutory mandate that a provider's allowable costs are the net expenses it incurs for items and services. ***In situations in which payments that are associated with the assessed tax are made to providers specifically to make the provider whole or partly whole for the tax expenses****, Medicare should similarly recognize only the* ***net*** *expense incurred by the provider. Thus, while a tax may be an allowable Medicare cost in that it is related to beneficiary care, the provider may only treat as a reasonable cost the* ***net*** *tax expense;* ***that is, the tax paid by the provider, reduced by payments the provider received that are associated with the assessed tax****.*
>
> ***
>
> Therefore, we proposed to clarify the policy set forth in sections 2122.1 and 2122.2 of the PRM–1 to reflect our concerns set forth above regarding when certain provider taxes may be allowable costs under the Medicare program.
>
> ***
>
> We believe that this provision, as articulated in the proposed rule, is a clarification of our current, longstanding policy which requires that "reasonable costs" claimed by providers must be "actually incurred." Currently, CMS and its Medicare contractors apply the longstanding reasonable cost principles at section 1861(v)(1)(A) of the Act and at 42 CFR 413.9 of the regulations to determine if a particular expense is an allowable cost under Medicare. One such principle, as discussed above, is that a ''reasonable cost'' must be "actually incurred."
>
> . . . . The discussion of taxes and allowable costs in the PRM–1 does not specifically address the requirement that costs must be ''actually incurred.'' However, the discussion of provider taxes in the PRM–1 should be considered in conjunction with the reasonable costs requirements set forth in the statute and regulations. To the extent that providers considered the list in section 2122.2 of the PRM–1 to permit a facility from counting, as part of its allowable costs, all but the listed provider taxes, regardless of whether the taxes listed were ''actually incurred,'' we

> are now clarifying that this approach is inconsistent with reasonable cost principles.
>
> We believe that it is consistent with the current and longstanding principles of cost reimbursement, as set forth in the statute and regulations, to remind both providers and our contractors, that although a particular tax may be an allowable cost, the amount of that tax that providers may claim for reasonable cost purposes, must reflect the amount of these assessed taxes that are actually incurred. Thus, in accordance with the Medicare statute, regulations, and PRM policies, Medicare contractors will continue to apply the current reasonable cost principles to determine if a provider tax incurred is an allowable cost and how much of that allowable cost is actually incurred to determine reimbursement.
>
> . . . . Moreover, to the extent that a particular tax might be an allowable expense, it still must be ''actually incurred."
>
> This clarification will not have an effect of disallowing any particular tax but rather make clear that our Medicare contractors will continue to make a determination of whether a provider tax is allowable, on a case-by-case basis, using our current and longstanding reasonable cost principles. *In addition, the Medicare contractors will continue to determine if an adjustment to the amount of allowable provider taxes is warranted to account for payments a provider receives that are associated with the assessed tax*.
>
> After consideration of the public comments we received, we are adopting our proposed clarification, as final, without modification. ***We will modify section 2122 of the PRM–1 to specifically reference our current, longstanding reasonable cost principles***.[90]

Accordingly, the Board finds that the addition of PRM 15-1 § 2122.7 was, as CMS stated, a clarification of existing policy as it already existed in the statute and regulations. More importantly, the preamble discussion of ***both*** the proposed rule and the final rule discusses the scenario that is presented in this case:

> For example, in accordance with the Medicaid statute and regulations, some States levy tax assessments on hospitals. The assessed taxes may be paid by the hospitals into a fund that includes all taxes paid, all Federal matching monies, and any penalties for nonpayment. The State is then authorized to disburse monies from the fund to the hospitals. We believe that these types

[90] 75 Fed. Reg. at 50362-64 (emphasis added).

> of subsequent disbursements to providers are associated with the assessed taxes and may, in fact, offset some, if not all, of the taxes originally paid by the hospitals.[91]

Accordingly, the Board finds that PRM 15-1 § 2122.7 is clearly based on CMS policy established through rulemaking and finalized as part of the FY 2011 IPPS Final Rule.

Finally, the Board finds the alleged failure to offset the SPA payment (as well as the outpatient reimbursement associated with the Maine Hospital Tax) for fiscal years both prior to and subsequent to FY 2012 is not sufficient proof that the offset in FY 2012 reflected a change in CMS' policy that would require additional Federal Register notice and comment publication. To the contrary, the Board finds that existing law and regulation, predating the addition of PRM § 2122.7, required that providers be paid the *actual costs* of providing quality care, only to the extent they are *actually incurred* and related to the care of beneficiaries. Therefore, the Board concludes that the addition of PRM § 2122.7 was a clarification of preexisting law.

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor properly offset the payments the Providers received from the MaineCare disbursements against the Maine Hospital Tax payments for the Providers' respective FY 2012.

BOARD MEMBERS

Clayton J. Nix, Esq.
Gregory H. Ziegler, C.P.A.
Robert A. Evarts, Esq.

FOR THE BOARD:

4/25/2022

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

[91] *Id.* at 50363; 75 Fed. Reg. 23852, 24019 (May 4, 2010).