PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2007-D4

PROVIDER -
Central Maine Medical Center
Lewiston, Maine

Provider No.: 20-0024

vs.

INTERMEDIARY-
BlueCross BlueShield Association/
Associated Hospital Service

DATE OF HEARING -
June 28, 2006

Cost Reporting Periods Ended -
June 30, 1996; June 30, 1997 and
June 30, 1998

CASE NOs.: 99-1159; 01-2664 and
02-0866

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ISSUE:

Whether the Intermediary's denial of the Provider's request for an adjustment to its TEFRA target amount was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

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

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

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

From the Medicare program's inception until 1983, hospitals were reimbursed the lower of their reasonable costs or customary charges for services provided to Medicare beneficiaries. 42 U.S.C. §l395x(v)(1)(A) defines reasonable costs as "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services . . . . " Congress ultimately amended the reasonable cost payment system because it was concerned that while being reimbursed the reasonable costs of covered services, providers had no incentive to provide services efficiently or otherwise limit their costs. Congress first modified the law by enacting 42 U.S.C. §1395ww(a), which established limits on operating costs of inpatient hospital services and authorized the Secretary of DHHS (Secretary) to establish prospective limits on the costs recognized as reasonable in furnishing patient care.

In 1982 Congress enacted the Tax Equity and Fiscal Responsibility Act (TEFRA), again modifying the reasonable cost reimbursement methodology in order to create incentives for providers to render services more efficiently and economically. TEFRA imposed a ceiling on the rate-of-increase of inpatient operating costs recoverable by a hospital. The TEFRA ceiling amount, or target amount, is calculated based upon the allowable

Medicare operating costs in a hospital's base year (net of certain other expenses such as capital-related and direct medical education costs) divided by the number of Medicare discharges in that year. The TEFRA target amount is updated annually based on an inflation factor. If a provider incurs costs below the applicable TEFRA target amount in a given cost reporting year, it is entitled to reimbursement for its reasonable costs plus an additional incentive payment. Because the TEFRA target amount serves as a ceiling, a provider may not be reimbursed for its costs above the applicable TEFRA target amount for a particular year.[1]

However, implementing regulations at 42 C.F.R. §413.40(e) established procedures by which providers may request and receive an adjustment to or an exemption from their TEFRA target amount. With respect to target amount adjustments, 42 C.F.R. §413.40(g)(2) states:

> *Extraordinary circumstances*. HCFA may make an adjustment to take into account unusual costs (in either a cost reporting period subject to the ceiling or the hospital's base period) due to extraordinary circumstances beyond the hospital's control. These circumstances include, but are not limited to, strikes, fire, earthquakes, floods, or similar unusual occurrences with substantial cost effects.

Also, 42 C.F.R. §413.40(g)(3) states, in part:

> *Comparability of cost reporting periods—(i) Adjustment for distortion*. HCFA may make an adjustment to take into account factors that would result in a significant distortion in the operating costs of inpatient hospital services between the base year and the cost reporting period subject to the limits.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Central Maine Medical Center (Provider) is a non-profit, general acute care teaching hospital located in Lewiston, Maine. The Provider's complex includes a 12-bed rehabilitation unit that qualifies as a distinct part unit under Medicare regulations and is subject to the TEFRA target amount. During its cost reporting periods ended June 30, 1996, 1997 and 1998, the Provider's rehabilitation unit incurred actual inpatient operating costs in excess of its cost per discharge reimbursement limit or TEFRA target amount. The Provider requested an adjustment to each year's applicable target amount pursuant to

[1] In 1983 Congress enacted the Social Security Amendments, P. L. No. 98-21, which created the Prospective Payment System (PPS) for hospital inpatient operating costs. After the implementation of PPS, only providers and units within providers exempt from PPS that continued to be paid under the reasonable cost system were subject to the TEFRA rate-of-increase limit.

42 C.F.R. §413.40(e), asserting that the excessive costs were attributable to a new tax (Maine Hospital Tax) assessed on hospitals by the State of Maine in 1991.[2] The Provider contends that because these costs were incurred subsequent to the Provider's base year, they result in a significant distortion in the operating costs between the base year and the fiscal years at issue under 42 C.F.R. §413.40(g)(3) and/or a significant wage increase under §413.40(g)(4). However, Associated Hospital Service (Intermediary) denied the Provider's requests based upon instructions received from CMS, who determined that the Maine Hospital Tax did not qualify as an extraordinary circumstance pursuant to 42 C.F.R. §413.40(g)(2), nor was it grounds for an adjustment based upon 42 C.F.R. §413.40(g)(3), which lists factors that could result in a significant distortion in the operating costs of inpatient hospital services between a given cost reporting period and the TEFRA base year.

The Provider appealed the Intermediary's denials to the Board pursuant to 42 C.F.R. §§405.1835-405.1841 and met the jurisdictional requirements of those regulations. The amount of Medicare funds in controversy is approximately $335, 245.[3]

The Provider was represented by Michael R. Poulin, Esq., of Skelton, Taintor & Abbott. The Intermediary was represented by Arthur E. Peabody, Jr., Esq., Associate Counsel, Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Provider contends that this case is exactly the same as Central Maine Medical Center v. Blue Cross Blue Shield Association/Associated Hospital Service, PRRB Dec. No. 2003-D22, April 24, 2003, dec'd. rev., CMS Administrator, July 3, 2003, in which the Board held that the Maine Hospital Tax was "clearly an event beyond the hospital's control that created a distortion between its base period costs and the costs of the affected reporting periods."[4]

The Provider disagrees with the Intermediary's argument that it is impossible to determine that the rehabilitation unit's costs in excess of the TEFRA limits are due to the Maine Hospital Tax without addressing every other overhead cost charged to the unit. The Provider contends that it is axiomatic that, "If one adds an entirely new cost, such as a tax, and one's total cost exceeds the cap, part of those excess costs can reasonably be attributed to that new tax."

The Provider also disagrees with the Intermediary's argument that there is a link between the Maine Hospital Tax and the State of Maine's Medicaid disproportionate share hospital (DSH) payments and that Medicaid DSH payments should be offset against the amount of the Maine Hospital Tax, thereby reducing the subject TEFRA target amount.

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[2] See Maine Legislature adopting 36 M.R.S.A. §2801-A, imposing a tax on all Maine hospitals equal to 6 percent of a hospital's "gross patient service revenue limit" (GPSRL). Provider's Final Position Paper, page 19.

[3] Provider's Supplemental Position Paper at 2.

[4] Id.

The Provider argues that it is illogical to make a correlation between the funds received for the treatment of Medicaid patients and the amount of reimbursement due for services furnished to Medicare patients. Also, the Intermediary has provided no evidence to show the extent to which the DSH payments received by the Provider were attributable to additional Federal matching funds paid to the State and represent a recovery of the new tax paid by hospitals.

The Intermediary contends that the Maine Hospital Tax was enacted to increase State funds through the Federal Government's participation in the State's Medicaid program. The State, by lowering the threshold for Medicaid DSH, increased payments to hospitals and the Federal Government's matching payments to the State. The State then recovered the increased DSH payments it had made to the hospitals by virtue of the new tax. In effect, the hospitals were in a "hold harmless" position and the State benefited through increased Federal funding. Therefore, if the new tax were to qualify as an increasing adjustment to the subject TEFRA target amounts, then it may be argued that the increased DSH payments should be recognized as a reduction of the Provider's costs and a decreasing adjustment to the Provider's TEFRA target amounts.[5]

The Intermediary also contends that the Maine Hospital Tax is not an extraordinary circumstance pursuant to 42 C.F.R. §413.40(g)(2), nor is the tax a factor distorting the Provider's costs pursuant to 42 C.F.R. §413.40(g)(3). The Intermediary relies upon the position taken by CMS in the Provider's previous appeal of this issue; i.e., that the Maine Hospital Tax is not similar to FICA taxes that could result in a target rate adjustment if they were not incurred in the base period, nor are they directly related to patient care as required by section 3004 of Medicare's Provider Reimbursement Manual, Part I (HCFA Pub. 15-1). Moreover, CMS questioned whether the Provider's costs in excess of the target amounts are attributable to the new tax, since the tax did not contribute to the Provider exceeding the TEFRA target rate in 1991 and 1992.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of Medicare law and guidelines, parties' contentions, and evidence presented, finds and concludes as it did in PRRB Dec. No. 2003-D22 pertaining to the Provider's fiscal years ended June 30, 1993 through 1995, as follows:

Section 1886(b) of the Social Security Act (42 U.S.C. §1395ww) establishes a limit on program payments made for inpatient hospital services. The limit applies to hospitals exempt from Medicare's prospective payment system, including hospital distinct part units. In accordance with the statute, the limit is based upon each affected hospital's cost per case or target amount determined from its inpatient operating costs in a base period. In most instances, the hospital's base period is its cost reporting period ended

[5] Intermediary's Revised Final Position Paper at 13. Also, Intermediary's Revised Final Position Paper at 22 referencing excerpts from the Portland Press Herald, a Deloitte & Touche newsletter, and the Commerce Clearing House Washington Bureau purporting to show a link between the Maine Hospital Tax and the State's DSH revenue.

immediately prior to the effective date of the limit or cost reporting periods beginning on or after October 1, 1982.

The statute also provides for an adjustment or increase to a hospital's target amount under certain circumstances. In part, the law explains that an adjustment is warranted "where events beyond the hospital's control or extraordinary circumstances" create a distortion between the hospital's costs in a cost reporting period subject to the limit and the hospital's base period.

Implementing regulations at 42 C.F.R. §413.40(g) explain that CMS may adjust a target amount for "unusual costs" incurred by a hospital due to circumstances beyond its control. These circumstances "include, but are not limited to, strikes, fire, floods, or similar unusual occurrences." 42 C.F.R. §413.40(g)(2)(emphasis added). Moreover, the regulations explain that CMS may adjust a hospital's target amount for "factors" that result in a "significant distortion" between its base period and a cost reporting period subject to the limit. The factors "include, but are not limited to" FICA taxes, malpractice insurance costs, increases in service intensity, etc. 42 C.F.R. §413.40(g)(3)(emphasis added).

With respect to the instant case, the Provider requested an adjustment to its target amounts applicable to its distinct part rehabilitation unit. The basis for the Provider's request was the fact that the State of Maine imposed a tax on all Maine hospitals' patient care revenue which immediately increased the Provider's distinct part rehabilitation unit's costs by approximately $100,000 a year. The State began assessing the tax in 1991, so its effect on cost was not present in the Provider's base period and is not reflected in its distinct part unit's target amounts.

The Intermediary denied an adjustment to the Provider's target amounts, finding, in part, that Maine's hospital revenue tax is not an unusual event such as a fire or earthquake warranting a target amount adjustment pursuant to 42 C.F.R. § 413.40(g)(2). The Intermediary asserts that rather than being a patient care related service, the tax is a revenue enhancement for the State; i.e., a mechanism by which the State can increase its revenue through federal matching funds. The Provider argues that its request should nevertheless be approved, because the new hospital revenue tax results in a significant distortion between its base period costs and the costs incurred in the affected reporting periods.

The Board finds that the Intermediary's denial of the Provider's request is improper. First, the Board finds there is no dispute regarding the nature of the subject hospital tax as an allowable cost. That is, Maine's hospital revenue tax is recognized as a reimbursable cost by the Medicare program. Next, the Board finds that the tax, having been imposed beginning in 1991, well after the Provider's base period and amounting to approximately $100,000 annually, fits squarely within the context and intent of the pertinent statute and regulations.

With respect to the provisions of 42 U.S.C. §1395ww, the Board finds that the subject tax is clearly an "event beyond the hospital's control" that created a distortion between its

base period costs and the costs of the affected reporting periods. The tax is imposed by the State, and the Provider is required to pay it.

Regarding the regulatory provisions of 42 C.F.R. §413.40(g)(3), the Board finds that a tax such as that at issue here and incurred after a provider's base period is a factor warranting an adjustment to a provider's target amount. The regulations list certain factors to be taken into account for target amount adjustments and specifically mention FICA taxes as one such factor. The Board finds no reason for the subject Maine hospital tax to be treated any differently than FICA taxes. In addition, the Board finds that the listing at 42 C.F.R. §413.40(g)(3) is meant to be illustrative rather than all-inclusive, since it uses general language "include, but are not limited to" with respect to factors to be taken into account for target amount adjustments.

The Board's position in this case is supported by the findings and conclusions of the Florida District Court in Tenet Healthsystems v. Shalala, 43 F. Supp.2d 1334, 1343 (M.D. Fla. 1999) (Tenet Healthsystems). At the heart of that case was a mandatory revenue tax imposed on hospitals by the State of Florida; in essence, the same type of tax confronting the Provider in the instant case. More specifically, however, in Tenet Healthsystems the District Court noted that the plaintiff hospitals successfully defended the Florida State hospital revenue tax as an allowable program cost. The court found that the providers were entitled to an adjustment to their target amounts as a result of that tax because it was an "unusual cost" that resulted in a "significant distortion" in the providers' costs pursuant to the aforementioned statute and regulations. The court also likened the Florida State revenue tax to the FICA tax and noted that FICA was mentioned in the regulations merely as an example of the type of costs that would trigger a target amount adjustment.

The Board acknowledges the Intermediary's argument that the court's decision in Tenet Healthsystems is not precedent setting, as neither the Intermediary nor the Provider is within the jurisdiction of the Florida District Court. However, the Board is not persuaded that the Administrator's decision in other cases requires its acquiescence. Rather, the Board notes that it consistently held for the providers in Tenet Healthsystems as well as in Sarasota Palms Hospital v. Blue Cross Blue Shield Association, PRRB Dec. No. 99-D23, Feb. 18, 1999, Medicare & Medicaid Guide (CCH) ¶ 80,159, rev'd., CMS Administrator, April 20, 1999, Medicare & Medicaid Guide (CCH) ¶ 80,196, rev'd., sub nom Sarasota Palms, Inc. v. Shalala, 125 F. Supp.2d 1085 (M.D. Fla. 2000), another similar case involving the Florida hospital tax and its effect on the provider's target amount.

Finally, the Board acknowledges but rejects the Intermediary's argument that Maine's hospital revenue tax should not be considered a factor warranting an adjustment to a provider's target amount because it is essentially a mechanism for the State to enhance revenues through federal matching funds. The Board notes that CMS became aware of hospital revenue taxes as early as 1991 through Florida's hospital revenue tax and the claim of providers to have their target amounts adjusted for that tax through Tenet

Healthsystems. CMS nevertheless failed to amend the regulation and guidelines to reflect its position that such taxes are not factors warranting target rate adjustments.

DECISION AND ORDER:

The Provider is entitled to have its TEFRA target amount adjusted (increased) to reflect the costs it incurred as a result of Maine's hospital revenue tax. The Intermediary's denial of Provider's request for an adjustment to the TEFRA target amount for its fiscal years ended June 30, 1996, June 30, 1997 and June 20, 1998 is reversed.

Board Members Participating:

Suzanne Cochran, Esq.
Dr. Gary B. Blodgett
Elaine Crews Powell, C.P.A
Anjali Mulchandani-West
Yvette C. Hayes

FOR THE BOARD:

DATE: November 14, 2006

Suzanne Cochran, Esq.
Chairman