CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

IN THE CASE OF:	CLAIM FOR:
Central Maine Medical Center **Lewiston, Maine** **Provider** **vs.** **Blue Cross Blue Shield Association/** **Associated Hospital Service** **Intermediary**	**Medicare Reimbursement** **Fiscal Years Ending: 06/30/96, 06/30/97, and 06/30/98** **REVIEW OF:** **PRRB Dec. No. 2007-D4** **Dated: June 28, 2006**

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 mandated in §1878(f)(1) of the Social Security Act (Act) [42 USC 1395oo(f)(1)], as amended. The parties were notified of the Administrator's intention to review the Board's decision. Subsequently, the CMS' Center for Medicare Management (CMM) and the Intermediary submitted comments requesting that the Board's decision be reversed. The Provider submitted comments requesting that the Board's decision be affirmed. All comments were timely received. Accordingly, the Board decision is now before the Administrator for final administrative review.

ISSUE AND BOARD DECISION

The issue is whether the Intermediary's denial of the Provider's request for an adjustment to its Tax Equity and Fiscal Responsibility Act (TEFRA) target amount for the fiscal years ending (FYEs) 06/30/96 through 06/30/98 was proper.

The Board found that the Intermediary's denial of the Provider's TEFRA exception request was improper. The Board stated that the Provider was entitled to the exception based upon the additional $100,000 in State taxes, which the State began to assess in 1991, after the Provider's TEFRA base year. The Board maintained that the tax fit within the

context and intent of the TEFRA statute and regulations. The Board also found that the tax was an "event beyond the hospital's control," which created a "distortion" between the Provider's base period costs and the costs in the fiscal years at issue, conditions which are listed in the regulations at §413.40(g) as possible reasons for exceptions or adjustments. Moreover, the Board thought it significant that §413.40(g)(3) specifically mentions the Federal Insurance Contributions Act (FICA) taxes as a factor warranting a TEFRA adjustment, and found no reason to treat the subject State tax differently than FICA taxes. The Board also noted that the list of factors warranting adjustments in the regulation was expressly not all-inclusive.

The Board cited to two Florida cases in which the U.S. District Court found that a State tax was the basis for TEFRA adjustments.[1] The Board acknowledged that the cases were not precedent-setting because neither the Provider nor the Intermediary are located within the Florida court's jurisdiction. The Board also stated that it was not persuaded that the Administrator's decisions in other cases affirming exception denials required its acquiescence. Finally, the Board rejected the Intermediary's argument that the tax at issue constituted an attempt by the State to receive matching Federal funds, and noted that CMS has been aware of such hospital revenue taxes since 1991, but has not amended the regulations to indicate that such taxes do not warrant an adjustment. In sum, the Board reversed the Intermediary's denial of the Provider's request for an adjustment to the TEFRA target amount for its fiscal years ended June 30, 1996, June 3, 1997, and June 30, 1998.

SUMMARY OF COMMENTS

Provider Comments

The Provider stated that the sole remaining issue in the case arises from the imposition of the Maine hospital tax, which was based on gross hospital inpatient service revenue. However, the Provider pointed out, because that tax had been repealed in 1998, it has had no impact on Medicare reimbursement beyond 1998. Further, the Provider maintained that, to the best of its knowledge, it was the only provider that had requested a TEFRA adjustment based on the Maine tax, which indicates that the effect of the tax on Medicare was extremely limited in scope and duration.

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[1] *Tenet Healthsystems v. Shalala*, 43 F.Supp. 2d 1334 (M.D. Fl. 1999), and *Sarasota Palms v. Shalala*, 125 F.Supp. 2d 1085 (M.D. Fl. 2000). At issue was the Florida Indigent Care Tax (FICT).

CMM Comments

CMM requested that the Administrator reverse the Board's decision. CMM maintained that the Intermediary's arguments in this case properly interpret the regulations and program policy governing TEFRA adjustments, and provide sufficient grounds for the hospital's request to be denied. CMM pointed out that a State tax, of which the Provider received advance notice, is not an extraordinary circumstance as defined at §413.40(g)(2), and as was affirmed by the CMS Administrator in an earlier decision.

In addition, CMM stated that a State tax is not a ground for an adjustment based on the factors listed at §413.40(g)(3). These factors could cause a significant distortion of a provider's operating costs in a subsequent cost year when compared to the TEFRA base year. CMM further noted that the regulation includes only one particular type of tax, i.e., the FICA tax, which might support a TEFRA adjustment. If the regulations were meant to apply to other kinds of taxes, it would have been indicated, or the regulation would have been more general. CMM also did not agree that FICA taxes are similar to the State hospital revenue in purpose or scope, and, thus, it was inappropriate to generalize from one to the other.

CMM also recognized that §3004 of the PRM specifies that the costs above the ceiling are required to be "directly related to patient care services" to be considered for adjustment purposes, and that is not the situation in this case. CMM also observed that, had the State taxes been "within the TEFRA target amount," Medicare would have reimbursed the Provider for them. However, one of the criteria for an *adjustment* is that the costs exceeding those in the target amount are due to the circumstances specified in the §413.40 regulations. CMM further questioned whether the costs in excess of the target amount are, in fact, attributable to the State taxes. Since the tax did not contribute to the Provider's exceeding its target rate in its 1991 and 1992 cost years, CMM questioned the Provider's claim that the tax was a factor in the Provider's 1993 cost year.

Finally, CMM disagreed with the Board's implication that CMS' failure to amend the regulations, to indicate that such taxes are not grounds for TEFRA adjustments, supports the Board's decision. CMS pointed out that there has been no change in CMS' policy regarding circumstances that may justify a TEFRA adjustment. Moreover, CMS noted that the factors listed in the regulations are those that could warrant an adjustment, not factors that would not warrant an adjustment. Thus, an amendment specifying one circumstance under which an adjustment would not be made would serve no purpose.

Intermediary Comments

The Intermediary commented that it stood on the positions articulated in its Final Position Paper and joined the views expressed by CMM. More specifically, the Intermediary

argued that the Gross Patient Service Revenue Tax is an overhead cost and is not related to direct patient care. The Intermediary maintained that the tax is the type of cost that does not qualify for a TEFRA adjustment.

DISCUSSION

The entire record furnished by the Board has been examined, including all correspondence, position papers, exhibits, and subsequent submissions. All comments timely received have been considered and included in the record.

Historically, Medicare paid for covered hospital inpatient services on the basis of "reasonable cost." In 1982, Congress amended the Act to enhance hospitals' incentives to render services more efficiently. TEFRA imposed a ceiling on the rate of increase of inpatient operating costs recoverable by a hospital.[2] Under TEFRA, providers' reasonable inpatient operating costs were calculated to create a "base year," then in each subsequent year, a predetermined factor was used to update the base year amount to determine each provider's maximum inpatient reimbursement amount or TEFRA "ceiling."[3] The base year for the Provider in the instant case was FYE 06/30/85.

Section 1886(b)(4)(A)(i) also established the Secretary's authority to grant an exemption from, and an adjustment or exception to, the rate of increase ceiling, "where events beyond the hospital's control or extraordinary circumstances … create a distortion in the increase in costs for a cost reporting period …." The regulations implementing TEFRA are set forth at 42 CFR 413.40. Section (g) establishes that CMS *may* adjust the amount of the operating costs considered in establishing the rate-of-increase ceiling for one or more cost years, including the provider's base year "under the circumstances specified." The regulation at (g)(1) goes on to state that CMS grants an adjustment "only to the extent that the hospital's operating costs are reasonable, attributable to the circumstances specified, separately identified by the hospital, and verified by the intermediary."

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[2] Section 1886(b). Congress amended the Act in 1983, replacing the TEFRA limits on reasonable costs with the Prospective Payment System (PPS), under which most hospitals are currently reimbursed. *See* §1886(d). However, certain providers, including rehabilitation units such as the Provider, were excluded from PPS. Medicare continued to reimburse these PPS-excluded providers for their operating costs on the basis of reasonable costs, subject to the TEFRA ceilings. *See* §1886(d)(1)(B).

[3] *See* §1886(b) of the Act. "Operating costs" are defined at §1886(a)(4) of the Act as including "all routine operating costs, ancillary service operating costs, and special care unit operating costs with respect to inpatient hospital services."

Section 413.40(g) further establishes that an adjustment may be granted under the following circumstances:

> (2) *Extraordinary circumstances*. [CMS] may make an adjustment to take into account unusual costs … 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.
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> (3) *Comparability of cost reporting periods* – (i) *Adjustment for distortion.* [CMS] 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.
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> (ii) *Factors*. The adjustments described in paragraph (g)(3)(i) of this section, include, but are not limited to, adjustments to take into account:
> (A) FICA taxes (if the hospital did not incur costs for FICA taxes in its base period).
> (B) Services billed under part B of Medicare during the base period, but paid under part A during the subject cost reporting period.
> (C) Malpractice insurance costs (if malpractice costs were not included in the base year operating costs).
> (D) Increases in service intensity or length of stay attributable to changes in the type of patient served.
> (E) A change in the inpatient hospital services that a hospital provides, and that are customarily provided directly by similar hospitals, such as an addition or discontinuation of services or treatment programs.
> (F) The manipulation of discharges to increase reimbursement. [Emphasis added.]

In addition, §3004 of the PRM explains that TEFRA adjustments may be granted only if certain conditions are met, including that the excess costs are related to direct patient care services; are attributable to the circumstances specified, are separately identified by the hospital, and are determined to be reasonable. In particular, §3004 of the PRM states that:

> The premise underlying the rate of increase ceiling is that inpatient operating costs remain comparable from year to year absent any significant change in services or patient population. Changes in the type of patients serviced or in patient care services that distort the comparability of a cost reporting period to the base year are grounds for an adjustment request. A hospital may request an adjustment to the payment allowed under the rate of increase ceiling in situations where there is a distortion in a hospital's operating costs

> in either its base period or a cost reporting period subject to the ceiling. [CMS] makes an adjustment at the hospital's request only under the following conditions:
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> - The hospital's allowable inpatient operating costs exceed the ceiling;
> - The excess costs are related to direct patient care services;
> - The excess costs are attributable to the circumstances specified;
> - The excess costs are separately identified by the hospital;
> - The excess costs are verified by the Intermediary; and
> - The excess costs are determined to be reasonable. [Emphasis added.]

Under §3004.1, the PRM explains that:

> [D]istortions in inpatient operating costs resulting in noncomparability of the cost reporting periods are generally the result of extraordinary circumstances or one or both of two factors:
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> 1. Increases in the average length of stay of Medicare patients, and/or
> 2. Changes in the volume or intensity of direct patient care services.
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> NOTE: … The following are examples of situations most commonly found as the factors causing a hospital to exceed its ceiling. A hospital is not precluded, however, from submitting and documenting other facts related to patient care services that contribute to its costs per discharge exceeding the target amount …. [Emphasis added.]

Notably, §3004.1.D. of the PRM goes on to state that:

> In cases where cost increases are only partly caused by factors related to direct patient care services, an adjustment is made only for cost increases attributable to factors related to direct patient care.

Furthermore, with respect to the documentation requirements, the regulations at 42 CFR 413.20 and 413.24 place the burden of proving that claimed costs are reimbursable on the provider. These regulations require that providers keep sufficient financial records and statistical data for the accurate determination of costs payable under Medicare. The methods of determining reimbursable costs involve making use of data available from the provider's usually-maintained accounts to determine the correct payment for services to beneficiaries.

In this case, the Provider has appealed the Intermediary's denial of the Provider's request for an adjustment to the TEFRA target amount for its fiscal years ended June 30, 1996, June 30, 1997, and June 30, 1998.[4] The Provider now argues that the imposition of the State tax met the definition of an "extraordinary circumstance" under §413.40(g)(2), and a "significant distortion" under §413.40(g)(3) in the Provider's operating costs between its 1985 base year and its 1996 through 1998 cost years. In addition, the Provider maintains that the State tax was "substantially similar" to FICA taxes and "nearly identical" to the Florida tax which was held by courts to support adjustments in two cases.[5] Moreover, the Provider emphasizes that the factors set forth in the regulations and in §3004 of the PRM for an adjustment are non-exclusive examples of reasons for an adjustment.

With respect to the Provider's arguments regarding the State tax as a basis for an adjustment, the Administrator notes that the State tax amounts were not included in the Provider's 1985 TEFRA base year, and were first assessed in 1991. The regulations at §413.40(g) do not express or imply that, if a cost could have been includable in a provider's TEFRA base year, it may be grounds for an adjustment. Instead, the regulations limit adjustments to specific types of costs, as set forth above. Therefore, the Administrator finds that, whether or not the State tax would have been an allowable TEFRA base year cost had it been imposed in 1985, is not dispositive in determining whether the Provider meets the criteria for an adjustment or an exception.

Moreover, the Administrator finds that the Maine tax does not constitute an "extraordinary circumstance." As set forth in §413.40(g)(2) an "extraordinary circumstance" supporting a TEFRA adjustment is one beyond the hospital's control, and one which causes unusual costs. Examples of such events are "strikes, fire, earthquakes, floods, or similar unusual occurrences with substantial cost effects." While the State tax may be "beyond the hospital's control," it is in no way an "unusual occurrence."[6] Unlike the list of extraordinary circumstances in the regulation, fluctuations in State taxes are to be expected. The Provider in this case has not disputed that it had advance notice of the State tax. Moreover, the Provider itself has pointed out that, just seven years after the first year of levying the tax in 1991, the State repealed the tax, in 1998. Thus, the Administrator finds that the imposition of a State tax on a provider is not similar to the unusual and

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[4] The Intermediary in fact partially granted the Provider's request for a TEFRA exception for FYE 06/30/96 with respect to increased ancillary resource utilization, but denied the request with respect to increased non-pass through overhead costs. Intermediary's Exhibit I-2.

[5] *See Tenet* and *Sarasota Palms*, n. 1

[6] In fact, the imposition of taxes similar to the Maine tax occurred in over half of the States at that time.

sudden event of an earthquake or a flood. In sum, the Administrator holds that the Maine taxes at issue do not qualify as grounds for an adjustment based upon §413.40(g)(2).[7]

However, the Provider has argued that the tax meets the definition at §413.40(g)(3) of a "significant distortion" between the operating costs in the base year and the later cost years at issue. The regulation at §413.40(g)(3)(ii) lists factors which could create a significant distortion, one of which is the FICA tax. The Provider has argued that the inclusion of FICA taxes in the list of significant distortions indicates that State taxes may also support an adjustment. However, there are notable differences between the Maine tax and the FICA tax. The only tax to be listed as a ground for an adjustment, the FICA tax, is a Federal tax. The inclusion of the FICA tax was as a result of specific congressional recognition of such a tax, under certain circumstances, pursuant to §1886(b)(6) of the Act, because of a change in Federal law. The language of the statute and the regulations does not similarly suggest that a State tax is a ground for an increase in a provider's TEFRA target amount. Furthermore, the record in this case does not demonstrate that the Maine tax was of the same nature and character as the FICA tax, which provides beneficiaries with senior and survivor's benefits.[8] In contrast, the tax at issue appears to be representative of those types of taxes imposed by States to increase Medicaid Federal financial participation, frequently resulting in hospitals receiving "rebates."

In addition, CMS has set forth interpretative guidelines of its policy in allowing exceptions at §3004 of the PRM. This section of the PRM states that operating costs in excess of a provider's TEFRA ceiling must be related to direct patient care services. The tax costs at issue represent overhead costs which §3004 of the PRM specifically precludes as a basis for an adjustment. CMS has consistently applied this policy in processing exception and adjustment requests, particularly with respect to the type of State tax involved in this case. The Administrator finds that this policy is reasonable, consistent with the intent of the TEFRA limitations, and within the authority and discretion of the agency to impose.

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[7] *Harmarville v. Secretary*, 1996 U.S. Dist. Lexis at 16-17, *aff'd* 107 F.3d 922 (D.C. Cir. 1996) (In denying the provider's claim for an adjustment due to a Medigap policy change, the U.S. District Court distinguished such a policy change from a prior CMS decision granting an exception to a hospital after the sudden departure of one physician led to a 21 percent drop in occupancy and a 50 percent increase in the cost per discharge. The Court found that, "[t]he Medigap policy change simply does not compare to the situation in terms of severity or <u>suddenness</u>" [emphasis added]. The Court also accepted the Secretary's definition of "extraordinary circumstance" as a "highly unusual occurrence of a severe, sudden and unexpected nature".)

[8] In the instant case, the Provider has attempted to compare the Maine tax to the FICT, which, as noted, was accepted in two U.S. District Court cases as a proper adjustment basis. However, those Courts are not binding in this case.

Finally, even assuming that overhead costs, such as a state tax, could ever provide the basis for an adjustment under 413.40(g)(3), the Administrator finds that to justify an adjustment, the costs must cause a "significant" distortion between the operating costs in the base year and the later cost years at issue. In addition, the provider must demonstrate that the costs were reasonable, attributable to the circumstances specified and separately identified by the hospital. For FYE 6/30/96, the Provider iterated several bases for its request, including increase in patient acuity, increase in ancillary resource utilization, and increase in non-pass through overhead costs.[9] The Administrator finds that the Provider's request for an adjustment for the FYE 1996 cost year does not identify the state tax as a basis for the higher non-passthrough overhead costs and thus failed to separately identify the costs and that the costs were attributable to the circumstances specified.[10]

The Provider requested an adjustment to its TEFRA target amount based on the Maine Hospital Tax and incremental costs associated with increase staffing and operation costs for both FYE 06/30/97 and 06/30/98.[11] For FYE 06/30/97, the Provider submitted two volumes of documentation of what appeared to be support for granting an exception based on the Main Hospital Tax, but no documentation to support the claim for increased staffing and operation costs.[12] The Intermediary followed up with Provider as to whether the tax was the only basis for the request, but received no additional response.[13] The Intermediary denied the request in its entirety.[14] For FYE 06/30/98, the Provider submitted a three-page exhibit to support its position for granting an exception based on the Main Hospital Tax, but no documentation was included to support the claim for increased staffing and operation costs.[15] This request was denied in its entirety by the Intermediary.[16]

The Provider experienced not only a significant decrease in both overall and Medicare utilization, but also a significant decrease in both the overall and Medicare average length of stay.[17] It was not evident from the Provider's request for any of the three years under review whether or not it took steps to defray the costs in the TERFRA unit as a result of the significant decrease in utilization. With a decrease in total days in the unit, the

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[9] Provider's Position Paper, Volume V, FYE 6/30/96, Exhibit P-11-D.
[10] Provider's Position Paper, Volume IV, FYE 6/30/96, Exhibit P-11-E.
[11] Provider's Position Paper, Volume IV, FYE 6/30/97, Provider Exhibit P-9-A, Intermediary I-5 and Provider's Position Paper, Volume III, FYE 6/30/98, Provider Exhibit P-6-B, Intermediary Exhibit I-9, respectively.
[12] Provider Exhibit P-9-A and Intermediary Exhibit I-5; Intermediary's Position Paper, Page 4.
[13] Id.
[14] Intermediary Position Paper, Exhibit I-7.
[15] Intermediary Position Paper, Page 5.
[16] Intermediary Position Paper, Exhibit I-10.
[17] Intermediary Position Paper, Table, Page 6.

Provider should have seen a decrease in the direct costs in the unit. These factors should have contributed to a substantial decrease in the Provider's cost per discharge, not an excess in the cost per discharge. It is not evident from the Provider's request as to its explanation of the cause for the increase in the TEFRA unit's costs. As noted in the PRM, Section 3004.2, a decline in utilization is not a basis for an adjustment as it is expected that a hospital will take means to decrease costs. The Provider failed to address the decrease in utilization as one of the factors causing the increase in its cost per discharge, and also failed to supports its request with documentation which is specific to the alleged basis for the increased costs in the TEFRA unit.

Consequently, the Administrator finds that even if the State tax could be the basis for an adjustment, the Provider has failed to demonstrate the necessary nexus between the state tax and the disproportionate increase in overhead costs for that period. That is, the Provider failed to demonstrate that the State tax was the cause of the costs in excess of its ceiling or caused a "significant" distortion of its costs in these later years.[18]

Accordingly, for all of the above reasons, the Administrator reverses the Board's decision in this case.

[18] The record indicates that the Maine tax was instituted in 1991, but was not identified by the Provider as a cause of its higher costs until later.

DECISION

The Administrator reverses the decision of the Board in this case consistent with the foregoing opinion.

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

Date: 1/12/07 /s/

Herb B. Kuhn
Acting Deputy Administrator
Centers for Medicare and Medicaid Services