

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

DIVISION OF TAXATION

ADMINISTRATIVE HEARING

FINAL DECISION AND ORDER

#2017-02

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
DEPARTMENT OF REVENUE
DIVISION OF TAXATION
ONE CAPITOL HILL
PROVIDENCE, RHODE ISLAND 02908

IN THE MATTER OF

14-T-0054
Healthcare Provider Tax

I. INTRODUCTION

The above-entitled matter came for hearing pursuant to a Notice of Hearing and Appointment of Hearing Officer issued on July 24, 2014 to the above-captioned taxpayers ("Taxpayers") by the Division of Taxation ("Division"). A hearing began on November 10, 2015 at which time, the Taxpayers made an oral argument. After that, the parties agreed to have this matter decided on an agreed statement of facts and briefs. The parties were represented by counsel and briefs were timely filed by November 21, 2016.

II. JURISDICTION

The Division has jurisdiction over this matter pursuant to R.I. Gen. Laws § 44-1-1 *et seq.*, R.I. Gen. Laws § 44-51-1 *et seq.*, *Division of Taxation Administrative Hearing Procedures, Regulation AHP 97-01*, and the *Division of Legal Services Regulation 1 Rules of Procedure for Administrative Hearings*.

III. ISSUE

Were certain categories of revenues received by the Taxpayers between January, 2007 and August, 2009 taxable as "gross patient revenues" under the Nursing Facility Provider Assessment Act (R.I. Gen. Laws § 44-51-1 *et seq.*)? The revenues at issue are (1) hospice; (2) ancillary; (3) Medicare Advantage; and (4) Tricare.

IV. MATERIAL FACTS AND TESTIMONY

The parties entered into an agreed statement of facts as follows:¹

1. _____ is a foreign limited partnership organized under the laws of Massachusetts that qualified to do business in Rhode Island in 1998. _____ is a foreign limited partnership that qualified to do business in Rhode Island in 1998. _____ is a foreign corporation that qualified to do business in Rhode Island in 1995. _____ is a foreign corporation that qualified to do business in Rhode Island in 1995. _____ is a foreign corporation that qualified to do business in Rhode Island in 1995. See Exhibits One (1), Four (4), Six (6), and Eight (8).²

2. _____ each own and operate a nursing care facility licensed by the State of Rhode Island. See Exhibits Two (2), Five (5), Seven (7), and Nine (9). _____ owned and operated a nursing care facility licensed by the State of Rhode Island. See Exhibit Three (3).³

3. The Division is a state agency statutorily charged with the collection, administration and enforcement of all state taxes including, *inter alia*, the Nursing Facility Provider assessment imposed under R.I. Gen. Laws § 44-51-1 *et seq.*

4. _____ routinely and regularly filed returns and remitted payments under the Nursing Facility Provider Assessment Act ("Act") to the Division for the period January, 2007 through September, 2008 inclusive. _____ routinely and regularly filed returns and remitted payments under the Act to the Division for the period August, 2007 through March, 2009 inclusive.

¹ See the parties' agreed statement of facts in which the parties also agreed to the issue in this matter.

² During the time period at issue (2007-2009), the Taxpayers were all members of the _____ which was acquired by _____ effective December 1, 2012.

³ This nursing facility closed on May 4, 2012 and its license expired as December 31, 2012.

5. On February 23, 2009, [redacted] filed a refund claim of \$ [redacted] with the Division on behalf of the [redacted] asserting that the Act's assessment had been overpaid during the period January, 2007 through March, 2007 inclusive. See Exhibits 10 and 11. On March 16, 2009, [redacted] filed a second refund claim of \$ [redacted] with the Division on behalf of the [redacted] asserting that the Act's assessment had been overpaid during the period April, 2007 through September, 2008 inclusive. See Exhibit 13. Both of [redacted] refund claims were timely filed and adequately documented. See Exhibit 14. On November 12, 2009, [redacted] refund claims of \$ [redacted] and \$ [redacted] were denied. See Exhibit 20.

6. On February 23, 2009, [redacted] filed a refund claim of \$ [redacted] with the Division on behalf of the [redacted] asserting that the Act's assessment had been overpaid during the period through January, 2007 through March, 2008 inclusive. See Exhibits 22 and 23. On March 16, 2009, [redacted] filed a second refund claim of \$ [redacted] with the Division on behalf of the [redacted] asserting that said assessment had been overpaid during the period April, 2007 through September, 2008 inclusive. See Exhibit 25. Both refund claims by [redacted] were timely filed and adequately documented. On November 12, 2009, [redacted] refund claims of \$ [redacted] and \$ [redacted] were denied. See Exhibit 32.

7. On September 22, 2009, [redacted] filed a refund claim of \$ [redacted] with the Division on behalf of the [redacted] asserting that the Act's assessment had been overpaid during the period August, 2007 through March, 2009 inclusive. See Exhibits 34 and 35. [redacted] refund claim for the period August, 2007 through March, 2009 was timely filed and adequately documented. See Exhibits 36, 37, and 38. On November 27, 2009, [redacted] refund claim of \$ [redacted] was denied. See Exhibit 39.

8. On February 23, 2009, [redacted] filed a refund claim of \$ [redacted] with the Division on behalf of the [redacted] asserting that the Act's assessment had been overpaid during the period August, 2007 through March, 2009 inclusive. See Exhibits 40 and 41. [redacted] refund claim for the period August, 2007 through March, 2009 was timely filed and adequately documented. See Exhibits 42, 43, and 44. On November 27, 2009, [redacted] refund claim of \$ [redacted] was denied. See Exhibit 45.

9. On September 9, 2009, [redacted] filed a refund claim of \$ [redacted] with the Division on behalf of [redacted] asserting that the Act's assessment had been overpaid during the period August, 2007 through March, 2009 inclusive. See Exhibits 46 and 47. [redacted] refund claim for the period August, 2007 through March, 2009 was timely filed and adequately documented. See Exhibits 48, 49, and 50. On November 27, 2009, [redacted] refund claim of \$ [redacted] was denied. See Exhibit 51.

10. On December 10, 2009, [redacted] filed, with the Division, timely written requests for administrative hearing regarding the denial of the Taxpayers' refund claims under the Nursing Care Provider Assessment. See Exhibit 52.

V. DISCUSSION

A. **Legislative Intent**

The Rhode Island Supreme Court has consistently held that it effectuates legislative intent by examining a statute in its entirety and giving words their plain and ordinary meaning. *In re Falstaff Brewing Corp.*, 637 A.2d 1047 (R.I. 1994). If a statute is clear and unambiguous, "the Court must interpret the statute literally and must give the words of the statute their plain and ordinary meanings." *Oliveira v. Lombardi*, 794 A.2d 453, 457 (R.I. 2002) (citation omitted). The Supreme Court has also established that it will not interpret legislative enactments in a manner that renders them nugatory or that would produce an unreasonable result. See *Defenders of Animals v. DEM*, 553 A.2d 541 (R.I. 1989) (internal citation omitted). In cases where a statute may contain ambiguous language, the Supreme Court has consistently held that the legislative intent must be considered. *Providence Journal Co. v. Rodgers*, 711 A.2d 1131 (R.I. 1998). The statutory provisions must be examined in their entirety and the meaning most consistent with the policies and purposes of the legislature must be effectuated. *Id.*

B. **Relevant Statutes and Regulations**

R.I. Gen. Laws § 44-51-2 states in part as follows:

Definitions. – Except where the context otherwise requires, the following words and phrases as used in this chapter shall have the following meaning:

(2) "Assessment" means the assessment imposed upon gross patient revenue pursuant to this chapter.

(3) "Gross patient revenue" means the gross amount received on a cash basis by the provider from all patient care services. Charitable contributions, donated goods and services, fund raising proceeds, endowment support, income from meals on wheels, income from investments, and other nonpatient revenues defined by the tax administrator upon the recommendation of the department of human services shall not be considered as "gross patient revenue".

(5) "Provider" means a licensed facility or operator, including a government facility or operator, subject to an assessment under this chapter.

R.I. Gen. Laws § 44-51-3 provides in part as follows:

Imposition of assessment – Nursing facilities. – (a) For purposes of this section, a "nursing facility" means a person or governmental unit licensed in accordance with chapter 17 of title 23 to establish, maintain, and operate a nursing facility.

(a) For purposes of this section, a "nursing facility" means a person or governmental unit licensed in accordance with chapter 17 of title 23 to establish, maintain, and operate a nursing facility.

(b) An assessment is imposed upon the gross patient revenue received by every nursing facility in each month beginning January 1, 2008, at a rate of five and one-half percent (5.5%) for services provided on or after January 1, 2008. Every provider shall pay the monthly assessment no later than the twenty-fifth (25th) day of each month following the month of receipt of gross patient revenue.

(c) The assessment imposed by this section shall be repealed on the effective date of the repeal or a restricted amendment of those provisions of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234) that permit federal financial participation to match state funds generated by taxes.

(d) If, after applying the applicable federal law and/or rules, regulations, or standards relating to health care providers, the tax administrator determines that the assessment rate established in subsection (b) of this section exceeds the maximum rate of assessment that federal law will allow without reduction in federal financial participation, then the tax administrator is directed to reduce the assessment to a rate equal to the maximum rate which the federal law will allow without reduction in federal participation. Provided, however, that the authority of the tax administrator to lower the assessment rate established in subsection (b) of this section shall be limited solely to such determination.

R.I. Gen. Laws § 44-51-1 *et seq.*, the Nursing Facility Provider Assessment Act, is a mechanism whereby the State⁴ receives funding for Medicaid via Federal Financial Participation ("FFP"). The Nursing Facility Provider tax assesses the gross patient revenue of nursing facilities. In imposing the Nursing Facility Provider tax, Rhode Island receives FFP matching funds.⁵ In order for states to receive Federal matching funds, states must comply with Federal guidelines.

⁴ "State" refers to the State of Rhode Island. When state is used with a small "s," that references a generic state within the United States.

⁵ Rhode Island enacted said tax statute in 1992 after Congress passed the Medicaid Voluntary Contribution and Provider – Specific Tax Amendments of 1991 codified as 41 USC § 1396(b). The statute provides that if Federal law is changed so that states are no longer allowed to raise matching Medicaid funds by health care provider taxes, the Rhode Island health care provider tax will cease. See R.I. Gen. Laws § 44-51-3(c).

See 42 USC § 1396b(w)(1)(A)(ii).⁶ The Federal statute provides that the sum to be paid to a state will be reduced by any revenues received by a state from health care related taxes, other than broad based health care related taxes.⁷ Regulations have been promulgated in relation to what is

⁶ 42 USC § 1396b is entitled "payment to the states." 42 USC § 1396b(w)(1)(A)(ii) provides in part as follows:

(w) Prohibition on use of voluntary contributions, and limitation on the use of provider-specific taxes to obtain Federal financial participation under Medicaid.

(1) (A) Notwithstanding the previous provisions of this section, for purposes of determining the amount to be paid to a State (as defined in paragraph (7)(D)) under subsection (a)(1) for quarters in any fiscal year, the total amount expended during such fiscal year as medical assistance under the State plan (as determined without regard to this subsection) shall be reduced by the sum of any revenues received by the State (or by a unit of local government in the State) during the fiscal year--

- (i) from provider-related donations (as defined in paragraph (2)(A)), other than--
 - (I) bona fide provider-related donations (as defined in paragraph (2)(B)), and
 - (II) donations described in paragraph (2)(C);
- (ii) from health care related taxes (as defined in paragraph (3)(A)), other than broad-based health care related taxes (as defined in paragraph (3)(B));
- (iii) from a broad-based health care related tax, if there is in effect a hold harmless provision (described in paragraph (4)) with respect to the tax; or
- (iv) only with respect to State fiscal years (or portions thereof) occurring on or after January 1, 1992, and before October 1, 1995, from broad-based health care related taxes to the extent the amount of such taxes collected exceeds the limit established under paragraph (5).

(3) (A) In this subsection (except as provided in paragraph (6)), the term "health care related tax" means a tax (as defined in paragraph (7)(F)) that--

- (i) is related to health care items or services, or to the provision of, the authority to provide, or payment for, such items or services, or
- (ii) is not limited to such items or services but provides for treatment of individuals or entities that are providing or paying for such items or services that is different from the treatment provided to other individuals or entities.

In applying clause (i), a tax is considered to relate to health care items or services if at least 85 percent of the burden of such tax falls on health care providers.

(B) In this subsection, the term "broad-based health care related tax" means a health care related tax which is imposed with respect to a class of health care items or services (as described in paragraph (7)(A)) or with respect to providers of such items or services and which, except as provided in subparagraphs (D), (F), and (I)--

(i) is imposed at least with respect to all items or services in the class furnished by all non-Federal, nonpublic providers in the State (or, in the case of a tax imposed by a unit of local government, the area over which the unit has jurisdiction) or is imposed with respect to all non-Federal, nonpublic providers in the class; and

- (ii) is imposed uniformly (in accordance with subparagraph (C)).

⁷ The parties agreed in their briefs that the determination of whether a state complies with the requirements for receiving funds under the FPP is made by the Centers for Medicare and Medicaid Services ("CMS").

permissible to be taxed in order to receive matching funds.⁸ The regulations require that such taxes must be broad-based, uniformly imposed, and not violate the hold harmless provision.⁹ The

⁸ 42 CFR § 433.50 provides in part as follows:

Basis, scope, and applicability

(a) § 433.50(a) Basis. This subpart interprets and implements--

(1) § 433.50(a)(1) Section 1902(a)(2) of the Act which requires States to share in the cost of medical assistance expenditures and permit both State and local governments to participate in the financing of the non-Federal portion of medical assistance expenditures.

(2) § 433.50(a)(2) Section 1903(a) of the Act, which requires the Secretary to pay each State an amount equal to the Federal medical assistance percentage of the total amount expended as medical assistance under the State's plan.

(3) § 433.50(a)(3) Section 1903(w) of the Act, which specifies the treatment of revenues from provider-related donations and health care-related taxes in determining a State's medical assistance expenditures for which Federal financial participation (FFP) is available under the Medicaid program.

(b) § 433.50(b) Scope. This subpart--

(1) § 433.50(b)(1) Specifies State plan requirements for State financial participation in expenditures for medical assistance.

(2) § 433.50(b)(2) Defines provider-related donations and health care-related taxes that may be received without a reduction in FFP.

(3) § 433.50(b)(3) Specifies rules for revenues received from provider-related donations and health care-related taxes during a transition period.

(4) § 433.50(b)(4) Establishes limitations on FFP when States receive funds from provider-related donations and revenues generated by health care-related taxes.

(c) § 433.50(c) Applicability. The provisions of this subpart apply to the 50 States and the District of Columbia, but not to any State whose entire Medicaid program is operated under a waiver granted under section 1115 of the Act.

⁹ 42 CFR § 433.68 provides in part as follows:

Permissible health care-related taxes

(a) § 433.68(a) General rule. A State may receive health care-related taxes, without a reduction in FFP, only in accordance with the requirements of this section.

(b) § 433.68(b) Permissible health care-related taxes. Subject to the limitations specified in § 433.70, a State may receive, without a reduction in FFP, health care-related taxes if all of the following are met:

(1) § 433.68(b)(1) The taxes are broad based, as specified in paragraph (c) of this section;

(2) § 433.68(b)(2) The taxes are uniformly imposed throughout a jurisdiction, as specified in paragraph (d) of this section; and

(3) § 433.68(b)(3) The tax program does not violate the hold harmless provisions specified in paragraph (f) of this section.

(c) Broad based health care-related taxes. § 433.68(c)

(1) § 433.68(c)(1) A health care-related tax will be considered to be broad based if the tax 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, and is imposed uniformly, as specified in paragraph (d) of this section.

(2) § 433.68(c)(2) If a health care-related tax is imposed by a unit of local government, the tax must extend to all items or services or providers (or to all providers in a class) in the area over which the unit of government has jurisdiction.

(3) § 433.68(c)(3) A State may request a waiver from CMS of the requirement that a tax program be broad based, in accordance with the procedures specified in § 433.72. Waivers from the uniform and broad-based requirements will automatically be granted in cases of variations in

licensing and certification fees for providers if the amount of such fees is not more than \$ 1,000 annually per provider and the total amount raised by the State from the fees is used in the administration of the licensing or certification program.

(d)§ 433.68(d) Uniformly imposed health care-related taxes. A health care-related tax will be considered to be imposed uniformly even if it excludes Medicaid or Medicare payments (in whole or in part), or both; or, in the case of a health care-related tax based on revenues or receipts with respect to a class of items or services (or providers of items or services), if it excludes either Medicaid or Medicare revenues with respect to a class of items or services, or both. The exclusion of Medicaid revenues must be applied uniformly to all providers being taxed.

(1)§ 433.68(d)(1) A health care-related tax will be considered to be imposed uniformly if it meets any one of the following criteria:

(i)§ 433.68(d)(1)(i) If the tax is a licensing fee or similar tax imposed on a class of health care services (or providers of those health care items or services), the tax is the same amount for every provider furnishing those items or services within the class.

(ii)§ 433.68(d)(1)(ii) If the tax is a licensing fee or similar tax imposed on a class of health care items or services (or providers of those items or services) on the basis of the number of beds (licensed or otherwise) of the provider, the amount of the tax is the same for each bed of each provider of those items or services in the class.

(iii)§ 433.68(d)(1)(iii) If the tax is imposed on provider revenue or receipts with respect to a class of items or services (or providers of those health care items or services), the tax is imposed at a uniform rate for all services (or providers of those items or services) in the class on all the gross revenues or receipts, or on net operating revenues relating to the provision of all items or services in the State, unit, or jurisdiction. Net operating revenue means gross charges of facilities less any deducted amounts for bad debts, charity care, and payer discounts.

(iv)§ 433.68(d)(1)(iv) The tax is imposed on items or services on a basis other than those specified in paragraphs (d)(1) (i) through (iii) of this section, e.g., an admission tax, and the State establishes to the satisfaction of the Secretary that the amount of the tax is the same for each provider of such items or services in the class.

(2)§ 433.68(d)(2) A tax imposed with respect to a class of health care items or services will not be considered to be imposed uniformly if it meets either one of the following two criteria:

(i)§ 433.68(d)(2)(i) The tax provides for credits, exclusions, or deductions which have as its purpose, or results in, the return to providers of all, or a portion, of the tax paid, and it results, directly or indirectly, in a tax program in which--

(A)§ 433.68(d)(2)(i)(A) The net impact of the tax and payments is not generally redistributive, as specified in paragraph (c) of this section; and

(B)§ 433.68(d)(2)(i)(B) The amount of the tax is directly correlated to payments under the Medicaid program.

(ii)§ 433.68(d)(2)(ii) The tax holds taxpayers harmless for the cost of the tax, as described in paragraph (f) of this section.

(3)§ 433.68(d)(3) If a tax does not meet the criteria specified in paragraphs (d)(1)(i) through (iv) of this section, but the State establishes that the tax is imposed uniformly in accordance with the procedures for a waiver specified in § 433.72, the tax will be treated as a uniform tax.

(f)§ 433.68(f) Hold harmless. A taxpayer will be considered to be held harmless under a tax program if any of the following conditions applies:

(1)§ 433.68(f)(1) The State (or other unit of government) imposing the tax provides for a direct or indirect non-Medicaid payment to those providers or others paying the tax and the payment amount is positively correlated to either the tax amount or to the difference between the Medicaid payment and the tax amount. A positive correlation includes any positive relationship between these variables, even if not consistent over time.

(2)§ 433.68(f)(2) All or any portion of the Medicaid payment to the taxpayer varies based only on the tax amount, including where Medicaid payment is conditional on receipt of the tax amount.

regulations categorize 19 classes of health care services and providers.¹⁰ Thus, if a state imposes health care related taxes that are not broad based as defined by statute and regulation, the amount paid to the state for FPP will be reduced by the amount of those noncompliant taxes.

(3)§ 433.68(f)(3)-The State (or other unit of government) imposing the tax provides for any direct or indirect payment, offset, or waiver such that the provision of that payment, offset, or waiver directly or indirectly guarantees to hold taxpayers harmless for all or any portion of the tax amount.

(i)§ 433.68(f)(3)(i)

(A)§ 433.68(f)(3)(i)(A) An indirect guarantee will be determined to exist under a two prong "guarantee" test. If the health care-related tax or taxes on each health care class are applied at a rate that produces revenues less than or equal to 6 percent of the revenues received by the taxpayer, the tax or taxes are permissible under this test. The phrase "revenues received by the taxpayer" refers to the net patient revenue attributable to the assessed permissible class of health care items or services. However, for the period of January 1, 2008 through September 30, 2011, the applicable percentage of net patient service revenue is 5.5 percent. Compliance in State fiscal year 2008 will be evaluated from January 1, 2008 through the last day of State fiscal year 2008. Beginning with State fiscal year 2009 the 5.5 percent tax collection will be measured on an annual State fiscal year basis.

(B)§ 433.68(f)(3)(i)(B) When the tax or taxes produce revenues in excess of the applicable percentage of the revenue received by the taxpayer, CMS will consider an indirect hold harmless provision to exist if 75 percent or more of the taxpayers in the class receive 75 percent or more of their total tax costs back in enhanced Medicaid payments or other State payments. The second prong of the indirect hold harmless test is applied in the aggregate to all health care taxes applied to each class. If this standard is violated, the amount of tax revenue to be offset from medical assistance expenditures is the total amount of the taxpayers' revenues received by the State.

¹⁰ 42 USC § 1396b(w)(7) defines eight (8) specific categories of health care items and services as well as a category indicating that more categories may be set by regulation. 42 CFR § 433.56 provides as follows:

Classes of health care services and providers defined

(a)§ 433.56(a) For purposes of this subpart, each of the following will be considered as a separate class of health care items or services:

(1)§ 433.56(a)(1) Inpatient hospital services;

(2)§ 433.56(a)(2) Outpatient hospital services;

(3)§ 433.56(a)(3) Nursing facility services (other than services of intermediate care facilities for individuals with intellectual disabilities);

(4)§ 433.56(a)(4) Intermediate care facility services for individuals with intellectual disabilities, and similar services furnished by community-based residences for individuals with intellectual disabilities, under a waiver under section 1915(c) of the Act, in a State in which, as of December 24, 1992, at least 85 percent of such facilities were classified as ICF/IIDs prior to the grant of the waiver;

(5)§ 433.56(a)(5) Physician services;

(6)§ 433.56(a)(6) Home health care services;

(7)§ 433.56(a)(7) Outpatient prescription drugs;

(8)§ 433.56(a)(8) Services of managed care organizations (including health maintenance organizations, preferred provider organizations);

C. Arguments

The Division argued that the Taxpayers were asserting a “right” of the CMS since CMS determines whether a state’s health care tax complies with statutory and regulatory requirements. The Taxpayers argued that they are not asserting a right of CMS, but rather argued that they overpaid taxes to Rhode Island so seek refunds. The parties disputed whether hospice and ancillary services may be taxed. Finally, the Taxpayers argued that insurance carriers are exempt under Federal law from being taxed under Tri-Care and Medicare Advantage so that as providers they should be exempt because the cost is passed through to the carriers; however, the Division argued that the Taxpayers are arguing for an exemption which as providers, they are not entitled.¹¹

(9)§ 433.56(a)(9) Ambulatory surgical center services, as described for purposes of the Medicare program in section 1832(a)(2)(F)(i) of the Social Security Act. These services are defined to include facility services only and do not include surgical procedures;

(10)§ 433.56(a)(10) Dental services;

(11)§ 433.56(a)(11) Podiatric services;

(12)§ 433.56(a)(12) Chiropractic services;

(13)§ 433.56(a)(13) Optometric/optician services;

(14)§ 433.56(a)(14) Psychological services;

(15)§ 433.56(a)(15) Therapist services, defined to include physical therapy, speech therapy, occupational therapy, respiratory therapy, audiological services, and rehabilitative specialist services;

(16)§ 433.56(a)(16) Nursing services, defined to include all nursing services, including services of nurse midwives, nurse practitioners, and private duty nurses;

(17)§ 433.56(a)(17) Laboratory and x-ray services, defined as services provided in a licensed, free-standing laboratory or x-ray facility. This definition does not include laboratory or x-ray services provided in a physician's office, hospital inpatient department, or hospital outpatient department;

(18)§ 433.56(a)(18) Emergency ambulance services; and

(19)§ 433.56(a)(19) Other health care items or services not listed above on which the State has enacted a licensing or certification fee, subject to the following:

(i)§ 433.56(a)(19)(i) The fee must be broad based and uniform or the State must receive a waiver of these requirements;

(ii)§ 433.56(a)(19)(ii) The payer of the fee cannot be held harmless; and

(iii)§ 433.56(a)(19)(iii) The aggregate amount of the fee cannot exceed the State's estimated cost of operating the licensing or certification program.

(b)§ 433.56(b) Taxes that pertain to each class must apply to all items and services within the class, regardless of whether the items and services are furnished by or through a Medicaid-certified or licensed provider.

¹¹ In addition, the Division argued that the Taxpayers were asserting a Federal preemption argument, but the Taxpayers argued that they were not arguing Federal preemption, but rather were arguing that the imposed taxes do not comply with Federal requirements. In addition, the Division argued that the Taxpayers were asserting a constitutional claim over which an administrative agency does not have jurisdiction. An administrative agency cannot

D. Whether the Taxpayers are entitled to any of their Refund Requests

1. Ancillary and Hospice Services

Pursuant to R.I. Gen. Laws § 44-51-7,¹² the Taxpayers requested a refund of taxes paid as part of Nursing Facility Provider assessments. The Taxpayers' argument is that they have overpaid their taxes because the provider taxes imposed by Rhode Island are noncompliant with Federal statutory and regulatory requirements for Rhode Island to receive Medicaid matching funds. However, there is no provision in the Federal law or regulation that any taxes imposed in contravention of the FPP provisions are somehow illegal and cannot be imposed by a state. Certainly Rhode Island expects that its provider assessments are solely for the purposes of receiving matching funds because such provider assessments are to be automatically repealed if the Federal government repeals the statute that permits FPP to match state funds generated by law, R.I. Gen. Laws § 44-51-3(c). However, the consequence under Federal law and regulation is that if a state imposes a tax in contravention of what is allowed by statute and regulation for matching funds, the amount paid to a state shall be reduced.¹³ Thus, if Rhode Island's provider assessments

invalidate state statutes as unconstitutional. See *Owners-Operators Independent Drivers Association of America v. Rhode Island*, 541 A.2d 69 (R.I. 1988). The Taxpayers were not seeking any type of declaration that the State law was unconstitutional. The issue of Federal preemption is not relevant to the legal analysis in this matter.

¹² R.I. Gen. Laws § 44-51-7 provides as follows:

Claims for refund - Hearing upon denial. - (a) Any provider subject to the provisions of this chapter may file a claim for refund with the tax administrator at any time within two (2) years after the assessment has been paid. If the tax administrator shall determine that the assessment has been overpaid, he or she shall make a refund with interest from the date of overpayment.

(b) Any provider whose claim for refund has been denied may, within thirty (30) days from the date of the mailing by the tax administrator of the notice of the decision, request a hearing and the tax administrator shall, as soon as practicable, set a time and place for the hearing and shall notify the provider.

¹³ The State would also be able to contest a CMS determination to reduce payment of FPP in Federal administrative proceedings. 42 CFR § 430.42. The State could also petition the Secretary of Human Services for a waiver of the Federal requirements regarding taxes. 42 CFR § 433.68(e). The State could also choose to amend any noncompliant tax statutes or it could accept the reduction in FPP.

were found by CMS to be noncompliant with FFP requirements, the amount to be paid to Rhode Island by the Federal government would be reduced by the amount of such noncompliant taxes.

There are no statutory or regulatory grounds in either Federal or State law that provide a basis to argue that a taxpayer has a right to a refund of a tax paid pursuant to a statute that contravenes the FFP requirements. Thus, even if CMS found the State's provider taxes were noncompliant with FFP requirements,¹⁴ it does not follow that a taxpayer has overpaid the tax.

In this situation, the Taxpayers requested that the Division find certain provider taxes do not comply with FFP. However, even if the Division felt that certain taxes were noncompliant, the result would still not be a refund of taxes paid. There is no basis to argue an overpayment of any taxes paid – assuming they are noncompliant - because there is nothing prohibiting those taxes from being imposed except for if a state chooses to participate fully in FFP. Therefore, it is irrelevant what the Division finds in terms of whether the taxes comply with FFP or not because even if they do not (as determined by CMS or the Division), the legal consequence is not that the taxes were overpaid, but that perhaps the State might have its payment reduced (depending on whether CMS or Division made the determination).

Therefore, in terms of the hospice and ancillary taxes, there is no reason to perform an analysis on whether those taxes are allowed because even if it was determined by the Division that they are noncompliant with Federal requirements of what taxes are allowed to be matched, such a determination does not result in a refund. The Taxpayers would not have overpaid a tax, but rather would have just paid a tax for which the Division thinks the State should not be paid for by the Federal government. Nonetheless, as set forth below, a statutory analysis demonstrates that both of these taxes are allowed by FFP.

¹⁴ There is no evidence that CMS has found any of the taxes that the Taxpayer argued were noncompliant to be noncompliant.

a. **Classification of Facilities**

The Taxpayers argued that Rhode Island does not meet the broad-based requirement for states to receive FPP matching funds due to the fact that they are charging a tax based on a classification of a facility and not for its services. The Division argued that the Federal statute allows the tax to be broad based if it is imposed on services in a class or providers of such items and in this situation the State has chosen to tax providers (nursing providers).

Neither the Federal statute nor the Federal regulations limit the tax to services. 42 USC § 1396b(w)(3) defines a tax that “is related to health care items or services, or to the provision of.” See footnote six (6). 42 CFR § 433.68(c) defines broad based health care related taxes if “imposed on at least all health care items or services in the class or providers of such items or services.” See footnote nine (9). The term “or” is “a disjunctive particle used to express an alternative or to give of choice of one among two or more things.” *In Re Abby D.*, 839 A.2d 1222, 1224 (R.I. 2004) (citing to *Black's Law Dictionary*). See also *Morrison v. C.I.R.*, 565 F.3d 658 (9th Cir.). Thus, the Federal statute provides that broad based taxes may be imposed on services or providers.

The Taxpayers argued that the State is taxing hospice and ancillary services at nursing facilities but not taxing hospice and ancillary services offered by other providers¹⁵ so that the State's tax is not broad based or uniform. However, the Federal requirements allow a tax to be broad based and uniform if applied to a provider. The Federal requirements do not limit taxes to services provided, but rather provide a choice. Rhode Island chose to tax nursing providers as provided for in R.I. Gen. Laws § 44-51-3. As all nursing providers are taxed, the tax is broad based and uniform. Thus, the taxes of hospice and ancillary services provided by a nursing facility are properly taxed.

¹⁵ The Taxpayers did not offer any evidence of this alleged different tax treatment.

b. Ancillary Services

The Taxpayers also argued that while ancillary services (physical, speech, occupational therapy) are included in the type of services that can be taxed, they are not nursing facility services which are being taxed. The Taxpayers argue that ancillary services are distinct from nursing services and just taxing ancillary services provided by nursing providers and not by other providers is not broad based and uniform.¹⁶ However, the State is taxing all nursing providers and there is no evidence that the tax is not broad based.

c. Hospice Services

The Taxpayers argued that the State by taxing hospice services is attempting to tax the nursing facilities for all services provided rather than the classification of services provided. The Taxpayers argued that hospice services are not nursing facility services and classifying such services is not permissible under the service categories.¹⁷ The Division relied on the Federal law and statute to argue that hospices are licensed so can be taxed. 42 USC § 1396b(w)(7)(A) provides that further classifications can be established by regulation and the regulation provides that licensed services may be taxed. See footnote ten (10). R.I. Gen. Laws § 23-17-1 *et seq.* requires that a "health-care facility" be licensed. Based on the definitions of a health care facility in place during the refund time period (and currently) hospices are to be licensed.¹⁸ R.I. Gen. Laws § 23-17-38 provides for the establishment of fees for the licensing of health care facilities and said statute's version in effect in 2007 indicated specific fees for the hospice licensing shall be

¹⁶ There was no evidence of this alleged different taxing structure.

¹⁷ The Taxpayers argued that Rhode Island does not meet the broad based requirement for states to receive FPP funds since the State is charging taxes based on classification of facilities and not services. The Taxpayers argue that the CMS has addressed this in other states, but did not provide any documentation or citation to such decisions.

¹⁸ For past versions of R.I. Gen. Laws § 23-17-2 (definitions) in place during the refund period, see P.L. 2003 ch. 376 art 34 § 1; P.L. 2008 ch. 245 art. § 1; and P.L. 2008, ch. 313, § 1.

established by regulation. P.L. 2007, ch. 73, art. 39, § 30. Section 3.1.1. of the *Rules and Regulations for the Licensing of Hospice Care* promulgated by the Department of Health that were effective in 2002 and then in July, 2007 both include a fee for the licensing of hospice care.

The Federal regulation established a category under which hospice services fall. There are no grounds to argue that such services cannot be taxed under the Federal statute and regulation.

2. Medicare Advantage and Tricare

Medicare Advantage is a health insurance program for Medicare eligible individuals and Tricare is a health program of the United States Department of Defense Military Health System. Both parties agreed that the law for both programs prohibit the taxing of insurance carriers.¹⁹ The parties agreed in their briefs that the test for both Medicare Advantage and Tricare has become (by

¹⁹ 42 CFR § 442.404 addresses the issue for Medicare Advantage:

State premium taxes prohibited

(a) Basic rule. No premium tax, fee, or other similar assessment may be imposed by any State, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa, or any of their political subdivisions or other governmental authorities with respect to any payment CMS makes on behalf of MA enrollees under subpart G of this part, or with respect to any payment made to MA plans by beneficiaries, or payment to MA plans by a third party on a beneficiary's behalf.

(b) Construction. Nothing in this section shall be construed to exempt any MA organization from taxes, fees, or other monetary assessments related to the net income or profit that accrues to, or is realized by, the organization from business conducted under this part, if that tax, fee, or payment is applicable to a broad range of business activity.

The relevant statutory cite for Tricare provides in part as follows:

10 USC § 1103. Contracts for medical and dental care: State and local preemption

(a) Occurrence of preemption. A law or regulation of a State or local government relating to health insurance, prepaid health plans, or other health care delivery or financing methods shall not apply to any contract entered into pursuant to this chapter by the Secretary of Defense or the administering Secretaries to the extent that the Secretary of Defense or the administering Secretaries determine that--

- (1) the State or local law or regulation is inconsistent with a specific provision of the contract or a regulation promulgated by the Secretary of Defense or the administering Secretaries pursuant to this chapter [10 USCS §§ 1071 et seq.]; or
- (2) the preemption of the State or local law or regulation is necessary to implement or administer the provisions of the contract or to achieve any other important Federal interest.

statutory incorporation and court cases), the pre-emption statute in the Federal Employee Health Benefits Act (FEHBA), 5 USC § 8909(f).²⁰

The Taxpayers agreed that the Division is correct in its assertion that the nursing assessment is being imposed on providers. However, the Taxpayers argued that the nursing assessment is indirectly being imposed on carriers because the tax is being passed through to carriers by the healthcare providers.

The Taxpayers admit that since their filing of their Medicare and Tricare refund claims, there have been several Federal and state decisions that do not support their position. However, the Taxpayers argued that such decisions are distinguishable. The Taxpayers argued that provider taxes are preempted by Federal law as the tax is indirectly imposed on carriers receiving revenue from the Medicare fund. Presumably since the tax is being passed by the providers to the insurance carrier, the carriers would be the ones to argue that they are being indirectly improperly taxed by this passed through tax. While there is no evidence as to whether the Taxpayers have passed through the taxes to insurance carriers, their argument is that the State has indirectly taxed the carriers because the providers are being reimbursed by the carriers for these taxes. Despite the question of whether the Taxpayers would even be the party to assert such a refund claim, an analysis of the Taxpayers' legal claims show that there are no grounds to grant such refunds claims.

²⁰ 5 USC § 8909(f) provides in part as follows:

(1) No tax, fee, or other monetary payment may be imposed, directly or indirectly, on a carrier or an underwriting or plan administration subcontractor of an approved health benefits plan by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, with respect to any payment made from the Fund.

(2) Paragraph (1) shall not be construed to exempt any carrier or underwriting or plan administration subcontractor of an approved health benefits plan from the imposition, payment, or collection of a tax, fee, or other monetary payment on the net income or profit accruing to or realized by such carrier or underwriting or plan administration subcontractor from business conducted under this chapter [5 USCS §§ 8901 et seq.], if that tax, fee, or payment is applicable to a broad range of business activity.

In their reply brief, the Taxpayers rely on *Travelers Ins. Co. v. Cuomo*, 14 F.3d 708 (2nd Cir. 1993)²¹ and *Health Maintenance Org. of New Jersey, Inc. v. Whitman*, 72 F.3d 1123 (3rd Cir. 1995) to support their argument that the provider tax is an indirect tax and as such are forbidden under the FEHBA. *Travelers* involved hospital surcharges added to carriers' bills based on the type of insurance coverage involved. *Whitman* involved a tax calculated by carriers' insurance premiums. As *United States v. West Virginia*, 339 F.3d 212 (4th Cir. 2003)²² found neither *Travelers* nor *Whitman* involved an indirect tax, but rather involved taxes imposed on carriers. The Taxpayers also relied on a Minnesota tax court decision, *HealthPartners, Inc. v. Comm'r of Revenue*, 1999 Minn. Tax LEXIS 6, but that decision found federal preemption for a tax imposed on an insurance carrier that was an indirect tax as it was imposed on carriers' revenues rather than premiums. That is not the situation here as the State's tax is imposed on nursing providers. Finally, the Taxpayers cited to *Group Health Coop. v. Seattle*, 146 Wash.App. 80 (2008) to support their argument. However, that case involved a city that imposed taxes on an insurance carrier of the type that are directly preempted by the FEHBA.

The statute at issue in this matter is a tax imposed on the gross patient revenues of nursing care providers. There is no requirement that the tax is passed through by the providers to insurance carriers. The tax is not based on premiums or anything related to insurance carriers. There are no grounds to find that a tax solely directed at nursing care providers is somehow an indirect tax on insurance carriers and under Federal law should be preempted.

3. Conclusion

Based on the forgoing, the Taxpayers are not entitled to any of their claimed refunds.

²¹ Reversed on other grounds by *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995); on remand *Travelers Ins. Co. v. Pataki*, 63 F.3d 89 (2nd Cir. 1995).

²² In their reply brief, the Taxpayers cite to the lower court decision in *West Virginia*, but that lower court decision was reversed by the 2003 fourth circuit decision.

VI. FINDINGS OF FACT

1. On or about July 24, 2014, the Division issued a Notice of Hearing and an Appointment of Hearing Officer to the Taxpayers.
2. A hearing began on November 10, 2015 at which time the Taxpayers made oral argument.
3. After the start of hearing, the parties agreed to have this matter decided on an agreed to statement of facts and briefs. Briefs were timely filed by November 21, 2016.
4. The facts contained in Section IV and V are reincorporated by reference herein.

VII. CONCLUSIONS OF LAW

Based on the testimony and facts presented:

1. The Division has jurisdiction over this matter pursuant to R.I. Gen. Laws § 44-1-1 *et seq.* and R.I. Gen. Laws § 44-51-1 *et seq.*
2. Pursuant to R.I. Gen. Laws § 44-51-1 *et seq.*, the Division appropriately denied all tax refunds requests made by the Taxpayers.

VIII. RECOMMENDATION

Based on the above analysis, the Hearing Officer recommends as follows:

Pursuant to R.I. Gen. Laws § 44-51-1 *et seq.*, the Division properly denied all of the Taxpayers' refund requests.

Date: 1/23/17


Catherine R. Warren
Hearing Officer

ORDER

I have read the Hearing Officer's Decision and Recommendation in this matter, and I hereby take the following action with regard to the Decision and Recommendation:

ADOPT
 REJECT
 MODIFY

Dated: 2/1/17

Neena S. Savage
Neena S. Savage
Tax Administrator

NOTICE OF APPELLATE RIGHTS

THIS DECISION CONSTITUTES A FINAL ORDER OF THE DIVISION. THIS ORDER MAY BE APPEALED TO THE SIXTH DIVISION DISTRICT COURT PURSUANT TO THE FOLLOWING WHICH STATES AS FOLLOWS:

R.I. Gen. Laws § 44-51-9 Appeals.

Appeals from administrative orders or decisions made pursuant to any provisions of this chapter shall be to the sixth division district court pursuant to chapter 8 of title 8. The provider's right to appeal under this section shall be expressly made conditional upon prepayment of all assessments, interest, and penalties unless the provider moves for and is granted an exemption from the prepayment requirement pursuant to § 8-8-26. If the court, after appeal, holds that the provider is entitled to a refund, the provider shall also be paid interest on the amount at the rate provided in § 44-1-7.1.

CERTIFICATION

I hereby certify that on the 2nd day February 2017 a copy of the above Decision and Notice of Appellate Rights was sent by first class mail to the Taxpayers' attorneys' addresses on record with the Division and by hand delivery to Bernard Lemos, Esquire, Department of Revenue, Division of Taxation, One Capitol Hill, Providence, RI 02908.

Paul Belasco