PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2015-D4

PROVIDERS –
Breckinridge Health, Inc., New Horizons Health Systems, Inc., CAH 2009 Provider Tax Group, CHC 2009 CAH Provider Tax CIRP Group, and ARH CAH Provider Tax CIRP Group
Provider Nos.: Various (see Appendix A)

vs.

INTERMEDIARY –
National Government Services, Inc. / CGS Administrators, LLC /Blue Cross and Blue Shield Association

DATE OF HEARING –
April 2, 2014

Cost Reporting Periods Ended - 2009 and 2010

CASE NOs.: 13-2038, 13-0452, 13-1454G, 11-0518GC and 11-0497GC

INDEX

ISSUE STATEMENT

Did the Medicare contractor properly offset the Kentucky provider tax assessment ("KP-Tax") for each of the seven hospitals for the fiscal years at issue by the corresponding amount of the Kentucky Medicaid Disproportionate Share Hospital ("Medicaid DSH") payment that each hospital received for those fiscal years?[1]

DECISION

After considering the Medicare law and regulations, the parties' contentions and the evidence submitted, the Board finds that the Medicare contractor properly offset the Medicaid DSH payments that the seven hospitals received from the Medical Assistance Revolving Trust ("MART") fund against the KP-Tax assessment payments that these Hospitals made for the fiscal years at issue in these appeals.

INTRODUCTION

Seven Kentucky hospitals appealed a reduction in Medicare reimbursement by the Medicare contractor. These Hospitals participate in the Medicare program as critical access hospitals and, accordingly, are reimbursed by the Medicare program for the reasonable costs incurred for providing medical services to Medicare beneficiaries.[2] Under this reimbursement system Medicare reimburses critical access hospitals for the payment of certain required provider taxes. The State of Kentucky taxes hospitals and other medical providers and pools the revenue into a fund which it redistributes to hospitals to partly compensate the hospitals for medical services they provide to uninsured, low-income individuals. The Medicare contractor reduced the provider tax reimbursement of each hospital by the amount distributed back to that hospital from the fund.[3]

A record hearing was held by the Provider Reimbursement Review Board ("Board"). The seven hospitals were represented by Matthew R. Klein, Esq., and David M. Dirr, Esq., of Dressman, Benzinger, LaVelle, PSC. The Medicare contractors, in this case, CGS Administrators, LLC and National Government Services, Inc. were represented by Brendan G. Stuhan, Esq., of the Blue Cross and Blue Shield Association.

STATEMENT OF THE FACTS

Seven Kentucky hospitals, including Breckinridge Memorial Hospital , appealed a reduction in reimbursement by the Medicare contractor. Breckinridge Memorial Hospital is the lead hospital in this case with the remaining seven hospitals having factual circumstances similar to Breckinridge Memorial Hospital. All hospitals in this case will hereinafter be referred to collectively as "Breckinridge."

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[1] *See* Stipulations at ¶ 25 (Dec. 17, 2013) ("Stipulations) (copy attached to Medicare Contractor Supplemental Position Paper at Exhibit I-15).
[2] See 42 U.S.C. § 1395x(v)(1)(A); 42 C.F.R. §§ 413.9, 413.70.
[3] *See* Stipulations at ¶¶ 23 and 24.

Breckinridge sought reimbursement for the amount of the Kentucky provider tax, (*i.e.*, "KP-Tax"), which it paid based on 2.5 percent of its gross revenues.[4] The Kentucky Department of Revenue deposited 100 percent of the revenue from the KP-Tax into the Medical Assistance Revolving Trust ("MART") fund. The Kentucky Department of Revenue transferred approximately 15 percent of the MART funds to the Department of Medicaid Services to partially fund the Kentucky disproportionate share program which reimburses hospitals for the cost of medical care provided to uninsured, low income patients who do not qualify for Medicare or Medicaid.[5] These Medicaid DSH payments cover roughly 45 percent of the cost of providing care to these low income patients during the previous fiscal year.[6] In effect, Breckinridge both paid into the KP-Tax and received a Medicaid DSH payment. Breckinridge filed its cost reports for fiscal years 2009 and 2010 ("FY 2009" and "FY 2010") claiming the tax payment into the KP Fund as a cost for which it sought reimbursement.

The Medicare contractor reviewed the cost reports for FYs 2009 and 2010, determined the total amount of reimbursement due, and issued Notices of Program Reimbursement[7] which reduced the reimbursement for the KP-Tax by the Medicaid DSH payments that Breckinridge received. The Medicare contractor adjustments effectively disallowed a portion of the KP-Tax payment that Breckinridge claimed for reimbursement. Breckinridge timely appealed the Medicare contractor's disallowances and satisfied the jurisdictional requirements for a hearing before the Board.[8]

The parties stipulated to various facts regarding the KP-Tax, the Medicaid DSH distributions from the MART, and the adjustments made in the cost reports for each hospital in this group appeal.[9]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

ARGUMENTS RELATING TO STATUTE, REGULATIONS AND MANUAL PROVISIONS

Breckinridge asserts that the Medicare contractor erred in disallowing a portion of its expense incurred in paying the KP-Tax because the KP-Tax met the definition of an allowable cost under the Medicare statute and regulations. Breckinridge explained that Kentucky critical access hospitals had always included the full cost of the KP-Tax on their cost reports and, until fiscal year 2009, the Medicare contractor had always reimbursed the provider tax without any offset of Medicaid DSH payments to the hospitals.

Breckinridge disputes the Medicare contractor's position that the Medicaid DSH payment functions to "pay back" or "refund" the provider taxes which it was obligated to pay under Kentucky law. Breckinridge maintains that the provider tax payment is, by statute and in fact,

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[4] Providers' Final Position Paper at 7. Provider explains that the tax was pegged based on the gross revenues from fiscal years 2005 and 2006.
[5] *Id.* at 8.
[6] *Id.* at 10.
[7] *See* Medicare contractor Exhibits I-2, I-3, I-4, I-5 at 1, I-6, I-7 at 1, I-8 at 1- 3.
[8] 42 C.F.R. §§405.1835 – 405.1841.
[9] Medicare contractor Exhibit I-15; Stipulations at ¶¶ 1-26.

unreimbursed and, therefore, "actually incurred" and constitutes a necessary and "reasonable cost" under 42 U.S.C. § 1395x(v). Therefore Medicare law requires reimbursement without offset. Further, Kentucky critical access hospitals actually incur two separate and unrelated expenses—first, the payment of the provider tax and, second, the cost of care to indigent patients. Breckinridge's Medicaid DSH payment simply reimburses it, in part, for the actual costs of treating non-Medicare, non-Medicaid, non-insured indigent population. Since these payments "do not even come close to covering the cost of indigent care, they cannot possibly serve as a reserve for refunding or discounting" Breckinridge's provider tax payments.[10]

Breckinridge disputes the Medicare contractor's contention that the Medicaid DSH payments it received from the MART fund were refunds of Breckinridge's KP-Tax assessment. Breckinridge contends that the payments do not meet the regulatory definition of refunds as defined in 42 C.F.R. § 413.98(b)(3) as "amounts paid back or a credit allowed on account of an overcollection" because there was no overcollection of the KP-Taxes assessed by Kentucky. Specifically, in Kentucky, Medicaid DSH payments are not *de jure* or *de facto* refunds of the KP-Tax expenses. Rather, Breckinridge asserts that, as previously explained, they are only partial payments for services that the hospitals furnished to Medicaid DSH-eligible patients.

Because Breckinridge's KP-Tax expenses were necessary costs, Breckinridge asserts that the Medicare contractor violated Medicare "reasonable cost" statutes by offsetting Breckinridge's KP-Tax expenses by its Medicaid DSH payments. Specifically, 42 U.S.C. § 1395x(v) requires that CMS, acting through the Medicare contractor, compensate acute care hospitals for the reasonable and necessary costs of providing services to Medicare patients. These provisions define reasonable costs as "the costs actually incurred" in providing covered services, including "both direct and indirect costs of providers of services" and "the necessary costs of efficiently delivering covered services to [Medicare] patients." Additionally, the Medicare program must compensate critical access hospitals for 101 percent of their reasonable and necessary costs.[11]

The Board finds that the reasonable cost reimbursement provision at 42 U.S.C. § 1395x(v) and the regulations at 42 C.F.R. § 413.9 implementing this provision control in these appeals. The statute provides, in part, that the "reasonable cost of any services shall be the cost *actually incurred*, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services."[12] Likewise, 42 C.F.R. § 413.9(c)(3) states, in part, that "the reasonable cost basis of reimbursement contemplates that the providers of services would be reimbursed *the actual costs* of providing quality care however widely the costs may vary from provider to provider and from time to time for the same provider."[13] The term "cost actually incurred" requires the assessment of costs as they are, *i.e.*, the totality of the circumstances to determine the real net economic impact of claimed costs.

This principle is the foundation for 42 C.F.R. § 413.98 which requires accounting for offsets for amounts such as discounts, allowances, and refunds that otherwise defray part of the claimed cost to which they relate. The regulation states in pertinent part:

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[10] Provider's Final Response Position Paper at 3.
[11] *See* 42 U.S.C. § 1395f(l).
[12] 42 U.S.C. § 1395x(v)(1)(A) (emphasis added).
[13] (Emphasis added.)

> (a) *Principle*. Discounts and allowances received on purchases of goods or services are reductions of the costs to which they relate. Similarly, refunds of previous expense payments are reductions of the related expense.…
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> (b) *Definitions*— . . . . (3) *Refunds.* Refunds are amounts paid back or a credit allowed on account of an over collection.
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> (d) As with discounts, allowances and rebates received from purchases of goods or services, refunds of previous expense payments are *clearly reductions in costs and must be reflected in the determination of allowable costs*. This treatment is equitable and is in accord with that generally followed by other governmental programs… . (emphasis added)

In determining the "cost actually incurred" for Breckinridge's KP-Tax assessments, the Board finds that it must look at the net economic impact of such assessments on the hospital. As explained above, this finding is consistent with the Medicare principles underlying 42 C.F.R. § 413.98 which specifies that refunds must be used to offset the related costs and are not income. Accordingly, the Board finds that, when Breckinridge received a Kentucky Medicaid DSH distribution, it is necessarily receiving back from the MART Fund some or all of the money that it paid into the MART Fund when it paid the KP-Tax assessment. Thus, the Board concludes that the Medicare contractor correctly determined that the gross KP-Tax assessed on Breckinridge during the fiscal years at issue is not the "cost actually incurred" but rather that Breckinridge's gross KP-Tax assessment for a fiscal year must be offset by the Medicaid DSH payment received for the same fiscal year.

ARGUMENTS RELATING TO THE AUGUST 2010 FINAL RULE

Next, Breckinridge argues that the Medicare contractor changed its policy in error due to a "misinterpretation of inapplicable advice" published in August 2010 in the preamble to the final rule for the 2011 Hospital Inpatient Prospective Payment System ("August 2010 Final Rule").[14] This rule stated: "In situations in which payments that are *associated with* the assessed tax are made to providers specifically to make the provider whole or partly whole for the tax expenses, Medicare should . . . recognize only the net expense incurred by the provider."[15] Breckinridge argues that the KP-Tax does not fall within the purview of this rule because: 1) there is no linkage between the actual KP-Tax that hospitals pay and the Medicaid DSH payments that some of those hospitals receive; and 2) the Medicaid DSH payments do not make the critical access hospitals whole or partially whole for their KP-Tax expenses.[16]
Breckinridge argues that the KP-Tax and the cost of indigent care are two separate and unrelated costs for the hospital for which the Medicaid DSH payment makes up for only a part of one of the costs. It asserts that there is no "linkage" between the KP-Tax and the Medicaid DSH payment giving numerous examples. For example, the Provider notes that the tax payments are

[14] 75 Fed. Reg. 50042, 50363 (Aug. 16, 2010).
[15] *Id.* (emphasis added). *See also* Provider's Final Position Paper at 11-12.
[16] *See* Provider's Final Position Paper at 15.

paid monthly and are calculated on the percent of gross revenue contrasted with the Medicaid DSH payment that is calculated based on a formula comparing the number of indigent patients served by the individual hospital compared to the total number of indigent patients served by hospitals throughout the state.[17] Further, Kentucky hospitals are required to pay the KP-Tax regardless of whether they report indigent care data to the Kentucky Medicaid program.[18]

Breckinridge asserts that CMS intended to apply the August 2010 Final Rule only to "recently enacted" provider taxes that ensured that providers paying the tax saw the tax expense refunded to them in the form of higher payments for Medicaid patients who are already being served by the hospital.[19] Further, Breckinridge maintains that the August 2010 Final Rule simply reiterates HHS's longstanding policy that Medicare auditors should only offset hospitals' provider tax expenses by payments from the state if those payments are *associated* with the assessed tax"[20] and are, in fact, "refunds" of the hospitals' provider tax assessments. Breckinridge then concludes that the August 2010 Final Rule is inapplicable to the established and longstanding provider tax program in Kentucky because Medicaid DSH payments are not "associated" or "inextricably linked" to the KP-Tax.[21]

Breckinridge highlights several other factors unique to the Kentucky program which demonstrate that there is no "linkage," including the fact that a hospital pays the KP-Tax monthly, and is subject to interest and penalties if it does not pay on time.[22] The Kentucky Department of Revenue advises hospitals of their Medicaid DSH allotments no earlier than October 15th of each year[23] and hospitals make their monthly KP-Tax payments in advance of receiving their DSH payments. As a result, hospitals cannot use the Medicaid DSH payments to cover their KP-Tax expenses. Thus, Breckinridge maintains that the Kentucky provider tax is significantly different from those in other states.

The Board finds that it will not rely upon the "clarification" issued in the preamble to the August 2010 Final Rule even if CMS intended this "clarification" to be retroactive.[24] The Final Rule was published on August 16, 2010 which is either subsequent to or during the fiscal years at issue in this case. Nonetheless, the Board notes that, contrary to Breckinridge's position, this "clarification" supports the Board's findings in this case as the taxes need only be "associated with" the subsequent disbursements and that CMS intended this "clarification" to be applied to pending appeals.[25]

The Board finds that the provider tax and the Medicaid DSH payment are inextricably linked. The Board notes that the *source* of the Medicaid DSH payment is the provider tax. *All* of the

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[17] *See id.* at 16.
[18] *See id.* at 17.
[19] *Id.* at 20.
[20] 75 Fed. Reg. at 50363.
[21] Provider's Final Position Paper at 22.
[22] *See* Ky. Rev. Stat §§ 142.32, 142.343, 142.359 (copies included at Provider Exhibits P-8, P-9, P-10 respectively).
[23] Ky. Rev. Stat. § 205.640(3)(d)(2)c, 204.640(3)(e) (copy included at Provider Exhibit P-5); Ky Admin. Regs. 10:802 § 4.
[24] *See also* Provider Reimbursement Manual, CMS Pub. No. 15-1, Transmittal 448 (Dec. 2011) (incorporating the "clarification" into § 2122 stating that an effective date was "Not Applicable").
[25] *See* 75 Fed. Reg. at 50363-50364.

revenue from the KP-Tax assessments is deposited into the MART Fund.[26] Kentucky statute and regulations also explicitly provide that the MART Fund is used to compensate the same hospitals that paid the KP-Tax for uncompensated care that they provide and that hospitals can *only* get Medicaid DSH distributions from the MART Fund.[27]

ARGUMENTS RELATING TO COURT CASES

Finally, Breckinridge attempts to distinguish the facts in two recent circuit court decisions involving Illinois and Missouri provider taxes from those in the present case. It argues that these circuit decisions are inapplicable to this case because these decisions only permit offsets where the state provides for refunds of the hospitals' provider tax assessments. Specifically, it notes that, in *Abraham Lincoln Mem'l Hosp. v. Sebelius* ("*Abraham Lincoln*"),[28] the Seventh Circuit Court of Appeal ("Seventh Circuit") found that the add-on payments to provider were refunds of the provider's tax payment because "the Illinois statute made clear that no installment of the Tax Assessment was 'due and payable' until the Hospitals actually received the Access Payments."[29] Breckinridge argues that the Kentucky tax is due and payable by the hospitals regardless of when and whether the hospitals receive any Medicaid DSH payment from the MART fund.

Similarly, in *Kindred Hosps. East, LLC v. Sebelius* ("*Kindred Hospitals*"),[30] the Eighth Circuit Court of Appeals ("Eighth Circuit") found that the redistribution of add-on payments from a private pool in amounts adequate to cover the provider tax expenses of each hospital constituted a refund of the providers' tax assessments.[31] In contrast, Breckinridge argues, the Kentucky Medicaid DSH program only provides for partial compensation (45 percent or less) to hospitals for the cost of providing services to low income patients and the payment is not related to the amount of KP-Tax paid by the hospital but rather on the number of indigent individuals each hospital serves.[32]

The Board is persuaded by the Seventh Circuit's rejection of Breckinridge's argument in *Abraham Lincoln.* The Seventh Circuit found that there was substantial evidence that the access payments were linked to the tax assessments, including the fact that the access payments were disbursed out of the same fund into which the tax assessments were paid.[33] The Seventh Circuit stated in pertinent part:

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[26] *See* Ky. Rev. Stat. § 205.640(2).
[27] *See* Ky Rev. Stat. § 205.640(3)(a) (stating "the provider tax revenues [*i.e.*, KP-Tax revenues from the MART fund] and federal matching funds shall be used to fund the [Kentucky] disproportionate share program"); Ky. Rev. Stat. § 205.640(3)(b) (stating that "[t]he Mart fund shall be used to compensate acute care hospitals . . . in the disproportionate share program for uncompensated care service"); Ky. Admin. Regs. 10:820 § 2(2) (copy included at the Medicare contractor Exhibit I-17); Provider Exhibit P-12 at 43 (Dep. of the Vice Pres. of Finance, Ky. Hosp. Ass'n).
[28] 698 F.3d 536 (7th Cir. 2012).
[29] *Id.* at 549.
[30] 694 F.3d 924 (8th Cir. 2012).
[31] *See id.* at 928.
[32] *See* Providers' Final Position Paper at 18.
[33] *See* 698 F.3d at 550-551.

> To simply ignore the Access Payments while recognizing the Tax Assessments in full in determining the Hospitals' reimbursable costs, as the Hospitals essentially request, would violate the statutory and regulatory directives that health care providers should be reimbursed only for the costs they have actually incurred, i.e. their net costs. This is especially so where the Tax Assessment moneys were deposited into the same Fund from which the Access Payments were disbursed.[34]

The Court also stated that the Secretary's interpretation of the regulations and Manual provisions pertaining to "refunds" which are intended to guide interpretation of what costs are actually incurred, was not plainly erroneous or inconsistent.[35]

The Board finds that, while there were differences in the provider tax program in Kentucky from the tax programs in Illinois and Missouri, the Seventh and Eighth Courts' conclusion that the Secretary's policy of reducing the cost of the provider tax by the subsequent payment to the hospital for indigent care is not unreasonable and is supported by evidence.

DECISION

After considering the Medicare law and regulations, the parties' contentions and the evidence submitted, the Board finds that the Medicare contractor properly offset the Medicaid DSH payments that the seven hospitals received from the MART fund against the KP-Tax assessment payments that these Hospitals made for the fiscal years at issue in these appeals.

BOARD MEMBERS PARTICIPATING:

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FOR THE BOARD:

/s/
Michael W. Harty
Chairman

DATE: FEB 10 2015

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[34] *See id.* at 549.
[35] *See id.* at 550.

APPENDIX A

SCHEDULE OF PROVIDERS BY CASE NUMBER

Case No.: 13-2038

Provider No.	Provider Name	FYE
18-1319	Breckinridge Health, Inc. d/b/a Breckinridge Memorial Hospital	12/31/2010

Case No.: 13-0452

Provider No.	Provider Name	FYE
18-1312	New Horizons Health Systems, Inc	12/31/2010

Case No.: 13-1454G

Provider No.	Provider Name	FYE
18-1319	Breckinridge Health, Inc. d/b/a Breckinridge Memorial Hospital	12/31/2009
18-1320	Livingston Hospital and Healthcare Services, Inc.	12/31/2009
18-1312	New Horizons Health Systems, Inc	12/31/2009
18-1310	Carroll County Memorial Hospital	12/31/2009

Case No.: 11-0518GC

Provider No.	Provider Name	FYE
18-1324	The Medical Center at Scottsville	03/31/2009
18-1318	The Medical Center at Franklin	03/31/2009

Case No.: 11-0497GC

Provider No.	Provider Name	FYE
18-1331	McDowell ARH Hospital	06/30/2009
18-1307	Morgan County ARH Hospital	06/30/2009