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Court of Appeals Upholds Medicare Offset in Provider Tax Case

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Many states assess taxes against hospitals or other providers as a means of funding their Medicaid programs. The revenues generated by the taxes are used, with CMS's approval, to fund Medicaid payments to various providers, and the federal government participates in these Medicaid payments by paying its share (called Federal Financial Participation). In the past, those providers reimbursed by Medicare on a reasonable cost basis often claimed the provider tax payments on their Medicare cost reports, and Medicare, too, paid its share of those taxes. This practice was consistent with the general rule that taxes assessed against providers are allowable costs under Medicare reasonable cost principles. See Provider Reimbursement Manual, § 2122. In more recent times, however, CMS has begun offsetting certain sums that the hospitals receive from the Medicaid program against these tax costs. Now, a recent decision from the United States Court of Appeals from the Eighth Circuit supports these offsets.

In *Kindred Hospital East v. Sebelius* [PDF], CA No. 11-3555 (8th Cir. Sept. 12, 2012), the court addressed Medicare's reimbursement of state-imposed provider taxes and whether those taxes are subject to offset. The case, which involved a hospital in Missouri, has somewhat unusual facts. The Missouri provider tax, like many, was based on hospital revenues, and it resulted in what were called winners and losers under the program. Hospitals that treated a large number of Medicaid patients received more Medicaid reimbursement and were winners when that reimbursement was measured against the amount of taxes paid. Conversely, hospitals that treated smaller numbers of Medicaid patients but that had comparatively high revenues paid more in taxes than they received in Medicaid and were considered to be losers. This inequality led the Missouri hospitals to initiate a pooling program under which certain Medicaid reimbursement amounts were transferred into a privately administered pool account and then used to

compensate the losers for their losses. More specifically, those hospitals whose Medicaid add-on payments exceeded the tax they paid contributed the excess amount into the pool, while hospitals whose Medicaid add-on payments were less than their provider taxes received payments from the pool.

For the years at issue, 2000-2003, Kindred was a pool recipient, and it claimed the amount of the provider tax it paid as an allowable Medicare expense. At the same time, however, the hospital recorded the pool payments it received as Medicaid revenue. The issue before the court was whether the pool payments that Kindred received should have been booked as a credit against the provider taxes it had earlier claimed as a reimbursable expense, thereby reducing its Medicare reimbursable costs.

The Administrator held that a reduction, or offset, was called for, and the court of appeals agreed. In so ruling, the court viewed the matter rather simplistically: "Do payments from the pool reduce a Medicare provider's cost actually incurred?" The Administrator had found that they did, and the court concluded that this was an "entirely reasonable" application of the statute and regulations. The court ruled that it was reasonable for the Administrator to conclude that the payments from the pool "functionally reduced Kindred's Medicare costs" and that, therefore, an offset was authorized under 42 U.S.C. § 1395x.

Ober|Kaler's Comments

The *Kindred* facts, which involved a pooling arrangement, are unusual. As a result, providers that are pursuing the provider tax issue may wish to assert that the decision holds little precedential value. As support for this, in the Missouri situation the Medicare contractor did not offset Medicaid payments against the provider tax for those hospitals that received more in Medicaid payments than they paid in taxes; only those hospitals that received payments from the pool were subject to the offset.

Having said that, however, providers have to recognize that the Eighth Circuit's ruling appears to give considerable discretion to CMS to apply the offset principle

("[b]ecause there was a true reduction in Kindred's costs incurred because of the pool, the payments it received from the pool . . . were appropriately treated as [refunds]."). Thus, while providers have a basis upon which to read the decision narrowly, CMS will likely assert that the decision has broad application. Indeed, CMS has already brought *Kindred* to the Seventh Circuit's attention, which court is currently weighing the provider tax arguments in *Abraham Lincoln v. Sebelius*, CA No. 11-2809.

Additionally, CMS issued a "clarification of policy" as part of its 2011 Inpatient Prospective Payment System (IPPS) final rule. In that clarification, CMS stated that while provider taxes are generally allowable, Medicare contractors should review claims for such taxes to determine whether an offset of Medicaid revenues should be made. See 75 Fed. Reg. 50362-64 (Aug. 16, 2010). The clarification —whose logic CMS will likely now say is supported by the *Kindred* decision— means that Medicare contractors, with increasing regularity, will likely be disallowing costs for provider taxes by offsetting Medicaid and related revenues against the tax assessments. This will affect not just critical access hospitals but also IPPS hospitals that have certain costs, such as organ procurement costs, paid on a reasonable cost basis. Thus, providers and their hospital associations should consider working closely with their Medicaid agencies in an effort to fashion provider tax programs in such a way that Medicare will find it difficult to assert that providers did not actually incur the tax.