No. 17-

IN THE

Supreme Court of the United States

BRECKINRIDGE HEALTH INC. ET AL.,

Petitioners,

v.

ALEX AZAR, SECRETARY, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether state Medicaid payments to hospitals that provide services to disproportionately low-income patients constitute a refund of costs those hospitals incurred in paying state taxes ordinarily reimbursable by Medicare, such that those taxes are no longer "actually incurred" costs for purposes of Medicare reimbursement.

2. Whether courts should defer to agency interpretation of statutes or regulations that involved embedded questions of state law.

PARTIES TO THE PROCEEDING

Petitioners Breckinridge Health, Inc. (d/b/a/ Breckinridge Memorial Hospital), Bowling Green-Warren County Community Hospital Corporation (d/b/a The Medical Center at Scottsville), The Medical Center at Franklin, Inc., and Appalachian Regional Healthcare, Inc. (d/b/a McDowell ARH Hospital and Morgan County ARH Hospital) were plaintiffs in the district court and the appellant in the Sixth Circuit.

Respondent Alex Azar, in his official capacity as Secretary of the United States Department of Health and Human Services, was the defendant in the district court and the appellee in the Sixth Circuit.

CORPORATE DISCLOSURE STATEMENT

Commonwealth Health Corporation, Inc. is the parent company of petitioner Bowling Green-Warren County Community Hospital Corporation (d/b/a The Medical Center at Scottsville) and of petitioner the Medical Center at Franklin, Inc. No other petitioner has a parent corporation, and no publicly held company owns ten percent or more of any petitioner's stock.

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The opinion of the United States Court of Appeals for the Sixth Circuit is reported at *Breckinridge Health, Inc. v. Price*, 869 F.3d 422 (6th Cir. 2017). App. 1a. The district court's opinion is reported at *Breckinridge Health, Inc. v. Burwell*, 193 F. Supp. 3d 788 (W.D. Ky. 2016). App. 14a. The decision of the Provider Reimbursement Review Board is unpublished. App. 32a.

JURISDICTION

The United States Court of Appeals for the Sixth Circuit entered judgment on August 23, 2017. The court denied rehearing on November 8, 2017. App. 49a. On January 22, 2018, Justice Kagan extended the time to file this petition to and including April 7, 2018. This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

Pertinent statutory and regulatory provisions are set forth in the appendix at App. 50a–83a.

STATEMENT

This case concerns the continued viability of rural hospitals serving this nation's working poor. Petitioners are "critical access hospitals" in Kentucky, meaning they are small acute care facilities serving patients who have no other option—no other such facility within 35 miles. But for petitioners, like critical access hospitals across Kentucky, existence is fragile. Given the economics of serving the rural poor, these hospitals often barely break even or operate at a loss.

Recognizing that these hospitals provide essential services to patients who would otherwise lack access to healthcare, Congress has enacted multiple federal laws to provide the hospitals with a more secure financial backing. First, under the Medicare statute, the Department of Health and Human Services (HHS) must reimburse critical access hospitals for 101% of their reasonable costs in caring for Medicare patients, and Congress has made clear that HHS may not pass those costs off to "individuals not … covered" by Medicare, i.e., other patients who must pay higher premiums to make up for any Medicare shortfall. 42 U.S.C. § 1395x(v)(1)(A). Second, under the Medicaid statute, Congress requires states that receive federal Medicaid funding to provide special "disproportionate share hospital" payments to hospitals, like petitioners, that serve a disproportionate share of indigent patients.

The Sixth Circuit upheld an agency interpretation that is inconsistent with the text and purpose of those laws and that threatens the survival of critical access hospitals across Kentucky. Reversing its prior practice, HHS concluded that the payments federal law requires hospitals to receive

for serving indigent patients constitute a "refund" of the payments that federal law separately requires hospitals to receive for serving Medicare patients. The effect is to reduce petitioners' reimbursement for the costs of caring for Medicare patients below the 101% that Congress ordered.

HHS reached this interpretation based on its interpretation of a state tax scheme. State hospital taxes attributable to the costs of caring for Medicare patients have long counted as reimbursable costs. But in Kentucky, that tax money goes into a general pot that the state uses to fund disproportionate-share payments to hospitals serving indigent patients (among other uses). HHS docked petitioners' Medicare reimbursement on the theory that the disproportionate-share payments are a "refund" of the tax, even though under Kentucky law a hospital's tax obligation is entirely unrelated to the amount it receives for indigent care. An eligible hospital would receive the indigent care funds even if it paid *no* tax.

The Sixth Circuit nonetheless upheld HHS's interpretation, in a decision that will have devastating costs for the poorest and sickest citizens of Kentucky. Congress wanted hospitals to receive compensation for serving Medicare patients *and* indigent patients. But under the decision below, the Medicare statute permits HHS to *penalize* hospitals that serve a disproportionate share of indigent patients, by reducing their Medicare reimbursement accordingly. This is backwards. And the consequences cannot be overstated. Two critical access hospitals in Kentucky have gone bankrupt since this litigation was filed in 2010, including one of the hospitals that was a party to the decision below.

HHS's interpretation is erroneous under any standard of review, and the stakes—the continued provision of healthcare to rural patients—could not be higher. But this Court should also grant review because the Sixth Circuit erroneously afforded *Chevron* deference to HHS's analysis of *Kentucky* law. Whether such deference is appropriate is outcome determinative here; under a de novo review of the Kentucky scheme, the court could not have concluded that payments for indigent care constituted a "refund" of wholly unrelated tax assessments on providers. The Tenth Circuit has joined with the Sixth Circuit in granting deference to agency interpretations of state law, but multiple other circuits properly decline to do so. Only this Court can resolve the division.

A. Statutory and Regulatory Background

This case involves the interplay between three intricate and intertwined statutory schemes: (1) Medicare, a federal program for the elderly and disabled; (2) Medicaid, a federal-state program for low-income individuals; and (3) provisions of Kentucky state law governing the assessment of taxes on health-care providers and the administration of the State's Medicaid disproportionate-share hospital program.

1. Medicare

Medicare is a federal health insurance program that provides medical benefits for elderly and disabled individuals. 42 U.S.C. § 1395 et seq. In 1997, Congress established the Medicare Rural Hospital Flexibility Program to improve the access of rural residents to vital medical services. Pub. L. No. 105-33, 111 Stat. 251, 369 (codified at 42 U.S.C. § 1395i-4). Under this program, each State may designate as

"critical access hospitals" medical facilities that meet certain geographic requirements. 42 U.S.C. § 1395i-4(c)(2). Such hospitals must, among other things, have no more than 25 inpatient beds, offer 24-hour, 7-day-a-week emergency care, and be located in a rural area at least a 35-mile drive away from any other hospital. *Sheikh v. Grant Reg'l Health Ctr.*, 769 F.3d 549, 550 (7th Cir. 2014).

Under § 1395f(*l*), the Medicare program reimburses critical access hospitals for "101 percent of the reasonable costs of the critical access hospital in providing [inpatient critical access hospital services]." 42 U.S.C. § 1395f(*l*). The Act defines a "reasonable cost" as a "cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services … ." *Id.* § 1395x(v)(1)(A).

Section 1395x(v)(1)(A) further directs the Secretary of HHS to promulgate regulations governing the calculation of such costs. But the statute requires the Secretary to ensure that "the necessary costs of efficiently delivering covered services to individuals covered by [Medicare] will not be borne by individuals not so covered." 42 U.S.C. § 1395x(v)(1)(A). In other words, Medicare itself pays the full 101 percent.

The Secretary has carried out this statutory mandate and issued regulations and other guidance governing the reimbursement of Medicare costs. Hospitals must submit data regarding the reasonable costs they incurred in providing care to Medicare beneficiaries, which Medicare then reimburses. 42 C.F.R. §§ 413.9(a), 413.24(a), 413.70. Reasonable costs include direct and indirect costs, including certain kinds of taxes. 42 C.F.R.

§ 413.9(b)(1); Provider Reimbursement Manual §§ 2122.1, 2122.2.

If a hospital receives a "refund[] of previous expense payments," Medicare deducts that amount from its reimbursement, on the theory that it constitutes a "reduction[] of the related expense." 42 C.F.R. § 413.98(a), (d)(2). HHS has defined "refunds" by regulation as "amounts paid back or a credit allowed on account of an overcollection." *Id.* § 413.98(b)(3). The Provider Reimbursement Manual similarly defines refunds as "amounts paid back by the vendor generally in recognition of damaged shipments, overpayments, or returned purchases." Provider Reimbursement Manual § 802.31.

On August 16, 2010, HHS issued a final rule to "clarif[y]" its policy regarding reimbursement of provider tax costs. 75 Fed. Reg. 50,041, 50,362 (Aug. 16, 2010) ("2010 Final Rule"). The agency noted that "some States levy tax assessments on hospitals. The assessed taxes may be paid by the hospitals into a fund that includes all taxes paid, all Federal matching monies, and any penalties for nonpayment. The State is then authorized to disburse monies from the fund to the hospitals. We believe that these types of subsequent disbursements to providers are associated with the assessed taxes and may, in fact, offset some, if not all, of the taxes originally paid by the hospitals." *Id.* at 50,363.

The agency further explained that "[i]n 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." *Id.* "Medicare contractors will continue to

apply the current reasonable cost principles to determine if a provider tax incurred is an allowable cost and how much of that allowable cost is actually incurred to determine reimbursement." *Id.*

2. Medicaid Disproportionate Share Hospital Program

Medicaid "is a cooperative federal-state program that provides federal funding for state medical services to the poor." *Frew ex rel. Frew v. Hawkins*, 540 U.S. 431, 433 (2004); 42 U.S.C. § 1396 et seq. The federal government reimburses participating States for part of their costs incurred in providing Medicaid services. The federal government's share of the State's Medicaid expenses varies from state to state depending on the state's per capita income, and ranges from between roughly 50 and 74% of the State's expenses.[1]

Among other things, Medicaid requires states to provide additional payments to hospitals that serve a disproportionate number of low-income patients, known as "disproportionate share hospitals." 42 U.S.C. §§ 1396a(a)(13)(A)(iv); 1396r-4(a)(1). States have significant latitude to create their own disproportionate-share hospital programs, including by designing the mechanisms by which they will fund the payments, defining eligible hospitals, and determining the amount of disproportionate-share hospital payments. *Id.* § 1396r-4. As with other Medicaid expenses, the federal government reimburses a portion of the State's disproportionate-share hospital payments.

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[1] Congressional Research Service, *Medicaid Disproportionate Share Hospital Payments* (June 17, 2016), at 1.

States are generally free to impose healthcare-related taxes on hospitals, to fund Medicaid and disproportionate-share payments based on those taxes, and to nonetheless receive federal matching funds based on the payments. Under a 1991 law, however, matching funds are only available if the tax is broad-based (i.e., it is imposed on all nonpublic, non-federal providers), and if the tax lacks a "hold harmless" provision (i.e., the state's Medicaid and disproportionate-share payments to any particular hospital are not tied to that hospital's tax payment). 42 U.S.C. §§ 1396b(w)(1)(ii)–(iii), (w)(4); *Protestant Mem'l Med. Ctr., Inc. v. Maram*, 471 F.3d 724, 727 (7th Cir. 2006).

3. Kentucky's Provider Tax and Disproportionate Share Hospital Program

The Kentucky disproportionate-share hospital program compensates Kentucky hospitals for the costs they incur in providing uncompensated services to "indigent" patients, defined as individuals with total annual incomes up to the federal poverty level who are not eligible for medical assistance or the Kentucky Children's Health Insurance Program. *See* Ky. Rev. Stat. §§ 205.640(3)(b), 205.640(5). Costs for providing care to patients eligible for Medicaid or Medicare do not qualify for disproportionate-share payments.

Kentucky funds its disproportionate-share hospital payments in part by collecting a broad-based 2.5% tax on the gross revenues of all providers of hospital services. Ky. Rev. Stat. § 142.303(1). This tax is assessed monthly and deposited into a state fund known as the Medical Assistance Revolving Trust (MART). *Id.* § 205.640. State matching funds,

collected from state university hospitals, are also deposited into the MART fund. MART fund money is used to fund other programs beyond the disproportionate-share program, including to collect health data, to supplement medical assistance-related general fund appropriations, and to enhance Medicaid Diagnosis Related Group payments. *Id.* § 205.640(2).

In addition to the state MART Fund, Kentucky also relies on federal matching funds to sustain its disproportionate-share hospital program. *Id.* § 205.640(3)(a). The federal medical assistance matching percentage for Kentucky was 70.13% in fiscal year 2009 and 70.96% in fiscal year 2010, 72 Fed. Reg. 67,306 (Nov. 28, 2007); 73 Fed. Reg. 72,052 (Nov. 26, 2008)—roughly $65.8 million out of $94 million. *See* Agency Record 841, 892–94.

Kentucky disburses disproportionate-share hospital payments to eligible hospitals once per year, on the later of October 15 or when federal matching funds become available. Ky. Rev. Stat. § 205.640(3)(e). Individual hospitals receive payments that correspond to their share of indigent care within a set of specified categories. *Id*. §§ 205.640(3)(a), (d); 907 Ky. Admin. Reg. 10:820. Disproportionate-share hospital payments are not contingent upon a particular hospital's payment of the provider tax. Nor is there any correlation or association between the amount of provider taxes each hospital pays and any annual disproportionate-share hospital payment it receives.

Disproportionate-share hospital payments do not necessarily cover the entire costs that critical-access hospitals in Kentucky incur to provide care to indigent individuals. Hospitals receive

reimbursement of their expenses only up to the amount of available disproportionate-share hospital funds. Moreover, to qualify for disproportionate-share hospital payments, hospitals must agree to forgo collection from the indigent patients themselves of any uncompensated balance. Ky. Rev. Stat. § 205.640(5). In the years at issue in these proceedings, disproportionate-share hospital payments covered only 45% of the costs incurred by critical-access hospitals—including petitioners—in providing indigent care. *See* App. 10a n.2.

B. Factual Background and Proceedings Below

1. Petitioners are five critical access hospitals operating in rural regions in Kentucky. Each of these hospitals has no more than 25 inpatient beds. The large majority of their patients, ranging from roughly 86 percent at the Medical Center at Franklin to 93 percent at the Morgan County ARH Hospital, receive either Medicaid or Medicare.[2]

By virtue of petitioners' critical access status, federal law requires the federal government to reimburse them for 101% of their costs in providing care to Medicare patients. And by virtue of petitioners' provision of care to indigent patients, federal law requires the state of Kentucky to reimburse petitioners for the costs of that care, through disproportionate-share hospital payments.

Petitioners filed Medicare cost reports for fiscal years 2009 and 2010, claiming the portion of their

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[2] Commonwealth of Kentucky, Cabinet for Health and Family Services, Office of Health Policy, 2015 Kentucky Annual Administrative Claims Data Report—Inpatient Hospitalizations (Sept. 2016), https://goo.gl/Y4VDfo.

provider tax payments attributable to Medicare patients as a "reasonable cost" to which they were entitled for Medicare reimbursement. From 1997 to 2008, the Secretary had reimbursed petitioners in full for these provider tax payments. *See* Agency Record 835. But in an abrupt reversal from prior practice, the Medicare contractor reduced petitioners' Medicare reimbursements by offsetting the *Medicaid* disproportionate-share payment each hospital received against the Medicare-attributable provider tax payments made for fiscal years 2009 and 2010. App. 3a.

Petitioners appealed to the Provider Reimbursement Review Board, where their appeals were consolidated with appeals by other Kentucky critical access hospitals raising the same issue. The Board upheld the offsets. The Board noted that the Medicare program requires reimbursement of costs "actually incurred," which in turn "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." App. 38a–39a. Thus, the Board stated that it "must look at the net economic impact of [the provider tax assessments] on the hospital" to determine whether the taxes were "costs actually incurred." App. 39a. According to the Board, this was "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." *Id*. The Board then stated without analysis 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." App. 39a–40a.[3] Thus, the Board concluded that the KP-Tax assessment had to be offset by the Medicaid disproportionate-share payment received, thus treating the Medicaid disproportionate-share payment as a refund for purposes of 42 C.F.R. § 413.98. App. 40a.

Though it stated that it "w[ould] not rely" on the 2010 Final Rule, the Board nevertheless noted that the 2010 Final Rule "support[ed]" its findings in this case, because "the taxes need only be 'associated with' the subsequent disbursements." App. 42a–43a. The Board further noted that "the source of the Medicaid DSH payments is the provider tax," which is deposited into the MART Fund, and that "hospitals can *only* get Medicaid DSH distributions from the MART Fund." App. 43a.

On March 27, 2015, the Administrator of the Centers for Medicare and Medicaid Services declined to review the Board's decision. App. 30a–31a. Accordingly, the Board's decision became the agency's final decision.

2. Petitioners sought judicial review in the U.S. District Court for the Western District of Kentucky under 42 U.S.C. § 1395oo(f)(1). On cross-motions for summary judgment, the district court granted summary judgment in favor of the Secretary and affirmed the Board's decision. The district court held that the agency decision was supported by substantial evidence and "based on a reasonable interpretation of the statutory term ['costs actually incurred']." App. 26a.

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[3] The Board used the term "Breckinridge" to refer to all the hospitals. App. 35a.

3. The Sixth Circuit affirmed. The court reasoned that "the net effect of the Medicaid DSH payment was to reimburse [petitioners] for the tax." App. 2a. Noting the "substantial deference" owed under *Chevron, U.S.A., Inc. v. NRDC*, 467 U.S. 837 (1984), and *Thomas Jefferson University v. Shalala*, 512 U.S. 504 (1994), to the agency's determination of what constitutes a reasonable cost meriting reimbursement, App. 5a, the Sixth Circuit concluded that "HHS's [offset] decision was not arbitrary, capricious, or manifestly contrary to the Medicare statute." App. 2a. The court stated that "[its] goal is not to find the *best* way to interpret the statute, but rather simply to determine whether a contrary result is *compelled* by the law or congressional intent." App. 10a.

The Sixth Circuit relied heavily on the decision of the Seventh Circuit in *Abraham Lincoln Memorial Hospital v. Sebelius*, 698 F.3d 536 (7th Cir. 2012). There, the Seventh Circuit had upheld the offset of Medicare reimbursements for tax assessments paid by hospitals in Illinois in connection with receipt of payments from the state Medicaid fund. The Sixth Circuit acknowledged differences between the Kentucky and Illinois statutes, but nevertheless concluded that the distinctions "do not compel a contrary result." App. 9a. In the court's view, because Kentucky law states that provider tax revenues and matching funds "shall be used to fund the disproportionate share program," Kentucky's scheme shared "fundamental elements" with the Illinois scheme. *Id.* Thus, the court concluded that "[i]t seems plausible … that when a provider receives a payment from [the Kentucky MART fund], the payment serves at least as a partial refund of the tax." *Id*. The Sixth Circuit further stated that the 2010 Final Rule

requires only that a separate payment be "associated with a tax" for that separate payment to reduce the amount of tax incurred. App. 13a.

The Sixth Circuit denied rehearing on November 8, 2017. App. 49a.

REASONS THE PETITION SHOULD BE GRANTED

I. The Question Presented is of Critical Importance to the Provision of Healthcare to Medicare Patients and Indigent Patients

For eleven years, from 1997 to 2008, the federal government reimbursed petitioners and other critical access hospitals in Kentucky for the portion of their state provider tax payments attributable to Medicare. But in 2009, HHS abruptly reversed course. HHS concluded that the disproportionate-share hospital program—a federally-required reimbursement for the cost of serving indigent patients *not* eligible for Medicare—constituted a "refund" of costs the critical access hospitals expended to serve *different* patients who *are* eligible for Medicare. The decision is enormously significant and threatens the survival of Kentucky's critical access hospitals, which rely on funding from Medicare to provide essential care in rural and otherwise underserved areas. Indeed, one of the critical access hospitals that was a party to the administrative proceedings went bankrupt after the Board's decision. HHS's interpretation of the Medicare and Medicaid statutes, and the decision below upholding that interpretation, imperils the sick and working poor in one of the poorest states in this country. The decision below affects federal reimbursements for every critical access hospital in

Kentucky. The question whether HHS's decision complies with federal law merits this court's review.

1. Due to a confluence of disadvantages—geographic isolation, long distances between towns, poor roads, bad weather, sparse populations, a weak economic base, and lack of education and other amenities—rural residents face high barriers to access to healthcare.[4] The problem is especially acute in Kentucky, where more than 40% of the population lives in rural areas.[5] In 2016, the poverty rate in rural Kentucky was 23.6%, compared with 14.9% in urban areas (and 11.3% nationwide).[6] The State's rural residents have shorter life expectancies than their urban counterparts.[7] Rural residents in Eastern Kentucky face particularly high incidences of cancer, cardiovascular disease, hypertension, asthma, and diabetes. For example, in Appalachian counties of Kentucky, approximately 16.3% of the population has been diagnosed with diabetes, as compared to 10.5% of the population in non-Appalachian counties.[8]

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[4] *See, e.g.*, F. Brundisini et al., *Chronic Disease Patients' Experiences With Accessing Health Care in Rural and Remote Areas*, 13 Ontario Health Technology Assessment Series 1 (2013), https://goo.gl/kLnjMn.

[5] U.S. Census Bureau, Kentucky: 2010 – Population and Housing Unit Counts (Sept. 2012), https://goo.gl/nAVZsN.

[6] *See* Kentucky, Rural Health Information Hub (Jan. 8, 2018), https://goo.gl/kMsSDs; United States, Rural Health Information Hub, https://goo.gl/sX4gdW.

[7] *See* Steven H. Woolf et al., *Geographic Health Disparities in Kentucky*, 5 Frontiers in Public Health Servs. & Sys. Res. (Vol. 5, Issue 3, Art. 1) (2016), https://goo.gl/kwhZBC.

[8] Univ. of Kentucky, Center of Excellence in Rural Health, About Improving Diabetic Outcomes, https://goo.gl/Kg5jbc.

Many rural hospitals are the only health facility available to the surrounding community.[9] Their survival and continued funding is key to ensuring the availability of essential medical services to populations that historically have lacked proper access to care. In Kentucky, rural hospitals provide health care to 45% of the state's residents, including a large share of low-income and elderly individuals.[10] Rural hospitals are also integral to local economies, providing much-needed employment opportunities in the areas they serve.[11]

2. In 1997, recognizing that hospitals in isolated geographic regions face significant financial pressures resulting from a large proportion of uncompensated care and diseconomies of scale, as well as the critical importance of these hospitals to their surrounding communities, Congress created the Medicare Rural Hospital Flexibility Program. Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251.[12] This program provides for the designation of certain cash-strapped rural hospitals as critical access hospitals, and permits them to obtain 101% of their reasonable and necessary costs

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[9] *See* Jane Wishner et al., *A Look at Rural Hospital Closures and Implications for Access to Care: Three Case Studies*, Kaiser Comm'n on Medicaid and the Uninsured (July 2016), https://goo.gl/1MmV3n.

[10] Adam H. Edelen, Auditor of Public Accounts, *Special Report on the Financial Strength of Kentucky's Rural Hospitals, Commonwealth of Kentucky* (2015).

[11] *See* Thomas C. Ricketts, *The Changing Nature of Rural Health Care*, 21 Annual Rev. of Pub. Health 639, 645-46 (2000).

[12] *See also* M.J. McCue, *A Market, Operation, and Mission Assessment of Large Rural For-Profit Hospitals with Positive Cash Flow*, 23 J. Rural Health 10 (2007).

in providing care to Medicare patients. By contrast, normal acute care hospitals receive reimbursement of approximately 92 to 93% of their Medicare costs. Agency Record 818.

The critical access hospital program, which provides increased reimbursement for Medicare patients, works in tandem with federal law requiring increased reimbursement for Medicaid. Critical access hospitals historically serve not only patients eligible for Medicare, but also—as a result of the demographics of the regions in which they are located—disproportionate percentages of low-income patients for whom they must deliver uncompensated services. Congress's answer was the Medicaid statute's Disproportionate Share Hospital program, which requires states to provide supplemental Medicaid payments to hospitals that serve a disproportionate percentage of low-income patients. *See* 42 U.S.C. § 1396a(a)(13)(A)(iv). These payments are "the primary method for states to directly subsidize safety-net hospitals, paying for nearly 30 percent of unreimbursed care."[13] Disproportionate-share hospital payments "help hospitals … [e]xpand health care services to the uninsured," "[d]efray the costs of treating indigent patients," and recruit physicians and other health care professionals.[14]

3. While the Medicare critical access hospital program has significantly improved the financial

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[13] Pamela L. Davidson et al., *A Framework for Evaluating Safety-Net and Other Community-Level Factors on Access for Low-Income Populations*, 41 Inquiry Online 21, 31 (2004).

[14] Thomas M. Suehs, Exec. Comm'r, Texas Health & Human Servs. Comm'n, *Presentation to the Senate Finance Subcommittee on Medicaid: Hospitals*, 18 (Feb. 21, 2011).

stability of these hospitals,[15] the hospitals nonetheless remain in a precarious position. Medicare does not reimburse hospitals for the costs of providing care to indigent patients, and disproportionate-share hospital payments under Medicaid cover only a fraction of all costs. For example, in Kentucky for the years in question, disproportionate-share hospital payments covered only about 45% of the costs of providing care to indigent patients, meaning that hospitals absorbed the remaining 55%. App. 10a n.2.

Approximately 34% of Kentucky's rural hospitals are considered in poor financial health.[16] Moreover, Kentucky's recent plan to impose work requirements on Medicaid beneficiaries, which will strip thousands of currently covered individuals of Medicaid coverage, is estimated to increase Kentucky hospitals' uncompensated care costs by about 20%.[17]

The problem is especially dire for critical access hospitals. When the program began in 1999 there were 32 critical access hospitals in Kentucky; today, that number is 27.[18] Two have gone bankrupt during

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[15] Karen E. Joynt et al., *Quality of Care and Patient Outcome in Critical Access Rural Hospitals*, 306 JAMA 45, 50 (2011). *See Bayside Cmty. Hosp. v. Sebelius*, No. 07-1562, 2009 WL 9536725 (D.D.C. Sept. 30, 2009).

[16] Edelen, *supra* n.10.

[17] *See* Rich Daly, *Why Hospitals Support Kentucky's Medicaid Waiver,* Healthcare Fin. Mgmt. Ass'n (Jan. 15, 2018), https://goo.gl/3Jnxq1.

[18] Kentucky Hospital Association, Kentucky Hospital Statistics 2016, at 7-8, https://goo.gl/hF4RXn; Flex Monitoring Team, *Critical Access Hospital Locations*, https://goo.gl/EybQxZ (as of Jan. 12, 2018).

the pendency of this litigation.[19] One of the casualties was New Horizons Medical Center, a critical access hospital based in Owen County, Kentucky, where more than 20% of children are below the poverty line.[20] New Horizons was an original party with petitioners before the agency in this matter, seeking full reimbursement for its Medicare costs, but it went bankrupt in 2015.[21]

Petitioners—like critical access hospitals in Kentucky generally—operate on a razor-thin margin. Four out of five of petitioners reported a profit margin of less than 3% in 2016,[22] well below the 4–6% margin necessary to keep pace with technology and to meet the community's healthcare needs.[23] One petitioner had a negative net income.[24] The amounts

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[19] *Nicholas County Hospital Announces Closing, To File for Bankruptcy*, Lexington Herald-Leader (May 12, 2014), https://goo.gl/GTgyxM; *New Horizons Medical Center Files for Bankruptcy*, Value Healthcare Services, https://goo.gl/f4H7Lv.

[20] *Selected Economic Characteristics—2012-2016 American Community Survey 5-Year Estimates: Owen County, Kentucky*, U.S. Census Bureau, https://goo.gl/z3RyZ6

[21] *New Horizons Medical Center Files for Bankruptcy*, Value Healthcare Services, *supra* n.19.

[22] *Free Profile: Breckinridge Memorial Hospital*, Am. Hosp. Directory (Jan. 30, 2018), https://goo.gl/Pw2CP8; *Free Profile: The Medical Center at Scottsville*, Am. Hosp. Directory (Jan. 25, 2018), https://goo.gl/de9wRi; *Free Profile: Morgan County ARH Hospital*, Am. Hosp. Directory (Dec. 7, 2017), https://goo.gl/eUBVEh; *Free Profile: McDowell ARH Hospital*, Am. Hosp. Directory (Dec. 6, 2017), https://goo.gl/HfC6jq.

[23] *See New Data Reveals More Rural Hospitals Losing Money*, Hospital & Healthsystem Association of Pennsylvania (Feb. 7, 2018), https://goo.gl/nvKvAW.

[24] *Free Profile: Breckinridge Memorial Hospital*, Am. Hosp. Directory (Jan. 30, 2018), https://goo.gl/Pw2CP8.

at stake—an average of about $88,000 per petitioner per year for the years in question—may not seem like a lot. *See* Agency Record 68–69. But their importance cannot be overstated to small hospitals that are already paying over half of the costs of treating indigent patients out of pocket.

4. The question whether federal law permits HHS to treat state Medicaid payments as "refunds" of costs that hospitals incur in serving Medicare patients—and thus as a reason to dock Medicare reimbursement—has been percolating through courts across the country. *See Dana-Farber Cancer Inst. v. Hargan*, 878 F.3d 336 (D.C. Cir. 2017) (Massachusetts); *Kindred Hosps. E., LLC v. Sebelius*, 694 F.3d 924 (8th Cir. 2012) (Missouri); *Abraham Lincoln*, 698 F.3d 536 (Illinois).[25]

Nowhere is the question of more significance than in the decision below, which implicates the provision of medical care by hospitals that serve the nation's poorest and most disadvantaged communities. Disproportionate-share hospital payments are critical to the survival of hospitals that serve low-income and uninsured patients. Without these payments, the average operating margin of safety-net hospitals nationwide would fall from +2.3 percent to *-6.1 percent*.[26] To prevent this outcome is why Congress required states to make disproportionate-share hospital payments in the first place.

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[25] The hospital in the *Dana-Farber* case has indicated that it intends to seek certiorari. *See* No. 17A962.

[26] Katherine Neuhausen et al., *Disproportionate Share Hospital Payment Reductions May Threaten Financial Stability of Safety-Net Hospitals*, 33 Health Affairs 988 (2014).

Yet the decision below permits HHS to eliminate disproportionate-share hospital payments by administrative fiat. That is the economic effect of HHS's decision to treat those payments as a "refund" and consequently to reduce federal Medicare reimbursement by the amount of the payment. The fact that some of the payments are funded by state taxes on hospitals does not alter the financial consequences of HHS's decision: those taxes are otherwise reimbursable and cover the provision of care to Medicare patients, rather than to the indigent and Medicaid patients whose treatment the disproportionate-share payments fund. The decision below thus simultaneously permits HHS to undercut Congress's decision to reimburse critical access hospitals for 101% of their costs in treating Medicare patients.

The ultimate question here is whether federal statutes and regulations ensuring that hospitals receive compensation for serving both Medicare and Medicaid/indigent patients can bear an interpretation that allows reimbursement for the latter to offset reimbursement for the former. That question is undeniably important, and it is especially so in the context of rural hospitals serving America's poorest patients, which the Medicare and Medicaid statutes treat with the most solicitude. Left undisturbed, the decision below not only undermines Congress's goals in enacting the Medicare and Medicaid statutes, but it will threaten the very existence of petitioners and other critical access hospitals. This Court should grant review to ensure rural residents' continued access to essential medical care.

II. The Courts of Appeals Are Divided Over the Deference Owed to Agency Interpretations of State Law

Certiorari is all the more warranted because the decision below presents an ideal opportunity to resolve a conflict among the circuits regarding the deference owed to agency decisions that include embedded issues of state law.

In the decision below, the Sixth Circuit accorded broad deference to the agency's determination that Kentucky's disproportionate-share hospital payments were "refunds" of petitioners' provider tax payments. That determination rested not only on the agency's interpretation of the Medicare statute and its refund regulations, but also of the Kentucky provider tax and disproportionate-share hospital statutes. The Sixth Circuit declined, however, to engage in de novo review of the Kentucky statutes, and instead merely held that the agency's view that the disproportionate-share hospital payments were a refund of the tax payments "seem[ed] plausible." App. 9a. In other words, the court of appeals afforded deference not only to HHS's interpretation of the Medicare statute and regulations, but also to its reading of state law.

Other courts have not deferred to the agency's analysis of the questions of state law embedded in the determination whether state Medicaid disproportionate-share payments effectively "refund" hospitals' payments of state provider taxes. In *Abraham Lincoln*, the Seventh Circuit conducted its own "plain reading" of the relevant statutes before concluding that the agency properly offset the hospitals' tax expenses by Medicaid payments. 698 F.3d at 549–50. Similarly, in *Dana-Farber Cancer*

Institute, 878 F.3d 336, the D.C. Circuit focused on "the manner in which Massachusetts administered the Hospital Tax." *Id.* at 341. The court highlighted the fact that Massachusetts sought only a net payment (the amount of its monthly tax liability, minus the monthly Medicaid payment) from the hospital in that case. *Id.* And the Eighth Circuit in *Kindred Hospitals*, 694 F.3d 924, also conducted a detailed review of the structure of Missouri's Medicaid payment scheme before concluding that the agency had correctly determined that an offset was appropriate. *Id.* at 925–27.

The disagreement between the Sixth Circuit and the other circuits in the context of Medicare reimbursement reflects a broader circuit split about the level of deference accorded to agency interpretations that turn on questions of state law. The Tenth Circuit, for example, has held that "when a court reviews an agency's careful and studied conclusions of [state and federal] law pertaining to a matter clearly within the agency's expertise, the court will affirm those conclusions if they are reasonable." *R.R. Comm'n of Texas v. F.E.R.C.*, 874 F.2d 1338, 1344 (10th Cir. 1989); *see also Walker Operating Corp. v. F.E.R.C.*, 874 F.2d 1320, 1332 (10th Cir. 1989) (similar).

Other circuits, in sharp contrast, have reasoned that general principles of administrative law counsel against such deference. The D.C. Circuit, for example, in *Cellwave Telephone Servs. L.P. v. F.C.C.*, 30 F.3d 1533 (D.C. Cir. 1994), applied de novo review to the FCC's determination regarding the status of particular entities under Delaware law. The court noted the Tenth Circuit's contrary approach, but reasoned that "[d]eference is appropriate when the agency has expertise in a particular area or the

Congress has entrusted the agency to administer a particular statute. … Neither condition obtains here." *Id.* at 1537. Likewise, the Fifth Circuit, in *Texas v. U.S. E.P.A.*, 690 F.3d 670 (5th Cir. 2012), declined to accord deference to the EPA's interpretation of Texas law, as "the EPA's interpretation [of state law] is not authoritative." *Id.* at 677; *see also, e.g.*, *Bd. of Governors of Univ. of N.C. v. U.S. Dep't of Labor*, 917 F.2d 812, 816 (4th Cir. 1990) (reviewing de novo agency's determination of its jurisdiction, which turned on its construction of a state statute).

This Court should intervene to resolve this longstanding division among the circuits. Commentators have noted significant disparities in the deference accorded to agency interpretations under *Chevron* in the courts of appeals, and have called on this Court to provide clearer guidance about *Chevron*'s application and scope. *See* Kent Barnett & Christopher J. Walker, Chevron *in the Circuit Courts*, 116 Mich. L. Rev. 1 (2017). For instance, while the D.C. Circuit applied the *Chevron* framework to agency statutory interpretations 88.6% of the time, the Sixth Circuit did so only 60.7% of the time. *Id.* at 46. But the Sixth Circuit ruled in the agency's favor in 88.2% of the cases when *Chevron* did apply—a percentage significantly higher than the D.C. Circuit, where the agency prevailed in 75.4% of the cases where *Chevron* applied. *Id.* at 48.

The Sixth Circuit's decision to accord broad deference to the agency's embedded interpretation of state law was outcome-determinative here. The court noted that the agency's conclusion that disproportionate-share hospital payments from Kentucky's MART fund were a tax refund "seem[ed] plausible," App. 9a, and conspicuously declined to state that the agency's decision would have survived

review under a less deferential standard. While the court stated that it was considering the "link" between the provider tax payments and the disproportionate-share payments, *see* App. 8a, it failed to consider, much less independently evaluate, the features of state law that undermined any notion of a link. For example: (1) Kentucky's provider tax assessment is not contingent on receipt of disproportionate-share payments, *see* Agency Record 35–37, 728, (2) the disproportionate-share payments are not calculated based on provider tax payments, *id.* at 35–37, 728, (3) a hospital could pay nothing in provider taxes and it would not affect the hospital's disproportionate-share payment, *id.* at 25, (4) disproportionate-share payments cover the costs of providing care to non-Medicare patients, *id.* at 36–37, while the portion of the tax at issue covers exclusively the costs of caring for Medicare patients, *see id.* at 737, (5) the provider taxes also fund Kentucky programs *other* than the disproportionate-share payments, so there is not a one-to-one relationship between the tax dollars and the payments, *id.* at 36, and (6) various sources of money besides provider tax assessments fund the disproportionate-share payments, *id*.

Under a de novo review of whether Kentucky's disproportionate-share payments constitute a refund of its tax assessments, all of those factors would undermine the agency's conclusion. Because the Sixth Circuit deferred to the agency's interpretation of state law, however, the court considered none of them. Because the court's role was "not to find the *best* way to interpret the statute," App. 10a, the court essentially asked whether any part of Kentucky's scheme arguably supported the agency's interpretation. Because the law stated that "provider

tax revenues," along with other funds, "shall be used to fund the disproportionate share program," App. 9a, the court concluded that the agency's "refund" interpretation was plausible.

This case thus presents an ideal opportunity to restore uniformity among the circuits regarding the level of deference owed to agency statutory interpretations that involve embedded questions of state law. If the court had conducted its own analysis of the Kentucky scheme, it would have reversed.

III. The Decision Below Is Wrong

The Sixth Circuit applied an overly deferential standard of review and, what is more, relied heavily on the Seventh Circuit's analysis of a *different* state's Medicaid payment scheme to bolster an erroneous interpretation. First, under any standard of review, deferential or otherwise, HHS's ultimate conclusion that Medicaid payments may be used to offset Medicare reimbursement violates federal statutes and HHS's own regulations. Second, the Sixth Circuit's decision to defer to HHS's interpretation of state law was contrary to this Court's precedent and to the rationales underlying agency deference.

A. Payments Received to Care for Indigent Patients Are Not "Refunds" of Medicare Costs Under Federal Law and Regulations

1. The plain text of the Medicare statute and the HHS regulations confirm that petitioners were entitled to full Medicare reimbursement for the expenses they incurred in paying the portion of the Kentucky provider tax attributable to Medicare patients. The only way a reduction of those expenses would have been justified was if petitioners did not "actually incur[]" the full amount of tax costs because

they received a "refund" of some portion of those costs. 42 U.S.C. § 1395x(v)(1)(A); 42 C.F.R. § 413.98. That was not the case here.

The plain language of the HHS regulation governing refunds states that "refunds of previous expense payments are reductions of the related expense." 42 C.F.R. § 413.98(a). The regulation then defines refunds as "amounts paid back or a credit allowed on account of an overcollection." *Id.* § 413.98(b)(3). The Kentucky disproportionate-share payments do not fit that definition. Those payments were not amounts paid back from an overcollection of the hospitals' provider taxes. Indeed, the disproportionate-share hospital payments have no substantive relation to the provider taxes at all.

Under Kentucky law, disproportionate-share hospital payments are intended to fund the provision of indigent care—by definition, patients who are not covered by Medicare. Section 205.640(3) provides that "an individual hospital shall receive distributions for indigent care provided by that hospital if the hospital meets the requirements of the disproportionate share program." Ky. Rev. Stat. § 205.640(3)(c); *see also* 42 U.S.C. §§ 1396a(a)(13)(A)(iv), 1396r-4(a)(1)(B). These funds come from several sources. In the years at issue in this case, for instance, federal matching funds provided 70% of the total amount of funding for Kentucky's indigent care program, or roughly $65.8 million out of $94 million. *See* Agency Record 841, 892–94. These funds are paid directly to hospitals. The remaining 30% derived from a combination of provider tax revenues and university hospital contributions, which had been commingled in the Kentucky MART fund. *Id.* at 840–41. It is thus impossible to definitively trace any portion of the

disproportionate-share payment a hospital received to the MART fund, much less to the taxes it had originally paid.

Conversely, provider taxes serve other important purposes beyond contributing to funding for Kentucky's disproportionate-share program. Ky. Rev. Stat. § 205.640(2). Indeed, while the MART fund contributed $28.2 million toward the Kentucky disproportionate-share payments in the years at issue here, that was a mere fraction of the $219 million in tax revenues and state university matching funds that comprised the MART fund. The remainder of the MART fund was used to reimburse providers treating Medicaid patients. Agency Record 823. The limited overlap between Kentucky's DSH and provider tax regimes demonstrates that the DSH payments are not designed to serve as "refunds" of any amounts paid.

Further underscoring the lack of correlation between the provider taxes and Kentucky's DSH payments, the amount of provider taxes any given hospital pays bears no relation to the annual disproportionate-share hospital payment it receives. Provider tax payments, collected monthly, are not conditioned on a hospital's receipt of disproportionate-share payments, which are paid annually in a lump sum. Ky. Rev. Stat. § 205.640(3)(e). To the contrary, while the tax assessment is a percentage of gross revenue, the disproportionate-share payments are calculated on the basis of the proportion of state-wide indigent care each hospital provided during the previous year.

Thus, for example, hospitals that served no indigent patients must nevertheless pay provider taxes amounting to 2.5% of their gross revenue.

Conversely, hospitals that served a disproportionate number of indigent patients could (at least in theory) pay *no* provider taxes, and yet would still be entitled to receive Medicaid disproportionate-share payments. And because the disproportionate-share payments are calculated on the basis of care provided, not on revenue, some hospitals' disproportionate-share payments significantly exceed their provider tax liability. For instance, the Livingston Hospital in Kentucky paid $165,890 in provider taxes in fiscal year 2009, and received a disproportionate-share distribution of $426,559. Agency Record 60. It would make little sense to suggest that the disproportionate-share payment—more than 2.5 times the amount of provider taxes the hospital paid—served as a "refund" or an amount paid back on account of an "overcollection."

2. The agency's contrary interpretation of the HHS refund regulations—which the Sixth Circuit upheld—is fundamentally inconsistent with the Medicare and Medicaid statutes, as well as its own regulations and prior determinations. *Cf. Chevron*, 467 U.S. at 844–45. It fails under both steps of *Chevron*.

Disproportionate-share hospital payments serve to compensate hospitals for providing care to indigent populations that are not eligible for Medicare or Medicaid and do not have private insurance. 42 U.S.C. §§ 1396a(a)(13)(A)(iv); 1396r-4(a)(1)(B). Medicare reimbursements, on the other hand, are intended to cover reasonable costs hospitals "actually incurred" in serving Medicare patients. 42 U.S.C. § 1395f(*l*). This rule is grounded in the principle that "the necessary costs of efficiently delivering covered services to [patients covered by

Medicare] will not be borne by individuals not so covered." 42 U.S.C. § 1395x(v)(1)(A).

The agency's conclusion that disproportionate-share hospital payments were "refunds" that offset the hospitals' Medicare costs contravenes this principle. The Board's interpretation deprives the hospitals of full reimbursement for the necessary costs of providing Medicare services, and forces non-Medicare patients and insurers—and the hospitals themselves—to cover the direct and indirect costs of providing services to Medicare patients. Those costs are burdens that Congress has determined the federal government should pay. Moreover, in offsetting Medicare costs by payments hospitals received to help fund their provision of indigent care, the ultimate effect of the government's interpretation is that hospitals that treat indigent patients (who are not covered by Medicaid or Medicare) receive less reimbursement for Medicare. That makes no sense.

The statute guarantees reimbursement of Medicare costs that hospitals "actually incur[]." 42 U.S.C. § 1395x(v). HHS agrees that taxes that hospitals pay to states attributable to Medicare patients constitute costs the hospitals "actually incur[]." It is simply not reasonable to conclude that a hospital no longer "actually incur[s]" those Medicare costs because it receives separate payments that are not triggered by the Medicare costs, that are required by a different federal law, and that are given as compensation for treating different patients.

3. The agency's interpretation also conflicts with its own regulations. *Cf. Auer v. Robbins*, 519 U.S. 452, 461 (1997). Medicare deducts "refund[s] of previous expense payments" from reimbursements, because

such amounts constitute a "reduction[] of the related expense" such that the full cost is not actually incurred. 42 C.F.R. § 413.98(a), (d)(2). HHS regulations define "refunds" as "amounts paid back or a credit allowed on account of an overcollection." *Id.* § 413.98(b)(3). The Provider Reimbursement Manual similarly defines refunds as "amounts paid back by the vendor generally in recognition of damaged shipments, overpayments, or returned purchases." Provider Reimbursement Manual § 802.31. But Kentucky disburses disproportionate-share hospital payments to hospitals in order to fund care provided to indigent patients, not to return funds on account of "overcollection" or "overpayment" of provider taxes. The disproportionate-share hospital payments were not "refunds" under a plain reading of the refund regulation.

Moreover, the agency stated in its 2010 Final Rule that Medicare should reduce reimbursements "[i]n 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*." 75 Fed. Reg. 50,363 (emphasis added). The rule further made clear that reimbursements would be evaluated according to long-standing reasonable cost principles, i.e., a case by case inquiry into whether provider taxes were actually incurred. Here, it is undisputed that the disproportionate-share hospital payments were not "specifically" to compensate the provider for tax expenses, so there was no basis for a reduction of the Medicare reimbursement.

In addition, the Board's decision is also inconsistent with the agency's treatment of the Kentucky provider tax as a permissible healthcare related tax for purposes of allocating federal

Medicaid matching funds. The Medicaid statute itself requires federal Medicaid matching funds to be offset by provider taxes that are not broad-based or that contain a hold-harmless provision—i.e., a provision that provides for state payments to the taxpayer based on taxes paid or the difference between taxes paid and the Medicaid payments received. *See* 42 U.S.C. § 1396b(w)(4). But the government has not contended that the Kentucky provider tax contains a hold-harmless provision, thus effectively acknowledging that Kentucky's disproportionate-share payments are not correlated with the provider tax as a matter of law. The Board's determination that the disproportionate-share payments serve as a refund of the taxes paid cannot be squared with the agency's acknowledgment that the provider tax contains no hold-harmless provision.

4. While other courts of appeals have upheld Board decisions to offset Medicare reimbursement for tax expenses by disproportionate-share payments received, those cases involved fundamentally different state statutory schemes. For example, in Illinois, the disproportionate-share payments were inseparable from the tax assessments; indeed, the taxes were not due until the hospitals received their disproportionate-share payments. *Abraham Lincoln*, 698 F.3d at 550. Similarly, in administering its provider tax, Massachusetts collected from each hospital only the difference between its provider tax liability and the disproportionate-share payments the hospital received. *Dana-Farber*, 878 F.3d at 341. Likewise in Missouri, there was a "strong correlation" between disproportionate-share payments and taxes assessed. *Kindred Hosps.*, 694 F.3d at 926–27. Unlike in Illinois, Massachusetts, and Missouri, the Kentucky provider tax and

disproportionate-share hospital programs are each self-contained statutory schemes; there is no relation between the two, and thus no reasonable basis to conclude that the disproportionate-share payments served as "refunds" of provider taxes paid.

B. Agency Interpretations of State Law Do Not Merit Deference

The Sixth Circuit also clearly erred in concluding that an agency interpretation of state law is entitled to deferential review.

Even assuming the validity of *Chevron* deference, such deference makes sense only "when it appears that Congress delegated authority to the agency generally to make rules carrying the force of law, and that the agency interpretation claiming deference was promulgated in the exercise of that authority." *United States v. Mead Corp.*, 533 U.S. 218, 226–27 (2001). In applying *Chevron*, the Court also considers "the degree of regulatory expertise necessary to [the] enforcement" of the provision at issue. *Babbitt v. Sweet Home Chapter of Cmtys. for a Great Or.*, 515 U.S. 687, 703–04, 708 (1995).

But as the D.C. Circuit explained in *Cellwave*, "[n]either condition obtains here." 30 F.3d at 1537. Federal agencies are not charged with enforcing or administering state law. Federal agencies similarly lack any special expertise in making authoritative pronouncements about the statutory regimes created by state legislative or regulatory bodies. That is why many courts of appeals have rightly concluded that they are owed no deference in the context of analyzing state law questions that are embedded in the interpretation of federal law. *See, e.g.*, *Singh v. Ashcroft*, 386 F.3d 1228, 1230–31 (9th Cir. 2004); *Texas v. U.S. E.P.A.*, 690 F.3d 670, 677 (5th Cir. 2012).

Just as this Court has concluded that no deference is owed to agency interpretations of criminal law, which agencies lack authority and expertise to enforce, *Gonzales v. Oregon*, 546 U.S. 243, 261–62 (2006), no deference is owed to an agency's interpretation of state law.

Moreover, the Sixth Circuit's blind deference to the agency's result-oriented interpretation implicates all of the concerns that undergird ongoing criticism of administrative deference. *See, e.g.*, *Michigan v. E.P.A.*, 135 S. Ct. 2699, 2712 (2015) (Thomas, J., concurring) (noting "serious questions about the constitutionality of our broader practice of deferring to agency interpretations of federal statutes"); *City of Arlington v. FCC*, 133 S. Ct. 1863, 1877–79 (2013) (Roberts, C.J., dissenting) (highlighting "the danger posed by the growing power of the administrative state"); *see also Gutierrez-Brizuela v. Lynch*, 834 F.3d 1142, 1149 (10th Cir. 2016) (Gorsuch, J., concurring); *Garco Constr., Inc. v. Speer*, No. 17-225, 583 U.S. __ (2018) (Mem.) (Thomas, J., and Gorsuch, J., dissenting from the denial of certiorari). This case is an ideal vehicle to consider the ongoing vitality of such wooden deference to agency decisionmaking.

* * *

The Court should grant review to decide the important question of whether the compensation for indigent care that Congress required states to provide should be deducted from the compensation for Medicare services that Congress required HHS to provide to critical access hospitals. The decision below is contrary to the text and purpose of the Medicare reimbursement statute and the federal disproportionate-share hospital payment statute; Congress intended hospitals like petitioners to receive both pots of money, not one or the other. And

the decision is undermining the provision of healthcare to the low-income working poor in one of the poorest states in the country.

CONCLUSION

The Court should grant the petition.

Respectfully submitted,

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April 9, 2018

APPENDIX

APPENDIX A

RECOMMENDED FOR FULL-TEXT PUBLICATION

Pursuant to Sixth Circuit I.O.P. 32.1(b)

File Name: 17a0194p.06

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

No. 16-6269

BRECKINRIDGE HEALTH, INC., *et al*.

Plaintiffs-Appellants,

v.

THOMAS E. PRICE, in his official capacity as Secretary of the United States Department of Health and Human Services,

Defendant-Appellee.

Appeal from the United States District Court for the Western District of Kentucky at Louisville

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No. 3:15-cv-00251—Joseph H. McKinley Jr., Chief District Judge.

Argued: April 27, 2017

Decided and Filed: August 23, 2017

Before: GUY, SILER, and DONALD, Circuit Judges.

COUNSEL

ARGUED: David M. Dirr, DRESSMAN BENZINGER LAVELLE PS, Crestview Hills, Kentucky, for Appellants. Carleen M. Zubrzycki, UNITED STATES DEPARTMENT OF JUSTICE, Washington, D.C., for Appellee. ON BRIEF: David M. Dirr, Mathew R. Klein, Richard G. Meyer, DRESSMAN BENZINGER LAVELLE PS, Crestview Hills, Kentucky, for Appellants. Carleen M. Zubrzycki, Michael S. Raab, UNITED STATES DEPARTMENT OF JUSTICE, Washington, D.C., for Appellee.

AMENDED OPINION

BERNICE BOUIE DONALD, Circuit Judge. Various Kentucky hospitals (collectively, "Appellants") sought Medicare reimbursement for certain state taxes they paid on their gross revenue. The United States Department of Health and Human Services ("HHS") offset the amount of Appellants' Medicare reimbursement by the Medicaid Disproportionate Share Hospital ("DSH") payments Appellants received, reasoning that those payments effectively refunded the taxes paid. The district court affirmed this decision. Because the net effect of the Medicaid DSH payment was to reimburse Appellants for the tax, HHS's decision was not arbitrary, capricious, or manifestly contrary to the Medicare statute. Accordingly, we AFFIRM the district court's judgment.

I.

Appellants are Critical Access Hospitals and are reimbursed by Medicare for the reasonable and necessary costs of providing services to Medicare patients.

The federal Medicaid program requires states to create a plan to provide additional payments to hospitals, like Appellants, that serve a disproportionate share of low-income patients. 42 U.S.C. § 1396a(a)(13)(A)(iv). In Kentucky, these DSH payments are matched at 70% by the federal government. Kentucky's contribution to DSH programs comes from two sources: Kentucky Provider Tax Revenue ("KP-Tax") and payments from state university hospitals. The KP-Tax is a 2.5% tax on the gross revenue of various hospitals, including Appellants. Ky. Rev. Stat. § 142.303(1). The KP-Tax revenue is deposited into the Medical Assistance Revolving Trust ("MART"), Ky. Rev. Stat. § 205.640(2), which in turn is used to fund the DSH payments, Ky. Rev. Stat. § 205.640(3)(a). The amount of DSH payments a hospital receives is unrelated to the amount of KP-Tax it paid. Also, during the years at issue, DSH payments covered only approximately 45% of the costs Appellants incurred providing care to indigent patients.

Appellants filed cost reports in 2009 and 2010 claiming their entire KP-Tax payment as a reasonable cost for reimbursement under the Medicare Act. Up until that point, they had received full reimbursement under the reasonable cost statute. However, for 2009 and 2010, the Medicare Administrative Contractor denied full reimbursement, offsetting the KP-Tax cost by the amount of Medicaid DSH payments Appellants received. The Provider Reimbursement Review Board ("PRRB") upheld the offsets, concluding that when Appellants received a Kentucky Medicaid DSH payment, they were actually receiving a refund of some or all of the KP-Tax they paid. So it concluded that the reimbursable Medicare cost "actually incurred" was the gross amount Appellants paid for the KP-Tax, minus the Medicaid DSH payments it received.

Appellants appealed this decision, but the Administrator of the Centers for Medicare and Medicaid Services issued a final decision declining to modify the PRRB's decision. Appellants then filed the instant action, asserting violations of the Administrative Procedure Act. The parties filed cross-motions for summary judgment.

The district court upheld the offset decision. Relying heavily on *Abraham Lincoln Memorial Hospital v. Sebelius*, 698 F.3d 536 (7th Cir. 2012), the district court agreed with the PRRB that the net economic impact of Appellants' receipt of the DSH payment in relation to the cost associated with the KP-Tax assessment indicated that the DSH payments served to reduce Appellants' expenses such that they constituted a refund. So, the district court concluded that the KP-Tax payment was properly offset by the DSH payment. Next, the district court rejected Appellants' argument that the PRRB's decision was inconsistent with the Final Rule of August 16, 2010, which, according to Appellants, requires a payment to be made specifically for the purpose of reimbursing a tax in order for the claimed reimbursement to be offset by the payment. The district court concluded that the Rule merely requires evidence that the DSH payment and the KP-Tax are related prior to offsetting the KP-Tax by the DSH payment. Finally, the district court rejected Appellants' argument that the offset decision deviated from longstanding practice, reasoning that an agency does not establish policy simply by not taking administrative action.[1]

[1] Appellants have not raised this argument on appeal, so we decline to consider it. *See Shirvell v. Gordon*, 602 F. App'x 601, 606 (6th Cir. 2015).

II.

Where, as here, Congress left it up to HHS to determine what constitutes a reasonable cost meriting reimbursement, we give its judgment controlling weight unless it is "arbitrary, capricious, or manifestly contrary to the statute." *Chevron U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 843–44 (1984). Our inquiry is not whether the HHS's interpretation is the best one; instead, we give substantial deference to its interpretation unless an "alternative reading is compelled by the regulation's plain language or by other indications of the Secretary's intent." *Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 512 (1994) (quoting *Gardebring v. Jenkins*, 485 U.S. 415, 430 (1988)). In the Medicare context, "broad deference is all the more warranted when, as here, the regulation concerns a complex and highly technical regulatory program, in which the identification and classification of relevant criteria necessarily require significant expertise and entail the exercise of judgment grounded in policy concerns." *Atrium Med. Ctr. v. HHS*, 766 F.3d 560, 568 (6th Cir. 2014) (quoting *Thomas Jefferson Univ.*, 512 U.S. at 512) (internal quotation marks omitted).

III.

a.

Under the Medi*caid* program, a state plan must provide that payments made to hospitals include an upward rate adjustment for hospitals that serve a disproportionate number of low-income patients that have special needs. 42 U.S.C. § 1396a(a)(13)(A)(iv); *Owensboro Health, Inc. v. HHS*, 832 F.3d 615, 618 (6th Cir. 2016). The purpose of this adjustment is to give relief to those hospitals that have few privately

insured patients to counteract the losses incurred from a large volume of uninsured patients. *Owensboro Health*, 832 F.3d at 618–19 (quoting H.R. Rep. No. 103-111, at 211 (1993)). In Kentucky, this upward adjustment, or DSH payment, is determined by regulation. 907 KAR 10:820 § 4.

Under Kentucky law, providers are also required to pay a 2.5% tax on gross revenues. Ky. Rev. Stat. § 142.303(1). The provider taxes, or KP-Tax assessment payments, are deposited into the MART fund. Ky. Rev. Stat. § 205.640(2). These "provider tax revenues and state and federal matching funds shall be used to fund the disproportionate share program." Ky. Rev. Stat. § 205.640(3)(a).

b.

A hospital may also enter into an agreement with the Secretary to render services to Medi*care* patients, in most circumstances without charge, in return for payments made by Medicare. 42 U.S.C. § 1395cc(a). To be reimbursed by Medicare, hospitals must provide adequate data, based on financial and statistical records, of the costs they incurred. 42 C.F.R. § 413.24(a). Medicare will then reimburse the hospital based on a method of apportioning the costs it will bear. 42 C.F.R. § 413.50(a). Hospitals providing services to Medicare patients are reimbursed for the reasonable costs of providing care to those beneficiaries. 42 U.S.C. § 1395x(v); 42 C.F.R. § 413.9(a). Which of the reasonable costs are "actually incurred" by a provider is determined by regulation, 42 U.S.C. § 1395x(v)(1)(A), and the Secretary has broad discretion to determine the reasonable costs that may be reimbursed, *Battle Creek Health Sys. v. Leavitt*, 498 F.3d 401, 410 (6th Cir. 2007). The regulations define reasonable costs to include direct and indirect costs of providing services.

42 C.F.R. § 413.9(b)(1). In short, the goal of this reimbursement scheme is to prevent covered individuals from bearing the costs of services, while ensuring that the Secretary does not bear the costs for non-covered patients. 42 C.F.R. § 413.9(b)(1).

Retroactive adjustments to the Medicare reimbursement amount are appropriate where the amount is deemed either inadequate or excessive. 42 U.S.C. § 1395x(v)(1)(A). To this end, the regulations provide that refunds—"amounts paid back or a credit allowed on account of an overcollection"—reduce the reimbursement amount. 42 C.F.R. § 413.98(b)(3). Refunds are "clearly reductions in costs," so must be taken into account in determining the "true cost" of services, or the "net amount actually paid for them." 42 C.F.R. § 413.98(d).

c.

The district court relied on *Abraham Lincoln* in reaching its conclusion that the offset applied here was appropriate. Though there are factual differences between *Abraham Lincoln* and this case, the Seventh Circuit's sound reasoning and the similarities to the core structure of the scheme at issue here naturally lead us to conclude that HHS's decision to uphold the offset was not arbitrary, capricious, or manifestly contrary to the legislative scheme.

In *Abraham Lincoln*, the agency found that the amount of the tax ("Tax Assessment") paid by the hospitals to the State of Illinois was a reasonable cost eligible for Medicare reimbursement, but was subject to an offset by payments the hospitals received from the state Medicaid fund. *Abraham Lincoln*, 698 F.3d at 540. The Tax Assessment was required to be deposited into a fund that also included other monies,

such as federal matching funds and "any other money received for the Fund from any other source." *Id.* at 545. Under the Illinois legislative scheme, certain hospitals were entitled to receive Medicaid "Access Payments" derived from that fund. *Id.* A hospital's Tax Assessment was contingent upon its receipt of Access Payments and approval from the Center for Medicare and Medicaid Services ("CMS") of the Access Payments and the Tax Assessment. *Id.* at 545–46.

In affirming the agency's judgment, the Seventh Circuit first rejected the hospitals' argument that the offset decision was a misapplication of the regulatory definition of "refund." *Id.* at 548. Under a plain reading of the state legislation—including provisions that (1) the Tax Assessment was not due until the hospitals received access payments, and (2) the Access Payments were not due until the Tax Assessment took effect—the court concluded that the Access Payments clearly served to reduce expenses like the Tax Assessment. *Id.* at 549. This conclusion found further support in the facts that hospitals may only be reimbursed for their net costs, and that the Access Payments were made from the fund in which the Tax Assessment was deposited. *Id.*

Next, the Seventh Circuit rejected the argument that the agency incorrectly decided that the hospitals did not "actually incur" the cost of the Tax Assessment. *Id.* at 551. It reasoned that, under the regulations' net cost approach, it was appropriate to look to the link between the Tax Assessment and the Access Payments to determine the economic impact of receiving the payment on the tax costs. *Id.* at 551–52. Because, in determining reasonable costs, we must look to the totality of the circumstances, the court rejected the hospitals' argument that the costs of the Tax

Assessment were actually incurred because they were billed for those costs and paid them. *Id.* at 552. This argument ignored the regulations' requirement that reimbursable costs be reduced by amounts that defray costs and ignored the real net economic impact of the Access Payments. *Id.*; *see also* 42 C.F.R. § 413.98(d) (noting that refunds are "clearly reductions in costs," so must be taken into account in determining the "true cost" of services, or the "net amount actually paid for them.")

The fundamental elements of the Illinois and Kentucky schemes are the same: under both systems, a tax is paid into a fund, that tax is commingled with other sources, and Medicaid payments derived from that fund are made to hospitals. Appellants are correct that there are differences between the instant case and *Abraham Lincoln*. But these distinctions do not compel a contrary result. For instance, Appellants point to the fact that, unlike in Kentucky, in Illinois hospitals do not pay the Tax Assessment until after they received the Access Payments and receive a refund if the Access Payment is not made. According to the Seventh Circuit, this indicated a legislative intent that Access Payments would reduce the Tax Assessment expenses. *Abraham Lincoln*, 698 F.3d at 549. Nonetheless, there is a similar indication of congressional intent here: Kentucky law states that "provider tax revenues and state and federal matching funds *shall be used to fund* the disproportionate share program." Ky. Rev. Stat. § 205.640(3)(a) (emphasis added). It seems plausible then, that when a provider receives a payment from that fund, the payment serves at least as a partial refund of the tax. As Appellants repeatedly insist, we should look to totality of the circumstances, so we are not limited by the lack of precise similarity between the two systems.

Therefore, that the congressional intent in Kentucky was expressed differently than that in Illinois does not undermine our reliance on *Abraham Lincoln*.

Appellants highlight other distinctions, like the fact that under the Illinois scheme, the tax and payments are subject to agency approval and hospitals do not have to incur additional costs by treating non-Medicaid patients. However, these differences do not make the net economic effect of the Appellants' DSH payments out of a fund consisting of their KP-tax payment any less of a refund.[2] Importantly, our goal is not to find the *best* way to interpret the statute, but rather simply to determine whether a contrary result is *compelled* by the law or congressional intent. *See Thomas Jefferson Univ.*, 512 U.S. at 512. We do not find so here. Under the guidance provided in *Abraham Lincoln*, HHS's offset decision was not arbitrary, capricious, or manifestly contrary to the Medicare statute.

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[2] We are sympathetic to the fact that Appellants have incurred costs of providing indigent care that have not fully been reimbursed. However, we cannot accept their argument that because they still bear 55% of the costs of providing indigent care, they must receive the full reimbursement for their KP-tax assessments. This would require us to determine the net economic effect of DSH payment on *all* of the costs incurred, not simply on the KP-tax cost incurred. Under this logic, hospitals would have to be reimbursed fully for every cost they paid up until the point that they are fully compensated for indigent care. This would render null the refund provisions in all cases where a hospital is not completely compensated for this care; there is no indication that Congress intended this effect. We, therefore, resolve only the narrow question of whether the net economic effect of the DSH payment was to reimburse Appellants for the amount they paid in KP-Taxes, not the amount paid for uncompensated care generally.

Appellants rely on *Loyola University of Chicago v. Bowen*, 905 F.2d 1061 (7th Cir. 1990), in support of their claim that HHS cannot shift costs to non-Medicare patients. This reliance is misplaced. First, aside from the existence of an offset issue, *Loyola* does not involve a factual scenario remotely similar to the one here. There, the University sought Medicare reimbursement under provisions allowing it to be reimbursed for the reasonable costs of medical services, including the cost of certain medical educational activities. *Id.* at 1064. The designated intermediary, however, reduced the University's reimbursement by fifty percent of the costs of residents and interns working in the University's outpatient clinic. *Id.* The Seventh Circuit concluded that this decision was erroneous. *Id.* at 1073. Unlike Appellants suggest, however, in *Loyola*, HHS did not impermissibly try to shift the costs of training residents and interns onto non-Medicare patients. Rather, HHS contended that the University attempted to do this, but the court disagreed, concluding that the University sought reimbursement only for patient care activities involving Medicare beneficiaries. *Id.* To the extent Appellants argue that allowing Medicaid DSH payments to refund the KP-Tax violates 42 U.S.C. § 1395x(v)(1)(A), by requiring individuals not covered by Medicare to bear costs of services provided by covered individuals, Appellants provide no explanation as to how this scheme requires non-Medicare patients to bear those costs.

In sum, Appellants incurred a reimbursable Medicare cost when they paid taxes on their gross revenue. However, they also received a Medicaid DSH payment to cover some of the costs of providing care to a disproportionate number of low-income patients. Because the DSH payments Appellants received

derived from the fund into which Appellants' KP-tax expenditures were placed, the net effect of the DSH payment is to reduce, at least in part, the costs Appellants incurred in paying the KP-tax. Therefore, it constituted a refund notwithstanding the fact that it was not labelled as such. *See Kindred Hospitals East, LLC v. Sebelius*, 694 F.3d 924, 928 (8th Cir. 2012) ("Because there was a true reduction in [the plaintiff's] costs incurred because of the pool, the payments it received from the pool looked like refunds, acted like refunds, and were appropriately treated as such, regardless of the label.")

d.

Lastly, although Appellants insist that "[t]he Final Rule does not set out a blackletter rule that disbursements to providers *must* offset taxes associated with the disbursements," Appellant Br. 13 (emphasis added), the Rule makes clear that, in determining the net amount of taxes incurred by a provider, the tax reimbursed should be reduced by the amount received *associated with* that tax. The Rule provides, in relevant part:

> 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 similarly recognize only the net expense incurred by the provider. Thus, while a tax may be an allowable Medicare cost in that it is related to beneficiary care, the provider may only treat as a reasonable cost the net tax expense; that is, the tax paid by the provider, reduced by payments the provider received that are associated with the assessed tax.

75 Fed. Reg. 50,363 (August 16, 2010). Appellants cling to the word "specifically" in the first sentence, maintaining that payments that are associated with the tax must be made specifically for the purpose of making the provider whole for the taxes paid in order for an offset to be appropriate. However, the subsequent sentence undermines that contention and clarifies that for a tax to be reduced by a separate payment, the payment need only be "associated with the tax." Appellants set forth no meaningful argument that the DSH payments, derived from a fund consisting of the KP-Tax, is not "associated with" that tax.

IV.

For the aforementioned reasons, we AFFIRM.

APPENDIX B

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF KENTUCKY
LOUISVILLE DIVISION

[Filed 06/15/16]

Civil Action No. 3:15CV-00251-JHM

BRECKINRIDGE HEALTH, INC., *et al*.

Plaintiffs

v.

SYLVIA MATHEWS BURWELL, SECRERTARY
OF HEALTH AND HUMAN SERVICES

Defendant

MEMORANDUM OPINION AND ORDER

This matter is before the Court on cross-motions for summary judgment by the parties [DN 28, DN 31]. Plaintiffs, Breckinridge Health, Inc. d/b/a Breckinridge Memorial Hospital ("Breckinridge"), New Horizons Health Systems, Inc. d/b/a New Horizons Medical Center ("New Horizons"), Livingston Hospital and Healthcare Services, Inc. ("Livingston"), Bowling Green-Warren County Community Hospital Corporation d/b/a The Medical Center at Scottsville ("Scottsville"), The Medical Center at Franklin, Inc. ("Franklin"), Appalachian Regional Healthcare, Inc. d/b/a McDowell ARH Hospital ("McDowell"), Appalachian Regional Healthcare, Inc. d/b/a Morgan County ARH Hospital ("Morgan County"), and Carroll County Memorial Hospital Corporation ("Carroll County"), bring this action pursuant to Title XVIII of the Social Security Act, 42 U.S.C.

§ 1395, *et seq.*, seeking judicial review of a final Medicare reimbursement decision by the Secretary of the Department of Health and Human Services ("HHS" or "the Secretary"). The Secretary determined that the Medicare reimbursement for Plaintiffs' provider tax expenses should be offset by the amount of the Medicaid Disproportionate Share Hospital ("DSH") payments the Hospitals received from the Commonwealth of Kentucky in Fiscal Years 2009 and 2010. Fully briefed, these matters are ripe for decision.

I. BACKGROUND

Medicare, Title XVIII of the Social Security Act, is a federally funded health insurance program for the elderly and disabled. 42 U.S.C. §§ 1395—1395cc. Medicaid, Title XIX of the Social Security Act, "is a federal grant program—unavailable to Medicare recipients—that requires each state to create federal-state partnerships to provide certain medical services to individuals 'whose income and resources are insufficient to meet the costs of necessary medical services.'" *Jackson Purchase Medical Center v. United States Dept. of Health and Human Services*, 122 F. Supp.3d 668, 669 (E.D. Ky. 2015)(quoting 42 U.S.C. § 13961).

A. Medicare Provisions

Part A of the Medicare statute provides health insurance for inpatient hospital medical services. 42 U.S.C. §§ 1395c, 1395d. "Under Part A, a participating hospital enters into an agreement with the Secretary whereby the hospital promises to render services to Medicare beneficiaries. § 1395cc. The hospital does not charge the Medicare beneficiaries for the services (except for certain deductible and coinsurance amounts), but instead, the federal government directly reimburses the hospital for the services rendered. § 1395cc(a)(1)."

University of Kansas Hospital Authority v. Sebelius, 953 F. Supp. 2d 180, 182 (D.D.C. 2013).

"[A] hospital is not reimbursed at the time of service, but rather, the hospital must file an annual report showing the costs it incurred during the fiscal year and the portion of those costs allocated to Medicare. 42 C.F.R. §§ 413.24, 413.50." *University of Kansas Hospital Authority*, 953 F. Supp. 2d at 182. "The report is filed with a fiscal intermediary ('FI')[or Medicare Administrative Contractors], which is typically a private insurance company acting under contract with the Secretary. 42 U.S.C. § 1395ww(d)(5), 42 C.F.R. § 413.20(b). After auditing the hospital's report, the FI determines the amount of reimbursement owed to the hospital by Medicare through the issuance of a Notice of Program Reimbursement ('NPR'). 42 C.F.R. § 405.1803(a)." *Id.* "If the hospital is dissatisfied with the FI's award, it has 180 days to appeal to the Provider Reimbursement Review Board (the "PRRB"), which issues a decision that the Secretary may reverse, affirm, or modify within sixty days. 42 U.S.C. § 1395oo(f)(1). If the hospital remains dissatisfied after either the PRRB or the Secretary issues a final decision, it may seek judicial review by filing suit in the appropriate federal district court." *Id.*

Generally, hospitals are not reimbursed for the actual cost of treating Medicare beneficiaries. Instead, Medicare reimburses most hospitals through a prospective payment system based on pre-set rates based on a patient's diagnosis at discharge. 42 U.S.C. § 1395ww(d). However, the Plaintiffs in this action are all Kentucky hospitals that are designated as Critical Access Hospitals. The Medicare Rural Hospital Flexibility Program permits states to designate an acute care hospital as a Critical Access Hospital if it meets certain criteria –

most importantly that the hospital be located in a rural area and have no more than 25 acute care beds. *See* 42 U.S.C. § 1395i-4. Critical Access Hospitals are not reimbursed on a pre-set basis, rather they are reimbursed for their reasonable and necessary costs for providing inpatient hospital services to Medicare patients. 42 U.S.C. § 1395x(v). The Medicare regulations require that those costs be offset for amounts such as discounts, allowances, and refunds that defray part of the claimed cost to which they relate. 42 C.F.R. § 413.98.

B. Medicaid

"Medicaid is a state-specific program where, pursuant to a federally approved 'state Medicaid plan,' the federal government provides matching payments for medical assistance to eligible, low-income individuals." *Jackson Purchase Medical Center*, 2015 WL 4875112, *2. The "state Medicaid plan" specifies the qualifications for eligibility and establishes the nature and scope of the medical care and services covered pursuant to the state plan. 42 C.F.R. § 430.10. "Accordingly, Medicaid programs vary from state to state, both with respect to persons and services covered, and to the scope and duration of benefits." *Verdant Health Commission v. Burwell*, 127 F. Supp.2d 1116, 1118 (W.D. Wash. Sept. 1, 2015). Once a state's Medicaid plan is approved, the Secretary "is authorized to pay the state matching funds for Medicaid expenditures," commonly referred to as Federal Financial Participation. *Waterbury Hospital Center v. Sebelius*, 2012 WL 4512506, *2 (D. Conn. Sept. 29, 2012); 42 U.S.C. §§ 1396a, 1396b(a)(1), 1396d(b).

C. Medicaid DSH, Kentucky's Medicaid Plan, and KP-Tax

The federal Medicaid program requires states to create a plan to provide additional payments to hospitals that serve a disproportionate share of low-income patients. 42 U.S.C. § 1396(a)(13)(A); 1396r-4(a)(1). These payments are referred to as Medicaid Disproportionate Share Hospital ("DSH") payments. "A state is given considerable discretion in determining how to calculate Medicaid DSH adjustments under its plan." *Waterbury Hospital Center*, 2012 WL 4512506, *2. The Kentucky Medicaid Plan established the requirements for statewide Medicaid eligibility.

The parties agree that Kentucky calculates its Medicaid DSH payments on the amount of uncompensated services that the hospitals provide to low-income patients who are not eligible for Medicaid, Medicare, or private insurance. The federal government provides matching funds for a state DSH program once the state contributes its portion. During the fiscal years in question, Kentucky's financial contribution to its Medicaid DSH program came from two sources: $27 million from the Kentucky Provider Tax Revenue ("KP-Tax" or "provider tax") and approximately $36 million from state university hospitals. (AR at 825.)

To obtain the KP-Tax revenue, Kentucky imposes a 2.5% tax on the gross revenues of hospitals, including the Plaintiff Hospitals here. Kentucky deposits 100% of the revenue from the KP-Tax into the Medical Assistance Revolving Trust ("MART") fund. Approximately 15% of the MART funds are used to partially fund the payments to hospitals that serve a disproportionate share of uninsured, low income patients who do not qualify for Medicare or Medicaid. (AR at 825.) In Kentucky, the amount of Kentucky's contribution to

the Medicaid DSH program is matched at 70 percent by the federal government. (AR at 827.) The Medicaid DSH payments cover approximately 45% of the cost of providing care to these low-income patients during previous fiscal years.

D. Administrative Proceedings

As noted earlier, under the Medicare Act, Critical Access Hospitals are reimbursed for their reasonable and necessary costs for providing inpatient hospital services to Medicare patients. 42 U.S.C. § 1395x(v). The Medicare Act defines "reasonable costs" of services as "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." 42 U.S.C.A. § 1395x(v)(1)(A). The Medicare regulations clarify how to determine the "cost actually incurred" requiring that costs be offset for amounts such as discounts, allowances, and refunds that defray part of the claimed cost to which they relate. 42 C.F.R. § 413.98.[1] Pursuant to the Secretary's regulations, "refunds of previous expense payments are to be treated as reductions of related expense." *Abraham Lincoln Memorial Hosp. v. Sebelius*, 698 F.3d 536, 551 (7th Cir. 2012)(citing 42 C.F.R. § 413.98(a); Manual § 800 (Rev. 450)). "Accordingly, the regulations and related Manual provisions employ a net cost approach for determining the amount of reimbursable expenses and provide that refunds are reductions, or offsets, of a related expense." *Id.* "In determining allowable costs, the Secretary should not look at costs in a vacuum,

[1] Specifically, 42 C.F.R. § 413.98(d) provides that "[a]s 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." 42 C.F.R. § 413.98(d)(2).

but must look at the totality of the circumstances." *Abraham Lincoln*, 698 F.3d at 552 (citing 42 C.F.R. §§ 413.5(c), 413.98).

Plaintiffs filed cost reports for fiscal years 2009 and 2010 claiming their entire KP-Tax payment as a "reasonable cost" for which they sought reimbursement under the Medicare Act. From 1994 to 2009, the Plaintiffs received full reimbursement for this cost under the Medicare reasonable cost statute. 42 U.S.C. § 1395x(v). However, in audits of the Plaintiffs' cost reports for fiscal years 2009 and 2010, the Medicare Administrative Contractor (MAC) denied full reimbursement and, instead, offset the Plaintiffs' provider tax cost by the amount of Medicaid DSH payments the Plaintiffs had received from the Commonwealth of Kentucky in each of the two fiscal years. (AR at 14.)

Plaintiffs challenged the MAC's offsets for Fiscal Years 2009 and 2010 by appealing to the Provider Reimbursement Review Board ("PRRB"). Plaintiffs maintained that the MAC's failure to allow full reimbursement for the KP-Tax expenses disregarded the express language of the Medicare reasonable cost statute and regulations. The PRRB consolidated Plaintiffs' appeals and held a consolidated hearing on the record on April 2, 2014. By decision dated February 10, 2015, the PRRB upheld the auditor's reductions or offsets of Plaintiffs' provider tax expenses. The PRRB found that the KP-Tax and the Medicaid DSH payment are related noting that the source of the Medicaid DSH payment is the KP-Tax. (AR 11-12.) The PRRB held that when the hospitals received a Kentucky Medicaid DSH payment, they were actually receiving a refund of some or all of the money paid as KP-Tax. Accordingly, the PRRB determined the "cost actually incurred" is the gross KP-Tax assessment paid by the hospital

less the Medicaid DSH payment received by the hospital for the same fiscal year. (AR 16.)

Plaintiffs appealed the PRRB's decision to the Administrator of the Centers for Medicare & Medicaid Services who issued a final decision on March 27, 2015. (AR 7.) The CMS Administrator declined to reverse or modify the PRRB decision. The Administrator's decision constitutes the final administrative decision of the Secretary. As a result of this decision, Plaintiffs filed this action asserting violations of the Administrative Procedure Act. The parties have filed cross-motions for summary judgment.

II. STANDARD OF REVIEW

The Supreme Court has established a two-step process for reviewing an agency's interpretation of a statute that it administers. *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc*., 467 U.S. 837 (1984). "'First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress.'" *Clark Regional Medical Ctr. v. United States Dept. of Health and Human Servs*., 314 F.3d 241, 244–45 (6th Cir. 2002)(quoting *Jewish Hosp., Inc. v. Secretary of Health and Human Servs*., 19 F.3d 270, 273 (6th Cir. 1994) (emphasis in original)). The Supreme Court has explained that "[t]he judiciary is the final authority on issues of statutory construction and must reject administrative constructions which are contrary to clear congressional intent." *Clark Regional Medical. Ctr.*, 314 F.3d at 245 (quoting *Chevron*, 467 U.S. at 843 n. 9).

Second, if the Court determines that Congress has not directly addressed the precise question at issue, that is, that the statute is silent or ambiguous on the specific issue, the Court must determine "'whether the agency's answer is based on a permissible construction of the statute.'" *Clark Regional Medical Ctr.*, 314 F.3d at 245 (quoting *Jewish Hosp.*, 19 F.3d at 273). "In assessing whether the agency's construction is permissible, [the Court] 'need not conclude that the agency construction was the only one it permissibly could have adopted to uphold the construction, or even the reading [the Court] would have reached if the question initially had arisen in a judicial proceeding." *Id.* at 245. "In fact, the agency's construction is entitled to deference unless 'arbitrary, capricious, or manifestly contrary to the statute.'" *Id.* (quoting *Chevron*, 467 U.S. at 844).

"Pursuant to 42 U.S.C. § 1395oo(f)(1), a decision by the [CMS] is subject to review under the [APA], 5 U.S.C. § 706(2)(A)." *Battle Creek Health System v. Leavitt*, 498 F.3d 401, 409 (6th Cir. 2007)(quoting *Clark Regional Med. Ctr.*, 314 F.3d at 245). Under the APA, the Court reviews an agency decision to see whether it is "arbitrary, capricious, an abuse of discretion, or otherwise not in accord with law." *Id.* (quoting *Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 512 (1994)). "Under the APA, an agency's interpretation of a regulation must be given controlling weight unless it is 'plainly erroneous or inconsistent with the regulation.'" *Id.*

III. DISCUSSION

A. Review of Secretary's Interpretation of Medicare Statutory Language

The question before the Court is whether the agency's decision to offset the KP-Tax cost by the amount of Medicaid DSH payments received is arbitrary, capricious, contrary to law, or unsupported by substantial evidence.

Here, the record reflects that all of the KP-Tax assessments paid by the Plaintiffs were placed into the MART Fund. The MART Fund then utilized a portion of those funds to pay Medicaid DSH payments to the Plaintiffs. The PRRB looked at the net economic impact of the Plaintiffs' receipt of the Medicaid DSH payments in relation to the cost associated with the KP-Tax assessment. In so doing, the PRRB assessed whether the Medicaid DSH payments served to reduce a related expense, such that they constituted a refund of the KP-Tax assessments, and concluded that the Medicaid DSH payments were indeed intended to reduce the cost of the KP Tax assessment. Specifically, the PRRB found

> that when [Plaintiffs] 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 [Plaintiffs] during the fiscal years at issue is not the "cost actually incurred" but rather that [Plaintiffs'] gross KP-Tax assessment for a fiscal year

> must be offset by the Medicaid DSH payment received for the same fiscal year.

(AR at 16.) The Court finds that the decision of the PRRB and its adoption by the Secretary is supported by substantial evidence.

The Seventh Circuit in *Abraham Lincoln Memorial Hospital v. Sebelius* supports this conclusion. 698 F.3d 536 (7th Cir. 2012). In *Abraham Lincoln*, the Illinois Department of Public Aid collected tax assessments and deposited the assessments in a Hospital Provider Fund. Like the MART Fund, the Hospital Provider Fund in Illinois was comprised of the tax assessments and other funds. The hospitals that paid money into the Hospital Provider Fund received payments back from the fund as additional Medicaid payments, referred to as access payments. *See Dana Farber Cancer Institute Boston, Massachusetts v. Bluecross Blueshield Association*, 2014 WL 11127854, *11 (PRRB May 28, 2014)(overview of *Abraham Lincoln).* The Seventh Circuit found that the MAC's decision to treat the access payments as refunds and offset these payments against the tax assessments was in keeping with the statutes and regulations. *Id.* The Seventh Circuit determined 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." *Id.* The Seventh Circuit "emphasized that the key to determining the costs that the provider actually incurred was the 'real net economic impact' of the payments." *Id.* "Because the real net economic impact of the access payments that the provider received was to reduce the full cost of the tax assessments that the provider paid, the Seventh Circuit affirmed the . . . Administrator's

decision that required tax payments to be offset by payments received from the funds into which the taxes were paid." *Id.* The Seventh Circuit's decision in *Abraham Lincoln* is consistent with the Secretary's decision in the present case.

Plaintiffs attempt to distinguish *Abraham Lincoln* and other cases cited by the Secretary claiming that unlike these cases, the Medicaid DSH program as set up in Kentucky was specifically designed to achieve the result of the partial compensation of indigent care, not the partial or full reimbursement of provider tax assessments. Plaintiffs argue that it is plainly erroneous to conclude that the provider tax paid by Plaintiffs was not "actually incurred" in full for purposes of 42 U.S.C. § 1395x(v), when the DSH payments at issue did not even fully reimburse the costs of services that Plaintiffs were required by KRS § 205.640 to provide in order to qualify in the first place for receipt of the DSH payments. (AR at 866-869.) Plaintiffs argue that their Medicaid DSH payments did not lessen the KP-Tax liability incurred by them, rather they served to reduce the cost of furnishing care to the low-income uninsured patients. Accordingly, Plaintiffs maintain that the KP-Taxes and the Medicare DSH distributions are not related or linked, and *Abraham Lincoln* is not applicable.

Despite some differences between the programs in Illinois and Kentucky, both the District Court and the Seventh Circuit in *Abraham Lincoln* addressed and rejected the same arguments raised by Plaintiffs in the present case. For example, in *Abraham Lincoln*, the hospitals argued that the Medicaid payments were not related or linked to the tax expenditures, but rather were solely designed by the State and approved by

CMS to enable hospital services for Medicaid beneficiaries. Specifically, the hospitals argued that they "paid tax assessments to the State of Illinois but the Medicaid payments to the Hospitals were not made to avoid or reduce the tax expenses, but rather, to reimburse the Hospitals for hospital services to Medicaid beneficiaries." *Abraham Lincoln Memorial Hospital v. Sebelius*, 3:10CV-03122, Plaintiffs' Combined Memorandum in Opposition to Defendant's Motion for Summary Judgment, DN 19 at 7-8 (C.D. Ill. January 28, 2011). In rejecting this argument, the Seventh Circuit concluded that the Medicaid payments were related or linked to the provider tax assessments finding significant the fact that the Medicaid payments were disbursed out of the same fund into which the tax assessments were paid. Ultimately, the Seventh Circuit concluded that under the Medicare Act, the Secretary's construction of the term costs "actually incurred" was based upon a reasonable interpretation of the statutory term and affirmed the Secretary's conclusion that provider taxes may be included as allowable costs on Medicare costs reports, but these costs must be offset by Medicaid payments funded by the provider taxes.

After a review of the statutory and regulatory language and the relevant case law, the Court similarly finds that the Secretary's construction of the term "cost actually incurred" is based on a reasonable interpretation of the statutory term. The Court finds that the Secretary's decision to offset the KP-Tax reimbursement by the Medicaid DSH payments received from the MART Fund was not arbitrary, capricious, contrary to law, or unsupported by substantial evidence.

B. Prior Interpretation

Plaintiffs maintain that the Secretary's current interpretation of Medicare's reasonable cost statute conflicts with the Secretary's prior interpretation of the reasonable cost statute as expressed in the Final Rule of August 16, 2010. (AR at 902-904.) Plaintiffs represent that the

Final Rule construed the "actually incurred" provision of the cost statute to justify an offset to the provider tax cost allowance only in limited circumstances, i.e. when a related receipt of funds was made specifically to make the provider whole or part whole for the tax expenses. Plaintiffs contend that that the Final Rule interpretation is in direct conflict with the current interpretation that any payment to a provider, if in some manner related to the tax, justifies a reduction in the tax expenditure allowance.

The Court rejects Plaintiffs' argument. An examination of the Final Rule as a whole reflects that it is not inconsistent with the Secretary's current interpretation of Medicare's reasonable cost statute. In addition to the language relied upon by Plaintiffs, the Final Rule also provides in part that

> in accordance with the Medicaid statute and regulations, some States levy tax assessments on hospitals. The assessed taxes may be paid by the hospitals into a fund that includes all taxes paid, all Federal matching monies and any penalties for nonpayment. The State is then authorized to disburse monies from the fund to the hospitals. We believe that these types of subsequent disbursements to providers are associated with the assessed taxes and may, in fact, offset

> some, if not all, of the taxes originally paid by the hospitals.

(AR 568). The Final Rule requires evidence that the Medicaid DSH payment and the provider tax are related in some manner prior to offsetting the Medicaid DSH payment from the provider tax under the Medicare Act. This is consistent with the Secretary's decision in the present case.

C. Long-Standing Practice

From 1994 to 2009, the Secretary did not offset Kentucky's provider tax payments with indigent care payments. Plaintiffs contend that there is no reason to accord deference to the Secretary's decision because the Secretary's "current view is a change from prior [longstanding] practice." *Decker v. Northwest Environmental Defense Center*, 133 S.Ct. 1326, 1337 (2013).

The Seventh Circuit in *Abraham Lincoln* rejected this argument finding that the Secretary's decision was not inconsistent with a prior policy statement. *Abraham Lincoln*, 698 F.3d at 557. As noted by the Seventh Circuit, a "federal agency does not establish policy by not taking administrative action." *Id.* (citing *Cooper Indus., Inc. v. Aviall Services, Inc.*, 543 U.S. 157, 170 (2004) ("Questions which merely lurk in the record, neither brought to the attention of the court nor ruled upon, are not to be considered as having been so decided as to constitute precedents."). The Court adopts the reasoning of the Seventh Circuit and finds that the Secretary's decision in the present case is not inconsistent with prior policies.

IV. CONCLUSION

For the reasons set forth above, IT IS HEREBY ORDERED that the motion for summary judgment by Plaintiffs [DN 28] is DENIED and the motion for summary judgment by Defendant, Sylvia Mathew Burwell, Secretary of Health and Human Services, [DN 31] is GRANTED. A Judgment shall be entered consistent with this Opinion.

[SEAL] /s/ Joseph H. McKinley, Jr.
Joseph H. McKinley, Jr., Chief Judge
United States District Judge

cc: counsel of record

APPENDIX C

CENTER FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C3-01-20
Baltimore, Maryland 21244-1850
Telephone 410-786-3176 Facsimile 410-786-0043

Office of the Attorney Advisor

MAR 27 2015

VIA FACSIMILE AND
FIRST CLASS MAIL

Mr. Mathew R. Klein, Jr.
Dressman Benzinger LaVelle psc
Thomas More Park
207 Thomas More Parkway
Crestview Hills, KY 41017-2596

Re: Breckinridge Health, Inc., PRRB Decision No. 2015-D4

Dear Mr. Klein:

This is to advise that the Administrator of the Centers for Medicare & Medicaid Services (CMS) has declined to review the decision entered by the Provider Reimbursement Review Board in the captioned case.

If the Provider wishes to obtain judicial review of the matter, civil action must be initiated within 60 days of the date the Board's decision was received in accordance with 42 CFR 405.1877.

Sincerely yours,
/s/ Jacqueline R. Vaughn
Jacqueline R. Vaughn
Attorney Advisor

Enclosure
cc: Brendan G. Stuhan, Esquire, Intermediary's Representative

CENTER FOR MEDICARE & MEDICAID SERVICES

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Office of the Attorney Advisor

Re: Breckinridge Health, Inc., PRRB Dec. No. 2015-D4 (02/10/15) (FYEs 20092010)

I recommend that the Administrator, Centers for Medicare & Medicaid Services, decline to review the decision entered by the Provider Reimbursement Review Board in this case.

/s/ Jacqueline R. Vaughn
Jacqueline R. Vaughn
Attorney Advisor

APPROVED:

Date: 3/24/15

/s/ Patrick H. Conway
Patrick H. Conway, M.D., MSc
Acting Principal Deputy Administrator
Centers for Medicare & Medicaid Services

APPENDIX D

PROVIDER REIMBURSEMENT
REVIEW BOARD DECISION
ON THE RECORD
2015-D4

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

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

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.

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[1] *See* Stipulations at ¶ 25 (Dec. 17, 2013) ("Stipulations) (copy attached to Medicare Contractor Supplemental Position Paper at Exhibit 1-15).

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

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[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.

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."

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

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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.

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

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[7] *See* Medicare contractor Exhibits 1-2, 1-3, 1-4,1-5 at 1,1-6,1-7 at 1,1-8 at 1-3.

[8] 42 C.F.R. §§405.1835 – 405.1841.

[9] Medicare contractor Exhibit I-15; Stipulations at ¶¶ 1-26.

obligated to pay under Kentucky law. Breckinridge maintains that the provider tax payment is, by statute and in fact, 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

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[10] Provider's Final Response Position Paper at 3.

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

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[11] *See* 42 U.S.C. § 1395f(1).

[12] 42 U.S.C. § 1395x(v)(1)(A) (emphasis added).

[13] (Emphasis added.)

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:

> (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 . . . .
>
> (b) *Definitions*— . . . . (3) *Refunds.* Refunds are amounts paid back or a credit allowed on account of an over collection.
>
> (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

[14] 75 Fed. Reg. 50042, 50363 (Aug. 16, 2010).

[15] *Id.* (emphasis added). *See also* Provider's Final Position Paper at 11-12.

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 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

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[16] *See* Provider's Final Position Paper at 15.

[17] *See id.* at 16.

[18] *See id.* at 17.

[19] *Id.* at 20.

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

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[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").

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 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

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[25] *See* 75 Fed. Reg. at 50363-50364.

[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 1-17); Provider Exhibit P-12 at 43 (Dep. of the Vice Pres. of Finance, Ky. Hosp. Ass'n).

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-

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[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.

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:

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

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[32] *See* Providers' Final Position Paper at 18.

[33] *See* 698 F.3d at 550-551.

[34] *See id.* at 549.

[35] *See id.* at 550.

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:

Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, C.P.A.

FOR THE BOARD:

/s/ Michael W. Harty
Michael W. Harty Chairman
DATE: FEB 10 2015

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

Case No.: 11-0497GC

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

APPENDIX E

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

[Filed 11/08/2017]

No. 16-6269

BRECKINRIDGE HEALTH, INC., *et al*.,

Plaintiffs-Appellants,

v.

THOMAS E. PRICE, in his official capacity as Secretary of the United States Department of Health and Human Services,

Defendant-Appellee.

ORDER

BEFORE: GUY, SILER, and DONALD, Circuit Judges.

The court received a petition for rehearing en banc. The original panel has reviewed the petition for rehearing and concludes that the issues raised in the petition were fully considered upon the original submission and decision of the case. The petition then was circulated to the full court. No judge has requested a vote on the suggestion for rehearing en banc.

Therefore, the petition is denied.

ENTERED BY ORDER OF THE COURT

/s/ Deborah S. Hunt
Deborah S. Hunt, Clerk

APPENDIX F

UNITED STATES CODE

Title 42 - The Public Health and Welfare
Chapter 7 - Social Security
Subchapter XVIII - Health Insurance for Aged and Disabled
Part A - Hospital Insurance Benefits for Aged and Disabled

42 U.S.C. § 1395f(*l*) Payment for inpatient critical access hospital services.

(1) Except as provided in the subsequent paragraphs of this subsection, the amount of payment under this part for inpatient critical access hospital services is equal to 101 percent of the reasonable costs of the critical access hospital in providing such services.

(2) In the case of a distinct part psychiatric or rehabilitation unit of a critical access hospital described in section 1395i-4(c)(2)(E) of this title, the amount of payment for inpatient critical access hospital services of such unit shall be equal to the amount of the payment that would otherwise be made if such services were inpatient hospital services of a distinct part psychiatric or rehabilitation unit, respectively, described in the matter following clause (v) 3 of section 1395ww(d)(l)(B) of this title.

(3)(A) The following rules shall apply in determining payment and reasonable costs under paragraph (1) for costs described in subparagraph (C) for a critical access hospital that would be a meaningful EHR user (as would be determined under paragraph (3) of section 1395ww(n) of this title) for an EHR reporting period for a cost reporting period beginning during a

payment year if such critical access hospital was treated as an eligible hospital under such section:

(i) The Secretary shall compute reasonable costs by expensing such costs in a single payment year and not depreciating such costs over a period of years (and shall include as costs with respect to cost reporting periods beginning during a payment year costs from previous cost reporting periods to the extent they have not been fully depreciated as of the period involved).

(ii) There shall be substituted for the Medicare share that would otherwise be applied under paragraph (1) a percent (not to exceed 100 percent) equal to the sum of–

(I) the Medicare share (as would be specified under paragraph (2)(D) of section 1395ww(n) of this title) for such critical access hospital if such critical access hospital was treated as an eligible hospital under such section; and

(II) 20 percentage points.

(B) The payment under this paragraph with respect to a critical access hospital shall be paid through a prompt interim payment (subject to reconciliation) after submission and review of such information (as specified by the Secretary) necessary to make such payment, including information necessary to apply this paragraph. In no case may payment under this paragraph be made with respect to a cost reporting period beginning during a payment year after 2015 and in no case may a critical access hospital receive payment under this paragraph with respect to more than 4 consecutive payment years.

(C) The costs described in this subparagraph are costs for the purchase of certified EHR technology to which purchase depreciation (excluding interest) would apply if payment was made under paragraph (1) and not under this paragraph.

(D) For purposes of this paragraph, paragraph (4), and paragraph (5), the terms "certified EHR technology", "eligible hospital", "EHR reporting period", and "payment year" have the meanings given such terms in sections 1395ww(n) of this title.

(4)(A) Subject to subparagraph (C), for cost reporting periods beginning in fiscal year 2015 or a subsequent fiscal year, in the case of a critical access hospital that is not a meaningful EHR user (as would be determined under paragraph (3) of section 1395ww(n) of this title if such critical access hospital was treated as an eligible hospital under such section) for an EHR reporting period with respect to such fiscal year, paragraph (1) shall be applied by substituting the applicable percent under subparagraph (B) for the percent described in such paragraph (1).

(B) The percent described in this subparagraph is–

(i) for fiscal year 2015, 100.66 percent;

(ii) for fiscal year 2016, 100.33 percent; and

(iii) for fiscal year 2017 and each subsequent fiscal year, 100 percent.

(C) The provisions of subclause (II) of section 1395ww(b)(3)(B)(ix) of this title shall apply with respect to subparagraph (A) for a critical access hospital with respect to a cost reporting period beginning in a fiscal year in the same manner as such subclause applies with respect to subclause (I) of such section for

a subsection (d) hospital with respect to such fiscal year.

(5) There shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise, of–

(A) the methodology and standards for determining the amount of payment and reasonable cost under paragraph (3) and payment adjustments under paragraph (4), including selection of periods under section 1395ww(n)(2) of this title for determining, and making estimates or using proxies of, inpatient-bed-days, hospital charges, charity charges, and Medicare share under subparagraph (D) of section 1395ww(n)(2) of this title;

(B) the methodology and standards for determining a meaningful EHR user under section 1395ww(n)(3) of this title as would apply if the hospital was treated as an eligible hospital under section 1395ww(n) of this title, and the hardship exception under paragraph (4)(C);

(C) the specification of EHR reporting periods under section 1395ww(n)(6)(B) 4 of this title as applied under paragraphs (3) and (4); and

(D) the identification of costs for purposes of paragraph (3)(C).

UNITED STATES CODE
Title 42 - The Public Health and Welfare
Chapter 7 - Social Security
Subchapter XVIII - Health Insurance for Aged and Disabled
Part E - Miscellaneous Provisions

42 U.S.C. 1395x(v). Reasonable costs

(1)(A) 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, and shall be determined accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulation referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs particular items or services, may provide for the establishment of limits on the direct or indirect overall

incur costs or incurred costs of specific items or services or groups of items or services to be recognized as reasons based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this subchapter, and may provide for the use of charges a percentage of charges where this method reasonably reflects the costs. Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient deliver services covered by the insurance programs established under this subchapter) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by insurance programs established by this subchapter will not be borne by individuals not so covered, and the cc with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

CODE OF FEDERAL REGULATIONS
Title 42 - Public Health
Chapter IV - Centers for Medicare & Medicaid Services, Department of Health and Human Services
Subchapter B - Medicare Program
Part 413 - Principles of Reasonable Cost Reimbursement; Payment for End-Stage Renal Disease Services; Prospectively Determined Pay Rates for Skilled Nursing Facilities

§ 413.9 Cost related to patient care.

(a) *Principle.* All payments to providers of services must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs incurred in furnishing the services, subject to principles relating to specific items of revenue and cost. However, for cost reporting periods beginning after December 31, 1973, payments to providers of services are based on the lesser of the reasonable cost of services covered under Medicare and furnished to program beneficiaries or the customary charges to the general public for such services, as provided for in § 413.13.

(b) *Definitions*—(1) *Reasonable cost.* Reasonable cost of any services must be determined in accordance with regulations establishing the method or methods to be used, and the items to be included. The regulations in this part take into account both direct and indirect costs of providers of services. The objective is that under the methods of determining costs, the costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program. These regulations also provide for the making of suitable retroactive adjustments

after the provider has submitted fiscal and statistical reports. The retroactive adjustment will represent the difference between the amount received by the provider during the year for covered services from both Medicare and the beneficiaries and the amount determined in accordance with an accepted method of cost apportionment to be the actual cost of services furnished to beneficiaries during the year.

(2) *Necessary and proper costs.* Necessary and proper costs are costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. They are usually costs that are common and accepted occurrences in the field of the provider's activity.

(c) *Application.* (1) It is the intent of Medicare that payments to providers of services should be fair to the providers, to the contributors to the Medicare trust funds, and to other patients.

(2) The costs of providers' services vary from one provider to another and the variations generally reflect differences in scope of services and intensity of care. The provision in Medicare for payment of reasonable cost of services is intended to meet the actual costs, however widely they may vary from one institution to another. This is subject to a limitation if a particular institution's costs are found to be substantially out of line with other institutions in the same area that are similar in size, scope of services, utilization, and other relevant factors.

(3) The determination of reasonable cost of services must be based on cost related to the care of Medicare beneficiaries. Reasonable cost includes all necessary and proper expenses incurred in furnishing services, such as administrative costs, maintenance costs, and

premium payments for employee health and pension plans. It includes both direct and indirect costs and normal standby costs. However, if the provider's operating costs include amounts not related to patient care, specifically not reimbursable under the program, or flowing from the provision of luxury items or services (that is, those items or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed health services), such amounts will not be allowable. 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 actual costs may vary from provider to provider and from time to time for the same provider.

[51 FR 34795, Sept. 30, 1986; 51 FR 37398, Oct. 22, 1986]

CODE OF FEDERAL REGULATIONS
Title 42 - Public Health
Chapter IV - Centers for Medicare & Medicaid Services, Department of Health and Human Services
Subchapter B - Medicare Program
Part 413 - Principles of Reasonable Cost Reimbursement; Payment for End-Stage Renal Disease Services; Prospectively Determined Pay Rates for Skilled Nursing Facilities

§ 413.98 Purchase discounts and allowances, and refunds of expenses.

(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.

(b) *Definitions*—(1) *Discounts.* Discounts, in general, are reductions granted for the settlement of debts.

(2) *Allowances.* Allowances are deductions granted for damage, delay, shortage, imperfection, or other causes, excluding discounts and returns.

(3) *Refunds.* Refunds are amounts paid back or a credit allowed on account of an overcollection.

(c) *Normal accounting treatment—Reduction of costs.* All discounts, allowances, and refunds of expenses are reductions in the cost of goods or services purchased and are not income. If they are received in the same accounting period in which the purchases were made or *expenses* were incurred, they will reduce the purchases or expenses of that period. However, if they are received in a later accounting period, they will reduce the comparable purchases or expenses in the period in which they are received.

(c) *Application.* (1) Purchase discounts have been classified as cash, trade, or quantity discounts. Cash discounts are reductions granted for the settlement of debts before they are due. Trade discounts are reductions from list prices granted to a class of customers before consideration of credit terms. Quantity discounts are reductions from list prices granted because of the size of individual or aggregate purchase transactions. Whatever the classification of purchase discounts, like treatment in reducing allowable costs is required. In the past, purchase discounts were considered as financial management income. However, modern accounting theory holds that income is not derived from a purchase but rather from a sale or an exchange and that purchase discounts are reductions in the cost of whatever was purchased. The true cost of the goods or services is the net amount actually paid for them. Treating purchase discounts as income would result in an overstatement of costs to the extent of the discount.

(2) 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 and third-party payment organizations paying on the basis of cost.

KENTUCKY REVISED STATUTES
Title XI – Revenue and Taxation
Chapter 142 – Miscellaneous Taxes

142.303 Tax on gross revenues of providers for hospital services – Exception.

(1) A tax is hereby imposed at a rate of two and one-half percent (2.5%) on gross revenues received by all providers on or after July 15, 1994, for the provision of hospital services. The tax imposed by this section shall not apply to gross revenues received for dispensing outpatient prescription drugs subject to tax under KRS 142.311.

(2) (a) Notwithstanding any other provision of the Kentucky Revised Statutes to the contrary, beginning in state fiscal year 2008-2009 and continuing annually thereafter, the tax imposed under subsection (1) of this section on providers of hospital services who paid taxes in state fiscal year 2005-2006 shall be assessed on gross revenues received by the provider during state fiscal year 2005-2006. Notwithstanding KRS 142.301 to 142.363, hospital provider taxes due in state fiscal year 2008 and continuing annually thereafter shall be paid in twelve (12) equal monthly installments, with each payment due no later than twenty (20) days after the last day of each calendar month. At least thirty (30) days prior to the beginning of the state fiscal year, the Department of Revenue shall send written notice to each provider of hospital services of the provider's total tax liability for the year, which shall be the amount the provider paid in taxes in state fiscal year 2005-2006. The provisions of this paragraph also shall apply if

the hospital subsequently undergoes a change in ownership.

(b) If a hospital was not in operation during state fiscal year 2005-2006, the hospital shall be taxed pursuant to the provisions of subsection (1) of this section, provided that, upon request of the provider, the Department of Revenue may adjust the hospital's annual tax liability in accordance with the gross revenues of a comparable hospital.

Effective: June 26, 2007

History: Amended 2007 Ky. Acts ch. 9, sec. 1, effective June 26, 2007. – Created 1994 Ky. Acts ch. 512, sec. 97, effective July 15, 1994.

KENTUCKY REVISED STATUTES
Title XVII – Economic Security and Public Welfare
Chapter 205 – Public Assistance and Medical Assistance

205.640 Medical Assistance Revolving Trust Fund (MART) – Distribution of disproportionate share funds – Authority for administrative regulations – Duties of hospitals receiving funds from MART.

(1) The commissioner of Medicaid services shall adopt a disproportionate share program consistent with the requirements of Title XIX of the Social Security Act which shall include to the extent possible, but not limited to, the provisions of this section.

(2) The Medical Assistance Revolving Trust Fund (MART) shall be established in the State Treasury and all provider tax revenues collected pursuant to KRS 142.301 to 142.363 shall be deposited in the State Treasury and transferred on a quarterly basis to the Department for Medicaid Services for use as specified in this section. All investment earnings of the fund shall be credited to the fund. Provider tax revenues collected in accordance with KRS 142.301 to 142.363 may be used to fund the provisions of KRS 216.2920 to 216.2929 and to supplement the medical assistance-related general fund appropriations for fiscal year 1994 and subsequent fiscal years. Notwithstanding the provisions of KRS 48.500 and 48.600, the MART fund shall be exempt from any state budget reduction acts.

(3) (a) Beginning in state fiscal year 2000-2001 and continuing annually thereafter, provider tax revenues and state and federal matching funds shall be used to

fund the disproportionate share program established by administrative regulations promulgated by the Cabinet for Health and Family Services. Disproportionate share funds shall be divided into three (3) pools for distribution as follows:

1. Forty-three and ninety-two hundredths percent (43.92%) of the total disproportionate share funds shall be allocated to acute care hospitals;

2. Thirty-seven percent (37%) of the total disproportionate share funds shall be allocated to university hospitals;

3. The percentage allowable by federal law pursuant to 42 U.S.C. sec. 1396r-4(h), up to nineteen and eight hundredths percent (19.08%) of the total disproportionate share funds shall be allocated to private psychiatric hospitals and state mental hospitals, with the allocation to each respective group of hospitals established by the biennial budget;

4. If there are any remaining disproportionate share funds from private psychiatric hospitals and state mental hospitals, fifty-four percent (54%) of those funds shall be distributed to the acute care hospitals and forty-six percent (46%) shall be distributed to the university hospitals; and

5. If, in any year, one (1) or both university hospitals fail to provide state matching funds necessary to secure federal financial participation for the funds allocated to university hospitals under this subsection, the portion of the funding allocation applicable to the hospital or hospitals that fail to provide state matching funds shall be made available to acute care hospitals.

(b) The MART fund shall be used to compensate acute care hospitals, private psychiatric hospitals, state mental hospitals, and university hospitals participating in the disproportionate share program for uncompensated service provided by the hospitals to individuals and families with total annual incomes and resources up to one hundred percent (100%) of the federal poverty level, as determined by the hospital pursuant to administrative regulations promulgated by the Cabinet for Health and Family Services in accordance with this section.

(c) An individual hospital shall receive distributions for indigent care provided by that hospital if the hospital meets the requirements of the disproportionate share program.

(d) Distributions to acute care and private psychiatric hospitals shall be made as follows:

1. The department shall calculate an indigent care factor for each hospital annually. The indigent care factor shall be determined by calculating the percentage of each hospital's annual indigent care costs toward the sum of the total annual indigent care costs for all hospitals within each respective pool. For purposes of this paragraph, "indigent care costs" means the hospital's inpatient and outpatient care as reported to the department multiplied by the hospital's Medicaid rate, or at a rate determined by the department in administrative regulation that, when multiplied by the hospital's reported indigent care, is equivalent to the amount that would be payable by the department under the fee-for-service Medicaid program for the hospital's total reported indigent care.

2. Each hospital's annual distribution shall be calculated by multiplying the hospital's indigent care

factor by the total fund allocated to all hospitals within the respective pool under paragraph (a) of this subsection.

a. Hospitals shall report uncompensated care provided to qualified individuals and families with total annual incomes and resources up to one hundred percent (100%) of the federal poverty level, including care rendered to indigent persons age twenty-two (22) to sixty-four (64) in a psychiatric hospital to the Cabinet for Health and Family Services on a quarterly basis. However, all data for care provided during the state fiscal year shall be submitted no later than August 15 of each year.

b. For state fiscal year 2001-2002 and each year thereafter, the department shall use data reported by the hospitals for indigent care services rendered for the twelve (12) month period ending June 30 of each year as reported by the hospital to the department by August 15 in calculating each hospital's indigent care factor. The hospital shall, upon request by the Cabinet for Health and Family Services, submit any supporting documentation to verify the indigent care data submitted for the calculation of an indigent care factor and annual payment.

c. By September 1 of each year, the department shall calculate a preliminary indigent care factor and preliminary annual payment amount for each hospital, and shall notify each hospital of their calculation. The notice shall contain a listing of each hospital's indigent care costs, their indigent care factor, and the estimated annual payment amount. Hospitals shall notify the department by September 15 of any adjustments in the department's preliminary calculations. The department shall make adjustments identified by hospitals and shall make a final determination of

each hospital's indigent care factor and annual payment amount by October 1. The department shall make a final determination of each hospital's annual payment amount upon notification through the Federal Register of the annual federal disproportionate share hospital allotment for the Commonwealth.

(e) The department shall issue to each hospital one (1) lump-sum payment on October 15, or later as soon as federal financial participation becomes available through notification by publication of the Federal Register, for the disproportionate share funds available during the corresponding federal fiscal year. The department may pay a portion of the expected annual payment prior to the publication of the annual federal allotment.

(4) Notwithstanding any other provision to contrary, total annual disproportionate share payments made to state mental hospitals, university hospitals, acute care hospitals, and private psychiatric hospitals in each state fiscal year shall be equal to the maximum amount of disproportionate share payments established under the Federal Balanced Budget Act of 1997 and any amendments thereto. Disproportionate share payments shall be subject to the availability of adequate state matching funds and shall not exceed total uncompensated costs.

(5) Hospitals receiving reimbursement shall not bill patients for services submitted for reimbursement under this section and KRS 205.641. Services provided to individuals who are eligible for medical assistance or the Kentucky Children's Health Insurance Program do not qualify for reimbursement under this section and KRS 205.641. Hospitals shall make a reasonable determination that an individual does not qualify for these programs and shall request the individual to

apply, if appropriate, for medical assistance or Kentucky Children's Health Insurance on forms supplied by and in accordance with procedures established by the Department for Medicaid Services. The hospital shall document any refusal to apply and shall inform the patient that the refusal may result in the patient being billed for any services performed. The hospital shall not be eligible for reimbursement if the patient was eligible for medical assistance or Kentucky Children's Health Insurance and did not apply. Hospitals receiving reimbursement under this section and KRS 205.641 shall not bill patients for services provided to patients not eligible for medical assistance with family incomes up to one hundred percent (100%) of the federal poverty level.

(6) The secretary of the Cabinet for Health and Family Services shall promulgate administrative regulations, pursuant to KRS Chapter 13A, for the administration and implementation of this section.

(7) All hospitals receiving reimbursement under this section and KRS 205.641 shall display prominently a sign which reads as follows: "This hospital will accept patients regardless of race, creed, ethnic background, or ability to pay."

(8) The hospital shall, upon request by the Cabinet for Health and Family Services, submit any supporting documentation to substantiate compliance with the audit requirements established by 42 C.F.R. sec. 455.

Effective: July 15, 2010

History: Amended 2010 Ky. Acts ch. 142, sec. 1, effective July 15, 2010. – Amended 2005 Ky. Acts ch. 99, sec. 258, effective June 20, 2005; and ch. 120, sec. 14, effective June 20, 2005. – Amended 2001 Ky. Acts

ch. 164, sec. 9, effective June 21, 2001. – Amended 2000 Ky. Acts ch. 310, sec. 2, effective April 4, 2000. – Amended 1998 Ky. Acts ch. 82, sec. 21, effective July 15, 1998; ch. 426, sec. 217, effective July 15, 1998; and ch. 545, sec. 1, effective July 15, 1998. – Amended 1994 Ky. Acts ch. 512, sec. 85, effective July 15, 1994. â€" Created 1993 (2d Extra. Sess.) Ky. Acts ch. 2, sec. 20, effective June 8, 1993.

2016-2018 Budget Reference. See State/Executive Branch Budget, 2016 Ky. Acts ch. 149, Pt. I, G, 3, b, (2) at 1072.

Legislative Research Commission Note (7/1/2006). The amendments to this statute made in 2005 Ky. Acts ch. 107, sec. 1, have not taken effect. Section 2 of 2005 Ky. Acts ch. 107 states: "This Act shall become effective upon certification to the Reviser of Statutes from the secretary of the Cabinet for Health Services that necessary federal approval of the proposed distribution of disproportionate share funds outlined in subsection (3) of Section 1 has been obtained. This Act shall not become effective if certification is not received prior to July 1, 2006." The Reviser of Statutes did not receive certification by that date.

Legislative Research Commission Note (7/15/98). This section was amended by 1998 Ky. Acts chs. 82, 426, and 545. Where these Acts are not in conflict, they have been codified together. Where a conflict exists between ch. 426 and ch. 545, Acts ch. 545, which was a nonrevisory Act, prevails under KRS 7.136(3).

KENTUCKY ADMINISTRATIVE REGULATIONS
Title 907 – Cabinet for Health and Family Services –
Department for Medicaid Services
Chapter 10 – Hospital Service Coverage and
Reimbursement

907 KAR 10:820. Disproportionate share hospital distributions.

RELATES TO: KRS 205.565, 205.637, 205.639, 205.640, 205.641, 216.380, 42 C.F.R. Parts 412, 413, 440.10, 440.140, 449250-447.280, 42 U.S.C. 1395f(l), 1395ww(d)(5)(f), 1395x(mm), 1396a, 1396b, 1396d, 1396r-4

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.560(2), 205.637(3), 205.639, 205.640, 216.380(12), 42 C.F.R. Parts 412, 413, 447.252, 447.253, 42 U.S.C. 1395ww(d)(5)(F), 1396a, 1396r-4

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205,520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed, or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes disproportionate share hospital fund distribution provisions in accordance with KRS 205.639 and 205.640.

Section 1. Definitions. (1) "Acute care hospital" is defined by KRS 205.639(1).

(2) 'Countable resource" means cash or an asset readily convertible to cash including a checking account, savings account, stock, bond, mutual fund, certificate

of deposit, money market account, or similar financial instrument.

(3) "Critical access hospital" or "CAH" means a hospital meeting the licensure requirements established in 906 KAR 1:110.

(4) "Department" means the Department for Medicaid Services or its designated agent.

(5) "Disproportionate share hospital" or "DSH" means an in-state hospital that:

(a) Has an inpatient Medicaid utilization rate of one (1) percent or higher; and

(b) Meets the criteria established in 42 U.S.C. 1396r-4(d).

(6) "DRG" or "diagnosis related group" means a clinically-similar grouping of services that can be expected to consume similar amounts of hospital resources.

(7) "DRG-reimbursed hospital" means an in-state hospital reimbursed via a DRG methodology pursuant to 907 KAR 10:825.

(8) "Federal Register" means the official daily publication for rules, proposed rules, and notices of federal agencies and organizations, as well as executive orders and other presidential documents.

(9) "Indigent care" means the unreimbursed cost to a hospital of providing a service on an inpatient or outpatient basis:

(a) To an individual who is:

1. Determined to be indigent in accordance with KRS 205.640; and

2. Not a Medicaid recipient; and

(b) For which an individual shall not be billed by the hospital.

(10) "Indigent care eligibility criteria' means the criteria as specified in Section 9 of this administrative regulation used by a hospital to determine if an individual is eligible for indigent care.

(11) "Inpatient equivalency" means the equivalency that is:

(a) Determined by taking a hospital's aggregate Medicaid DRG reimbursement, dividing it by the aggregate Medicaid DRG allowed days, and determining a per diem amount paid; and

(b) Based on the Medicaid schedule contained in the most recently finalized Medicare cost report.

(12) "Long-term acute care hospital" means a hospital that meets the requirements established in 42 C.F.R. 412.23(e).

(13) "Per diem rate" means a hospital's all-inclusive daily rate as calculated by the department.

(14) "Private psychiatric hospital" is defined by KRS 205.639(2).

(15) "Pro rata basis" means a basis for allocating an amount proportionately to all hospitals within a hospital category.

(16) "Rehabilitation hospital" means a hospital meeting the licensure requirements as established in 902 KAR 20:240.

(17) "Resident" means an individual living in Kentucky who is not receiving public assistance in another state.

(18) "State mental hospital" is defined by KRS 205.639(3).

(19) 'Third-party payor" means a payor of a third party pursuant to KRS 205.510(16).

(20) "University hospital" is defined by KRS 205.639(4).

Section 2. Disproportionate Share Hospital Distribution General Provisions. A DSH distribution shall:

(1) Be made to a qualified hospital;

(2) Be based upon available funds in accordance with KRS 205.640;

(3) Be based upon a hospital's proportion of inpatient and outpatient indigent care from the preceding state fiscal year;

(4) Be a prospective amount. For example, a DSH distribution made to a hospital in October 2007 shall cover the state fiscal year beginning July 1, 2007 and ending June 30, 2008;

(5) Not be subject to settlement or revision based on a change in utilization during the year to which it applies; and

(6) Be made on an annual basis.

Section 3. Disproportionate Share Hospital Distribution to a DRG-Reimbursed Acute Care Hospital. The department shall determine a DSH distribution to a DRG-reimbursed acute care hospital by:

(1) Determining a hospital's average reimbursement per discharge;

(2) Dividing the hospital's average reimbursement per discharge by Medicaid days per discharge;

(3) Multiplying the amount established in subsection (2) of this section by the hospital's total number of inpatient indigent care days for the most recently completed state fiscal year to establish the hospital's inpatient indigent care cost;

(4) Determining an in-state hospital's outpatient indigent care cost by multiplying each in-state hospital's indigent outpatient charges by the most recent cost-to-charge ratio used by the Department of Labor in accordance with 803 KAR 25:091;

(5) Combining the inpatient indigent care cost established in subsection (3) of this section with the outpatient indigent care cost established in subsection (4) of this section to establish a hospital's indigent care cost total; and

(6) Comparing the total indigent care cost for each DRG-reimbursed hospital to the indigent care costs of all hospitals receiving DSH distributions under the acute care pool pursuant to KRS 205.640(3)(d) to establish a DSH distribution on a pro rata basis.

Section 4. Disproportionate Share Hospital Distribution to a Critical Access Hospital, Rehabilitation Hospital or Long Term Acute Care Hospital. The department shall determine a DSH distribution to a critical access hospital, rehabilitation hospital, or long term acute care hospital:

(1) For the period beginning with the state fiscal year beginning July 1, 2007 and ending June 30, 2008 by:

(a) Multiplying the hospital's per diem rate in effect as of June 30, 2007 by its total number of inpatient indigent care days for the preceding state

fiscal year (July 1, 2006 - June 30, 2007) to establish the hospital's inpatient indigent care cost;

(b) Determining an in-state hospital's outpatient indigent care cost by multiplying each in-state hospital's indigent outpatient charges by the most recent cost-to-charge ratio used by the Department of Labor in accordance with 803 KAR 25:091;

(c) Combining the inpatient indigent care cost established in paragraph (a) of this subsection with the outpatient indigent care cost established in paragraph (b) of this subsection to establish a hospital's indigent care cost total; and

(d) Comparing the indigent care cost totals for each critical access hospital, rehabilitation hospital and long term acute care hospital to the indigent care costs of all hospitals receiving DSH distributions from the acute care pool pursuant to KRS 205.640(3)(d) to establish a hospital's DSH distribution on a pro rata basis; and

(2) For the state fiscal year period beginning July 1, 2008 and subsequent state fiscal years, by:

(a) Multiplying the hospital's per diem rate in effect as of August 1 of the state fiscal year period included in the state fiscal year period referenced in subsection (2) of this Section by its total number of inpatient indigent care days for the preceding state fiscal year to establish the hospital's inpatient indigent care cost;

(b) Determining an in-state hospital's outpatient indigent care cost by multiplying each in-state hospital's indigent outpatient charges by the most recent cost-to-charge ratio used by the Department of Labor in accordance with 803 KAR 25:091;

(c) Combining the inpatient indigent care cost established in paragraph (a) of this subsection with the outpatient indigent care cost established in paragraph (b) of this subsection to establish a hospital's indigent care cost total; and

(d) Comparing the indigent care cost totals for each critical access hospital, rehabilitation hospital and long term acute care hospital to the indigent care costs of all hospitals receiving DSH distributions from the acute care pool pursuant to KRS 205.640(3)(d) to establish a hospital's DSH distribution on a pro rata basis.

Section 5. Disproportionate Share Hospital Distribution to a Private Psychiatric Hospital. The department shall determine a DSH distribution to a private psychiatric hospital:

(1) For the period beginning with the state fiscal year beginning July 1, 2007 and ending June 30, 2008 by:

(a) Multiplying the hospital's per diem rate in effect as of June 30, 2007 by its total number of inpatient indigent care days for the preceding state fiscal year (July 1, 2006 – June 30, 2007) to establish the hospital's inpatient indigent care cost;

(b) Determining an in-state hospital's outpatient indigent care cost by multiplying each in-state hospital's indigent outpatient charges by the most recent cost-to-charge ratio used by the Department of Labor in accordance with 803 KAR 25:091 or by establishing an inpatient equivalency;

(c) Combining the inpatient indigent care cost established in paragraph (a) of this subsection with

the outpatient indigent care cost established in paragraph (b) of this subsection to establish a hospital's indigent care cost total; and

(d) Comparing the indigent care cost totals of each private psychiatric hospital to establish, using the DSH funding allocated to private psychiatric hospitals, a private psychiatric hospital's DSH distribution on a pro rata basis; and

(2) For the state fiscal year period beginning July 1, 2008 and subsequent state fiscal years, by:

(a) Multiplying the hospital's per diem rate in effect as of August 1 of the state fiscal year period included in the state fiscal year period referenced in subsection (2) of this Section by its total number of inpatient indigent care days for the preceding state fiscal year to establish the hospital's inpatient indigent care cost; and

(b) Determining an in-state hospital's outpatient indigent care cast by multiplying each in-state hospital's indigent outpatient charges by the most recent cost-to-charge ratio used by the Department of Labor in accordance with 803 KAR 25:091 or by establishing an inpatient equivalency;

(c) Combining the inpatient indigent care cost established in paragraph (a) of this subsection with the outpatient indigent care cost established in paragraph (b) of this subsection to establish a hospital's indigent care cost total; and

(d) Comparing the indigent care cost totals of each private psychiatric hospital to establish, using the DSH funding allocated to private psychiatric hospitals, a private psychiatric hospital's DSH distribution on a pro rata basis.

Section 6. Disproportionate Share Hospital Distribution to a State Mental Hospital. The Department shall determine a DSH distribution to a state mental hospital by:

(1) Comparing each state mental hospital's costs of services provided to individuals meeting the indigent eligibility criteria established in Section 9 of this administration regulation, minus any payment made by or on behalf of the individual to the hospital; and

(2) Using the DSH funding allocated to state mental hospitals to establish a state mental hospital's DSH distribution on a pro rata basis.

Section 7. Disproportionate Share Hospital Distribution to a University Hospital. The department's DSH distribution to a university hospital shall:

(1) Be based on the hospital's historical proportion of the costs of services to Medicaid recipients, minus reimbursement paid via 907 KAR 10:825 or 907 KAR 10:815, plus the costs of services to indigent and uninsured patients minus any distributions made on behalf of indigent and uninsured patients;

(2) Be contingent upon a facility providing up to 100 percent of matching funds to receive federal financial participation for distribution under this subsection; and

(3) Comply with KRS 205.640(3)(a)2.

Section 8. Indigent Care Eligibility. (1) Prior to billing a patient and prior to submitting the cost of a hospital service to the department as uncompensated, a hospital shall use the indigent care eligibility form, DSH-001, Application for Disproportionate Share Hospital (DSH) Program, and the Disproportionate

Share Hospital (DSH) Program Manual, to assess a patient's financial situation to determine if:

(a) Medicaid or Kentucky Children's Health Insurance Program (KCHIP) may cover hospital expenses; or

(b) A patient meets the indigent care eligibility criteria.

(2) An individual referred to Medicaid or KCHIP by a hospital shall apply for the referred assistance, Medicaid or KCHIP, within thirty (30) days of completing the DSH-001, Application for Disproportionate Share Hospital Program (DSH), at the hospital.

Section 9. Indigent Care Eligibility Criteria. (1) A hospital shall receive disproportionate share hospital funding for art inpatient or outpatient medical service provided to an indigent patient under the provisions of this administrative regulation if the fallowing apply:

(a) The patient is a resident of Kentucky;

(b) The patient is not eligible for Medicaid or KCHIP;

(c) The patient is not covered by a third-party payor;

(d) The patient is not in the custody of a unit of government that is responsible for coverage of the acute care needs of the individual;

(e) The hospital shall consider all income and countable resources of the patient's family unit and the family unit shall include:

1. The patient;

2. The patient's spouse;

3. The minor's parent or parents living in the home; and

4. Any minor living in the home;

(f) A household member who does not fall in one (1) of the groups listed in paragraph (e) of this subsection shall be considered a separate family unit;

(g) The annual countable resources of a family unit shall not exceed:

1. $2,000 for an individual;

2. $4,000 for a family unit size of two (2); and

3. Fifty (50) dollars for each additional family unit member;

(h) Countable resources shall be reduced by unpaid medical expenses of the family unit to establish eligibility; and

(i) The patient or family unit's gross income shall not exceed the federal poverty limits published annually in the Federal Register and in accordance with KRS 205.640.

(2) Except as provided in subsection (3) of this section, total annual gross income shall be the lessor of:

(a) Income received during the twelve (12) months preceding the month of receiving a service; or

(b) The amount determined by multiplying the patient's or family unit's income, as applicable, for the three (3) months preceding the date the service was provided by four (4).

(3) A work expense for a self-employed patient shall be deducted from gross income if:

(a) The work expense is directly related to producing a good or service; and

(b) Without it the good or service could not be produced.

(4) A hospital shall notify the patient or responsible party of his eligibility for indigent care.

(5) If indigent care eligibility is established for a patient, the patient shall remain eligible for a period not to exceed six (6) months without another determination.

Section 10. Indigent Care Eligibility Determination Fair Hearing Process. (1) if a hospital determines that a patient does not meet indigent care eligibility criteria as established in Section 9 of this administrative regulation, the patient or responsible party may request a fair hearing regarding the determination within thirty (30) days of receiving the determination.

(2) If a hospital receives a request for a fair hearing regarding an indigent care eligibility determination, impartial hospital staff not involved in the initial determination shall conduct the hearing within thirty (30) days of receiving the hearing request.

(3) A fair hearing regarding a patient's indigent care eligibility determination shall allow the individual to:

(a) Review evidence regarding the indigent care eligibility determination;

(b) Cross-examine witnesses regarding the indigent care eligibility determination;

(c) Present evidence regarding the indigent care eligibility determination; and

(d) Be represented by counsel.

(4) A hospital shall render a fair hearing decision within fourteen (14) days of the hearing and shall provide a copy of its decision to:

(a) The patient or responsible party who requested the fair hearing; and

(b) The department.

(5) A fair hearing process shall be terminated if a hospital reverses its earlier decision and notifies, prior to the hearing, the patient or responsible party who requested the hearing.

(6) A patient or responsible party may appeal a fair hearing decision to a court of competent jurisdiction in accordance with KRS 13B.140.

Section 11. Indigent Care Reporting Requirements. (1) On a quarterly basis, a hospital shall collect and report to the department indigent care patient and cost data,

(2) If a patient meeting hospital indigent care eligibility criteria is later determined to be Medicaid or KCHIP eligible or has other third-party payor coverage, a hospital shall adjust its indigent care report previously submitted to the department in a future reporting period.

Section 12. Merged Facility, If two (2) separate entities merge into one (1) organization and one (1) of the merging entities has disproportionate status and the other does not, the department shall retain for the merged entity the status of the entity which reported the highest number of Medicaid days paid.

Section 13. Incorporation by Reference. (1) The following material is incorporate by reference:

(a) "The Disproportionate Share Hospital (DSH) Program Manual", January 2008 edition; and

(b) The "DSH-001, Application for Disproportionate Share Hospital (DSH) Program", March 2007 edition.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m. (34 Ky.R. 1610; Am. 2195; 2409; eff. 6-6-2008; Recodified from 907 KAR 1:820; eff. 5-3-2011.)