AHA NEWS

American Hospital Association

Vol. 46, No. 21 • October 18, 2010

Warning of harm to CAHs, the AHA seeks rollback of provider tax policy

The AHA last week expressed support for legislation designed to reverse a new Centers for Medicare & Medicaid Services (CMS) policy that permits Medicare contractors to disallow all or a portion of Medicare reimbursement for the provider taxes that critical access hospitals (CAH) pay to their states.

In the fiscal year 2011 inpatient prospective payment system rule, CMS "clarified" its policy on how Medicare treats Medicaid provider taxes for purposes of CAH reimbursement. The agency said Medicare contractors can determine on a case-by-case basis if a reduction of the allowable tax expenses is necessary to offset the payments that CAHs receive as a result of the state taxes, which help pay for the costs of Medicaid.

The rule states that, "while a tax may be an allowable Medicare cost in that it is related to beneficiary care, the provider may only treat as reasonable cost the net tax expense; that is, the tax paid by the provider reduced by payments the provider received and that are associated with the assessed tax."

But the AHA and hospital leaders have made the case to CMS that Medicare contractors have allowed provider taxes as administrative and general costs for years without offsetting revenues received from states. Under Medicare's general cost reimbursement principles, the taxes have qualified as reimbursable costs.

Warning that the new policy is "jeopardizing the financial sustainability of CAHs," the AHA called for passage of the "Rural Hospital Protection Act," H.R. 6346, in Oct. 12 letters to the bill's sponsors, Reps. Ron Kind, D-WI, and Sam Graves, R-MO.

In its letters of support for the bill, the AHA asserted that "these provider taxes are clearly allowable, and the fact that there may be payments made by the state to the provider – or the fact that Medicaid payments from the state may be funded by the provider taxes – does not change this result." The association told the lawmakers that their legislation "would allow CAHs to continue to be appropriately reimbursed for these taxes." (For more, go to "Letters" under the "Advocacy" section of *www.aha.org*.)

Rescinding CMS' provider tax policy is part of the AHA's fall advocacy agenda. See the list of key hospital issues below.

Critical issues for the lame-duck session

The AHA is fighting to ensure that hospitals have the resources needed to care for their communities and that new proposals do not get in the way of coverage expansion.

- The CODING OFFSET contained in the IPPS rule is too large. Hospitals are underpaid by Medicare and Medicaid and cannot continue to do more with less.
- The IT rule does not reflect congressional intent to treat hospitals equitably. Most immediately, MULTI-CAMPUS SYSTEMS will not be eligible for payments that reflect their size.
- PHYSICIAN SUPERVISION in the proposed outpatient rule should use an approach that provides high-quality, safe patient care without unnecessary and onerous requirements. It should not jeopardize access to outpatient therapeutic services in small, rural and critical access hospitals.
- CMS disallowed provider taxes as legitimate expenses that Medicare should pay, that could jeopardize CRITICAL ACCESS HOSPITALS' financial sustainability.
- When the "PHYSICIAN FIX" expires in November, Medicare payments will drop 23%; Congress must prevent this from happening.
- Congress should pass "EXTENDERS" legislation that includes 340B inpatient expansion to certain uninsured populations, 340B coverage of orphan drugs for children's hospitals, and rural hospital and Section 508 extensions.
- Under its proposed physician fee schedule rule, CMS would cut payments for OUTPATIENT THERAPY SERVICES by about $100 million in 2011. CMS should withdraw the proposal, which could hinder access to rehabilitative care, particularly in rural and other underserved areas.