

Congress of the United States
Washington, DC 20515

May 16, 2012

Ms. Marilyn Tavenner
Acting Administrator, Chief Operating Officer
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Tavenner:

We are writing to express our serious concerns about the implementation of CMS's final rule clarifying the treatment of provider taxes and its impact on West Virginia's critical access hospitals (CAHs). We believe that West Virginia's CAHs face a unique situation due to the manner in which provider taxes are collected and Medicaid payments are distributed among providers in our state. We, therefore, urge CMS to immediately convene a meeting with subject matter experts, Palmetto GBA, impacted Critical Access Hospitals in West Virginia, state Medicaid officials, State Tax Department officials, and our staffs, to reach a better understanding of the specific nature in which provider taxes are levied and utilized for Medicaid funding in West Virginia.

Provider tax amounts paid by West Virginia's CAHs have historically been treated as allowable costs by CMS and the Medicare Administrative Contractors (MACs). CMS's Provider Reimbursement Manual has historically not allowed certain types of taxes to be reimbursed, such as income taxes, but has allowed reimbursement of costs such as franchise taxes that providers must pay even though they have no net income. This past treatment is consistent with CMS's general rule that "taxes are allowable costs to the extent they are actually incurred and related to the care of beneficiaries."

CMS finalized its proposed clarification regarding the agency's treatment of provider taxes for Medicare reimbursement purposes in the FY 2011 IPPS final rule, which was published in the August 16, 2010 Federal Register. In the final rule, CMS specifically noted that "the Medicare statute and regulations set forth a different standard that requires a determination of how much of the allowable tax expense is actually "incurred" by the provider." The final rule further noted that "in accordance with the Medicare statute, regulations, and PRM policies, 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," and that "this clarification will not have an effect of disallowing any particular tax but rather make clear that our Medicare contractors will continue to make a determination of whether a provider tax is allowable, on a case-by-case basis, using our current and longstanding reasonable cost principles."

The new section 2122.7 of the Provider Reimbursement Manual states that “while a tax may fall under a category that is generally accepted as an allowable Medicare cost, the provider may only treat the net tax expense as the reasonable cost actually incurred for Medicare payment purposes.” CMS stated that this alteration was a “clarification of policy” and not a change in policy, which means the decision may be applied retroactively. The revised CMS Manual defines net tax as a “tax paid by the provider, reduced by payments the provider received that are associated with the assessed tax.”

It seems that, through the implementation of this clarification, West Virginia hospitals have been unfairly impacted by having previously permissible provider taxes disallowed. West Virginia hospitals do not receive a hospital-specific payment based on the amount of provider tax they paid; instead, the taxes are paid into a general fund that is then used to pay all Medicaid providers including hospitals, nursing homes, physicians, and others. Furthermore, our hospitals have been unable to obtain clarification from CMS or Palmetto GBA regarding the rationale for disallowing reimbursement of the taxes at these specific hospitals. We would consequently ask CMS and/or Palmetto GBA to provide further information regarding the “case-by-case” estimates that have led CMS to disallow provider taxes for at least seven West Virginia CAHs, with potentially more to come.

West Virginia’s provider tax is not optional and is not levied solely on government reimbursements. Instead, the tax is imposed “[f]or the privilege of engaging or continuing within [West Virginia] in the business of providing inpatient hospital services.” The amount of West Virginia’s provider tax is set statutorily at 2.5 percent and is assessed on the hospital’s inpatient revenues. It is also important to highlight that West Virginia’s provider tax is payable on the revenues earned by CAHs, including revenues from private payers and third party insurers, regardless of whether or not the CAHs have received government reimbursements or have earned a profit.

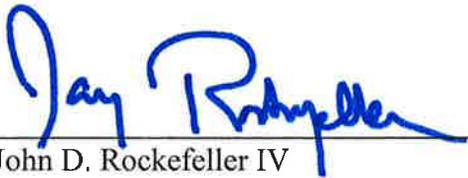
We are very concerned about the dire fiscal situation facing this nation. However, while you look for savings and additional efficiencies, we urge you to avoid taking actions that might impair the fiscal solvency of CAHs that serve our constituents in West Virginia. West Virginia has 18 CAHs, which by some estimates stand to lose in excess of \$5 million in annual reimbursements. These facilities are key employers in our state and are essential to the health care needs of our state’s rural and aging population. The application of the recent provider tax clarification threatens the financial stability of our CAHs and could result in a loss of access to vital hospital services for many of our constituents.

Since each state is unique in how they apply their provider tax laws, we request that CMS delay application of its policy clarification in West Virginia until after it has had the opportunity to have a stakeholder meeting to discuss West Virginia’s laws and regulations as they pertain to the provider tax. Accordingly, we request that CMS review West Virginia’s laws and regulations on an individual basis and that CMS provide further information about its case-by-

case calculations. In order to reach a better understanding of the specific nature of West Virginia's provider tax and the costs incurred by West Virginia's CAHs, we ask that this review include a review of determinations from both the current and previous MACs serving West Virginia. We also request an explanation as to why the provider tax costs are being disallowed retroactively to 2009, when the final rule clarifying the reimbursement of provider taxes applied to Fiscal Year 2011. We feel that once this review is completed that CMS will be more accurately able to apply its rules and regulations when determining whether West Virginia's provider taxes are an allowable cost. At the very least, given the importance of CAHs and their limited financial resources, we urge CMS not to apply the new interpretation retrospectively.

We thank you for your prompt attention to this matter.

Sincerely,



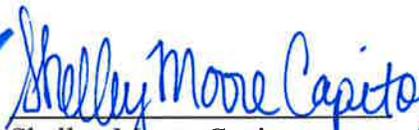
John D. Rockefeller IV
United States Senator



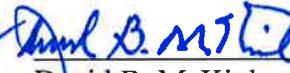
Joe Manchin III
United States Senator



Nick J. Rahall, II
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Shelley Moore Capito
Member of Congress



David B. McKinley, P.E.
Member of Congress