STATE OF LOUISIANA
BOARD OF TAX APPEALS
LOCAL TAX DIVISION

IASIS GLENWOOD
REGIONAL MEDICAL CENTER, L.P.,
Petitioner

VS. **DOCKET NO. L00033**

CITY OF MONROE,
TAXATION AND REVENUE DIVISION,
Respondent

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JUDGMENT

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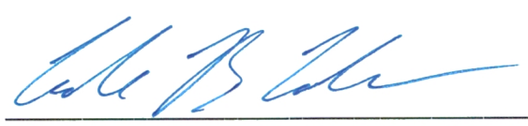
On February 4, 2020, this matter came before the Local Division (the "Board") for a hearing on the merits, with Local Tax Judge Cade R. Cole presiding. Present at the hearing were Nicole Gould Frey and Kelsey Clark on behalf of Iasis Glenwood Regional Medical Center, L.P. (the "Petitioner") and Drew Talbot on behalf of the City of Monroe, Taxation and Revenue Division (the "Collector"). After the hearing, the matter was taken under advisement. The Board now issues Judgment in accordance with the written reasons attached hereto.

IT IS ORDERED, ADJUDGED AND DECREED that Judgment be rendered in favor of the Collector and against the Petitioner, dismissing the Petition with prejudice.

Judgment Rendered and Signed at Baton Rouge, Louisiana, this 1st day of December, 2020.

FOR THE BOARD:



LOCAL TAX JUDGE CADE R. COLE

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WRITTEN REASONS FOR JUDGMENT

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This matter came before the Board of Tax Appeals - Local Division (the "Board") for hearing on February 4, 2020, with Local Tax Judge Cade R. Cole presiding. Participating in the hearing were Nicole Gould Frey and Kelsey Clark on behalf of Iasis Glenwood Regional Medical Center, L.P. (the "Petitioner") and Drew Talbot on behalf of the City of Monroe, Taxation and Revenue Division (the "Collector"). After the hearing, the matter was taken under advisement. The Board now issues the Judgment attached herewith in accordance with the following written reasons.

This case is a refund denial appeal under La. R.S. 47:337.81. Petitioner operates a 278-bed hospital located in West Monroe, Louisiana. The issue in this case is whether a Petitioner's wholesale purchases of prescription drugs, implants, and medical supplies were made "under the provisions of Medicare," and thus excluded from sales tax under La. R.S. 47:301(10)(u). Petitioner also claims that these purchases were made "under" Medicaid and are exempt from sales tax under La. R.S. 47:305(D)(5).

The parties stipulated to Petitioner's status as a Medicare and Medicaid provider. Petitioner's Medicare provider number is 190160 and has been effective

since February 1, 2006. Petitioner is also a certified Medicaid Provider under Title XIX of the Federal Social Security Act. Petitioner further maintained in-patient pharmacy licenses numbers 000424 and 005756, which were active during the tax periods of February 1, 2007 through July 31, 2010 (the "Claim Period") and were issued by the Louisiana Board of Pharmacy.

Petitioner was audited for Ouachita Parish sales and use tax by the Collector for the Claim Period. The audit was performed using a three-month block sample: October 2007; August 2008; and July 2009 (collectively the "Test Months"). The audit revealed an underpayment, which Petitioner paid with interest and penalties. Thereafter, on August 23, 2013, Petitioner filed a claim for refund in the amount of $2,970,579.78. The Collector denied the claim on July 9, 2014. Petitioner filed this appeal on October 7, 2014.

Petitioner seeks a refund of taxes paid on purchases of items from medical and pharmaceutical wholesale suppliers. Petitioner divides the items purchased into four categories: (1) Cardinal Prescription Drugs ("Cardinal Drugs"); (2) Patient Specific Implants ("Patient Specific Implants"); (3) Chargeable Prescription Drugs, Implants, and Medical Supplies ("Chargeables"); and (4) Non-chargeable Medical Supplies ("Non-chargeables") (collectively the "Disputed Items"). Items in the Cardinal Drugs, Patient Specific Implants, and Chargeables categories are itemized on patient invoices and charged to individual patients. Patient Specific Implants are further identified on patient invoices by serial number. Items in the Non-chargeables category are not itemized or charged to individual patients. Instead, Non-Chargeables are factored into room charges. Non-Chargeables include items such as band aids, gauze, and tongue depressors.

Petitioner claims that the Disputed Items are excluded from Ouachita Parish sales and use tax under La. R.S. 47:301(10)(u). La. R.S. 301(10)(u) excludes "the

sale of tangible personal property if such sale is made under the provisions of Medicare" from the definition of "sale at retail" for purposes of local sales tax. The Petitioner claims that the Disputed Items were purchased under the provisions of Medicare because they were purchased to be administered to Medicare participants. Following the same logic, Petitioner also claims that the Disputed Items were purchased under Medicaid. The Collector argues that La. R.S. 47:301(10)(u) and 305(D)(5) apply only to transactions between a hospital and its patients, and not to a hospital's wholesale purchases of supplies and drugs.

The Collector claims that the controlling authority in this case is *Crowe v. Bio-Medical Application of Louisiana, LLC*, 14-0917 (La. App. 1 Cir. 6/3/16) (hereafter "*Bio-Medical*"), 208 So.3d 473, *adhered to on reh'g*, 2014-0917 (La. App. 1 Cir. 2/17/11); 241 So.3d 328, *and writ denied*, 2017-0502 (La. 5/12/17); 219 So.3d 1106. The taxpayer in *Bio-Medical* was a dialysis clinic that purchased prescription drugs from wholesale suppliers. The dialysis clinic administered the drugs it purchased to both Medicare and non-Medicare patients. The dialysis clinic claimed that its purchases were excluded under La. R.S. 47:301(10)(u), and exempt or excluded under La. R.S. 47:337.9(F). The Court in *Bio-Medical* held that the dialysis clinic's purchases were not made under the provisions of Medicare. Medicare did not control the choice of vendor, the price paid, the payment of sales tax, or the decision to buy in bulk.

The matter subsequently went before a five-judge panel for re-hearing. On re-hearing, a divided Court issued a short *per curiam* opinion upholding the original decision. This would seem to support the Collector's position. However, a careful reading of the concurrences and dissents reveals that the *per curiam* opinion actually reflects the opinion of just one of the five Judges.

Judges Calloway and Holdridge dissented, and would have remanded the matter for trial to determine the correct amount of the refund. Judge Welch, concurring, stated that the result would have been different if the dialysis clinic had purchased prescription drugs for Medicare patients separately. Judge Chutz, concurring in the result, found that the summary judgment evidence in the record could not support the dialysis clinic's calculations. The dialysis clinic attempted to calculate its refund by multiplying the per-patient ratio of the clinic's Medicare patients over all of the clinic's patients by the total tax paid on the drugs at issue. Judge Chutz found that the per-patient ratio assumed that each patient received the same medicines in the same doses. However, the evidence actually showed the opposite: different patients were treated differently.

Petitioner finds itself facing the same dilemma as the dialysis clinic in *Bio-Medical*. Medicare is not involved in Petitioner's wholesale purchases. Nor does Medicare reimburse Petitioner for its purchases of medical supplies and prescription drugs. This is because Medicare Parts A and B reimburse healthcare providers according to a Prospective Payment System ("PPS"). The PPS is a pre-determined formula that represents the expected reasonable cost of providing services to Medicare Participants. That amount may be more or less than the actual cost.

Medicare Part A uses the Inpatient[1] Prospective Payment System ("IPPS"). The IPPS divides patients into Medicare Severity - Diagnosis Related Groups ("DRG"). The DRG represents the expected cost of treating a type of illness or condition. Each DRG is assigned a "weighing factor," a percentage that reflects the relationship between the cost of treating patients within that group and the average cost of treating all Medicare patients. The DRG weighing factor is multiplied by a

[1] An "inpatient" is a patient who is admitted to a hospital for purposes of receiving inpatient hospital services, with the expectation that the individual will require hospital care that will span two midnights or more. CMS, Medicare Benefit Policy Manual (CMS Pub. 1 00-02), Ch. 1, § 10.

base payment. The base payment is a standardized dollar amount that is intended to reflect average operating costs of inpatient hospital services. The product of the DRG and the base payment is generally the amount Medicare will reimburse the provider. However, the reimbursement may be adjusted for certain geographic area differentials, and for high-cost outlier patients. However, the reimbursement amount is never a dollar-for-dollar reimbursement of actual costs.

Medicare Part B uses the Outpatient Prospective Payment System ("OPPS"). OPPS pays hospitals based on service categories called Ambulatory Payment Classifications ("APC"). Medicare sets pre-determined payment "weights" for APC's based on the average resources needed to perform a particular service. Medicare multiplies the APC weight by a conversion factor to arrive at a dollar payment rate. Medicare further adjusts the payment rate for non-labor costs and regional labor costs. As with Part A, reimbursement under Part B does not depend on the hospital's actual costs.

Nevertheless, Petitioner indisputably purchased the Disputed items to fulfill its obligations under Medicare and Medicaid to provide medical services to Medicare and Medicaid patients. *See* 42 C.F.R. § 489.20; La. R.S. 46:446.5. Further, Petitioner actually did administer some portion of those supplies and drugs to Medicare and Medicaid patients (hereinafter sometimes referred to for convenience as "Medicare patients"). The problem for the Petitioner is how to calculate that portion of the Disputed Items. The Petitioner must do so in a way that would have changed the result in *Bio-Medical*.

Judge Welch suggested separate purchasing. If Petitioner had done that, it could have calculated the tax paid on the earmarked items. However, the Petitioner in this case did not separately purchase or store items. In fact, the testimony offered by Petitioner at the hearing made it very clear that separate Medicare storerooms

would be economically and medically impractical. Petitioner cannot afford an undue delay in retrieving supplies or drugs in effectuating medical treatment.

Alternatively, Petitioner could track individual items from purchase to use on a patient. Tracking individual items would require serial numbers, or similar identifying information. Petitioner did not track items by serial number. The exception would be for Patient Specific Implants, which are tracked by serial number as required by law. Those items comprise a small portion of the overall claim.

Consequently, for the majority of the Disputed Items, the Petitioner must find another way to establish it is entitled to a refund. The dialysis clinic in *Bio-Medical* used a per-patient ratio. That ratio failed because patients were "not administered the same medicines in the same doses." The per-patient ratio lacked consistency as a unit of measurement. A viable ratio should be based on a unit of measurement that is consistent in terms of the types and dosages of medicine consumed.

The Petitioner offers a formula it describes as a "revenue" ratio. The Petitioner's revenue ratio is simply the total dollar amount charged to Medicare patients over the total dollar amount charged to the total of all patients. Petitioner derives a separate revenue ratio for each Test Month. Petitioner then multiplies a particular Test Month's revenue ratio by the total tax paid on Disputed Items during that Test Month.

Petitioner is using dollars billed as its unit of measurement. For this approach to succeed, each dollar billed must reflect the consumption of the same types and dosages of medicine. Petitioner produced the testimony of Erica Love in an attempt to establish that its revenue ratio is based on a uniform consumption of resources. Ms. Love testified that Petitioner billed its patients according to a "Chargemaster." According to Ms. Love, the Chargemaster is a list of Petitioner's billable services, and shows Petitioner's price for each procedure, service, supply, prescription drug,

and test provided to patients. Ms. Love testified that the charged amounts were the only consistent factor across the Petitioner's patient base.

Ms. Love's testimony demonstrates that Petitioner billed Medicare and non-Medicare patients the same gross billed charge for the same services. Further, the Petitioner contends that the amount billed for a particular service represented a uniform amount of drugs and supplies consumed in rendering that service. Thus, every charge for a particular service, for example urinalysis, represents the administration of a uniform amount of medical supplies and drugs.

However, the revenue ratio combines amounts charged for many different services into one lump sum. Lumping different services together creates inconsistency in the Petitioner's unit of measurement. For example, according to Petitioner's Exhibit 10, a sample patient invoice, Petitioner administered Potassium Chloride tablets to a patient at a charge of $4.70 per dose. Petitioner also provided that same patient with physical therapy gait training at a rate of $98.70 every fifteen minutes. The measurement of both services from the perspective of the revenue ratio is dollars billed. The charge per unit of Gait training is twenty-one times the amount charged for a Potassium Chloride tablet. The types and dosages of medicines consumed are not the same.

Measuring resources consumed by dollar amounts billed does not work if the amounts billed for different services are lumped together. A revenue-based approach could be successful only if broken down and separated according to the services billed. For example, Petitioner could calculate a revenue ratio specific to Potassium Chloride tablets, and then ascertain a ratio of the uses of that drug for Medicare patients over the total uses of that same drug. Petitioner could also calculate the number of doses of a particular medicine administered to Medicare patients over the number of doses of that same medicine administered to all patients.

The Petitioner's overall revenue ratio is not sufficient. The patient specific implants presumably could have been cross referenced with the names of Medicare patients to identify in a schedule which implants purchased actually went into Medicare patients. The Board is sympathetic to the significant complexity and extraordinary volume of these records, indeed we have spent extensive time reviewing the voluminous file in an attempt to ascertain if the information discussed above can be gleaned from the record.

The Board recognizes that it would be a formidable task to tie particular items purchased to particular patients. The Petitioner's revenue ratio is a plausible estimate for the purpose of approximation and settlement discussion. However, the Board cannot use those estimates to fill the evidentiary gap present in this case. In a trial on the merits, the Petitioner bears the burden of proving the elements of its case.

Accordingly, the Board finds that Petitioner has failed to carry its burden of proving the amount of the refund to which it would be entitled under La. R.S. 47:301(10)(u) and La. R.S. 47: 305(D)(5). In order to calculate the correct amount of the refund, Petitioner must reliably calculate the medical supplies and prescription drugs administered to Medicare or Medicaid patients. This calculation cannot be made based on the ratio of the lump sum amount billed—including unrelated non-prescription charges--to Medicare/Medicaid patients over the lump sum amounts of everything billed to all patients. Specific proof must tie the use of a particular prescription drug for which tax was paid to an actual Medicare patient.

Baton Rouge, Louisiana this 1st day of December, 2020.

FOR THE BOARD:

LOCAL TAX JUDGE CADE R. COLE