Submitter : **Mr. Rick Pollack** **Date: 05/21/2007**

Organization : **American Hospital Association**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2275-P-1-Attach-1.DOC

American Hospital Association

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May 21, 2007

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Re: (CMS-2275-P) Medicaid Program; Health Care-Related Taxes (Vo. 72, No. 56), March 23, 2007

Dear Ms. Norwalk:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 37,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule changing Medicaid policy on health care-related taxes used by the states to support their share of Medicaid expenditures. The AHA raises serious concerns regarding CMS' changes to the standards for determining whether an impermissible hold harmless arrangement exists within a health care-related tax.

The proposed rule represents a substantial departure from long-standing Medicaid policy by imposing subjective, overly broad standards for determining the existence of hold harmless arrangements. These proposed policy changes could create great uncertainty for state governments and hospitals, making it difficult for them to adopt or implement Medicaid health care-related tax programs with reasonable assurance that they are compliant. As a result, states and hospitals will be left open to after-the-fact challenges. In addition, the vaguer and broader standards CMS proposes will limit states from implementing legitimate provider tax programs that are consistent with the Medicaid statute and congressional intent. The AHA recommends that CMS withdraw the proposed changes discussed below regarding the standards for determining an impermissible hold harmless arrangement.

STANDARDS FOR DETERMINING A HOLD HARMLESS ARRANGEMENT

The current standards for determining the existence of impermissible hold harmless arrangements within health care-related taxes are: the positive correlation test; the Medicaid

payment test; and the guarantee test. Through the *Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991* (P.L. 102-234), Congress provided guidance on how to frame the standards for determining when a tax-paying provider is being held harmless for the payment of a tax. The implementing regulations further clarified the standards for the hold harmless test and were developed jointly with state governments and other key stakeholders. The agency sought to apply clear and specific rules for identifying a hold harmless arrangement because, as it noted in the 1993 final rule, a more subjective analysis would be administratively burdensome and virtually impossible to apply fairly (HCFA Final Rule, Health Care-Related Taxes, 58 Federal Register 43,156, 43166, 43167 (August 13, 1993)).

However, in this proposed rule, CMS clearly states in the preamble that some degree of subjectivity will be part of its analysis of hold harmless arrangements, and in doing so, the agency implies it is now willing to accept the uncertainty and potential unfairness of a subjective standard (FR Vol. 72, No. 56 13729). Furthermore, under the proposed rule, states and hospitals would no longer be able to rely on explicit standards contained in CMS regulations when considering provider tax programs, but would have to live with the uncertainty that subjective analysis undoubtedly brings.

POSITIVE CORRELATION TEST

The 1993 rule defined the term "positively correlated" to require a statistical analysis. However, in the proposed rule, CMS now argues that establishing a positive correlation should not be limited to a quantitative analysis but be broadened to include a more subjective analysis, such as finding linkages between a tax rate and other payments to providers. CMS claims that a positive correlation could be found simply by the fact that a provider payment, grant or credit program and a provider tax are enacted in the same legislative session. CMS appears to be reserving as much leeway as possible to determine what is and is not an appropriate tax. In doing so, the agency is making its guidance so broad as to be meaningless, using as a rationale that it is impossible to anticipate all the hold harmless arrangements that could be created.

MEDICAID PAYMENT TEST

Current federal law governing health care-related taxes states that the prohibition of hold harmless arrangements "...shall not prevent the use of the tax to reimburse health care providers in a class for expenditures under this subchapter, nor preclude States from relying on such reimbursement to justify or explain the tax in the legislative process" (U.S.C. Section 1936b(w)(4)). The law and current regulation recognize that a provider's expenses for the Medicaid portion of a provider tax are an allowable Medicaid expenditure. CMS, through this proposed rule, would reverse policy and statute by asserting that a hold harmless arrangement is present when the state makes Medicaid payments to providers in a supplemental form or otherwise, and the payment is measured by the Medicaid portion of the provider's tax liability.

GUARANTEE TEST

The third test the agency uses to determine if an impermissible hold harmless arrangement exists is whether the taxpayers are directly or indirectly held harmless for any portion of tax costs. CMS states in the preamble that a direct guarantee does not need to be an explicit promise or assurance of payment. The agency suggests that merely having a state statute, regulation or

policy that provides for a payment to the provider would be enough to trigger the suspicion of a hold harmless arrangement. CMS reverses its own long-standing policy found in the 1993 regulation and acts contrary to the language of the statute when it states that a direct guarantee can be triggered even in the absences of an explicit assurance. Once more, CMS relies on subjective analysis to determine the existence of a hold harmless arrangement when looking at the direct guarantee test.

Through this proposed rule, CMS gives itself broad sweeping authority to determine when an impermissible hold harmless arrangement exists. CMS admits that it is using subjective analyses when making these determinations. The effect of this new rule may be to eliminate provider tax programs that are authorized by the statute and that Congress intended states to be able to maintain. The proposed rule also may reduce the ability of state government and hospitals to understand whether a provider tax program that is being developed will meet CMS' approval. This degree of subjective analysis and uncertainty is unacceptable. The AHA urges CMS to withdraw the proposed policy changes regarding the standards for determining an impermissible hold harmless arrangement that we have identified.

If you have any questions regarding our comments, please contact me or Molly Collins Offner, senior associate director for policy, at (202) 626-2326 or mcollins@aha.org.

Sincerely,

Rick Pollack
Executive Vice President

Submitter : Ms. Christine Bronson **Date:** 05/21/2007

Organization : Minnesota Department of Human Services

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Provisions of the Proposed Rule

Provisions of the Proposed Rule

Thank you for the opportunity to comment on the proposed rule. Minnesota shares the goal of protecting the fiscal integrity of the Medicaid program. However, we have serious concerns regarding several of the policy changes to the hold harmless provisions of the regulation. The use of provider taxes as a funding source for Medicaid services has been explicitly allowed by statute for the last fifteen years. Many states have implemented tax programs relying on longstanding policy interpretations outlined in the implementing regulations. The provisions of this proposed regulation have the potential to undercut the foundations of states' existing tax programs and generate a great deal of uncertainty as to their continued compliance with federal statutes and regulations. We recommend that CMS consider these concerns and withdraw the hold harmless provisions from the final regulation.

CMS-2275-P-2-Attach-1.PDF

Minnesota Department of **Human Services**

May 21, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2275-P
PO Box 8017
7500 Security Boulevard
Baltimore, MD 21244-8017

Minnesota Department of Human Services Comments on:
Docket: CMS-2275-P, Medicaid Program; Health Care-Related Taxes

Dear Ms. Norwalk:

Thank you for the opportunity to comment on the proposed rule. Minnesota shares the goal of protecting the fiscal integrity of the Medicaid program. However, we have serious concerns regarding several of the policy changes to the hold harmless provisions of the regulation. The use of provider taxes as a funding source for Medicaid services has been explicitly allowed by statute for the last fifteen years. Many states have implemented tax programs relying on longstanding policy interpretations outlined in the implementing regulations. The provisions of this proposed regulation have the potential to undercut the foundations of states' existing tax programs and generate a great deal of uncertainty as to their continued compliance with federal statutes and regulations. We recommend that CMS consider these concerns and withdraw the hold harmless provisions from the final regulation.

CMS is proposing to significantly revise key definitions for and broaden the scope of the hold harmless provisions, and fundamentally alter the standards by which compliance with those provisions will be determined. This shift from objective standards to subjective determinations is a complete reversal to the approach in the 1993 regulation. In the 1993 final rule, CMS specifically rejected subjective analysis of the hold harmless provisions[1].

[1] Comment from 1993 final rule:
Comment: One commenter suggested that we raise hold harmless as an issue only when the facts demonstrate a compelling case of intention to and effect of relieving nursing homes from any significant impact of the tax.
Response: We believe that subjective analysis does not allow for a reasonable test of the hold harmless provisions. The use of a subjective analysis would result in a lack of specific standards by which hold harmless could be measured. In addition, a subjective analysis would be administratively burdensome and virtually impossible to apply fairly throughout the nation.

The proposed changes to the interpretation of the hold harmless provisions move CMS' oversight of state provider taxes away from an objective standard to a subjective approach. The objective standard was established in the 1993 rule developed in consultation with the governors. The proposed approach depends on a subjective CMS analysis of the *intent* behind states' implementation of provider tax programs and Medicaid payment changes. Minnesota believes that the objective approach established in the 1993 rule is the only approach that can be applied in a consistent and impartial manner and that would allow states a reasonable assurance that their tax programs remain in compliance with the provider tax rules.

General Comments on Proposed Changes to the Regulation

Required Consultation Not Conducted

Section 5(c) of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234), mandates that the Secretary of Health and Human Services consult with the states before issuing any regulations under the public law. There is no indication in either the statutory text or the accompanying conference report language that this requirement was specific to the first issuance of regulations or that it is limited by any time period. Aside from the Congressionally-mandated changes to the list of permissible classes and the indirect guarantee test safe harbor percentages, CMS, of its own volition, has made significant changes to the regulatory interpretations of the hold harmless provisions at §1903(w)(4) of the Social Security Act. Consultation with states was required prior to the issuance of the regulatory changes and the consultation did not occur as required. We recommend that CMS withdraw the changes to the hold harmless regulations that were not mandated by Congress, refrain from finalizing the Congressionally-mandated changes, and engage in consultation with the states as required by law.

Provisions of the Proposed Rule

Standardizing Definitions of "Tax Amount" and "Payment Amount"

CMS is proposing to redefine the terms "tax amount" and "payment amount" broadly. Under the proposed rule, tax amount and payment amount can mean the rate of the tax or payment, amount of payment or the tax paid, total tax costs, the difference between a Medicaid payment and a tax payment, or the incremental increase in a tax or a payment. The revised terms represent a significant change from current policy and will result in an overly broad definition of hold harmless under the positive correlation test.

Positive Correlation Test

CMS is proposing to expand the definition of the phrase "positive correlation" well beyond its current context, which is in the statistical sense. The positive correlation test is used to determine if states are using a non-Medicaid payment to repay providers for a portion of their tax costs. CMS' proposed definition of "positive correlation" would include the following situations:

- When the tax and payment are correlated in the statistical sense *or*,
- When the rate of tax and the rate of the payment are based on the same numerical factors (i.e. revenue or bed days). This needs to be clarified as this would be true even when the variables had a perfect negative correlation (in the statistical sense) *or*
- When the non-Medicaid payment is conditional on payment of the tax.

Again, this represents a significant departure from the current interpretation and will result in an overbroad definition of hold harmless. The new definition of positive correlation and the broadness of the terms "tax amount" and "payment amount" effectively enable the agency to compare different permutations of "tax amounts" and "payment amounts" until a combination that has a positive correlation is found. The result is that no state could ever be assured that their tax programs are *not* in violation of the hold harmless provisions.

Direct and Indirect Payments in the Direct Guarantee and Positive Correlation Tests
CMS proposes to interpret the phrase "direct and indirect payments" broadly for the purposes of the positive correlation and guarantee tests and promises to interpret the phrase in a "revenue source neutral" manner. CMS proposes to grant itself the discretion to consider any payment that comes from a source "controlled or influenced" by the state in determining whether or not a direct or indirect repayment has been made. The phrase "controlled or influenced" is overly broad and could encompass a virtually limitless assortment of governmental and non-governmental payments.

Finally, CMS proposes to change the guarantee test provisions so that an indirect payment, which will be interpreted in a revenue neutral manner, could constitute a direct guarantee. Since the standard for a direct guarantee is only that the taxpayer has a "reasonable expectation" of being held harmless for any portion of the tax, virtually any state payment could be viewed as a violation of the direct guarantee test.

The expansive interpretations of the positive correlation and guarantee tests and non-state payments virtually ensure that CMS will be able to find any provider tax program in violation of the hold harmless provisions if that is the agency's desired outcome. Because Congress clearly intended to allow provider-specific taxes, we believe these amendments exceed CMS' statutory authority.

We recommend that CMS withdraw the proposed changes to the positive correlation and direct guarantee tests and work with states to develop *objective* standards by which compliance with these two hold harmless provisions can be measured. Such objective standards are necessary so that states can have some reasonable expectation that tax programs meeting the standards will not later be declared impermissible by CMS on the basis of a subjective analysis of endless permutations of the taxes paid by providers and any payments, credits, grants, or other considerations they may receive from the state or other entities.

Conditional Payments
For the purposes of determining whether or not a Medicaid payment is being used to repay a taxpayer for tax costs, CMS proposes that a Medicaid payment will be considered to vary based on the tax amount, and therefore violate the Medicaid payment test, whenever the Medicaid payment is conditional on the tax payment. CMS intends to apply the conditional payment test in the aggregate by contending that *any* Medicaid payment that is funded with dedicated provider tax revenue would result in a violation of the Medicaid payment test. CMS reaches this conclusion by reasoning that when a new or increased Medicaid payment is funded by dedicated tax revenue, the only difference between the new Medicaid payment (i.e. a quality incentive payment) and no Medicaid payment is the tax amount itself. CMS argues that this constitutes a hold harmless on its face.

Also, in the discussion regarding the indirect guarantee test (§433.68(f)(3)), CMS proposes to define an enhanced Medicaid payment as a payment for which any branch of government has indicated that the payment can be reduced or eliminated if the provider tax is discontinued.

In proposing these new interpretations of the Medicaid payment test and the indirect guarantee test, CMS is asserting that any Medicaid payment that is funded with dedicated tax revenue or which is subject to elimination or reduction if the tax revenue is eliminated represents a structural repayment of the tax and therefore violates the hold harmless provisions. In the preamble language explaining the changes to the Medicaid payment test, CMS states the changes are intended to affect "States that seek to use rates that are based solely on the receipt of provider taxes, rather than on overall provider costs." CMS further states that the changes are intended to "limit the ability of States to expressly condition payment rates on tax receipts rather than on a process that determines rates that are consistent with efficiency, economy and quality of care..."

We are greatly concerned by CMS' apparent willingness to declare a Medicaid payment to be uneconomical solely because the revenue from the tax is dedicated to funding the Medicaid payment. In viewing the Medicaid payments as a repayment of the dedicated tax revenue funding source, the agency is making a subjective judgment that the intent of the Medicaid payment is to compensate providers for the cost of the tax. CMS is interfering with legal taxation by presupposing that rates explicitly supported by tax revenue are too high and therefore not economical.

The fact that a Medicaid payment or a payment rate increase is funded by provider tax revenue is *not* an indication that the payment rate is uneconomical. In fact, it is irrelevant to the determination as to whether or not the payment amount is consistent with a reimbursement level that would provide sufficient compensation to providers who are efficient and economical providers of quality health care services. The agency's argument that dedicated provider taxes automatically result in uneconomical Medicaid payments is simply a modified version of the net expenditure argument put forth in its original attempts to prohibit the use of provider taxes in Medicaid. In proposed rules published in 1990 and 1991, the agency argued that because provider taxes essentially reduced the actual expenditures made by the state, the amount of the provider tax revenue should be deducted from total state spending so that only "real" or "net" state expenditures would be matched with federal dollars. Congress rejected that argument by including language prohibiting the agency from finalizing the 1991 interim final rule into the 1991 Medicaid Amendments[2].

The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 represent the clearest statement of congressional intent regarding states' use of provider taxes. That law explicitly gives the state the right to use the revenue received from broad-based and uniform provider taxes to fund payments for Medicaid services *and* to use the Medicaid payment to justify the tax.

[2] §2(c)(3) of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 nullified the October 31, 1991 interim final rule. §2(b)(2) struck the amendments to §1903(i) added by section 4701(b)(3)(B) of OBRA 90 relating to prohibitions for FFP on certain tax revenue.

We believe the agency's reliance on the concept of conditional Medicaid payments in the hold harmless tests are intended to undermine provider support for provider taxes. Health care providers are often reluctant to support new or increased taxes unless there is an explicit assurance (often in statutory language), that the revenue from the taxes will be dedicated to increasing payments for Medicaid services and not used for other purposes. Similarly, many state legislatures are reluctant to increase Medicaid liabilities without the ability to make them contingent on the funding source. The proposed regulation seeks to prohibit those explicit assurances. Stated assurances that provider tax revenue will be used for a specific category of Medicaid expenditures are not equivalent to holding taxpayers harmless for the cost of the tax.

Revenue Limit – Two-Pronged Indirect Safe Harbor
CMS proposes new regulatory language to implement the 6% and 5.5% safe harbor percentages under the two-pronged indirect guarantee test as required by the Tax Relief and Health Care Act of 2006. However, in implementing the percentage threshold changes, the agency has gone beyond the legislative directive by further amending the regulatory text to specify that the percentage thresholds apply to net operating revenues.

CMS' conclusion that the safe harbor percentages should be restricted to net revenue is not supported in the legislative history. Minnesota believes that states should be permitted to interpret the phrase "revenue received by the providers" as either gross or net revenue.

The proposed changes to the three hold harmless provisions do not represent a reasonable interpretation of the federal statutory language. The changes will result in a definition of hold harmless that is so broad and subjective that virtually any tax could be found to be in violation of at least one of the three provisions. Federal law explicitly allows states to tax health care providers and to use the revenues from those taxes to fund state Medicaid programs. The proposed changes in this rule would restrict states' ability to use provider taxes in a manner and to a degree that are clearly inconsistent with federal law.

Minnesota recommends that CMS withdraw all provisions in the proposed rule that are not explicitly required by either the Deficit Reduction Act of 2005 or the Tax Relief and Health Care Act of 2006. Minnesota further recommends that CMS conduct the required consultation with states prior to finalizing this rule or issuing any further regulations regarding provider taxes or provider related donations.

Sincerely,

Christine Bronson

Christine Bronson
Medicaid Director

Submitter : Mr. Ralph Gronefeld **Date:** 05/22/2007

Organization : ResCare, Inc.

Category : Other Health Care Provider

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2275-P-3-Attach-1.DOC

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May 22, 2007

BY ELECTRONIC FILING AND BY HAND

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Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
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Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: ***Medicaid Program; Health Care-Related Taxes; Proposed Rule, 72 Fed. Reg. 13726 (March 23, 2007)***

Dear Ms. Norwalk:

This letter presents comments and recommendations of ResCare, Inc. ("ResCare") to certain aspects of the proposed rule referenced above. In particular, we offer our comments on the proposal to exclude grandfathered community residences from the intermediate care facilities for the mentally retarded ("ICF/MR") permissible class of health care items and services. We also offer comments on the proposal to expand the tests for determining whether a broad-based health care related tax contains a hold harmless provision.

ResCare is the nation's leading provider of services to persons with developmental and other disabilities and people with special needs. Founded in 1974, ResCare offers services to some 32,000 people in 36 states, Washington, D.C., Puerto Rico and Canada. At its core, ResCare is a human service company that provides residential, therapeutic, job training and educational support to people with developmental or other disabilities, to youth with special needs and to adults who are experiencing barriers to employment.

For the reasons stated below, we strongly urge the Centers for Medicare & Medicaid Services ("CMS") not to implement the proposed rule. We believe the regulatory language and policies advanced in the proposed rule are flawed and will cause harm to an undetermined number of persons who rely on Medicaid for access to health care services. At a minimum, CMS should delay implementation of the proposed rule until state legislatures can assess the implications of the proposed rule and take action necessary to ensure proper funding of existing mental health programs.

I. Executive Summary

CMS has provided no rational explanation for its proposal to exclude grandfathered community-based residences from the permissible class of health care items and services that may be taxed. The existing class of ICF/MR and grandfathered community-based services has existed since 1992 without any issue raised by CMS. Failure to provide any rationale support for the proposed rule creates an arbitrary and capricious limitation on health care related taxes and donations in violation of the Administrative Procedures Act ("APA").

The proposed rule would give extensive new authority to CMS to examine health care related payments to determine if providers are held harmless from some or all of the cost of the tax as a bona fide donation, including payments to patients of the provider. Congress established the exclusive test for determining if taxes and donations are available for matching federal funds. The proposed rule is inconsistent with the statutory language and, therefore, violates section 706(2)(A) of the APA. The intent of the statute must be given effect by applying the hold harmless tests as adopted by Congress. Congress did not authorize the Secretary to expand the tests for determining whether state spending programs hold taxpayers harmless for tax amounts. Furthermore, the agency's interpretation of the statute is unreasonable. Under the expansive language of the proposed rule, any state tax or health care spending program could be deemed to include a hold harmless provision. This regulatory expansion of the limits on state funding of Medicaid programs will cause undue hardship to Medicaid beneficiaries by broadly expanding the type of taxes and donations that may be considered hold harmless arrangements without allowing states to review or adjust existing laws. As a result, existing Medicaid services may be severely and abruptly reduced.

At the earliest, existing state laws can not be changed until the close of the next legislative session. Any implementation of the proposed rule should be delayed to allow time for the legislative process to address the impact of the rule before Medicaid services are reduced or eliminated.

Finally, CMS should encourage state funding of home and community-based residences (together "CBRs") for the mentally retarded and developmentally disabled by including CBRs as part of the ICF/MR class of health care items and services that may be subject to a broad based tax.

II. Discussion

A. Proposals to exclude grandfathered community-based residences from ICF/MR permissible class of health care items and services

1. Summary of proposal

CMS provides federal financial participation ("FFP") to match certain state Medicaid expenditures. The FFP provided by the federal government to match state expenditures is reduced by the revenue that the state receives from health care related taxes. The FFP is not reduced, however, by tax revenue that meets specified criteria, including that the taxes are "broad-based" (i.e., applied to all health care providers within the same class) and "uniform" (i.e., applied equally to all taxed providers). A tax is considered broad-based if uniformly imposed on all non-Federal, non-public providers in a specified class and all business of providers in that class.

In section 1903(w)(7)(A)(iv) of the SSA, Congress identified ICF/MR as a class of providers that may be taxed without deducting the tax revenue from the FFP calculation. In an

interim final rule implementing the statute, CMS included within the class of services for ICF/MR those services furnished by CBRs operating under a waiver under section 1915(c) of the SSA, in those states in which, as of December 24, 1992, at least 85 percent of CBRs were classified as ICF/MRs before the grant of the waiver ("Grandfathered Facilities").

CMS now proposes to terminate the grandfathered status of these CBRs by eliminating the grandfathered language from the regulation. As a result, tax revenue generated from the Grandfathered Facilities will be deducted from the calculation of FFP for each applicable state.

2. ResCare response

CMS correctly included CBRs as part of the ICF/MR class of services when the rule was finalized. This approach recognized the substantial similarity in services provided by CBRs and community ICF/MRs that serve a relatively small number of residents. In the preamble to the interim final rule, CMS acknowledge the similarities of the facilities and the ability of the state to easily include CBRs in the same licensing category as ICF/MRs. CMS justified the original approach by asserting that existing group homes were included in the ICF/MR class of services "because of [CMS's] desire to ensure that taxes are as broad-based as possible." Since the services provided in CBRs and community ICF/MR facilities are significantly similar, as are the needs of persons who receive their services, a broad-based tax must necessarily include both facilities. The tax cannot be said to be broad based if it excludes a substantial number of facilities that but for a Medicaid waiver program under section 1915(c) would otherwise still be licensed as ICF/MRs. By effectively narrowing the class of health care providers, CMS would cause the class to no longer be truly broad based.

In order for this class of services to be broad based and equitable, CMS should incorporate all types of home and community residences for persons with mental retardation and developmental disabilities as part of one class of services on which permissible taxes may be enacted by the states. Most services for the mentally retarded and developmentally disabled are now provided in home and small group environments. In addition, consideration should be given to the fact that Section 6086 of the Deficit Reduction Act allows a state to include home and community-based services in its Medicaid plan, thereby eliminating the need for a waiver. On April 5, 2007, the Department of Health and Human Services approved the first state plan option under this provision in agreeing to Iowa's new benefit effective January 1, 2007, which targets persons with severe mental illness and provides for home and community-based case management services and habilitation services at home or in-day treatment programs. Clearly the public policy of the federal government is to support more home and community-based services, not less. Permitting states to tax home and community-based services will provide states with greater resources to assist this population and to carry out the federal government's stated public policy.

The proposed rule will restrict home and community-based alternatives for individuals who would otherwise be institutionalized in ICF/MRs. Funds generated from taxes imposed on the existing class of ICF/MR providers, together with matching FFP, are used to enhance Medicaid provider reimbursement rates paid under approved waiver programs. By increasing, or at least maintaining, reimbursement to these providers, the Medicaid program improves the quality of care to the most vulnerable of all Medicaid beneficiaries and decreases the number of patients institutionalized in ICF/MRs by transitioning them to CBR programs. This approach is supported by clinical research and health care professionals across the country. Furthermore, state governments have already, and continue to, take steps to ensure the cost-effectiveness of Medicaid programs. The importance of these steps is already heightened as a result of demographic changes, such as the aging of persons with developmental disabilities. As a result of people with developmental disabilities enjoying increased longevity, the demand for services for people with developmental disabilities is increasing at a rate greater than population growth

alone. While faced with a growing need, state governments have increasingly come to realize that investment in home and community-based services result in less spending on hospital and primary care, homeless programs, correctional facilities and other social costs. CMS should support this effort by expanding the ICF/MR class to include all home and community-based programs for the mentally retarded and developmentally disabled.

CMS has not provided a reason that would support revoking special status of Grandfathered Facilities. In the preamble to the proposed rule, CMS provides only that "it is not equitable to accord different treatment to States that converted ICF/MRs before December 24, 1992 than to other States." 72 Fed. Reg. at 13731. CMS fails to offer a reason why the existing rule, which was equitable when it was implemented in 1992, is suddenly inequitable in 2007. CMS provides no analysis of the number of states that actually converted ICF/MRs under a waiver under section 1915(c) of the SSA or the number of facilities this change may impact. Instead, CMS contradicts itself by declaring without analysis or delay that Grandfathered Facilities are excluded from the class of health care items and services that may be subject to taxation. If CMS is concerned about whether the policy is in fact equitable, it could just as easily include all CBRs in the ICF/MR class. This approach is far more equitable by ensuring the same treatment of all facilities providing services to persons with mental retardation or developmental disabilities.

CMS is required to provide a rational explanation for abruptly reversing the grandfathered status of CBRs identified in 42 C.F.R. § 433.56(a)(4). The APA governs judicial review of agency actions, including the proposal to exclude Grandfathered Facilities from the ICF/MR class. When the validity of an agency regulation is challenged, the APA authorizes the reviewing court to "decide all relevant questions of law, interpret constitutional and statutory provisions, and determine the meaning or applicability of the terms of an agency action." 5 U.S.C.S. § 706. An agency's action may be set aside if it is, among other things, arbitrary, capricious an abuse of discretion or otherwise not in accordance with law. See Id. § 706(2)(A). The seminal case on the traditional standard for arbitrary and capricious review is Motor Vehicle Mfrs. Ass'n v. State Farm Mutual Auto. Ins. Co, 463 U.S. 29 (1983). After concluding that it would not accept the agency "counsel's *post hoc* rationalizations for [the] agency action," the Court held that the NHSTA failed to supply the requisite reasoned analysis "to enable [the Court] to conclude that the rescission was the product of reasoned decisionmaking." Id. at 52 and 57. Without a clear rational basis for an agency action, courts have followed State Farm to strike down regulations. See Shays v. Federal Election Comm'n, 337 F. Supp.2d 28, 92 (D.D.C. 2004), aff'd 414 F.3d 76 (D.C. Cir. 2005) (concluding that the Commission had not "articulated an explanation for its decision that demonstrates its reliance on a variety of relevant factors and represents a reasonable accommodation in light of the facts before the agency."); Athens Community Hospital v. Shalala, 21 F. 3d. 1176 (D.C. Cir. 1994) (finding that the Secretary failed to provide a rationale to support her rule).

CMS has a heightened obligation to supply a reasoned analysis for the change in classification of Grandfathered Facilities beyond that which may be required when an agency does not act in the first instance. Merely declaring the current rule to be inequitable is insufficient analysis to change the rule when it was previously determined (by the same agency) to be equitable. Since November 24, 1992, States have relied upon the existing classes of health care services and items to craft state law and policy. Now, without sufficient explanation, CMS proposes to change the ICF/MR class without delay or consideration of its impact on existing state Medicaid programs.

Revocation of the grandfathered status is likely to have a substantial negative impact on state Medicaid programs. CMS has provided no analysis of how this action will impact existing state tax laws. Existing laws were developed to comply with the rules governing FFP at the time they were certified and legislators could not have predicted that CMS would so dramatically alter

the ICF/MR class of health care items and services so as to further limit health care related taxes. By continuing to alter the rules governing FFP, CMS creates immeasurable degree of uncertainty for state Medicaid programs that ultimately results in increased costs and inefficiency in providing Medicaid services. State tax laws and licensing rules are not easily changed and require substantial time and planning.

3. ResCare position and alternatives

Grandfathered Facilities should not lose their current status. CMS has not provided a legitimate reason for revising the ICF/MR class. We strongly encourage CMS not to finalize its proposal to exclude grandfathered community residences from ICF/MR permissible class of health care items and services.

The ICF/MR class should be expanded to include all home and community-based programs for the mentally retarded and developmentally disabled. Given the similarity of the services provided and the needs of recipients of those services, it is appropriate to include these programs in the ICF/MR class in order for any qualifying tax to be truly broad based and uniform. ICF/MR facilities exhibit an increasing number of similarities with home and community-based programs. This overlap dictates including home and community-based programs as part of this class of health care providers.

B. CMS proposal to define "positive correlation" to include any positive relationship between a payment amount and a tax amount, even if inconsistent over time

1. Summary of proposal

Section 1903(w)(4) of the SSA describes health care related taxes that, despite uniform application to a permissible class of health care providers, cause a reduction in the amount of matching federal funds because they are deemed to hold the taxpayer harmless from the tax amount. Congress established three separate tests for identifying a hold harmless provision. Under the first of the three statutory tests, tax revenue is ineligible for matching federal funds if the state or local government "imposing the tax provides (directly or indirectly) for a [non-Medicaid] payment to taxpayers and the amount of such payment is positively correlated either to the amount of such tax or to the difference between the amount of the tax and the amount of payment under the State plan." 42 U.S.C. § 1396b(w)(4)(A).

Existing regulations match the statutory language of the first hold harmless test. The preamble to the existing regulation further defines positive correlation as having the same meaning as its "statistical sense." Unsatisfied with the decision of the Departmental Appeals Board ("DAB") in DAB No. 1981, which reversed disallowances issued by CMS to five states, CMS now proposes a new understanding of when payments and taxes are positively correlated. The proposed rule would define "positive correlation" to include "any positive relationship between these variables, even if not consistent over time." A statistical correlation would not be required to find a positive correlation between the variables.

2. ResCare response

Congress has directly addressed whether state taxes and donations are available for matching federal funds. The proposed rule is inconsistent with the statute and, therefore, violates section 706(2)(A) of the APA as an abuse of discretion. By including any positive correlation over any amount of time, the proposed rule destroys any standard by which a state may assess whether or not a funding scheme will be determined by CMS to be a hold harmless provision. The breadth of the proposed rule will cause any tax structure to be correlated in some manner to

a payment. Accordingly, the proposed rule is an arbitrary and capricious application of the statutory limits on health care related taxes and donations.

CMS has no authority to implement regulations that alter the tests Congress established for determining whether a health care related tax includes a hold harmless provision. Congress assigned the Secretary the task of determining the existence of a hold harmless provision. It did not authorize regulations that expand or restrict the existing statutory test. While it is within CMS's discretion to determine compliance with the hold harmless provision, nowhere in the statute did Congress confer authority upon CMS to alter the hold harmless test. Accordingly, CMS has exceeded its statutory authority by advancing the proposed rule. The APA requires courts "hold unlawful and set aside agency action, findings and conclusions found to be-- in excess of statutory jurisdiction, authority, or limitations, or short of statutory rights." 5 U.S.C. § 706(2)(C). If, as is the case here, a statute directs that certain procedures must be followed, an agency cannot modify what Congress has required of it. CMS is powerless to revise the statutory definitions of a hold harmless provision. It is the agency's duty to make factual determinations, not to revise the nature of the statutory test. Congress has set forth a clear and precise standard that neither requires nor permits revision.

The Department of Health and Human Services Departmental Appeal Board ("DAB") has recognized the role and intent of Congress in establishing a means for identifying hold harmless arrangements and preventing such arrangements from artificially inflating FFP. In an administrative hearing concerning the disallowance of FFP claimed by five different states, the DAB summarized the role of Congress and the statutory scheme as follows:

> As the record in this case indicates, the Medicare Voluntary Contribution and Provider Specific Tax Amendments of 1991 (Public Law No. 102-234) were intended to resolve a lengthy controversy between CMS and the states about taxes states imposed on health care items or services. CMS believed that such taxes were being used to artificially inflate federal Medicaid funding to states and had proposed regulations to reduce Medicaid funding if states imposed any health-care related taxes and made any payment linked to those taxes. States considered this an interference with their taxing authority and obtained congressional moratoria on CMS's proposals. Ultimately, CMS and the states reached a compromise that was adopted almost verbatim in the 1991 law. CMS viewed the 1991 law as intended to stop state schemes to inflate federal funding, and states argued that the statute protected them from CMS's overreaching by permitting health-care related taxes, with no reduction in Medicaid funding, so long as they met certain requirements. Essentially, the requirements were that the tax be broad-based and uniformly imposed (unless the state obtained a waiver of these requirements by showing that the tax was generally redistributive and met other requirements), and that the state not hold taxpayers harmless, in any one of three ways described in the statute.

2005.06.24 DAB 1981. CMS now proposes to alter the status by changing the language and interpretation of the hold harmless provision. As acknowledged in the DAB decision, the statute governing allowance of health care-related taxes was carefully considered and its language adopted "almost verbatim" from the compromise. Congress, after input from major stakeholders, passed legislation with precise language governing the conditions under which states may impose health care-related taxes. CMS may not on its own accord alter this carefully crafted compromise.

The hold harmless test of section 1903(w)(4) can be distinguished from other provisions of the same section of the SSA which grant CMS authority to adopt and implement regulations. In particular, Congress granted CMS the authority to regulate provider related donations. "The

Secretary may by regulation specify types of provider-related donations described in the previous sentence that will be considered to be bona fide provider-related donations." 42 U.S.C. § 1396b(w)(2)(B). Even in the section of the act that immediately precedes the hold harmless test, Congress authorized the Secretary to specify types of credits, exclusions, and deductions that meet the requirement for a waiver for taxes that are not otherwise broad-based and applicable to a permitted class of health care providers. See Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, Pub. L. 102-234 (Dec. 12, 1991). The fact that Congress did not specifically authorize CMS to implement regulations addressing the hold harmless test is conclusive evidence of its intent to provide the exclusive and final word on whether a health care related tax contains a hold harmless provision. The proposed rule improperly infringes on the authority of the legislative branch.

3. ResCare position and alternatives

Any analysis of the positive correlation between the tax amount and payment amount should be interpreted in its statistical sense in order to provide consistency and confidence in the funding of state Medicaid programs.

Regulations addressing the conditions under which a taxpayer will be considered to be held harmless under a tax program should match the statutory language verbatim. The changes to section 433.68 offered by the proposed rule are beyond the authority delegated to CMS by Congress.

C. CMS proposes to broadly interpret "direct or indirect non-Medicaid payment" as that phrase is used to determine if a payment is positively correlated to the tax amount or to the difference between the Medicaid payment and tax amount

1. Summary of proposal

The statute includes both the terms "indirect" and "direct" in describing whether a payment is positively correlated to the tax amount or the difference between the Medicaid payment and tax amount. The statute also includes both terms in describing whether a donation or voluntary payment is made to a state or local government. In the preamble to the proposed rule, CMS states that "[w]e propose to interpret the phrase 'direct and indirect non-Medicaid payment' broadly." A discussion, including examples, of how this interpretation would be applied is included in the preamble. CMS offers no specific regulatory language related to how "direct or indirect non-Medicaid payment" will be interpreted, instead CMS simply announces in the preamble a general intent to broadly interpret the phrase.

2. ResCare response

CMS must propose regulatory language before interpreting the phrase in any way other than its plain meaning under the statute. In the preamble to the proposed rule, CMS simply states that it is considering a change in how the agency interprets whether a non-Medicaid payment is indirectly made to a provider. However, in violation of section 533(b) of the Administrative Procedure Act ("APA"), CMS provided no specific regulatory language to implement this proposed policy. See 5 U.S.C. § 533(b)(requiring a notice of proposed rulemaking to include "the terms or substance of the proposed rule"). Without adequate notice of the regulatory language that CMS intends to use, interested parties are improperly limited in the degree to which they are able participate in the rulemaking process. See United Church Board for World Ministries v. SEC, 617 F. Supp. 837, 840 (D. D.C. 1985) ("A general request for comments is not adequate notice of a proposed rule change. Interested parties are unable to participate meaningfully in the rulemaking process without some notice of the direction in which the agency proposes to go.") Moreover, courts have consistently found that where notice is not

"clear and to the point," it is inadequate and the agency's "consideration of the comments received in response thereto, no matter how careful, cannot cure the defect." McLouth Steel Products Corporation v. Thomas, 267 U.S. App. D.C. 367 (D.C. Cir. 1988) (citing cases) (citations omitted). Accordingly, regardless of whether it receives comments on its proposal, CMS may not implement this policy in a final rule until it publishes sufficient notice in the form of substantive regulatory language pursuant to section 533(b) of the APA and as required by interpretive case law. Until CMS offers specific regulatory language to the contrary, CMS must interpret whether a non-Medicaid payment is indirectly made to a provider based solely on the plain meaning of the statute, existing regulations, and judicial interpretations.

Uncertainty of how the proposed rule will be interpreted will harm Medicaid beneficiaries and the state legislative process. Due to the increased possibility that health care related spending could be interpreted as hold harmless arrangements, state legislatures will be reluctant to address the needs of their Medicaid program. The proposed rule will have a chilling effect on state funding of Medicaid programs by not adequately describing what arrangements will be result in decreased federal spending. CMS acknowledges that its proposed approach would create uncertainty. "We recognize that this test interjects some degree of subjectivity into this analysis." 72 Fed. Reg. at 13729. This approach is completely contrary to the agency's previously stated policy. In the Final Rule addressing provider related donations and taxes dated August 13, 1998, CMS rejected out of hand any subjective analysis of the hold harmless provisions.

> Comment: One commenter suggested that we raise hold harmless as an issue only when the facts demonstrate a compelling case of intention to and effect of relieving nursing homes from any significant impact of the tax.
>
> Response: **We believe that subjective analysis does not allow for a reasonable test of the hold harmless provisions**. The use of a subjective analysis would result in a lack of specific standards by which hold harmless could be measured. In addition, a subjective analysis would be administratively burdensome and virtually impossible to apply fairly throughout the nation.

58 Fed. Reg. at 43,166-43,167 (emphasis added).

Finally, as discussed in section II.B.2 above, Congress established the exclusive test for determining whether a health care related tax includes a hold harmless provision, including whether a non-Medicaid payment is indirectly made to a health care provider. CMS is charged with applying this test, but not permitted to arbitrarily expand its application through ambiguous examples in the preamble to a proposed rule.

3. ResCare position and alternatives

CMS has not proposed a change to the regulations with sufficient specificity for the public to provide meaningful comments. If CMS intends to alter its understanding of "indirect" for purposes of identifying hold harmless provisions, the agency should work directly with Congress to clarify the statutory language itself- not create more confusion by adopting a subjective standard that CMS knows the states will find difficult to understand and follow.

D. CMS proposal regarding Medicaid payments conditioned on the payment of the tax amount

1. Summary of proposal

The statute excludes all or any portion of a Medicaid payment to a taxpayer that varies based solely on the amount of tax paid from calculating the amount of matching federal funds. Existing regulations are consistent with the statutory language, providing that CMS will identify as a hold harmless provision any arrangement where "[a]ll or any portion of the Medicaid payment to the taxpayer varies based only on the amount of the total tax payment." 42 C.F.R. § 433.68(f)(2).

In addition to the existing language, the proposed rule will prohibit consideration of any tax amount when the Medicaid payment is entirely conditional on payment of the tax. CMS states in the preamble that it believes this proposed rule is consistent with the statute.

2. ResCare response

The proposed rule is inconsistent with the language of the statute and the intent of Congress. Conditioning Medicaid reimbursement upon receipt of taxes due state or local government is different than determining whether Medicaid payments vary based on the amount of taxes paid. In the latter case, Congress determined that varying payments on the taxes paid would result in a hold harmless arrangement that requires the revenue to be excluded from the total amount expended by the state for Medicaid services. Congress did not address the former case. CMS reasons that conditioning reimbursement on payment of a tax amount is inconsistent with "efficiency, economy, and quality of care, and is based solely on the return of funding received through the tax program." CMS does not consider that states may have other legitimate reasons for conditioning payments from the state's treasury upon a taxpayer's proper payment of taxes due and outstanding. Will CMS reduce FFP under the proposed rule if a state insists that health care providers pay their taxes before the provider is eligible for state funds? It is in the best interest of state government and the state Medicaid programs that the state requires, through whatever means available, health care providers pay their fair share of <u>any</u> tax before benefiting from a public program. Congress did not impede states from exercising their right to collect taxes. The statutory language makes clear that Congress prohibited states from varying the Medicaid reimbursement "based <u>only</u> upon the <u>amount</u> of the tax paid." For purposes of determining FFP, Congress prohibits states from truly holding health care providers harmless from their contribution to state revenues. Congress does not prohibit states from holding health care providers accountable for the payment of valid and outstanding taxes. As discussed in section B.2 above, CMS has no authority to alter the hold harmless test Congress established.

CMS suggests in the preamble that states using cost-based payment systems would not be precluded from "including provider tax costs as one of many provider costs that are considered in setting individualized provider rates." 72 Fed. Reg. at 13,730. If CMS proceeds with the proposed rule, we encourage the agency to explicitly include this protection in the rule itself. Given that CMS intends to reverse its position on Grandfathered Facilities, as well as the use of statistical analysis in finding positive correlations, it is conceivable that CMS will at some future date reverse its position on whether cost-based payment systems make reimbursement conditional upon receipt of health care related taxes. This issue underscores the importance of relying upon the hold harmless test established by Congress.

3. ResCare position and alternatives

Congress has established tests for determining whether state taxes and donations are available for matching federal funds. This proposal changes the substance of these tests in

violation of the statute. Furthermore, any proposal to exclude state revenue generated by taxes that a provider must pay to be eligible for Medicaid reimbursements encroaches upon a state's right to enforce its tax code.

E. CMS proposal to prohibit any indirect guarantee to hold taxpayers harmless for any portion of the tax amount

1. Summary of proposal

The statute provides that any payment, offset, or waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax will not be eligible for matching federal funds. Existing regulations match the statutory language. A taxpayer will be deemed held harmless from a tax amount if the "State (or other unit of local government) imposing the tax provides, directly or indirectly, for any payment, offset, or waiver that guarantees to hold taxpayers harmless for all or a portion of the tax." 42 C.F.R. § 433.68(f)(3).

The proposed rule would expand how CMS determines whether a payment, offset or waiver guarantees to hold taxpayers harmless from the tax amount. In addition to direct guarantees that hold taxpayers harmless, the proposed rule would include indirect guarantees. In the preamble, CMS distinguishes an indirect guarantee from a direct guarantee in that "the payment to the provider is through regular or enhanced payments for pre-existing Medicaid obligations." Applying this distinction in the preamble, CMS declares its intent to "consider as 'enhanced Medicaid payments' any amount that any branch of the State, including legislative and executive branches, has indicated could be subject to reduction in the absence of provider tax revenues."

2. ResCare response

Congress has directly addressed when a tax provides for an impermissible hold harmless guarantee and CMS is obligated to follow the congressional directive. The proposed rule is contrary to the statute. As discussed in section II.B.2 above, this change is not authorized by Congress and in direct conflict with its intent.

The breadth of the proposed rule will cause any reimbursement system to be interpreted as an indirect guarantee of payment. Accordingly, the proposed rule is an arbitrary and capricious application of the statutory limits on health care related taxes and donations.

3. ResCare position and alternatives

The regulations should mimic the statutory language. Any change in the substance of these tests must be addressed by Congress.

F. Undue hardship on Medicaid beneficiaries; delay of effective date needed

The proposed rule greatly expands the type of taxes and donations that are excluded from federal matching funds without allowing states to put in place alternate means of financing its Medicaid program. As a result, Medicaid services may be severely and abruptly reduced in the rush to comply with the proposed rule, or in the event that FFP is cut upon implementation of the rule. It is critical that CMS delay the effective date of the proposed rule in order to give states the time required to adjust their laws and regulations. Concluding that states were on notice that regulations in this area were likely for more than a year and a half, CMS still offered a 6-month delay to the initial proposed rule governing the state share of FFP. See 56 Fed. Reg. 56,132. "[I]n order to avoid hardship in the case of any State that is interested in revising its tax or provider donation arrangements to be consistent with the provisions of this rule, we are willing to

consider delaying the effective date of the rule in that State for six months to enable the State to enact or implement the necessary change." Id. CMS has not provided a grace period for implementation of the rule. A reasonable grace period of six to twelve months will allow states to go through the legislative process for making changes to their tax programs, as necessary.

Any changes to the hold harmless provisions must allow states adequate time to make necessary conforming changes to state statutes and regulations. If changes to the state tax code or Medicaid state plan are required, a state must be permitted time to identify alternative approaches and then execute a change without harming or penalizing Medicaid beneficiaries by decreasing funding or access to health care services. The time required for this process varies widely between states. In some states the legislative session is long with ample opportunity to address curative legislation, in other states the legislature meets only biannually with no opportunity to make changes to the tax laws between sessions.

Taking into consideration increasing demand for home and community-based alternatives over institutional settings, states craft laws, regulations and Medicaid plans to fund and provide access to home and community-based services. In so doing, it is critical that state policymakers can rely upon clear, unambiguous guidance from CMS on the requirements for FFP. Varying standards in determining whether a tax arrangement constitutes a hold harmless arrangement creates uncertainty in the funding and delivery of important health services. As discussed above, changes to state statutes, regulations and policies require consultation with numerous stakeholders and extended debate among their representatives. Accordingly, consistent, discernible rules governing FFP are of the utmost importance.

III. Conclusion

We strongly urge CMS to reconsider the proposed rule. In particular, Grandfathered Facilities should not lose their current status as part of the ICF/MR class. States have relied upon the definition of the ICF/MR classification since 1992 to develop and implement state tax and health care programs. Now, without sufficient reason, CMS proposes to change this classification. We urge CMS to abandon this aspect of the proposed rule. It does nothing to protect federal funds or advance the well-being of Medicaid beneficiaries. A better policy is to expand the ICF/MR class to include all home and community-based programs for the mentally retarded and developmentally disabled. At a minimum, CMS must delay the effective date of this change until state legislatures and policy-makers have the opportunity to address its impact and, if necessary, make conforming changes.

The proposed rule conflicts with the statutory tests for determining whether a health care related tax or donation constitutes a hold harmless arrangement. Congress established the rules for identifying a hold harmless arrangement and charged CMS with the authority to determine when the rules apply. Congress did not authorize CMS to expand or alter the hold harmless test to do so through the adoption of the proposed rule is an *ultra vires* act.

Further weakening the proposed rule, CMS provides no rational explanation for its proposed changes. As a result, the rule violates section 706(2)(A) of the APA as arbitrary, capricious an abuse of discretion. CMS is required to provide a rational explanation for the policies proposed, including why a group of health care providers should no longer be included in the ICF/MR class.

Finally, we urge CMS to consider the impact of the proposed rule on both existing state Medicaid programs, proposed amendments to those programs and their beneficiaries. Swift enactment of the proposed rule will harm Medicaid beneficiaries by imposing new restrictions on state funding without adequate opportunity to review or amend current state financing structures to continue the care that is currently being provided to Medicaid beneficiaries across the country.

Thank you for your consideration.

Respectfully submitted,

Ralph G. Gronefeld, Jr.
President and CEO
ResCare, Inc.

Submitter : Ms. Nancy Linehan **Date:** 05/22/2007

Organization : NYS Dept. of Health

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2275-P-4-Attach-1.DOC

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

May 22, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2275-P
P.O. Box 8017
Baltimore, MD 21244-8017

To Whom It May Concern:

Enclosed are New York State's comments on the Centers for Medicare & Medicaid Services' proposed rule published in the March 23, 2007, Federal Register, which removes and reserves 42 CFR sections 433.58 and 433.60 and modifies 42 CFR sections 433.54, 433.56, 433.57, 433.66, 433.67, 433.68, and 433.70.

Please note that all comments on CMS's proposed modifications to provider tax regulations under 42 CFR 433.68 apply also to CMS's proposed modifications to provider donation regulations under 42 CFR 433.54.

Questions regarding these comments may be addressed to John Ulberg, of my staff, at (518) 474-6350.

Sincerely,

Deborah Bachrach

Deborah Bachrach
Medicaid Director
Deputy Commissioner
Office of Health Insurance Programs

Enclosure

PROVISIONS OF THE PROPOSED RULE

Overview of CMS's Proposed Modifications to 42 CFR 433.68

This regulatory section enumerates the conditions under which health care providers are considered to be directly or indirectly held harmless from health care related taxes. In such cases, the **entire** tax program is deemed "impermissible" and Medicaid federal financial participation (FFP) is reduced by an amount equivalent to the total tax revenue collected from the provider class (e.g., inpatient hospital, outpatient hospital, etc.) multiplied by the applicable state's Federal Medical Assistance Percentage (FMAP).

In conformance with Section 403 of the Tax Relief and Health Care Act of 2006, Public Law 109-432, CMS is changing the regulatory threshold for the first prong of the indirect guarantee hold harmless test from 6 percent to 5.5 percent, for any portion of fiscal years beginning on or after January 1, 2008, though September 30, 2011. The intent of the statute was to preclude CMS from implementing proposed regulations that would have reduced the threshold to 3 percent, which would have devastated many states' health care programs.

Unfortunately, CMS has chosen to make other changes to the existing hold harmless provisions of provider tax regulations that we believe Congress would also have blocked had they known this was CMS's plan. These provisions could have an even more ominous impact on States' health care programs than the 3 percent rule that Congress thwarted. Further, the intent of CMS's proposed regulatory changes, as explained in its preamble, directly contradicts provisions of the Social Security Act. For these reasons, we believe the proposed additional rule changes violate the intent of Congress, which is to preserve states' existing health care systems that rely in part on health provider taxes.

CMS states the additional regulatory changes are in response to a June 29, 2005, adverse decision by the Department of Health and Human Services (HHS) Departmental Appeals Board (DAB No. 1981) that overturned substantial disallowances CMS imposed on five states, totaling nearly $1 billion. Each disallowance was based on CMS's finding of provider tax hold harmless arrangements that resulted from the states' enactment of grant programs and tax credits to private pay residents of nursing homes. The DAB found, however, that CMS did not properly interpret and apply its own regulations and, as a consequence, had not established the existence of hold harmless arrangements in the five states.

Instead of committing itself to properly applying the existing hold harmless regulations in conformance with the DAB decision, CMS is now choosing to alter the regulations that have been in effect since August 13, 1993, by imposing what we believe to be entirely new regulatory standards.

Comments Specific to Proposed Changes to CFR 433.68(f)(1)

The current regulation establishes that providers shall be found to be held harmless from a tax based on a "positive correlation" between: (1) non-Medicaid payments to providers or others

paying the tax and (2) the amount of the tax or the difference between the Medicaid payment and the total tax cost. CMS defined "positively correlated" in the 1993 provider tax rule as having the "same meaning as the statistical term".

CMS now states in the preamble to the proposed regulation that the term "positive correlation" represents ".... any positive relationship between these variables, even if not consistent over time" and freely admits that this revised definition would allow it to find the existence of hold harmless arrangements through entirely subjective factors, such as enactment of additional funding to providers in the same legislative sessions as provider taxes are enacted, or other factors that CMS cannot envision at this time. CMS states in the preamble: "It is simply impossible to anticipate all the hold harmless plans that could be created".

Clearly, CMS is now recasting the regulatory and statutory meaning of "positive correlation" from being a quantitative test to a subjective test. The State objects strenuously to this new interpretation, because it provides no actual standard by which states can know they are structuring provider tax programs in a permissible manner. The following excerpts from the DAB decision support this view:

- "Moreover, CMS does not deny that the term "positive correlation" is a term of art in statistics and use of the word "correlated" by itself certainly connotes something more than a mere relationship or association."

- "The preamble to the final rule stated that the term "positive correlation" is used in its statistical sense. Thus, the term "positive correlation" means a relationship in which one variable increases as the other variable increases."

- "CMS neither did any statistical analysis of the correlation between the two relevant variables, or found that one variable would increase automatically as the other increased. Instead, CMS argues that we should find that the positive correlation test was met because of the "relationship" or "association" between the States' health care-related tax programs and grant or credit programs. See, e.g., Tr. at 22-23, 62-63. To evidence this "relationship" or "association", CMS relies on factors such as the simultaneous authorization of the provider tax program and the grant or credit program, the stated intent that the grants or credits were to benefit the private pay patients who otherwise would bear the burden of the tax, and the fact that the providers were not generally precluded from passing the cost of the tax through to private pay patients."

- "The preamble to the final rule specifically rejected using such subjective factors, however, stating that this 'would result in a lack of specific standards by which hold harmless could be measured,' and 'would be administratively burdensome and virtually impossible to apply fairly throughout the nation.' 58 Fed. Reg. at 43,167. Indeed, CMS had informed the States early on in the negotiations over the hold harmless provisions of its position that statistical tests should be used, and this approach was merely reaffirmed in the regulation. See, e.g., JAF Ex. 26, at 4."

Comments Specific to Proposed Changes to CFR 433.68(f)(2)

The current regulation establishes that providers shall be found to be held harmless from a tax when all or a portion of a Medicaid payment to the taxpayer varies based only on the amount of the total tax payment. CMS proposes to amend the regulation by deleting the word "total". We believe deletion of the word "total" is aimed at circumventing the DAB's determination that CMS did not properly apply a test that was related to the **total** tax cost, as required by the existing regulation and statute. For this reason, the State objects to this change.

CMS also proposes to add to CFR 433.68(f)(2) the phrase "including where Medicaid payment is conditional on receipt of the tax amount" as a new criteria for determining the existence of a hold harmless arrangement. This change is highly problematic for the following reasons:

- The proposed language would appear to have the effect of prohibiting states from enforcing tax obligations on delinquent providers through intercept of Medicaid payments. For CMS to find a hold harmless arrangement to exist based on this entirely reasonable administrative practice places the State in an untenable situation. Further, we believe CMS should be concerned that its policy may result in situations where health provider taxes that are statutorily established in a manner that complies with the broad based and uniformity requirements of the Social Security Act (SSA) cannot be enforced as such. How can a tax be broad based if the State does not have all the tools necessary to collect it from all providers in the class? We encourage CMS to rethink this policy.

- CMS's preamble asserts that the proposed regulatory changes provide clarification that the requirements of Social Security Act §1902(a)(30)(a), that rates be consistent with efficiency, economy and quality of care, preclude states from making Medicaid payments (including "supplemental" payments) conditional on receipt of taxes. CMS also seems to imply that states may reimburse the Medicaid portion of a provider tax solely through cost-based reimbursement methodologies. The State believes such interpretations put form over substance. There are a number of ways states may accurately reimburse providers for the Medicaid share of a tax, including increasing Medicaid rates by the enacted tax percentage. The State believes any contrary policy would violate the intent of SSA §1903(w)(4), which provides that the hold harmless test shall not be read to prevent states from reimbursing the Medicaid share of providers' health care related taxes.

Comments Specific to Proposed Changes to CFR 433.68(f)(3)

The current regulation establishes that a provider shall be found to be held harmless from a tax in instances where taxpayers are directly or indirectly guaranteed to be held harmless from all or any portion of the tax through payment, offset or waiver. A direct guarantee is evidenced by an **explicit assurance** by a state of repayment.

CMS is now interpreting a direct guarantee to mean: "the reasonable expectation that the payment would result in the taxpayer or a related party being held harmless for any part of the

tax. A direct guarantee does not need to be an explicit promise or assurance of payment. Instead, the element necessary to constitute a direct guarantee is the provision for payment by State statue, regulation, or policy".

Here again, CMS is replacing a clear standard, that being an explicit assurance of repayment, with an overly broad interpretation. We object to this new definition, because it does not reflect statutory intent and would have the effect of implicating as a hold harmless arrangement any instance of a state payment that is related in any way to a provider tax. The following excerpts of the DAB decision support the State's position:

- "Contrary to what CMS now argues, moreover, there is no direct assurance of any payment to a provider taxpayer under the State programs at issue here. As the States point out, even assuming that the grant payment or tax credit could be considered an indirect payment to the provider (which the States do not concede), the provider had no assurance that such a payment would be made to it since even imputed receipt of such a payment was contingent on factors beyond the provider's control, such as the provider having private pay patients who qualified for the grant or credit and those patients actually applying for and obtaining the grant or credit. Contrary to what CMS argues, the mere "possibility" that some funds might ultimately flow through the provider taxpayer is not tantamount to a direct guarantee of payment. See Tr. at 127-38."

- "We find no such assurance in those provisions. Nothing required the private pay patients to apply for the tax credit, nor was a provider even assured by the law of having some patients who could claim the tax credit and would in fact timely do so."

Overall Comments Specific to Proposed Changes to CFR 433.68

For the following reasons, the State believes the current regulatory framework, should not be changed in the manner proposed by CMS:

- It would be inappropriate for CMS to replace empirical analysis with inherently subjective criteria to determine the existence of a hold harmless arrangement. CMS's proposal would effectively give it unfettered authority to make such determinations on a selective basis and there would be few if any parameters by which CMS could be judged to have made an incorrect finding.

- The DAB decision correctly finds that the current regulatory framework allows states to provide tax credits and grants to residents of nursing homes, without an automatic finding of a hold harmless arrangement. Influencing the DAB decision is the fact that it is health care providers, not recipients of their services, which are the "taxpayers". Moreover, the DAB emphasized the requirement for a finding of statistical positive correlation between the tax credits or grants and the total cost of the tax. The State believes these determinations are appropriate.

- We believe DAB's articulation of CMS's original regulatory intent is true to the Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991

(Pub.L. 102-234), enacted December 12,1991, which was carefully crafted to address the competing interests of many stakeholders, including states, health care providers, Congress and the Executive Branch. The proposed regulations seek to alter the fundamental principles of this statute sixteen years after the fact and jeopardize the ability of states to partially fund essential health care initiatives with provider taxes.

The State's position is supported by the DAB decision, which states: "While some CMS officials and others have in the past opposed any health care-related tax, Congress decided to permit such taxes so long as they met certain restrictions. As the States argue, those restrictions were carefully negotiated and are much more narrow than the restrictions that CMS had originally promulgated (and that Congress rejected) that would have proscribed any "linkage" between a tax program and any payment to a taxpayer. See 56 Fed. Reg.46,380; 46,387 (Sept. 12, 1991); 56 Fed Reg. 56,132,56,139 (Oct. 31, 1991). CMS cannot now reasonably fail to apply the restrictions Congress enacted, as interpreted in the regulations and preambles, simply because grant or credit programs might counteract opposition to the tax programs."

- As CMS is aware, some of New York's provider taxes are related to a health care financing system that was originally implemented in 1983, under the name "New York Prospective Hospital Reimbursement Methodology" (NYPHRM), with Medicare participating through a federal waiver. While the federal waiver and Medicare participation ceased as of 1986, NYPHRM existed through 1996 and was succeeded by the "Health Care Reform Act" (HCRA) in 1997. NYPHRM and HCRA provide the methodologies that govern Medicaid and certain other payors' reimbursement of inpatient hospital services and include provisions for pooling of revenue from various sources to fund health care initiatives that are crucial to the well being of all New Yorkers, especially the State's most vulnerable populations. Both NYPHRM and HCRA are reflected in various forms in our approved Medicaid State Plan. Also reflected in the State's approved Medicaid State Plan is a health care related tax on intermediate care facility services for the mentally retarded, the proceeds of which play a part in the overall funding of essential services to New York residents with disabilities.

If CMS's proposed regulations were in place these many years, subjective determinations regarding hold harmless arrangements could have jeopardized integral and essential components of the State's health care delivery system.

This theoretical look at the past highlights the negative impact CMS's regulatory interpretations could have on the future. As the State moves forward to address myriad health care issues and restructure its health care systems, the use of provider taxes will likely continue to be utilized to foster changes that will be beneficial to both the State and Federal Government. The State cannot make progress in these areas unless it has a quantifiable process for determining the permissibility of future provider tax programs.

- We believe CMS's proposed regulations reflect a fundamental suspicion of states' Medicaid financing practices. We encourage CMS to address any inappropriate financing arrangements through enforcement of current regulatory standards on a case-

by-case basis and not through the wholesale reinterpretation of existing regulations on a national basis.

Requested Assurances of CMS's Intent

CMS is characterizing these regulations as merely providing clarification to address confusion by parties outside CMS (apparently including the DAB) as to the original intent of their regulations. We do not believe this is in fact the case, and are very concerned that CMS's characterization may be a aimed at applying these new rules to states' existing provider tax programs. Since we believe this would be inappropriate, CMS should provide an assurance that our concerns are unfounded, and put in writing its intent that provider tax programs in existence prior to the proposed effective date of this regulation shall not be determined to contain hold harmless arrangements unless they are supported by the parameters and requirements established by the DAB decision.

Regarding the hold harmless provisions, CMS states: "If States enact a tax program that violates any of these tests, FFP will be reduced by the amount collected through that tax program". Our understanding is that the existence of a hold harmless arrangement results in a FFP disallowance equivalent to the total collections of the tax program from each affected provider tax class multiplied by the state's applicable FMAP. We ask for CMS's assurance that this understanding is correct.

COMMENTS REGARDING PROPOSED MODIFICATION TO 42 CFR 433.56

In conformance with Section 6051 of the Deficit Reduction Act of 2005 (DRA) (Pub.L. 109-171), enacted on February 8, 2006, the proposed regulation establishes a provider tax class defined as "Services of managed care organizations (including health maintenance organization, preferred provider organizations)." The state encourages CMS to consider proposing a definition for the term "preferred provider organizations" so that states may know what entities must be included in a tax program on this class of providers for it to comply with the broad based requirement of the SSA and associated regulations.

Submitter : **Mr. Mark Birdwhistell** **Date: 05/22/2007**

Organization : **Kentucky Cabinet for Health and Family Services**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See attachment

CMS-2275-P-5-Attach-1.PDF

CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF THE SECRETARY

Ernie Fletcher
Governor

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Mark D. Birdwhistell
Secretary

May 22, 2007

Honorable Leslie V. Norwalk
Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-2275-P
P.O. Box 8017
Baltimore, MD 21244-8017

Dear Ms. Norwalk:

I am writing to express my concern regarding provisions of the Centers for Medicare and Medicaid Services' (CMS) proposed rule #13726 on Medicaid and Health-Care Related Taxes. I urge CMS to reconsider the adoption of this rule due to the financial and administrative burden for states, if this rule is adopted as proposed.

Kentucky's Medicaid program has led the nation in improving the efficiency and effectiveness of services to low-income families and individuals. Kentucky has already taken several steps to address provider taxes in its Medicaid Modernization initiative.

In particular, I am concerned that provisions related to the reclassification of certain community-based residences that provide care for individuals with developmental disabilities will adversely affect Kentucky's home and community-based services.

In addition, because Kentucky's General Assembly does not meet again until January of 2008, I recommend that the implementation date for the proposed rule be delayed for six months. This change will allow state agencies the opportunity to work with their state legislatures to ensure no disruption in funding for the state Medicaid program, particularly for vulnerable populations that rely on Medicaid.

I strongly urge your reconsideration of this proposed rule. Thank you.

Sincerely,

Mark D. Birdwhistell

Submitter : Mr. Jerry Freidman **Date:** 05/22/2007

Organization : American Public Human Services Association

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2275-P-6-Attach-1.DOC

APHSA
American Public Human Services Association

NASMD
National Association of State Medicaid Directors
an affiliate of the American Public Human Services Association

May 22, 2007

Leslie V. Norwalk, Esq.
Acting Administrator
U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS–2275-P: Comments on Proposed Rule *Medicaid Program; Health Care Related Taxes*, 72 Federal Register 13726

Dear Ms. Norwalk:

The American Public Human Services Association (APHSA) and its affiliate, the National Association of State Medicaid Directors (NASMD), respectfully submit this comment letter on the health care-related tax regulation published in the March 23, 2007 *Federal Register* (72 FR 13726) for the Centers for Medicare and Medicaid Services (CMS).

Please be assured that the state Medicaid agencies share the federal government's strong commitment to protecting the fiscal integrity of the Medicaid program. We welcome any opportunity to work with CMS to develop proposals and guidance that will provide consistency and stability to the Medicaid program.

States understand that Congress approved a modification of the hold harmless indirect guarantee safe harbor threshold from 6 percent to 5.5 percent for the period January 1, 2008 through September 30, 2011, (Tax Relief and Health Care Act of 2006, P.L. 109-432) and codified certain other provisions of the provider tax program. However, we respectfully submit that this proposed rule oversteps the clear authority and guidelines that Congress granted when it approved the 2006 statute and the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L.102-234). In addition, the proposal infuses a level of obscurity into a policy that states believe has left little room for ambiguity or disagreement in the past.

The analysis conducted by states indicates that the proposed regulation is likely to upend federal regulations and guidance that have allowed them to develop a clear understanding of what is appropriate and approvable. Policy that allows for unambiguous interpretation

is fundamental to ensuring consistency and stability throughout a program like Medicaid that otherwise provides for considerable flexibility in implementation and design. It is disconcerting why CMS is proposing to reverse such standard interpretation and application.

In addition to a chilling effect on states' future efforts to design and implement health care related taxes, CMS also has proposed revising the regulations at §433.68(f) in a way that threatens the viability of existing health care-related tax programs. In turn, this could require new analysis and administrative oversight of existing policies that could result in inefficiencies for states and the federal government. We believe there is no reasonable justification for the agency to pursue such a sweeping change and essentially compel states to dismantle appropriate financing mechanisms that already have been scrutinized and approved by CMS.

For these reasons, APHSA and NASMD respectfully request that the agency reconsider the proposed changes to the health care-related tax other than the required modification of the hold harmless indirect guarantee safe harbor threshold from 6 percent to 5.5 percent for the period specified by the Tax Relief and Health Care Act of 2006. Instead, we encourage CMS to work with states to develop *objective* standards by which compliance with the hold harmless provisions for health care-related taxes can be measured. Such objective standards are necessary so that states can have some reasonable expectation that tax programs meeting the standards will not later be declared impermissible by CMS on the basis of a subjective analysis of endless permutations of the taxes paid by providers and any payments, credits, grants, or other considerations they may receive from the state or other entities.

The three major areas of concern identified by states include:

- States may be required to dismantle, or, at a minimum, invest significant time newly reviewing and seeking re-approval for existing health care-related taxes;
- The re-interpretation of the definitions of "positive correlation," "Medicaid payment," and "direct guarantee" standards removes consistency and clarity in interpretation and application; and
- CMS has exceeded its authority by proposing regulatory language that Congress previously has rejected and which also goes beyond the congressionally approved health care-related statutory language set forth in the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234) and section 403 of the Tax Relief and Health Care Act of 2006 (P.L. 109-432).

We appreciate the opportunity to provide you with the following comments which we believe will retain clear and precise standards for determining permissible and impermissible health care-related taxes.

Provisions of the Proposed Rule

§433.68(f) Tests to Determine Hold Harmless Arrangements

As CMS notes, currently the regulations at §433.68(f) set forth three broad tests to determine if there is a hold harmless arrangement associated with a health care-related tax. As detailed below, states are concerned with the modifications CMS has proposed to these tests which would have the affect of adding a layer of confusion to the interpretation and application of the tests and narrowing the scope of permissible taxes.

Revenue Limit
CMS proposes new regulatory language to implement the 6% and 5.5% safe harbor percentages under the two-pronged indirect guarantee test as required by the Tax Relief and Health Care Act of 2006. However, in implementing the percentage threshold changes, the agency has gone beyond the legislative directive by further amending the regulatory text to specify that the percentage thresholds apply to net operating revenues.

We believe that CMS has exceeded its authority in revising the current regulations at §433.68(f) by restricting the safe harbor percentages to net revenue. As such we request that CMS clarify that states will continue to be permitted to interpret the phrase "revenue received by the providers" as either gross or net revenue.

§433.68(f)(1) Positive Correlation Test
The positive correlation test assesses whether the state is making a non-Medicaid payment to a provider that is linked either to the amount of the tax or the difference between the provider's Medicaid reimbursement and the tax payment. CMS has proposed that the amount returned would not have to match exactly the amount paid in taxes to be positively correlated, and the correlation could be based on individual units of tax and payment amounts, or on aggregate payments over a period of time. Further, CMS has stated that prohibited payments could be direct or indirect, broadly interpreted.

In its proposed rule, for the purposes of identifying a positive correlation, CMS removes the strict adherence to a statistical relationship between tax and payment amounts. Instead the agency has proposed applying amorphous guidelines to expand its ability to identify positive correlation. CMS newly asserts that a positive correlation can be determined not just through a quantitative analysis of a series of tax and payment amounts, but also through (1) a finding that the same rate is used to impose a tax and to distribute a new Medicaid payment, (2) a finding that the non-Medicaid payment is conditional on payment of the tax, or (3) other evidence that tax and payment programs are "linked," including the fact that a tax and a grant or credit program are enacted in the same legislative session.

We wish to draw your attention to the fact that in 1991 Congress rejected a CMS' proposed interpretation of "positive correlation," similar to this proposed regulation, that established a hold harmless whenever a provider tax and benefit to providers was "linked" (H. Rep. No. 102-310, at 11). There has been no indication that Congress has changed its interpretation or position on how a positive correlation should be defined.

Further, rather than clarifying the standards for identifying a positive correlation as stated in the preamble, CMS merely has asserted new authority to review any and all possible provider tax programs. States believe this needlessly complicates the policymaking process for states as well as for CMS.

As such, APHSA and NASMD respectfully request that CMS retract these provisions of the proposed rule and retain the strict mathematical test for identifying a positive correlation.

§433.68(f)(2) Medicaid Payment Test

The Medicaid payment test determines whether any portion of a provider's Medicaid payment varies based on its total tax payment, including Medicaid and non-Medicaid payments. CMS proposes to deviate from established interpretations by reading §433.68(f)(2) to provide a hold harmless whenever the Medicaid payment varies based on the tax amount. Although CMS characterizes the proposed language as a clarification, this change contradicts Section 1903(w)(4), which states, "The provisions of this paragraph shall not prevent use of the tax to reimburse health care providers in a class for expenditures under this subchapter, nor preclude States from relying on such reimbursement to justify or explain the tax in the legislative process."

On behalf of states, we note that according to the statute, providers' expenses for the Medicaid portion of provider taxes are allowable Medicaid expenditures. Yet, the proposed rule contradicts the explicit authority granted to states to make Medicaid payments to providers measured by the Medicaid portion of tax liability, including supplemental payments conditioned on receipt of taxes. States are concerned that in its attempt to identify hold harmless arrangements, CMS has inappropriately restricted states' authority to reimburse providers for the costs of Medicaid services.

In addition, CMS' proposed shift in terminology from the phrase "amount of the total tax payment" to "the tax amount," represents a significant departure from statutory and regulatory language at SSA § 1903(w)(4)(B) and 42 C.F.R. § 433.68(f)(2). Under the Medicaid payment test, all or a portion of a Medicaid payment to the taxpayer must vary based only on the amount of the total tax paid. The portion of a provider's health care-related tax payment attributable to Medicaid services is an allowable cost, and Medicaid reimbursement may be furnished for it. It is permissible for states to implement health care-related taxes whereby a Medicaid payment varies based on the Medicaid portion of provider tax amounts. Approved statutory and regulatory language clearly states that only

a Medicaid payment varying based on total provider tax amounts (including the non-Medicaid portion) represents a hold harmless.

States are concerned that they would be prohibited from applying appropriate and effective policy wherein a provider's payment of its taxes is a necessary requirement to receive a Medicaid payment. Contrary to the language proposed in this rule, this does not necessarily establish a correlation between the two amounts. In effect, under this proposed regulation, states would be prohibited from requiring overdue taxes as a condition for any payments otherwise due to a taxpayer, a policy tool states utilize to ensure cost-efficient, fair tax and payment systems.

For these reasons, APHSA and NASMD request that CMS retain the phrase "amount of the total tax payment" in the Medicaid payment test. As noted above, states also request that CMS clarify the proposed language to ensure that states retain the ability to use rates that are based solely on the receipt of provider taxes, rather than on overall provider costs.

§433.68(f)(3) Guarantee Test

Under the third test for a hold harmless arrangement, the guarantee test determines if there is a direct or indirect guarantee that holds taxpayers harmless for any portion of their tax cost. States recognize that Congress sought to provide clarity through the Tax Relief and Health Care Act of 2006, by incorporating the indirect guarantee "safe harbor" test provision into Section 1093(w)(4)(C) of the statute.

However, states are concerned that in the preamble of this proposed rule, CMS asserts broader authority than authorized or intended by Congress for examining when such a direct or indirect guarantee may exist. Specifically, CMS states that only the provision for payment by state statute, regulation or policy is necessary to establish a direct guarantee. CMS has removed the requirement for a declared promise or assurance of payment, thereby seemingly contracting the definition of "direct." CMS asserts that the factor distinguishing a direct from indirect guarantee is that under the indirect guarantee, the benefit to a provider is through regular or enhanced payments for preexisting Medicaid obligations.

States strongly oppose CMS' intention to deem a "direct guarantee" to exist simply by the agency's identification of a proposed or enacted state statute that provides for a payment, offset or waiver to a provider or a provider's patient, and under the assumption that some person might have a reasonable expectation that the taxpayer would be held harmless as a result. Since the standard for a direct guarantee is only that the taxpayer has a "reasonable expectation" of being held harmless for any portion of the tax, virtually any state payment could be viewed as a violation of the direct guarantee test. By its own admission, CMS stated that the agency recognizes that this test interjects some degree of subjectivity into this analysis. We believe that rather than interjecting subjectivity, CMS should maintain the clear and precise definitions currently in place.

Such a sweeping generalization is far too broad a test to apply for states seeking to develop and enact policies unique to their individual state. In fact, it is reasonable to believe that the proposed language could allow CMS to find any provider tax program in violation of the hold harmless provisions. Further, the agency also needlessly could place states' existing provider tax programs at risk.

To this end, APHSA and NASMD request that CMS retain the clear and precise standard for a "direct guarantee": the assurance that a taxpayer will be held harmless.

Conclusion

States believe that the standards of the statute and the regulations for health care-related taxes have proved workable, allowing States to develop compliant tax programs with confidence. Where States sought to employ taxes that deviated from the standards of the law, waivers have been sought, and the precise waiver standards embodied in the regulations have allowed CMS to act consistently on waiver applications.

We would be happy to provide you with additional information on our comments as you go forward. Please contact Martha Roherty, Directory of NASMD, at (202) 682-0100 if we can be of further assistance.

Sincerely,

Jerry Friedman
Executive Director
American Public Human Services Association

David Parrella
Chair
NASMD Executive Committee

Submitter : Mr. Jeff Saxon **Date:** 05/22/2007

Organization : SC Department of Health and Human Services

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-2275-P-7-Attach-1.DOC

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Susan B. Bowling
Acting Director

May 22, 2007

Ms. Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2275-P
P.O. Box 8017
Baltimore, MD 21244-8017

Dear Ms. Norwalk:

The South Carolina Department of Health and Human Services is submitting the following comments on the proposed rule regarding the Medicaid Program – Health Care Related Taxes published in the Federal Register on March 23, 2007.

Provisions of the Proposed Rule – Tests to Determine Hold Harmless Arrangements - 42 CFR 433.68 (f)

South Carolina understands that the provisions of the proposed rule address the application of the hold harmless/positive correlation provisions on direct and indirect non-Medicaid payments and gives CMS significant latitude in defining hold harmless arrangements. Additionally, we also note that CMS intends to maintain maximum flexibility in analyzing the relationships between a tax program and Medicaid payments under these provisions as well.

It is our state's position that the concept of positive correlation was never one that could be applied to the tax situation. States can tax providers, tax revenue goes into the State's share of the Medicaid Program and provider payments go up (as they almost certainly will). Under this scenario, would not there always be a positive correlation between the tax and the Medicaid payments under the new provisions? To address/clarify this, it is recommended that CMS work with the states to agree on an acceptable coefficient of correlation between provider taxes and the Medicaid reimbursement received by the providers.

Bureau of Reimbursement Methodology and Policy
P.O. Box 8206 • Columbia, South Carolina 29202-8206
(803) 898-1040 • Fax (803) 255-8228

The hold harmless provision will not be workable if defined broadly. Again, that is because as the state share goes up, so will the payment to providers. The intent was to make sure there was not an obvious deal between the state and providers to get back the tax costs from Medicaid payments. Broadening the definition will penalize the states that have other non-Medicaid funding initiatives for health care organizations.

Provisions of the Proposed Rule – Permissible Class of Services – Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) - 42 CFR 433.56 (a) (4)

CMS should more precisely define ICF/MRs to include all facilities licensed as ICF/MRs, no matter the size of the facility.

To summarize, broadening the hold harmless provision is not the way to go. CMS should develop a formula that is easily understandable for the states to use to determine up front if proposed provider taxes are compliant with federal regulations.

We appreciate your consideration of our comments.

Sincerely,

Jeff Saxon
Bureau Chief

JAS/wsh

Submitter : Mr. Carl Tubbesing **Date:** 05/22/2007

Organization : National Conference of State Legislatures

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-2275-P-8-Attach-1.PDF

NATIONAL CONFERENCE *of* STATE LEGISLATURES

The Forum for America's Ideas

Leticia R. Van de Putte, R. Ph.
State Senator
Texas
President, NCSL

Stephen R. Miller
Chief, Legislative Reference Bureau
Wisconsin
Staff Chair, NCSL

William T. Pound
Executive Director

May 22, 2007

The Honorable Michael Leavitt
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: CMS-2275-P

Dear Secretary Leavitt:

On behalf of the National Conference of State Legislatures (NCSL), I submit the following comments on the proposed rule published in the March 23, 2007 *Federal Register, " Medicaid Program, Health Care-Related Taxes."* NCSL remains committed to strong standards of fiscal integrity within the Medicaid program. The Medicaid provider tax law established in 1991 **encroaches on traditional state taxing authority** in an unprecedented way by limiting how a state may use its taxing authority regardless of the nexus of the tax to Medicaid. The proposed rule, which could have simply implemented changes in Medicaid law enacted by Congress, includes provisions not initiated by Congress that would **encroach on state spending authority** as well.

Tests to Determine Holdharmless (Section 433.68 (f))

The proposed rule notes that money is fungible and that the tests proposed in the rule "interjects some degree of subjectivity" into the analysis that would determine whether or not a state meets the appropriate standards for reimbursement. We are particularly concerned about the process proposed for determining: (1) positive correlation; and (2) direct or indirect guarantee. Under the proposed process, payments states make to health care providers as part of regular business, unrelated to Medicaid, could become entangled in efforts to implement and enforce this rule. The degree of subjectivity interjected into the process of determining what constitutes a "holdharmless" is extremely troublesome. In addition, the rule proposes to authorize agency staff to, in some cases, determine state legislative intent and to make reimbursement decisions based on these findings. This is unacceptable.

NCSL is very much opposed to the regulatory activism displayed in this proposed rule and other regulatory proposals recently published that: (1) propose changes not initiated by the Congress that substantially change major provisions within the Medicaid statute; (2) further complicate the implementation and administration of the Medicaid program; and (3) unfairly constrain the state's ability to fund not only the Medicaid program, but other health care programs within the state.

We appreciate this opportunity to share our concerns. Please contact Joy Johnson Wilson, Health Policy Director at 202-624-8689 or at joy.wilson@ncsl.org if you have any questions or if NCSL can be of additional assistance to you.

Sincerely,

Carl Tubbesing

Denver
7700 East First Place
Denver, Colorado 80230
Phone 303.364.7700 Fax 303.364.7800

Washington
444 North Capitol Street, N.W. Suite 515
Washington, D.C. 20001
Phone 202.624.5400 Fax 202.737.1069

Website www.ncsl.org

Deputy Executive Director

Submitter : Mr. Larry Gage **Date:** 05/22/2007

Organization : National Association of Public Hospitals

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See Attachment

CMS-2275-P-9-Attach-1.PDF

National Association of Public Hospitals and Health Systems

1301 Pennsylvania Avenue, NW
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202 585 0100 tel / 202 585 0101 fax
www.naph.org

May 22, 2007

Leslie Norwalk
Interim Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2275-P
P.O. Box 8017
Baltimore, Maryland 21244-8017

Re: CMS-2275-P – Medicaid Program; Health Care-Related Taxes; Proposed Rule, 72 Fed. Reg. 13726 (March 23, 2007); Comments on Section II.B. Tests to Determine Hold Harmless Arrangements -- § 433.68(f)

Dear Ms. Norwalk

The National Association of Public Hospitals and Health Systems ("NAPH") appreciates the opportunity to submit comments on the above-captioned Proposed Rule.

NAPH represents more than 100 metropolitan area safety net hospitals and health systems. Our members are deeply reliant on government-sponsored health programs. Approximately 71 percent of our revenues come from government sources, including Medicare, Medicaid, and local subsidies. Approximately 35 percent of NAPH member net revenues is from Medicaid. NAPH members provide critical inpatient services with NAPH hospitals averaging 2.5 times as many inpatient admissions as the hospital industry average. NAPH members also provide certain specialized services essential to their entire communities, such as emergency and trauma care, burn care, and neonatal intensive care. Our members are multifaceted institutions, often operating facilities at multiple sites and frequently serving as major training centers for medical residents and interns.

Particularly given our members reliance on the Medicaid program, NAPH and its members have a significant interest in maintaining the viability of the Medicaid program. Many states use provider taxes, as permitted by the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, to assist in financing their program. Although NAPH recognizes the importance of maintaining the fiscal integrity of the Medicaid program and ensuring that provider tax programs comply with the no hold harmless tests outlined in federal law, NAPH is concerned that CMS's proposed interpretation of the proposed hold harmless provisions will hinder the ability of states to fund their Medicaid programs and ultimately decrease funding to

crucial providers and threaten access to care for their patients. NAPH recommends that CMS withdraw the proposed rule to avoid having a detrimental impact on state Medicaid programs.

Specific Comments Regarding Tests to Determine Hold Harmless Arrangements

NAPH's comments in particular relate to CMS's clarification of the "no hold harmless" requirement associated with provider taxes and donations. NAPH is concerned that CMS's proposed interpretation of the proposed hold harmless provisions, particularly in combination with proposed authority to examine the correlations between taxes and payment programs, will hinder the ability of states to fund their Medicaid programs and ultimately decrease funding to crucial providers and threaten access to care for their patients.

A. The proposed changes to the hold harmless tests further limit states' ability to fund the non-federal share of their Medicaid programs in an already restrictive regulatory and budgetary environment.

CMS's proposed clarifications to the existing hold harmless tests, particularly its broader interpretation of the positive correlation test, analysis of direct and indirect payments, and scrutiny of arrangements where funding is distributed to or collected from providers through third parties, will reduce states' options in adopting provider taxes and make it more difficult for states to support their Medicaid programs. In addition, these proposed changes could potentially implicate existing tax programs that CMS has approved and on which states currently rely as sources of critical funding. For example, CMS should clarify that States will continue to be able to condition a Medicaid rate increase on the implementation of a provider tax that will be used as a funding source, which is essential to responsible fiscal management of state programs. Particularly given the recently-issued proposed regulation restricting the use of intergovernmental transfers ("IGTs") and certified public expenditures ("CPEs"), CMS should not further limit states' ability to fund the non-federal share of their Medicaid programs.[1]

Restricting the availability of federal financial participation ("FFP") for funding derived from health care-related taxes will result in a further loss of funding to Medicaid programs and the safety net system. In the Regulatory Impact Analysis for this proposed rule, CMS estimates that these proposed changes will reduce federal funding to Medicaid programs by $85 million per year in FY 2008 and by $115 million per year in FY 2009 through FY 2011. While the agency acknowledges a chance that this could result in lower Medicaid reimbursement to health care facilities, CMS also suggests that it is "uncertain how States will alter their Medicaid reimbursements in response to the reduced tax limit" and that "[i]f States choose to maintain reimbursement rates, small health care facilities may receive higher net Medicaid

[1] 72 Fed. Reg. 2236 (Jan. 18, 2007)

reimbursement in light of the reduced tax burden."[2] NAPH is concerned that CMS inadequately acknowledges the significant financial issues confronting states and the continual pressure to contain Medicaid spending in the face of limited state budgets. Particularly in conjunction with CMS's recently-proposed regulations tightening the use of IGTs and CPEs, states will have difficulty finding additional sources of non-federal share and payments to crucial Medicaid providers such as our members will be affected. Further removing money from the system will result in adverse effects on safety net providers and their patients' access to essential health care services.

B. The proposed rule unnecessarily grants CMS authority to delve into the relationships between states and local governments while not providing sufficient clarity on how CMS will evaluate these arrangements.

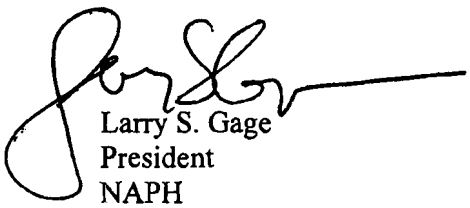
In CMS's discussion in Section II.B. of its intended analysis of the relationships between direct and indirect provider payments and state tax programs as well as its application of the positive correlation test at § 433.68(f), CMS interprets its proposed hold harmless provisions to "permit maximum flexibility in analyzing the relationships between tax and payment programs."[3] CMS will "look at all relevant circumstances surrounding a tax and payment program to determine whether a linkage exists to establish an indirect payment" and may "look to extrinsic evidence ... to establish the positive correlation."[4] NAPH is concerned that this rule provides authority to scrutinize currently legitimate arrangements between governments and providers that may, under some permutation of the broader positive correlation test, be deemed to create a hold harmless situation. Of further concern, CMS has not clearly articulated how it will determine that such situations exist. The agency acknowledges that its interpretation of the positive correlation test "interjects some degree of subjectivity into this analysis" and that indirect payments to providers may be "difficult to detect," yet provides only "broad examples" of arrangements that would violate the tests.[5] Such broad and open-ended interpretations of guidelines could result in case-by-case inconsistencies and confusion on the part of states attempting to structure provider tax programs in accordance with CMS regulations.

* * * * * * *

[2] 72 Fed. Reg. 13726, 13731 (Mar. 23, 2007).
[3] 72 Fed. Reg. at 13729.
[4] *Id.*
[5] *Id.*

NAPH appreciates the opportunity to submit these comments on the Proposed Rule and CMS's consideration of the concerns of the provider community. We look forward to working with CMS to ensure that this proposed clarification does not negatively impact essential funding for critical Medicaid providers such as our membership.

Sincerely,



Larry S. Gage
President
NAPH

::ODMA\PCDOCS\WSH\423214\1

Submitter : Dr. Marcia Nielsen **Date:** 05/22/2007

Organization : Kansas Health Policy Authority

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See attached document.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See attached document.

Regulatory Impact Analysis

Regulatory Impact Analysis

See attached document.

CMS-2275-P-10-Attach-1.DOC

KPA
Kansas Health Policy Authority

MARCIA J.NIELSEN, PhD, MPH
Executive Director

ANDREW ALLISON, PhD
Deputy Director

May 22, 2007

Leslie V. Norwalk
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–2275–P
P.O. Box 8017
Baltimore, MD 21244–8017

(Electronically submitted)

Re: Comments of Kansas Medicaid on the proposed regulations regarding Health Care-Related Taxes
CMS-2275-P

Dear Ms. Norwalk:

Thank you for the opportunity to comment on the proposed rules regarding the Medicaid program and health care-related taxes, as published in the Federal Register on March 23, 2007.

We ask that the Centers for Medicare & Medicaid Services (CMS) *not adopt* the proposed regulations as written.

The proposed regulations would be a dramatic departure from the policies that have been in place since Congress passed the Medicaid Voluntary Contribution and Provider-Specific Amendments of 1991, P.L. 102-234 found at 42 U.S.C. Sec. 1396b(w) and since HCFA adopted regulations now found at 42 C.F.R. Sec. 433.54, et seq.

The compromise between the states and HCFA, as worked out by Congress in the early 1990's, has provided a stable financing environment, in which states had clear guidance on what health-care related taxes were within safe harbors. This period of relative stability has lasted almost seventeen years.

Asserting administrative authority to substantially change the financial structure of states in the latter stages of this administration will likely cause disruption to many states. The proposed regulation will likely have a negative effect on many states, and will cause a shift in the burden of health care financing from the federal government to the States.

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The issue of addressing any perceived problems in the interaction between state tax laws and Medicaid financing would be better addressed through legislation.

Thank you for your attention to this matter.

Sincerely,

Marcia Nielsen, PhD, MPH
Executive Director

Andy Allison, PhD
Deputy Director, Medicaid Director