ANCOR American Network of Community Options and Resources
A National Network of Providers Offering Quality Supports to People with Disabilities

MAY 24 2007

May 21, 2007

MAY 22 2007

Leslie Norwalk
Acting Administrator
U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: Comments on File Code CMS 2275-P; RIN 0938-AO80: Proposed Rule on Medicaid Program's Health-Care Related Taxes

Dear Administrator Norwalk:

The American Network of Community Options and Resources (ANCOR) is taking this opportunity to provide written comments to the agency on the CMS proposed rule, *Medicaid Program; Health Care-Related Taxes* (CMS 2275-P) published in the *Federal Register*, Vol. 72, No. 56 on March 23, 2007.

ANCOR is the national network representing more than 800 private providers offering quality community living and vocational/employment supports to more than 380,000 people with disabilities throughout the nation. ANCOR is dedicated to advancing excellence in supports and services and is committed to leading the way to communities of choice, assisting providers in developing their capacity to support the choices of individuals with significant disabilities—including persons with mental retardation and other developmental disabilities. For the most part, ANCOR members provide supports to individuals with significant disabilities who are totally dependent on Supplemental Security Income (SSI) and Medicaid.

ANCOR's providers offer a wide range of community living and employment supports through a variety of programs financed through federal, state, local, and private funding. These supports are offered based on individual needs and preferences, requiring providers to be flexible in working with public funders to meet the desired goals of each person. These supports not only vary from state to state, but within the same state.

This inter-state and intra-state variability is very much dependent upon state and local economic, social, and political factors in meeting public policy goals at all levels. Providers—whether individually or collectively—accommodate the services and supports they offer in light of these variables. ANCOR strongly supports the ability of providers to work with their individual states and localities in developing strategies—as well as the financing mechanisms—to offer individualized supports that meet the needs and choices of each person.

ANCOR encourages federal public policy that enhances the capacity of States and providers to work together and supports their abilities to identify state-specific relationships to meet common goals. To that end, ANCOR's comments are predicated on several premises:

1. Congress has deemed provider taxes as a legitimate means of financing State Medicaid programs with these tax initiatives carried out by states in cooperation with and support by the various provider

communities. Congress has statutorily addressed its concerns on several occasions since 1990 through legislative modifications. Congress has codified the use of existing provider taxes and has established statutory authority over the programs, providing approval of state provider tax initiatives over time. As legitimate sources of state revenues for FFP, as authorized by Congress, provider taxes are a strong and healthy component of state FFP programs. Rather than exercising a broadened discretion that appears to propose new sweeping interpretations, CMS should apply clear and consistent rules as many in Congress and the states have asked.

2. Congress has recognized the importance of updating its historical listing of permissible classes of providers, items, and services by extending authority to the Secretary to adopt additional provider classes through regulation.

3. Congress, by its legislative actions over time as well as decisions not to change provisions in the Medicaid statute, has recognized the importance of provider taxes and the need for a collaborative relationship between States and providers to meet state-specific health care goals.

4. Congress established the Medicaid program as a joint federal-state partnership recognizing that states should have the broadest flexibility in supporting federal health and state health care policy goals.

5. ANCOR believes this proposed rule provides CMS with broad discretion which appears to far exceed the authority covered by statutory direction. ANCOR believes that CMS has taken a particularly restrictive and rigid path in its clarifications and changes to current regulations. ANCOR believes CMS' approach represents a proposed regulation that is detrimental to State Medicaid programs, undermines the collaborative efforts of States and providers to seek resources necessary to meet the growing and changing nature of Medicaid supports and services, and, ultimately, threatens supports to Medicaid's beneficiaries with disabilities.

Provisions of the Proposed Rule

I. Section 433.56(a)(4) Permissible Class of Services—Intermediate Care Facilities for the Mentally Retarded

CMS is proposing to delete from the definition of the permissible ICF/MR class, the current inclusion of similar services furnished by community-based residences under section 1915(c) of Title XIX. ANCOR disagrees with the proposed change and urges CMS to, at minimum, maintain the status quo.

The interim final rule implementing the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 expanded the statutory class of health care items services at section 1903(w)(7(iv) for ICFs/MRs to include similar services furnished by "community-based residences" for persons with mental retardation and related conditions under section 1915 (c) of Title XIX as of December 24, 1992and had at least 85 percent of those facilities classified as ICF/MRs before the granting of those waivers. According to the proposed rule advanced, the rationale for expanding this class was that many former ICF/MRs were converted to group home under the waiver.

The justification for eliminating the inclusion of the expanded services cites that (1) this narrow exception is no longer appropriate because CMS is no longer concerned that States will convert group homes back to ICF/MRs and (2) it is not equitable to accord different treatment to States that converted ICF/MRs before December 24, 1992 than to other States. To the contrary CMS should, at minimum, retain the status quo on the ICF/MR permissible class to include community-based residences.

ANCOR disagrees with the agency's rationale for eliminating the expansion of this permissible class of services, finding the justification unreasonable in light of (1) today's reality of providing Medicaid supports and services and (2) the statutory authority granted by Congress to the Secretary to consider other permissible classes (Section 1903(w) (7) (A) (iv) and add other health care items and services through regulation.

CMS should, in fact, take the reverse position than that proposed. The agency has previously reached out to States encouraging them to propose additional permissible classes. In an October 9, 1997 letter to State Medicaid Directors, HCFA's CMSO Director Sally K. Richardson informed states in writing of several policy interpretations which it had adopted related to the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, Pub. L. No 102-234 2(a) (codified at section 1903(w) of the Social Security Act (The Act)), and related regulations as part of a review of HCFA's policies in the area of provider taxes, *and were adopted* as part of a review of HCFA's policies in the area of provider taxes.

> *In this letter, we first clarify HCFA's interpretation of the requirement that health care related taxes be applied uniformly. Second, we clarify that, when the Secretary has granted a waiver with regard to a health care related tax because she has concluded that the tax is generally redistributive, a later uniform change in the rate of tax will not require the State to submit a new waiver request.* ***Third, we are reminding States of their opportunity to propose additional classes of providers, items, or services which the Secretary may consider including as permissible classes....*** [Emphasis added.]

Reaching out to States and inviting proposals to add classes of providers, items, or services is a good mechanism to employ as it (1) helps update the Medicaid program; (2) recognizes that Medicaid providers, items, or services change over time; (3) identifies permissible classes that should be added; (3) acknowledges that individual State environments are different; (4) supports Congressional intent that authorizes the HHS Secretary to consider additional classes; and (5) recognizes that individual States and providers should be free to collaborate and choose the means best suited to address the financing relationships to meet their state's needs.

It is true that the number of individuals living in ICFs/MR and the percentage of growth in Medicaid funding States invest in ICFs/MR has decreased while the number of individuals supported and the investments in home and community-based waivers has significantly increased. This shift has resulted in a three year pattern in which the number of individuals supported by and growth of HCBS state spending outpaces that of ICFs/MR. ANCOR not only strongly supports this trend, but believes that states have not moved fast enough to shift their investments in home and community supports and end the institutional bias built into the Medicaid statute and state operations.

However, individual state decisions to levy taxes on ICFs/MR providers are responsible in part for expansions in HCBS services in some states. States have, in fact, by maximizing the use of federal "medical assistance," begun addressing waiting lists, increased provider capacity, at least maintained reimbursement rates in difficult times or increased them to help providers recruit and retain staff, and helped states meet the growing demand for home and community-based services. By maintaining the ability of States and providers to utilize taxes on community residences as part of this permissible class, providers and States can work together to increase access to home and community-based supports and services and address waiting lists for those services.

In addition, federal and state policies have made strides this decade to support the choice and right of individuals with disabilities to live in the community and to address the unnecessary institutional bias in Medicaid: the U.S. Supreme Court's 1999 Olmstead decision, President Bush's 2001 New Freedom Initiative, and the new home and community options in the Deficit Reduction Act.

Clearly, federal public policy supports home and community-based supports. Federal policy should also support States' abilities to have the flexibility in their financing mechanisms to home and community-based supports.

ANCOR agrees that it is not equitable to accord different treatment to states that converted ICFs/MR into waivers before December 24, 1992 than to other states. CMS should end this inequitable treatment by allowing all states to utilize community residences under the ICF/MR permissible class.

ANCOR Recommendation on Permissible Class of Services—Intermediate Care Facilities for People with Mental Retardation and Related Conditions (ICFs/MR):

- **CMS should not delete the inclusion of community-based residences from the present definition of *permissible class of Services* –Intermediate Care Facilities for the Mentally Retarded (section 433.56(a) (4).**
- **CMS should permit all states to include community residences within the permissible ICFs/MR class—regardless of date of approval of waivers.**

Provisions of the Proposed Rule

II. Section 433.68(f)—Hold Harmless Arrangements

This 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 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.

CMS has taken the opportunity to propose a rule implementing the Tax Relief and Health Care Act of 2006, Pub. L. 109-432, (Tax Relief and Health Care Act) to also modify other aspects of the provider tax rule--including the hold harmless provisions in the Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 and its final regulations in 1993. CMS (then HCFA) and the states reached a compromise in that legislation regarding hold harmless arrangements to prevent such arrangements from artificially inflating federal financial percentage (FFP).

CMS now indicates that a recent Departmental Appeals Board (DAB) decision has drawn into question how the current hold harmless provisions will be interpreted and applied. Through this proposed regulation, CMS is now taking the opportunity to propose modification of certain terms in each of these hold harmless tests. The agency is proposing to alter the status by changing the language and interpretation of the hold harmless provision even after Congress reached a compromise with stakeholders by passing legislation with precise language governing the conditions under which states may impose health care-related taxes. 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.

The statute includes both 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. In the preamble to the CMS proposed rule, it proposes to "interpret the phrase 'direct and indirect non-Medicaid payment 'broadly." Aside from mentioning its general intent to broadly interpret the phrase *direct or indirect non-Medicaid* payment, CMS offers no specific regulatory language.

Without proposing specific regulatory language—issued with *clear* and *consistent* meaning—ANCOR believes that states and their legislatures are not afforded plain meaning to this phrase. In fact, CMS acknowledges this degree of uncertainty with its proposed approach when it states on page 13729 of the proposed rule: *We recognize that this test interjects some degree of subjectivity into this* analysis. ANCOR believes that the proposed rule will lead to the increased possibility that health care-related spending could be interpreted as hold harmless arrangements. This would have a chilling affect on state legislatures.

This 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 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. Unlike other provisions of the Act (bona fide provider-related donations), Congress did not specifically authorize CMS to implement regulations addressing the hold harmless test. The proposed rule improperly infringes on the authority of the legislative branch.

Without proposing specific regulatory language to implement this proposed policy, interested parties are not afforded the opportunity to comment direct and meaningful comment in the rulemaking process. In the absence of plain language, states may be held to differing interpretations by CMS.

ANCOR Recommendation. ANCOR believes that CMS may not, on its own accord and through this proposed regulation, alter the carefully crafted legislative compromise passed by Congress in the Medicaid Voluntary Contribution and Provider Specific Amendments of 1991. Regulations addressing the conditions under which a taxpayer will be considered to be held harmless under a tax initiative should mirror the statutory language enacted in the 1991 amendments. The changes to section 433.68 in the proposed rule are beyond the authority delegated by Congress to CMS.

ANCOR Recommendation. Without adequate specificity for public comment to CMS' intention to broadly interpret *indirect* for purposes of identifying hold harmless provisions and its acknowledgement of interjecting *subjectivity* into its analysis, ANCOR believes that CMS is not providing clarification and, instead, is adding confusion and making it more difficult for states to understand and follow. CMS should abandon its proposed approach.

Provisions of the Proposed Rule

III. Section 433.68 (f)(2)—Medicaid Payment Test

ANCOR is unclear as to whether the regulatory clause ... *a Medicaid payment will be considered to vary based on the tax amount when the payment is conditional on the tax payment...* would prohibit a state from mandating through state statute that all or some percentage of the taxes, along with corresponding federal match, must be used for rate increases.

Prohibiting a state from legislatively mandating that all or some percentage of the taxes, along with corresponding federal match, must be used for rate increases would be inconsistent with Section 1903 (w)(4) of the provider tax law, 42 U.S.C. § 1396b(w)(4). The law indicates that the hold harmless provisions shall not prevent use of the tax to reimburse health care providers in a class for expenditures under this title nor preclude states from relying on such reimbursement to justify or explain the tax in the legislative process. Furthermore, **such state legislation assures that provider tax revenue shall be used for Medicaid services and thus obviates any question regarding misuses of tax revenue that have arisen in connection with other types of FFP funding.**

- **ANCOR Recommendation: ANCOR believes that provider taxes offer states a legitimate and statutorily approved means to address what some call the "miserly Medicaid" provider reimbursements—significantly lower than Medicare rates—that undermine and threaten access to many Medicaid services and supports. CMS should clarify that the amended regulation would not prohibit a state from mandating through state law that all or some percentage of the taxes, along with corresponding federal match, must be used for rate increases.**

- **ANCOR Recommendation: CMS should affirm that the newly modified regulation does not jeopardize any approved state plan amendments or provider tax submissions and that it will continue to approve plan amendments and provider tax submissions with similar features in the future. In the absence of such affirmation, CMS should identify with written explanation which specific already approved plan amendments or submissions that would be problematic under the amended regulation and explain why. State legislatures, state Medicaid programs, and providers need and deserve such guidance.**

Conclusion

CMS has taken the opportunity to propose a rule implementing the Tax Relief and Health Care Act of 2006, Pub. L. 109-432,) to also modify other aspects of the provider tax rule—including permissible class of services and hold harmless provisions.

ANCOR Recommendation: ANCOR strongly urges the Centers for Medicare and Medicaid (CMS) not to implement this proposed rule as written. At this time, CMS should move forward on a rule that only implements the Tax Relief and Health Care Act of 2006. We believe the regulatory language and policies advanced beyond that implementing rule—as set forth in the proposed rule—will cause harm to those persons who rely on Medicaid for access to health care and long term care services. Any efforts to change or alter this program should at least be delayed until CMS works closely with the states and providers to establish some optional funding solutions for the health-related care provided by Medicaid programs. In particular, we are concerned with the proposal to exclude community residences from the intermediate care facilities for the mentally retarded("ICF/MR") permissible class of health care related taxes.

Sincerely,

Suellen R. Galbraith
Director for Government Relations

2

LNHA

LOUISIANA NURSING HOME ASSOCIATION

MAY 22 2007

May 21, 2007

Leslie Norwalk
Acting Administrator
U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: CMS-2275-P: Comments on Proposed Rule *Medicaid Program; Health Care-Related Taxes*, 72 Federal Register 13726 (March 23, 2007)

Dear Ms. Norwalk:

Louisiana Nursing Home Association (LNHA) represents more than 250 proprietary and non-profit facilities dedicated to continuous improvement in the delivery of professional and compassionate care, which is provided daily by thousands of caring employees to 30,000 of our state's frail, elderly and disabled citizens who live in nursing facilities. On their behalf, we ask that you consider the following comments regarding the proposed rule, *Medicaid Program; Health Care-Related Taxes*, 72 Federal Register 13726 (March 23, 2007).

In 1993, Louisiana implemented provider fees (provider taxes) on nursing homes and several other provider groups. These fees have been utilized by Louisiana's Medicaid program to provide many quality improvement programs and are essential for providing quality care to Louisiana's nursing home residents. As you are aware, Louisiana is recovering from Hurricane Katrina and Hurricane Rita. The health care system in the storm impacted areas is still suffering from continuing impact of the storms. Changes to the existing provider tax regulations will further exacerbate the health care challenges that Louisiana faces as the provider fee is a major funding component for Louisiana's Medicaid program.

LNHA reviewed the comments of the American Health Care Association (AHCA). LNHA fully supports the comments and recommendations of AHCA as they relate to clarifying the issues in the proposed rule. Clarification of the issues that AHCA has raised can only help to ensure that CMS administers the provider tax program fairly and consistently. LNHA strongly encourages CMS to carefully consider AHCA's comments and recommendations when promulgating the final rule.

Sincerely,

Joseph A. Donchess

Joseph A. Donchess
Executive Director

JAD:jb

7844 Office Park Blvd. · Baton Rouge, LA 70809 · Ph. 225.927.5642 · Fx. 225.927.5250 · www.lnha.org

KENTUCKY ASSOCIATION OF PRIVATE PROVIDERS

"A STATEWIDE ASSOCIATION OF PROVIDERS FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES"
P.O. BOX 1328
RICHMOND, KY 40476-1328
859-626-9206 (PRIMARY)
606-877-9209 (ALTERNATE)

May 18, 2007

Leslie Norwalk
Acting Administrator
U.S. Department of Health and Human Services
Center for Medicare & Medicaid Services
Room 445-G
Hubert Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

2007 MAY 23 AM 9:53

RE: Comments on CMS 2275-P; RIN 0938-A080
Proposed Rule on Medicaid Program's Health-Care Related Taxes

Dear Administrator Norwalk:

The Kentucky Association of Private Providers (KAPP) is taking this opportunity to provide written comments to the agency on the CMS proposed rule, Medicaid Program: Health-Care Related Taxes (CMS 2275-P) published in the Federal Register, Vol. 72, No. 56 on March 23, 2007.

KAPP, in existence since 1983, was founded to improve the quality of life for persons with mental retardation and developmental disabilities. Our member agencies collectively support over two-thirds of all waiver recipients in Kentucky who have chosen community based services instead of an ICF/MR.

KAPP is very concerned about the potential consequences of the proposed rule as it jeopardizes the future of provider tax agreements between the states and the federal government.We strongly urge the Centers for Medicare and Medicaid (CMS) not to implement this proposed rule. We believe the regulatory language and policies advanced in the proposed rule will cause harm to those persons who rely on Medicaid for access to health care and long term care services. In particular, we are concerned with the proposal to exclude grandfathered community residences from the intermediate care facilities for the mentally retarded ("ICF/MR") permissible class of health care related taxes.

The provider tax program is a legitimate, sound and well-administered program between the states and CMS, with cooperation and support of the provider community. Any

efforts to change or alter this program, should at least be delayed until CMS works closely with the states, and providers, to establish some optional funding solutions for the care provided by Medicaid programs.

Congress has codified the use of existing provider taxes and has established statutory authority over the programs. This CMS proposed rule gives CMS broad discretion which appears to far exceed that authority covered by statutory direction.

Further, 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 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.

Those provider tax initiatives in many states which have been previously approved by CMS should in no way be jeopardized; however, this proposed rule certainly makes that a possibility. Grandfathered facilities should not lose their current status as part of the ICF/MR class. A better policy is to expand the ICF/MR class to include all homes and community-based programs for the mentally retarded and developmentally disabled.

While CMS is no longer concerned that state will convert home and community-based programs back to ICF/MRs because of the general success of the HCBS program, not allowing HCBS providers the option to pay provider taxes can become an obstacle and disincentive to transition from institutional to community settings. ICF/MRs would have access to additional funds not available to HCBS, which would be contrary to desired federal policy.

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 this rule will harm Medicaid beneficiaries by imposing new restrictions on state funding without adequate opportunity to review or amend state financing structures to continue the care that is currently being provided to Medicaid beneficiaries across the country.

Sincerely,

Johnny Callebs

Johnny Callebs
KAPP President

Cc:

Senator Mitch McConnell
361-A Russell Senate Office Bldg.
Washington, D.C. 20510

Senator Jim Bunning
316 Hart Senate Office Bldg.
Washington, D.C. 20510

aahsa
creating the future of aging services

Received by Fulton-Kinnis
MAY 22 2007

6

May 21, 2007

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

RE: CMS-2275-P "Medicaid Program; Health Care-Related Taxes," Proposed Rule, Federal Register: March 23, 2007 (Volume 72, Number 56)

Dear Ms. Norwalk:

The American Association of Homes and Services for the Aging (AAHSA) appreciates the opportunity to comment on the Proposed Rule, published in the Federal Register on March 23, 2007, to implement changes required by Congress and clarify various provisions of the existing regulations governing provider taxes and donations.

AAHSA members serve over one million people every day through mission-driven, not-for-profit organizations. Seventy percent of our members are faith-based. Our members offer the continuum of aging services: home and community based programs, adult day programs, continuing care retirement communities, nursing homes, assisted living, and senior housing. AAHSA's vision is for all Americans to receive the care they need, when they need it, in a place they call home.

Background

The Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 (Pub. L. 102-234), enacted December 12, 1991, amended section 1903 of the Social Security Act to specify limitations on the amount of FFP available for medical assistance expenditures when States receive certain funds donated from providers and revenues generated by certain health care-related taxes, commonly known as "provider taxes." A final rule was issued on August 13, 1993 (58 FR 43156). The 1991 law requires that compliant provider taxes must, among other things, avoid certain hold harmless arrangements in which collected taxes are returned directly or indirectly to taxpayers, as defined in the law and regulations.

One of the hold harmless tests, set forth in current rules, defines arrangements that are considered to be prohibited indirect guarantees. Provider taxes may not exceed 6 percent of total revenues received by the taxpayers unless the State makes a showing that, in the aggregate, 75 percent of

taxpayers do not receive 75 percent or more of their total tax costs back in enhanced Medicaid payments or other state payments. The President's Budget for FY 2007 contained a proposal to reduce the maximum permissible tax from 6 percent to 3 percent. However, on December 20, 2006 the Tax Relief and Health Care Act of 2006 was signed into law as Public Law 109-432. Section 403 of that law incorporated the existing regulatory test for an indirect guarantee into the Medicaid statute but provided for a temporary reduction. Specifically, the indirect hold harmless threshold has been reduced from 6 percent to 5.5 percent effective in any portion of fiscal years beginning on or after January 1, 2008 and through September 30, 2011. Importantly, the 6 percent maximum, which previously was in regulation but not statute, has now been codified.

The current regulations also specify additional prohibited hold harmless arrangements, including those involving non-Medicaid payments such as grants or certain tax relief arrangements. The proposed regulations propose certain clarifications to these.

Provisions of the Proposed Rule: Comments

AAHSA is pleased to see the codification of the 6 percent maximum and agrees with CMS' implementation of Section 403 of the Tax Relief and Health Care Act of 2006. We also agree with CMS that provider taxes are not an optimal approach to sustainable, appropriate, equitable Medicaid funding. Among other things, as the proposed regulations note, provider taxes "create a significant tax burden for health care providers that do not participate in the Medicaid program or that provide limited services to Medicaid individuals." But in the absence of an alternative in many states, AAHSA was very concerned that sharply curtailing provider taxes by substantially cutting the maximum allowed below the existing 6 percent would result in Medicaid payment reductions that would harm low income people needing care.

AAHSA appreciates the opportunity to submit our views on this issue and the time and consideration you devote to the comment process. We look forward to working with you toward a smooth implementation of the proposed changes.

Sincerely,

William L. Minnix, Jr.
President and CEO

5

ResCare
10140 Linn Station Road
Louisville, Kentucky 40223-3813

phone: 502.394.2100
fax: 502.394.2206

Received
MAY 22 2007

May 22, 2007

BY ELECTRONIC FILING AND BY HAND

Hon. Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2275-P
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.

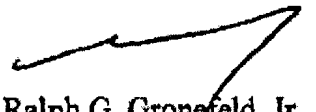
The proposed rule conflicts with the statutory tests for determining whether a health care related tax or donation constitutes a hold harmless arrangement. Congress established the rules for identifying a hold harmless arrangement and charged CMS with the authority to determine when the rules apply. 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.

4

ahca
American Health Care Association

1201 L Street, NW, Washington, DC 20005-4046
Main Telephone: 202-842-4444
Main Fax: 202-842-3860 2nd Main Fax: 202-289-4253
Writer's Telephone: 202-898-2858
Writer's E-Mail: byarwood@ahca.org
www.ahca.org

May 22, 2007

Leslie Norwalk
Acting Administrator
U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: CMS-2275-P: Comments on Proposed Rule *Medicaid Program; Health Care-Related Taxes*, 72 Federal Register 13726 (March 23, 2007)

Dear Ms. Norwalk:

The American Health Care Association (AHCA) appreciates the opportunity to comment on the proposed rule, *Medicaid Program; Health Care-Related Taxes,* 72 Federal Register 13726 (March 23, 2007).

AHCA is the nation's leading long term care organization. AHCA and its membership are committed to performance excellence and Quality First, a covenant for healthy, affordable and ethical long term care. AHCA represents more than 10,000 non-profit and proprietary facilities dedicated to continuous improvement in the delivery of professional and compassionate care provided daily by millions of caring employees to more than 1.5 million of our nation's frail, elderly and disabled citizens who live in nursing facilities, assisted living residences, subacute centers and homes for persons with mental retardation and developmental disabilities.

In these comments, AHCA first examines the background of the proposed rule. It then furnishes an executive summary of its comments and its recommendations. Next, a detailed explanation of AHCA's views is provided. Finally, AHCA offers its basic conclusions concerning the proposed rule.

I. BACKGROUND ON THE PROPOSED RULE

The Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 (Pub. L. 102-234), enacted December 12, 1991, amended section 1903 of the Act, 42 U.S.C. § 1396b, to specify limitations on the amount of federal financial participation (FFP) available for medical assistance expenditures in a fiscal year when states receive

certain funds donated from providers and revenues generated by certain health care-related taxes.

Section 1903(w) of the Social Security Act, 42 U.S.C. § 1396b(w), requires that, for state health care-related taxes to be approvable, they must be imposed on a permissible class of health care services; be broad based or apply to all providers within a class; be uniform, such that all providers within a class must be taxed at the same rate; and avoid hold harmless arrangements in which collected taxes are returned directly or indirectly to taxpayers. Section 1903(w)(3)(E) of the Act, 42 U.S.C. § 1396b(w)(3)(E), specifies that the Secretary shall approve broad based (and uniform) waiver applications if the net impact of the health care-related tax is generally redistributive and that the amount of the tax is not directly correlated to Medicaid payments. The broad based and uniformity provisions are waivable through a statistical test that measures the degree to which the Medicaid program incurs a greater tax burden when a State tax program is otherwise not compliant with the broad based and/or uniformity requirement.

CMS issued regulations to implement the statutory provisions concerning provider donations and health care-related taxes in an interim final rule (with comment period) published on November 24, 1992[1] and a final rule issued on August 13, 1993.[2] 42 C.F.R. § 433.50 *et seq.* Currently, the regulations at § 433.68(f) set forth three broad tests to determine if there is a hold harmless arrangement with respect to a health care-related tax – the positive correlation, Medicaid payment, and direct or indirect guarantee tests. If states enact a tax program that violates any of these tests, federal financial participation (FFP) will be reduced by the amount collected through that tax program.

CMS has now issued a proposed rule implementing the Tax Relief and Health Care Act of 2006, Pub. L. 109-432, (Tax Relief and Health Care Act) but also modifying other aspects of the rule including the hold harmless provisions.[3] CMS indicates that a recent Departmental Appeals Board (DAB) decision has drawn into question how the current hold harmless provisions will be interpreted and applied.[4] CMS took the opportunity to propose modification of certain terms in each of these hold harmless tests.

First, the proposed rule would revise the threshold under the indirect guarantee hold harmless arrangement test to reflect and conform with the provisions of the Tax Relief and Health Care Act, by providing that, when determining whether there is an indirect guarantee under the two-pronged test for any part of a fiscal year on or after January 1, 2008 through September 30, 2011, the allowable amount that can be collected from a

---

[1] 57 Federal Register 55118.

[2] 58 Federal Register 43156.

[3] Proposed Rule *Medicaid Program; Health Care-Related Taxes*, 72 Federal Register 13726 (March 23, 2007).

[4] In a June 29, 2005 decision involving the Medicaid programs of Hawaii, Illinois, Louisiana, Maine, and Tennessee, the HHS Departmental Appeals Board (DAB), DAB No. 1981, found that the hold harmless regulations did not clearly preclude certain types of arrangements that CMS believed to be within the scope of the statutory hold harmless prohibition and implementing regulations. The DAB consequently reversed disallowances issued by CMS to these five states. In each of these reversed disallowances, the state imposed a tax on nursing homes and simultaneously created a program that awarded grants or tax credits to private pay residents of those nursing homes. These grants and/or tax credits were designed by the states to compensate private pay residents of nursing homes for the costs of the tax passed on to them by their nursing homes through increased charges. CMS had concluded that the grants and tax credits amounted to hold harmless arrangements prohibited from receiving FFP under the Medicaid statute and regulations.

health care-related tax is reduced from 6 to 5.5 percent of net patient revenues received by the taxpayers.

Secondly, the proposed rule would clarify the standard for determining the existence of a hold harmless arrangement under the positive correlation test, Medicaid payment test, and the guarantee test.

Lastly, the proposed rule would alter the description of a certain class of health care services that is permissible under the federal statute for purposes of taxes on health care providers.

II. EXECUTIVE SUMMARY

A. AHCA Comments

AHCA understands the underlying policy and concerns addressed in the provider tax legislation at Section 1903(w) of the Social Security Act, 42 U.S.C. § 1396b(w), and by CMS to the effect that if certain types of payment arrangements were permitted, there would be no restraint on states' ability to use provider taxes as the source of the non-federal share of Medicaid payments.[5] CMS in the preamble to the current proposed rule also expresses concern about a recent trend in states' efforts to maximize non-federal share funding opportunities under current Medicaid law through taxation of health care providers, which had led CMS to consider a reduction of the 6 percent threshold related to the indirect guarantee hold harmless provision to 3 percent.[6]

As you know, AHCA was opposed to such a reduction because it would have constituted at a minimum a $1.5 billion loss in federal matching funds annually to long term care facilities. Long term care could not have sustained such a loss.

As it is, nationwide long term care facilities already face an average Medicaid reimbursement shortfall of $13.10 per patient day.[7] The funding system is unstable and inconsistent. AHCA has expressed repeatedly that CMS should coordinate with state government representatives and providers to work out a broad regulatory framework or substantially improve on the current one to help to ensure consistency and stability in the Medicaid program, assure adequate payment for Medicaid providers, and meet the highest standards of fiscal integrity. Such a framework should enable states to implement rate methodologies resulting in rates consistent with efficiency, economy and quality of care in compliance with section 1902(a)(30)(A) of the Act, 42 U.S.C. § 1396a(a)(30)(A), rather than solely on budget considerations.

Provider tax revenues are a legitimate source of state revenues for FFP, as countenanced by Congress, and a strong and healthy component of state FFP programs. While AHCA recognizes the need for the agency to implement the temporary change from 6 percent to

---

[5] *Medicaid Program; Limitations on Provider-Related Donations and Health Care Related Taxes; Limitations on Payments to Disproportionate Share Hospitals, Interim Final Rule With Comment Period*, 57 Federal Register 55118, November 24, 1992, as corrected at 58 Federal Register 6096, January 26, 1993. *See also Medicaid Program; Limitations on Provider-Related Donations and Health Care-Related Taxes; Limitations on Payments to Disproportionate Share Hospitals,* Final Rule, 58 Federal Register 43156, August 13, 1993, corrected at 58 Federal Register 44536, August. 23, 1993, corrected at 58 Federal Register 51130, September 30, 1993.

[6] 72 Federal Register at 13733.

[7] BDO Seidman LLP, *A Report on Shortfalls in Medicaid Funding for Nursing Home Care*, June 2006.

5.5 percent for the indirect hold harmless test, AHCA questions the breadth of the proposed regulation changes and interpretations. Under the proposal, CMS would reserve for itself sweeping discretion, the potential impact of which is extremely difficult to understand or, more importantly, to forecast. AHCA believes that the unfettered scope of CMS' proposed discretion appears to go well beyond statutory direction while creating needless doubt and uncertainty for state Medicaid programs.

Plainly, CMS has the responsibility to be vigilant. But it also has the obligation to be helpful, fair and consistent. Recently, Senator Max Baucus stated that "CMS's rules for Medicaid provider payments need to be clear and consistent, period. Continued confusion over the appropriate ways to finance Medicaid services will result in less focus on serving patients as states try to keep up with CMS's ever-changing standards."[8]

AHCA believes that the proposed rule should have no impact on already approved provider tax programs and corresponding state plan amendments, including those states with provider tax waivers. AHCA asks CMS to confirm specifically that there is no such impact and, if there is, to identify precisely those state plan amendments and waivers that would be problematic under the new rule and exactly why they might no longer pass muster. AHCA also asks for confirmation that CMS's historical review and approval criteria for provider tax waivers and state plan amendments are not changing as a result of this proposed rule and, if they are, to enumerate in detail how they will change.

Provider tax programs in place now should be sustained under the proposed rule. AHCA does not believe that they are in jeopardy. However, AHCA has provided its analysis and concerns immediately below and a detailed explanation regarding its concerns in the Discussion portion (Section III, *infra*) of these comments.

Again, the provider tax program is a sound and well-administered program to the credit of both the states and CMS. AHCA believes that clarification of the following issues can help to keep the provider tax program strong and effective until alternative solutions to funding needed care provided by Medicaid are found.

B. AHCA Recommendations

1. AHCA Recommendations on Medicaid Payment Test:

- *CMS should clarify that the amended regulation would not prohibit a state from mandating through state law that all or some percentage of the taxes, along with corresponding federal match, must be used for rate increases. AHCA believes that the clause should not prohibit such state laws, which are within both the letter and the spirit of the federal law.*

- *CMS should clarify that the preamble language on state use of tax proceeds and federal match to increase Medicaid rates in the form of Medicaid supplemental payments should not prohibit states from using tax proceeds and federal match to increase Medicaid rates in the form of Medicaid per diem add-ons or rate supplements.*

---

[8] Press Release, United States Senate, Committee on Finance, Max Baucus, Chairman, April 30, 2007.

- *CMS should verify that the amended regulation does not jeopardize any approved state plan amendments or provider tax submissions and that it will continue to approve plan amendments and provider tax submissions with similar features in the future. If CMS is unable or unwilling to make such a verification, it should identify with particularity already approved plan amendments or submissions that would be problematic under the amended regulation and explain why. State legislatures, state Medicaid programs, and providers need and deserve such guidance.*

2. ***AHCA Recommendation on Direct Guarantee Test:***

   - *Due to the sweeping breadth of the discretion that CMS has proposed to assume regarding interpretation of the phrase "direct and indirect," CMS should clarify its application of this concept to the guarantee test when other than non-Medicaid payments are involved, and should confirm that use of provider tax receipts to increase Medicaid rates for or to enhance the Medicaid rate methodology applicable to the taxed provider class is not prohibited.*

3. ***AHCA Recommendations on Indirect Guarantee Hold Harmless Arrangements:***

   - *CMS should confirm that the following preamble language would only be applicable if the taxes exceed the 6 percent or 5.5 percent thresholds. The passage reads as follows: "CMS may 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."* 72 Federal Register 13730.

   - *CMS should remove this language entirely since many states have provisions in their provider tax legislation indicating that if their tax programs are not approved by CMS, sunset, are declared invalid, or otherwise terminate, Medicaid rates revert to those in effect prior to implementation of the tax programs.*

   - *If CMS retains this preamble language, it should enumerate all existing states with provider tax programs that run afoul of this interpretation and explain why.*

4. ***AHCA Recommendation on Permissible Class of Services – Intermediate Care Facilities for People With Mental Retardation (ICFs-MR):***

   - *CMS should not modify the definition of the ICF-MR class of services enabled to utilize provider taxes to delete the inclusion of community-based residences. AHCA requests that community-based residences not be removed given their inclusion over such a long period of time in the provider tax program and the interest by the federal government and all care givers in appropriate care across the spectrum of care. Excluding community-residences could have a negative effect on access to such care sites. Retention meets good public policy and beneficiary needs*

III. PROVISIONS OF THE PROPOSED RULE: AHCA DISCUSSION

A. Hold Harmless Modifications

As indicated above, the goal of the Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 and implementing regulations was to provide a restraint on as a state's ability to use provider taxes as the source of the non-federal share of Medicaid payments. Providers commenting on the 1992 interim final rule had many concerns regarding the relationship between the Medicaid payment to the provider tax payer and the amount of the tax payment. CMS tried to address these concerns in the 1993 final rule.

For example, one major concern was whether or not a tax could be claimed as an allowable cost and included in the establishment of reimbursement rates. CMS would not exclude pass-through costs associated with health care-related taxes from the hold harmless provisions but indicated that such a pass-through would not necessarily constitute a hold harmless situation. The agency referenced Section 1903(w)(4) of the Act, 42 U.S.C. § 1936b(w)(4), which provides that the hold harmless provisions did not "prevent the use of the tax to reimburse health care providers in a class for expenditures under title XIX nor preclude States from relying on such reimbursement to justify or explain the tax in the legislative process."

Several 1992 commenter's indicated that it was difficult and restrictive to apply the hold harmless test in determining that some portion of the Medicaid payment varies directly with the amount of the tax paid. They were concerned that where a provider receives Medicaid payment that is greater than or equal to the amount of tax paid, it would be possible to show that there was one-to-one correspondence between some portion of Medicaid payment and the tax. CMS' response was simply that it had "developed a test in the regulation which allows States some degree of 'one-to-one' correspondence within certain limitations at §433.68(f)." 58 Federal Register 43166. However, the agency did not elaborate further.

AHCA believes that the subsequent implementation and operation of the provider tax regulations have in practice demonstrated on an ongoing basis CMS' intent expressed in the 1992 and 1993 preambles, but AHCA is concerned that the modifications to the hold harmless tests would again create confusion regarding the relationship between the Medicaid payment to the provider tax payer and the amount and nature of the tax payment. AHCA seeks clarification and confirmation of its interpretation, provided below, of the proposed modifications to the tests. Its concerns lie with the proposed changes to the second and third tests: the Medicaid payment test and the guarantee test.

1. Medicaid Payment Test – 42 CFR §433.68(f)(2)

Under the current second hold harmless test, a hold harmless arrangement exists if all or any portion of the Medicaid payment varies based only on the amount of the total tax payment. CMS is proposing to revise this rule to use the standardized terminology "tax amount" instead of tax payment and also adding a clause indicating that "a Medicaid payment will be considered to vary based on the tax amount when the payment is condi-

tional on the tax payment."[9] CMS adds that, when the payment is conditional on the tax payment, "... the variation between a payment of zero and a positive payment would be based only on the payment of the tax amount."

As a prelude to its comments on the Medicaid payment test proposal, AHCA notes that states with provider tax programs typically alter their Medicaid rates and rate methodologies for the provider class being taxed in one or more of three ways when they enact such programs: (1) the providers receive a Medicaid rate supplement or add-on per day; (2) the rate methodology is modified to enhance Medicaid rates in some way (*e.g.*, use of an inflation factor or higher rate ceilings); and/or (3) some combination of (1) and (2). Further, such alternatives are typically the direct result of, and are frequently tied to, enactment of a provider tax program. During the past 15 years, CMS has repeatedly approved state Medicaid plan amendments and provider tax submissions that use such approaches.

As such, AHCA is appreciative of the assurances in the preamble to the effect that the proposed language does not abrogate and is consistent with the legislative directive to the effect that provider taxes may be an allowable Medicaid cost.[10] AHCA is also encouraged to see that the proposal would not preclude states that use cost-based payment mechanisms from including provider tax costs as one of many provider costs that are considered in setting individualized provider rates. However, AHCA asks CMS to provide further clarification regarding two issues.

First, AHCA is uncertain whether the regulatory clause – "... a Medicaid payment will be considered to vary based on the tax amount when the payment is conditional on the tax payment..." – would prohibit a state from mandating through state statute that all or some percentage of the taxes, along with corresponding federal match, must be used for rate increases. AHCA believes that the clause should not prohibit such state statutes that are within both the letter and the spirit of the federal law.

Prohibiting a state from mandating legislatively that all or some percentage of the taxes, along with corresponding federal match, must be used for rate increases would be inconsistent with Section 1903 (w)(4) of the provider tax law, 42 U.S.C. § 1396b(w)(4). The law indicates that the hold harmless provisions shall not prevent use of the tax to reimburse health care providers in a class for expenditures under this title nor preclude states from relying on such reimbursement to justify or explain the tax in the legislative process. In addition, such legislation assures that provider tax revenue shall be used for Medicaid services and thus obviates any question regarding misuses of tax revenue that have arisen in connection with other types of FFP funding.

Secondly, AHCA seeks clarification of the preamble language indicating that the proposed modification would affect states that seek to use rates "that are based solely on the receipt of provider taxes, rather than on overall provider costs (such as supplemental

---

[9] The proposed rule would modify 42 CFR §433.68 to read as follows: "A taxpayer would be considered to be held harmless under a tax program if ... all or any portion of the Medicaid payment to the taxpayer varies based only on the tax amount, including where Medicaid payment is conditional on receipt of the tax amount." 72 Federal Register at 13734.

[10] CMS writes "We do not believe this clarification is inconsistent with the provision in section 1903(w)(4) of the Act that indicates that the restrictions on hold harmless arrangements does not prevent States from using taxes "to reimburse health care providers in a class for expenditures under this title." 72 Federal Register at 13730.

payments conditioned on receipt of taxes)." 72 Federal Register 13730. CMS indicates that, where Medicaid payment is conditioned on receipt of taxes, it would view the payment to be, in part or in full, to repay the taxes in a hold harmless arrangement rather than as a protected reimbursement for costs of Medicaid services. CMS further states that the clarification is thus necessary to ensure that Medicaid payments are not made simply to repay providers for the tax, but also to ensure the integrity of the development of sound payment rates in compliance with the requirements of section 1902(a)(30) of the Act, 42 U.S.C. § 1396a(a)(30). Lastly, according to CMS, the proposed language would, however, 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 in compliance with section 1902(a)(30)(A) of the Act, 42 U.S.C. § 1396a(a)(30)(A).

AHCA is concerned about the impact of this preamble language on state use of tax proceeds and federal match to increase Medicaid rates in the form of Medicaid per diem add-ons or rate supplements. We believe this provision should not prohibit states from using tax proceeds and federal match to increase Medicaid rates in the form of Medicaid per diem add-ons or rate supplements.

Many states use some elements of a pricing model in their payment system to promote efficiency and economy in care delivery and a Medicaid per diem rate add-on is simply one form of that. This approach does not direct dollars to lower volume Medicaid providers, but in fact, does just the opposite. Higher volume Medicaid providers reap the greatest benefit in that these rate adjustments are provided per Medicaid day; the greater the number of Medicaid days; the greater the Medicaid revenue enhancement. This allows more of the higher volume Medicaid providers an opportunity to be reimbursed rates that are in closer proximity to their costs.

Accordingly, AHCA asks CMS to confirm that: (a) no existing approved Medicaid state plan amendments or provider tax submissions would be jeopardized by this regulatory amendment; and (b) pending or future plan amendments or provider tax submissions with similar features to those already approved would continue to receive CMS approval in the future. If CMS cannot make such a confirmation, it should identify particular plan amendments or provider tax submissions that would no longer be approvable and explain exactly why that is the case.

AHCA Recommendations on Medicaid Payment Test:

- *CMS should clarify that the amended regulation would not prohibit a state from mandating through state law that all or some percentage of the taxes, along with corresponding federal match, must be used for rate increases. AHCA believes that the clause should not prohibit such state laws, which are within both the letter and the spirit of the federal law.*

- *CMS should clarify that the preamble language on state use of tax proceeds and federal match to increase Medicaid rates in the form of Medicaid supplemental payments should not prohibit states from using tax proceeds and federal match to increase Medicaid rates in the form of Medicaid per diem add-ons or rate supplements.*

- *CMS should verify that the amended regulation does not jeopardize any approved state plan amendments or provider tax submissions and that it will continue to approve plan amendments and provider tax submissions with similar features in the future. If CMS is unable or unwilling to make such a verification, it needs to identify with particularity already approved plan amendments or submissions that would be problematic under the amended regulation and explain why. State legislatures, state Medicaid programs, and providers need and deserve such guidance.*

2. Guarantee Test – 42 CFR §433.68(f)(3)

a. Direct Guarantee – 42 CFR §433.68(f)(3)

Under the current third hold harmless test, a hold harmless arrangement exists if there is a direct or indirect guarantee that holds taxpayers harmless for any portion of their tax cost. CMS proposes to modify this test to specify that a direct or indirect guarantee may occur through a direct or indirect payment.[11] We ask CMS to provide further clarification regarding three issues.

First, in the preamble, CMS states that 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 statute, regulation, or policy. Again, as with the modifications to the Medicaid payment test, we request confirmation that this preamble language does not prohibit a state from mandating legislatively that all or some percentage of the taxes, along with corresponding federal match, must be used for rate increases. Such a prohibition would be inconsistent with Section 1903(w)(4) of the provider tax law, 42 U.S.C. § 1396b(w)(4), which indicates that the hold harmless provisions shall not prevent use of the tax to reimburse health care providers in a class for expenditures under title 19 nor preclude states from relying on such reimbursement to justify or explain the tax in the legislative process.

Secondly, CMS reiterates in the preamble that an indirect payment to the taxpayer would also constitute a direct guarantee. One such example of this indirect payment providing a direct guarantee would be found where a state imposing a tax on nursing facilities provided grants or tax credits to private pay residents of those facilities that could be used to compensate those residents for any portion of the tax amount that the state has allowed to be passed down to them by their nursing homes. This example was also provided by CMS in its preamble discussion of the positive correlation test which applies to non-Medicaid payments to providers or others paying the tax. This was the type of indirect payment that CMS had endeavored, but failed, to prohibit in the 1993 DAB decision referenced above in note 4. However, CMS cautioned that the purpose of this plus other examples was only to provide illustration of the broad scope of indirect payments. CMS concluded that:

---

[11] The proposed rule, at 42 C.F.R. § 433.68(f)(3), would determine a hold harmless to exist when "The State (or other unit of government) imposing the tax provides for any direct or indirect payment, offset, or waiver such that the provision of that payment, offset, or waiver directly or indirectly guarantees to hold taxpayers harmless for all or any portion of the tax amount." 72 Federal Register at 13734.

> Due to the difficulty in predicting all possible types of indirect payments, this example does not limit our ability to detect other indirect payments in the future. We recognize that this test interjects some degree of subjectivity into this analysis. We will look at all relevant circumstances surrounding a tax and payment program to determine whether a linkage exists to establish an indirect payment. 72 Federal Register 13729.

AHCA's concern is that CMS intends to interpret "broadly" the phrase "direct and indirect" and indicates that its discussion of direct and indirect non-Medicaid payments is applicable to both the positive correction test and the guarantee test.

AHCA does not believe that states in the future will look to non-Medicaid payment approaches as part of provider tax programs. However, due to the sweeping breadth of the discretion that CMS has assumed regarding interpretation of the phrase "direct and indirect," AHCA asks for clarification as to CMS's application of this statement the guarantee test when other than non-Medicaid payments are involved.

Lastly, CMS interprets the phrase "all or any portion of the tax amount" to mean that a guarantee exists when a taxpayer is assured that money will be made available for repayment for any identifiable portion of the tax liability. We believe this should not be applicable when the tax proceeds are used to increase Medicaid payment rates and providers are partially or fully reimbursed for the Medicaid portion of the provider tax through the Medicaid payment methodology, a reimbursement permitted by law at Section 1903(w)(4), 42 U.S.C. § 1396b(w)(4).

AHCA Recommendation on Direct Guarantee Test

- *Due to the sweeping breadth of the discretion that CMS has assumed regarding interpretation of the phrase "direct and indirect," CMS should clarify its application of this concept to the guarantee test when other than non-Medicaid payments are involved and should confirm that use of provider tax receipts to increase Medicaid rates for or to enhance the Medicaid rate methodology applicable to the taxed provider class is not prohibited.*

b. Indirect Guarantee Hold Harmless Arrangements – 42 C.F.R. § 433.68(f)(3)(i)

AHCA has concerns regarding the preamble discussion of the second prong of the indirect guarantee provisions.

Currently, under 42 C.F.R. § 433.68(f)(3)(i), an indirect hold harmless violation is determined using a two pronged test. Under the first prong, if a health care-related tax or taxes are applied at a rate that produces revenues at or less than 6 percent of the revenues received by the taxpayers, the tax or taxes will not be in violation of the indirect hold harmless provision. The Tax Relief and Health Care Act has lowered the maximum threshold under the indirect hold harmless provision from 6 percent of net patient service revenue to 5.5 percent effective in fiscal years beginning on or after January 1, 2008 through September 30, 2011. CMS has accordingly proposed modification of the rule.

The second prong of the test addresses a provider tax that produces revenues greater than 6 percent of the revenues received by the taxpayers or 5.5 percent while the Tax Relief and Health Care Act is in effect. Pursuant to this regulation, when the tax or taxes produce revenues in excess of the applicable percentage of the revenue received by the taxpayer, CMS will consider an indirect hold harmless provision to exist if 75 percent or more of the taxpayers in the class receive 75 percent or more of their total tax costs back in *enhanced Medicaid payments* or other State payments.

CMS has not proposed modifying this part of the test, but in the preamble, CMS indicates that in applying this test, it may 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. AHCA seeks confirmation that this part of the indirect guarantee test would only be applicable if the taxes exceed the 6 percent or 5.5 percent thresholds.

Equally important, AHCA questions whether there is any need or purpose for such language in the preamble. Many states have provisions in their provider tax legislation indicating that, if their tax programs are not approved by CMS, sunset, are found to be unlawful, or otherwise lapse or expire, Medicaid rates revert to those in effect prior to implementation of the tax program. This not only makes good business and budgetary sense but is consistent with the law at Section 1903(w)(4), 42 U.S.C. § 1396b(w)(4), in that this type of statutory language is "relying on such reimbursement to justify or explain the tax in the legislative process." If CMS insists on retaining this language in any final rule, it should identify all existing states with provider tax programs that are in jeopardy as a result and furnish a detailed explanation of why that is the case.

AHCA Recommendations on Indirect Guarantee Hold Harmless Arrangements:

- *CMS should confirm that the following preamble language would only be applicable if the taxes exceed the 6 percent or 5.5 percent thresholds. The passage reads as follows: "CMS may 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." 72 Federal Register 13730.*

- *CMS should remove this language entirely since many states have provisions in their provider tax legislation indicating that if their tax program are not approved by CMS, sunset, are declared invalid, or otherwise terminate, Medicaid rates revert to those in effect prior to implementation of the tax programs.*

- *If CMS retains this preamble language, it should enumerate all existing states with provider tax programs that run afoul of this interpretation and explain why.*

B. Permissible Class of Services – Intermediate Care Facilities for People With Mental Retardation – 42 CFR §433.56(a)(4)

CMS proposes a modification to the definition of the permissible ICF-MR class to delete the inclusion of community-based residences from the definition of the class. AHCA requests that community-based residences not be removed from the definition given their

inclusion over such a long period of time and the interest of the federal government and all care givers in appropriate care across the spectrum of care.

In order for a tax to be considered broad based, it must apply to all items and services within a class of items and services specified in section 1903(w)(7)(A) of the Act, 42 U.S.C. § 1395w(b)(7)(A). In § 433.56, CMS incorporated the classes of health care services and providers specified in this provision. Congress had included intermediate care facility services for persons with mental retardation in the statutory classification and also granted CMS the authority to add other health care items and services by regulation.

The statute includes, within the list of health care items and services on which permissible taxes may be enacted, services of intermediate care facilities for the mentally retarded (ICF-MRs). In incorporating this class in the regulation, CMS clarified the provision to include within that class of facilities certain group homes for persons with mental retardation that provide services, under a waiver, similar to ICF-MR services. The current regulation reads as follows:

> (4) Intermediate care facility services for the mentally retarded, and similar services furnished by community-based residences for the mentally retarded, under a waiver under section 1915(c) of the Act , in a State in which, as of December 24, 1992, at least 85 percent of such facilities were classified as ICF-MRs prior to the grant of the waiver;

CMS indicates that these services furnished by the residences were added because in some states, many former ICF-MRs were converted to group homes under the waivers and CMS feared that these facilities could easily be converted back to ICF-MRs. CMS explains that this exception was very narrow and was only intended to capture those states that, before the issuance of the interim final rule December 24, 1992, were granted waivers that converted existing ICF-MRs to community-based residences.

CMS now no longer believes that it is appropriate to include community residences in the ICF-MR class even to the extent of this narrow exception. CMS is no longer concerned that states will convert group homes back to ICF-MRs because of the general success of the home and community based services program. Important also to CMS, is the fact that it is not equitable to accord different treatment to states that converted ICF-MRs before December 24, 1992 than to other states.

First, AHCA agrees that it is not equitable to accord different treatment to states that converted ICF-MRs before December 24, 1992 than to other states. It believes that they should all be afforded the same treatment and that is to permit them to be included in state provider ICF-MR tax programs as a qualified service category for provider taxes for all states. States that have been able to include community residences in their provider programs should not, after 14 years, be forced to exclude them, and all states should be afforded the opportunity to include them in the permissible class. AHCA's reason is precisely that referenced by CMS above – the success of the home and community-based services program. Most ICF-MR services are now provided in more homelike environments (typically small group home residences or supportive living arrangements). Extending the tax to community-based services for people with developmental disabilities provides the opportunity for greater resources for services to these individuals.

Further, while CMS is no longer concerned that states will convert group homes back to ICF-MRs because of the general success of the home and community based services (HCBS) program, not allowing HCBS providers to pay the provider tax (and later get federal funds) can be a barrier to individuals' ability to transition from institutional to community settings. This is because ICFs/MR would have additional funds that HCBS providers do not have, which may limit HCBS that are available.

The individual's right to move from an institutional to a community based setting is an integral part of the New Freedom Initiative, the Deficit Reduction Act (DRA), and the Supreme Court's *Olmstead* decision. In addition, consideration should be given to the fact that Section 6086 of the DRA allows a state to include HCBS in its Medicaid plan, thereby eliminating the need for a waiver. On April 5, 2007, the Department of Health and Human Services (HHS) 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 HCBS 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 HCBS. AHCA's policy, too, is that publicly and privately financed long term care and related supports and services must meet consumer and family needs, and respond to their preferences. AHCA believes that there must be a sufficient investment in federal and state governmental infrastructure so as to ensure long term care delivery systems provide an adequate array of services administered by knowledgeable providers – who are committed to quality – across the entire long term care spectrum.

Accordingly, CMS should modify the provisions in question to remove outdated references to December 24, 1992 but should retain the inclusion of community-residences with ICFs-MR. AHCA recommends the following language:

> Intermediate care facility services for the mentally retarded, and similar services furnished by community-based residences for the mentally retarded, under a waiver under section 1915(c) of the Act and or under the Deficit Reduction Act home and community state plan options.

Such retention better meets good public policy and beneficiary needs.

AHCA Recommendation on Permissible Class of Services – Intermediate Care Facilities for People With Mental Retardation:

- *CMS should not modify the definition of the ICF-MR class of services enabled to utilize provider taxes to delete the inclusion of community-based residences. AHCA requests that community-based residences not be removed given their inclusion over such a long period of time in the provider tax program and the interest by the federal government and all care givers in appropriate care across the spectrum of care. Excluding community-residences could have a negative effect on access to such care sites. Retention meets good public policy and beneficiary needs.*

IV. CONCLUSION

Thank you for consideration of these comments. Again, the provider tax program is a legitimate, sound, and well-administered program to the credit of both the states and CMS. Clarification of the issues that AHCA has raised will help to keep the provider tax program strong and effective until alternative solutions to funding needed care provided by Medicaid are found.

Sincerely,

Bruce Yarwood
President and CEO

Cc: Herb Kuhn, CMS
James Frizzera, CMS