Submitter : **Dr. Rhonda Medows** **Date: 05/22/2007**

Organization : **Georgia Department of Community Health**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

Thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule. I understand that a recent DAB decision prohibited CMS from preventing States from using tax credits to private pay patients as a mechanism to provide indirect payments for provider taxes. While I can understand CMS need to further clarify what are allowable practices for states with health care-related tax programs, these proposed rules appear to make extreme changes that do more than respond to this issue. I am additionally concerned that these rules do not include finite or reasonable definitions of the indirect payments that CMS wishes to prohibit nor do they provide the appropriate specificity in defining which statistical and numeric factors will be used to meet waiver requirements. I respectfully ask that CMS amend these proposed rules and include the level of detail necessary to ensure that all states are treated uniformly in administering health-care related tax programs.

Submitter : Ms. Caroline Brown

Date: 05/22/2007

Organization : Covington & Burling LLP

Category : State Government

Issue Areas/Comments

GENERAL

GENERAL

See attached.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See attached.

Regulatory Impact Analysis

Regulatory Impact Analysis

See attached.

CMS-2275-P-12-Attach-1.DOC

Before the
UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

In the Matter of	)	
	)	
MEDICAID PROGRAM; HEALTH CARE-RELATED TAXES	)	CMS-2275-P
	)	

COMMENTS OF THE STATE OF RHODE ISLAND

The State of Rhode Island submits these Comments on the Centers for Medicare & Medicaid Services' ("CMS") proposed rule revising the regulations on health care-related taxes, published March 23, 2007, at 72 Fed. Reg. 13,726. Rhode Island has joined in Joint Comments submitted on behalf of a group of states in opposition to the proposed rule, and believes that those Comments set forth the many reasons for CMS to abandon its proposed interpretations of and certain revisions to the "hold harmless" provision of the provider tax regulations, 42 C.F.R. § 433.68(f). Rhode Island additionally submits these individual Comments in order to object to the provision of the proposed rule which narrows the class of intermediate care facility for the mentally retarded ("ICF/MR") health care services, at 42 C.F.R. § 433.56(a)(4), to exclude similar services furnished by community-based residences for the mentally retarded under a waiver.

The proposed revision would adversely affect Rhode Island, which has had a tax on ICFs/MR, including waiver homes, for over fifteen years, collecting nearly $10 million in revenue for the State. The revenue raised helps support the State's ongoing efforts to provide effective home- and community-based services for the mentally retarded / developmentally

disabled ("MR/DD") population in community-based settings -- a goal consistent with the Administration's New Freedom initiative. Therefore, CMS should retract the proposal. At the very least, since Rhode Island has for many years reasonably relied on the rule including services furnished in waiver homes in the ICF/MR class, the State is entitled to an extended transition period in order to phase out the tax on these providers in a way that minimizes the disruption to the State budget process.

PROVISIONS OF THE PROPOSED RULE

Under the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, Public Law 102-234 (the "Provider Tax Amendments"), Section 1903(w) of the Social Security Act ("SSA"), taxes must be broad-based and apply uniformly to all providers included within one or more of eight classes of health care items or services. SSA § 1903(w)(3), (7). The list of classes includes "[s]ervices of intermediate care facilities for the mentally retarded." *Id.* § 1903(w)(7)(A)(iv). The statute also provides that CMS may establish by regulation other categories of health care items or services consistent with the statute. *Id.* § 1903(w)(7)(A)(ix).

In a 1992 interim final rule, CMS (then HCFA) implemented these statutory provider classes at 42 C.F.R. § 433.56(a). Addressing the ICF/MR class, HCFA "clarif[ied] this provision to include within that class of facilities certain group homes for the mentally retarded that provide services, under a waiver, similar to ICF/MR services." HCFA, Interim Final Rule, Limitations on Provider-Related Donations and Health Care-Related Taxes, 57 Fed. Reg. 55,118, 55,122 (Nov. 24, 1992). The class in the regulation includes ICF/MR services "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." 42 C.F.R. § 433.56(a)(4). HCFA reasoned in the rulemaking that it wished to ensure that taxes are as broad-based as possible. 57 Fed. Reg. at 55,122.

CMS currently proposes to revise the implementing regulation, 42 C.F.R. § 433.56, to omit these waiver homes from the ICF/MR class described in subsection (a)(4).

Comment: Rhode Island strenuously opposes this measure. The effect of the revision is to penalize Rhode Island for its pioneering policies in the area of home- and community-based services ("HCBS").

CMS approved Rhode Island's request for a waiver under Section 1915(c) of the Act to provide HCBS to the MR/DD population in 1991. The State then made a strong push to offer services in a home or community setting to persons with developmental disabilities, as an alternative to institutionalization. The State began with a goal of closing all institutions with sixteen or more beds for the developmentally disabled, and by 1994 it had become one of only two states, along with the District of Columbia, to meet this goal. U.S. GENERAL ACCOUNTING OFFICE, WAIVER PROGRAM FOR DEVELOPMENTALLY DISABLED IS PROMISING BUT POSES SOME RISKS 9-10 (July 1996). As part of this initiative, Rhode Island converted former ICFs/MR into group homes, which also serve as providers of waiver services. These facilities improve the quality of life of disabled persons by providing an environment where residents can improve their skills of daily living through independence and greater community participation. The importance of Rhode Island's efforts was confirmed by the holding of the Supreme Court of the United States in *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 599 (1999), that "unjustified institutional isolation of persons with disabilities is a form of discrimination prohibited by the [Americans with Disabilities Act]."

At the time that HCFA issued its 1992 interim final rule and since that time, Rhode Island has had in place continuously a tax on ICFs/MR, including group homes providing waiver services for the MR/DD population. At the time of the HCFA rulemaking more than 85 percent of Rhode Island's waiver homes had previously been ICFs/MR. Mindful that the State had been implementing these reforms, HCFA in 1992 included these converted community-based residences in the ICF/MR class. This decision signified that the State should not be penalized for changing its Medicaid program in order to advance the goal of effective community-based care -- a goal that HCFA / CMS has strongly promoted.

Today, the same principle supports preserving these group homes, which also serve as HCBS providers, as part of the ICF/MR class. The tax raises nearly $10 million a year in state revenue, most of which comes from community residences, as the State now has only five ICFs/MR remaining, and serves over 1800 individuals in small community settings. By implementing the proposed revision, CMS will deny the State a source of funding on which it has relied since the original implementation of the provider tax rules, and will create a financial disincentive to further de-institutionalization.[1] This funding is essential to the effective delivery of care in Rhode Island HCBS programs.

If CMS insists on implementing this revision to Section 433.56(a), then it should at the least provide Rhode Island and any other affected States with an extended transition period for phasing out the tax on group homes providing waiver services. This has been the agency's

[1] To justify its decision to remove these providers from the ICF/MR class, CMS states 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 13,731. If inequity is CMS's concern, then CMS should include in the ICF/MR class all waiver homes serving the developmentally disabled in States in which 85 percent of such homes were previously ICFs/MR, omitting any cutoff date. CMS should not remove from the class homes in a State that made the conversion before the cutoff date.

longstanding policy when it revises regulations in a manner that significantly impacts previously-approved arrangements financing the non-federal share of Medicaid expenditures. For example, the regulations implementing the Provider Tax Amendments included a transition period for States with taxes that would be affected by the new rules. 42 C.F.R. § 433.58(b). In addition, HCFA's 2001 regulations implementing new upper payment limit ("UPL") rules included several tiers of transition rules. The agency provided a five-year transition period for "noncompliant" State plan amendments (i.e., previously approved amendments conflicting with the new UPL rules) effective before October 1, 1999. HCFA, Final Rule Revision to Medicaid Upper Payment Limit Requirements, 66 Fed. Reg. 3148, 3176-77 (Jan. 12, 2001); 42 C.F.R. § 447.272(e)(2)(ii)(B). It provided a shorter transition period, one year, for noncompliant amendments effective after September 30, 1999 and approved before January 22, 2001, reasoning that States in the latter category "are not likely to have developed the same level of reliance on the enhanced payments addressed in this proposed rule as States with older programs." Proposed Rule, 65 Fed. Reg. 50,151, 60,154 (Oct. 10, 2000); 42 C.F.R. § 447.272(e)(2)(ii)(A). In the final rule, HCFA added a third, most expansive (seven years), transition period for States with noncompliant plan amendments in effect before October 1, 1992. 66 Fed. Reg. at 3149; 42 C.F.R. § 447.272(e)(2)(ii)(C).

Rhode Island's inclusion of waiver homes in its tax on ICFs/MR is a quintessential example of reasonable reliance, warranting a transition period of at least seven years. Since the outset of the regulatory regime governing provider taxes, Rhode Island's waiver homes have been included in the ICF/MR provider class set forth in Section 433.56(a)(4). Therefore, the State has been not just permitted but *required,* absent a waiver of the broad-based requirement, to include these homes in any tax on ICFs/MR. Far from suggesting in its 1992

interim final rule that the provision defining the scope of the ICF/MR class was temporary, HCFA affirmed that inclusion of waiver homes in the class was necessary "because of our desire to ensure that taxes are as broad-based as possible." 57 Fed. Reg. at 55,122.

Rhode Island currently faces a large budget deficit, and this potential loss of revenue has not been accounted for in the budget for the coming state fiscal year. The loss in general revenue would come at a particularly difficult time for the State and could result in substantial cuts to programs and services. It is inequitable for CMS to reverse the current rule without providing Rhode Island a transition window to locate alternative funding sources.

CONCLUSION

The State of Rhode Island respectfully requests that CMS withdraw its proposed revision to 42 C.F.R. § 433.56(a)(4), because this measure penalizes the State for having implemented effective policies to expand community-based care for the MR/DD population. If CMS persists in revising Section 433.56(a)(4) as set forth in the proposed rule, then CMS should provide affected States with an extended transition period for compliance.

Respectfully submitted,

Caroline M. Brown
Susannah Vance
Covington & Burling LLP
1201 Pennsylvania Ave., NW
Washington, DC 20004

On behalf of the State of Rhode Island

CMS- 2275-P 13

Because the referenced comment number was withdrawn per commentator's request- , it is not included in the electronic public comments for this regulatory document.

Submitter : **Ms. Caroline Brown** **Date: 05/22/2007**

Organization : **Covington & Burling LLP**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

See attached.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See attached.

Regulatory Impact Analysis

Regulatory Impact Analysis

See attached.

CMS-2275-P-14-Attach-1.DOC

Before the
UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

In the Matter of MEDICAID PROGRAM; HEALTH CARE-RELATED TAXES	)))))))	CMS-2275-P

COMMENTS OF THE STATE OF RHODE ISLAND

The State of Rhode Island submits these Comments on the Centers for Medicare & Medicaid Services' ("CMS") proposed rule revising the regulations on health care-related taxes, published March 23, 2007, at 72 Fed. Reg. 13,726. Rhode Island has joined in Joint Comments submitted on behalf of a group of states in opposition to the proposed rule, and believes that those Comments set forth the many reasons for CMS to abandon its proposed interpretations of and certain revisions to the "hold harmless" provision of the provider tax regulations, 42 C.F.R. § 433.68(f). Rhode Island additionally submits these individual Comments in order to object to the provision of the proposed rule which narrows the class of intermediate care facility for the mentally retarded ("ICF/MR") health care services, at 42 C.F.R. § 433.56(a)(4), to exclude similar services furnished by community-based residences for the mentally retarded under a waiver.

The proposed revision would adversely affect Rhode Island, which has had a tax on ICFs/MR, including waiver homes, for over fifteen years, collecting nearly $10 million in revenue for the State. The revenue raised helps support the State's ongoing efforts to provide effective home- and community-based services for the mentally retarded / developmentally

disabled ("MR/DD") population in community-based settings -- a goal consistent with the Administration's New Freedom initiative. Therefore, CMS should retract the proposal. At the very least, since Rhode Island has for many years reasonably relied on the rule including services furnished in waiver homes in the ICF/MR class, the State is entitled to an extended transition period in order to phase out the tax on these providers in a way that minimizes the disruption to the State budget process.

PROVISIONS OF THE PROPOSED RULE

Under the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, Public Law 102-234 (the "Provider Tax Amendments"), Section 1903(w) of the Social Security Act ("SSA"), taxes must be broad-based and apply uniformly to all providers included within one or more of eight classes of health care items or services. SSA § 1903(w)(3), (7). The list of classes includes "[s]ervices of intermediate care facilities for the mentally retarded." *Id.* § 1903(w)(7)(A)(iv). The statute also provides that CMS may establish by regulation other categories of health care items or services consistent with the statute. *Id.* § 1903(w)(7)(A)(ix).

In a 1992 interim final rule, CMS (then HCFA) implemented these statutory provider classes at 42 C.F.R. § 433.56(a). Addressing the ICF/MR class, HCFA "clarif[ied] this provision to include within that class of facilities certain group homes for the mentally retarded that provide services, under a waiver, similar to ICF/MR services." HCFA, Interim Final Rule, Limitations on Provider-Related Donations and Health Care-Related Taxes, 57 Fed. Reg. 55,118, 55,122 (Nov. 24, 1992). The class in the regulation includes ICF/MR services "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." 42 C.F.R. § 433.56(a)(4). HCFA reasoned in the rulemaking that it wished to ensure that taxes are as broad-based as possible. 57 Fed. Reg. at 55,122.

CMS currently proposes to revise the implementing regulation, 42 C.F.R. § 433.56, to omit these waiver homes from the ICF/MR class described in subsection (a)(4).

Comment: Rhode Island strenuously opposes this measure. The effect of the revision is to penalize Rhode Island for its pioneering policies in the area of home- and community-based services ("HCBS").

CMS approved Rhode Island's request for a waiver under Section 1915(c) of the Act to provide HCBS to the MR/DD population in 1991. The State then made a strong push to offer services in a home or community setting to persons with developmental disabilities, as an alternative to institutionalization. The State began with a goal of closing all institutions with sixteen or more beds for the developmentally disabled, and by 1994 it had become one of only two states, along with the District of Columbia, to meet this goal. U.S. GENERAL ACCOUNTING OFFICE, WAIVER PROGRAM FOR DEVELOPMENTALLY DISABLED IS PROMISING BUT POSES SOME RISKS 9-10 (July 1996). As part of this initiative, Rhode Island converted former ICFs/MR into group homes, which also serve as providers of waiver services. These facilities improve the quality of life of disabled persons by providing an environment where residents can improve their skills of daily living through independence and greater community participation. The importance of Rhode Island's efforts was confirmed by the holding of the Supreme Court of the United States in *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 599 (1999), that "unjustified institutional isolation of persons with disabilities is a form of discrimination prohibited by the [Americans with Disabilities Act]."

At the time that HCFA issued its 1992 interim final rule and since that time, Rhode Island has had in place continuously a tax on ICFs/MR, including group homes providing waiver services for the MR/DD population. At the time of the HCFA rulemaking more than 85 percent of Rhode Island's waiver homes had previously been ICFs/MR. Mindful that the State had been implementing these reforms, HCFA in 1992 included these converted community-based residences in the ICF/MR class. This decision signified that the State should not be penalized for changing its Medicaid program in order to advance the goal of effective community-based care -- a goal that HCFA / CMS has strongly promoted.

Today, the same principle supports preserving these group homes, which also serve as HCBS providers, as part of the ICF/MR class. The tax raises nearly $10 million a year in state revenue, most of which comes from community residences, as the State now has only five ICFs/MR remaining, and serves over 1800 individuals in small community settings. By implementing the proposed revision, CMS will deny the State a source of funding on which it has relied since the original implementation of the provider tax rules, and will create a financial disincentive to further de-institutionalization.[1] This funding is essential to the effective delivery of care in Rhode Island HCBS programs.

If CMS insists on implementing this revision to Section 433.56(a), then it should at the least provide Rhode Island and any other affected States with an extended transition period for phasing out the tax on group homes providing waiver services. This has been the agency's

[1] To justify its decision to remove these providers from the ICF/MR class, CMS states 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 13,731. If inequity is CMS's concern, then CMS should include in the ICF/MR class all waiver homes serving the developmentally disabled in States in which 85 percent of such homes were previously ICFs/MR, omitting any cutoff date. CMS should not remove from the class homes in a State that made the conversion before the cutoff date.

longstanding policy when it revises regulations in a manner that significantly impacts previously-approved arrangements financing the non-federal share of Medicaid expenditures. For example, the regulations implementing the Provider Tax Amendments included a transition period for States with taxes that would be affected by the new rules. 42 C.F.R. § 433.58(b). In addition, HCFA's 2001 regulations implementing new upper payment limit ("UPL") rules included several tiers of transition rules. The agency provided a five-year transition period for "noncompliant" State plan amendments (i.e., previously approved amendments conflicting with the new UPL rules) effective before October 1, 1999. HCFA, Final Rule Revision to Medicaid Upper Payment Limit Requirements, 66 Fed. Reg. 3148, 3176-77 (Jan. 12, 2001); 42 C.F.R. § 447.272(e)(2)(ii)(B). It provided a shorter transition period, one year, for noncompliant amendments effective after September 30, 1999 and approved before January 22, 2001, reasoning that States in the latter category "are not likely to have developed the same level of reliance on the enhanced payments addressed in this proposed rule as States with older programs." Proposed Rule, 65 Fed. Reg. 50,151, 60,154 (Oct. 10, 2000); 42 C.F.R. § 447.272(e)(2)(ii)(A). In the final rule, HCFA added a third, most expansive (seven years), transition period for States with noncompliant plan amendments in effect before October 1, 1992. 66 Fed. Reg. at 3149; 42 C.F.R. § 447.272(e)(2)(ii)(C).

Rhode Island's inclusion of waiver homes in its tax on ICFs/MR is a quintessential example of reasonable reliance, warranting a transition period of at least seven years. Since the outset of the regulatory regime governing provider taxes, Rhode Island's waiver homes have been included in the ICF/MR provider class set forth in Section 433.56(a)(4). Therefore, the State has been not just permitted but *required*, absent a waiver of the broad-based requirement, to include these homes in any tax on ICFs/MR. Far from suggesting in its 1992

interim final rule that the provision defining the scope of the ICF/MR class was temporary, HCFA affirmed that inclusion of waiver homes in the class was necessary "because of our desire to ensure that taxes are as broad-based as possible." 57 Fed. Reg. at 55,122.

Rhode Island currently faces a large budget deficit, and this potential loss of revenue has not been accounted for in the budget for the coming state fiscal year. The loss in general revenue would come at a particularly difficult time for the State and could result in substantial cuts to programs and services. It is inequitable for CMS to reverse the current rule without providing Rhode Island a transition window to locate alternative funding sources.

CONCLUSION

The State of Rhode Island respectfully requests that CMS withdraw its proposed revision to 42 C.F.R. § 433.56(a)(4), because this measure penalizes the State for having implemented effective policies to expand community-based care for the MR/DD population. If CMS persists in revising Section 433.56(a)(4) as set forth in the proposed rule, then CMS should provide affected States with an extended transition period for compliance.

Respectfully submitted,

Caroline M. Brown
Susannah Vance
Covington & Burling LLP
1201 Pennsylvania Ave., NW
Washington, DC 20004

On behalf of the State of Rhode Island

Submitter : **Mr. Charles Miller** **Date: 05/22/2007**

Organization : **Covington & Burling LLP**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

See attached.

Provisions of the Proposed Rule

Provisions of the Proposed Rule

See attached.

Regulatory Impact Analysis

Regulatory Impact Analysis

See attached.

CMS-2275-P-15-Attach-1.DOC

Before the
UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

In the Matter of	)	
	)	
MEDICAID PROGRAM;	)	CMS-2275-P
HEALTH CARE-RELATED TAXES	)	
	)	

JOINT COMMENTS OF NINETEEN STATES AND STATE MEDICAID AGENCIES

The agencies and officials responsible for administering the Medicaid program in Alaska, Connecticut, Idaho, Illinois, Kentucky, Louisiana, Maine, Maryland, Michigan, Missouri, New Jersey, New Mexico, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, and Wisconsin ("the Commenting States") submit the following comments on the proposed rule regarding health care-related taxes published by the Centers for Medicare & Medicaid Services ("CMS") on March 23, 2007.

PROVISIONS OF THE PROPOSED RULE[1]

Responding to the proposed rulemaking presents a special challenge, because of the disconnect between the quite limited changes in the actual text of the regulations and the very

[1] These Comments do not address the proposals to modify the definition of the Managed Care Organization class of services (42 C.F.R. § 433.56(a)(8)) to comply with the changes made by Section 6051 of the Deficit Reduction Act of 2005, or the modification of the hold harmless indirect guarantee safe harbor threshold from 6 percent to 5.5 percent for the period January 1, 2008 through September 30, 2011, as mandated by section 403 of the Tax Relief and Health Care Act of 2006. Likewise, they do not address the proposed elimination of transition provisions from the current regulations, or the proposal to eliminate reference to community-based residences from the definition of the ICF-MR class of service contained in section 433.56(a)(4) of the regulations. The latter proposal will be addressed separately in comments on behalf of the State of Rhode Island.

expansive meaning attributed to those changes in the preamble. The modest changes in language proposed for the hold harmless regulations, on their face, would not be particularly troublesome, but for the boundless interpretation of the hold harmless rules set forth in the preamble. The Commenting States urge the Centers for Medicare & Medicaid Services ("CMS") to retract these interpretations, for the following reasons:

- The interpretations conflict with the plain language and the intended meaning of the 1991 governing statute.
- Congress has repeatedly rejected proposals similar to the current one, on the ground that they exceeded CMS's authority.
- The interpretations conflict with, rather than clarifying, the regulation. If the interpretations are enforced, the regulation will not reflect actual standards governing the hold harmless.
- Counter to Congress' intent, the interpretations give CMS *carte blanche* to find a hold harmless in almost any type of provider tax arrangement.

To the extent CMS's proposed amendments to the regulation are meant to embody the interpretations set forth in the preamble, they should not be adopted, for they would make the regulations contrary to the statutory regime that governs this area.

It appears that the proposals are motivated by a desire to reach arrangements of the kind involved in the *Hawaii Department of Human Services* decision of the Departmental Appeals Board (DAB No. 1981, June 24, 2005) ("the *Hawaii* decision"), involving private grant and tax relief provisions for nursing home residents. A suitable response would have been to propose a rule modification that would apply the hold harmless standards to such private grant or tax relief provisions, notwithstanding that the benefits accrue to private pay patients rather than to the taxpaying facilities directly. Instead, CMS has launched a disproportionate response that undercuts the substantive standards themselves.

Nothing in the *Hawaii* decision supports CMS's present attempt to "clarify" the hold harmless tests through a new and unjustified "interpretation" of the substantive standard for

each hold harmless provision. Far from signaling ambiguities in the regulation that required clarification, the *Hawaii* decision simply held that CMS had failed, when it issued disallowances against five States, to follow the clear standards set forth in its own regulation and in the governing statute. The preamble to CMS's current proposed rule represents a second attempt to disregard these standards. In short, there is nothing "broken" about the hold harmless provisions in the regulation, and therefore there is no need to fix them.

These Comments begin with a review of the events leading up to the enactment by Congress of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, Public Law 102-234 (the "Provider Tax Amendments"), and the adoption of the regulations that implemented that statute, for they reveal with clarity the Congressional purpose of establishing specific ground rules that States could know in advance and apply with assurance that if they met the standards their taxes would be secure against federal challenge.

That goal was crucial, for nothing is more disruptive to state governmental operations than to build and implement a budget only to be confronted later with a challenge to the validity of a funding source and a threatened loss of anticipated revenue (in this case federal financial participation ("FFP") from the Medicaid program). That kind of disruption was threatened by proposals advanced by the agency (then HCFA) in 1990 and again in 1991, which bore a striking resemblance to the interpretations advanced in the preamble to the pending proposal. Congress acted then, first to delay and ultimately to reject the HCFA approach, in favor of the specific ground rules contained in Public Law 102-234. Those ground rules still govern. They do not allow for the kind of generalized "I know it when I see it" approach to the hold harmless provisions that is embodied in the interpretations set forth in the preamble to the proposed rules.

I. Legislative and Regulatory History

Through the Provider Tax Amendments, Congress sought to end HCFA's pattern of proposing regulations on provider-specific taxes that exceeded the agency's authority under the Social Security Act. Congress therefore enacted a statute setting forth with precision the parameters for permissible provider taxes and the tests to determine whether a Medicaid or non-Medicaid payment holds providers harmless for tax liability.

Before the Provider Tax Amendments, HCFA regulations concerning the non-federal share of Medicaid expenditures contained no specific limitations on provider taxes. In 1988 and 1989, in response to an indication in the President's budget for fiscal year 1989 that HCFA intended to issue regulations limiting the use of provider donations as the state share of medical assistance expenditures, Congress placed moratoria on the regulation of provider-specific taxes and donations, in effect through December 31, 1990. Pub. L. No. 100-647, § 8431, 102 Stat. 3342 (1988); Pub. L. No. 101-239, § 6411(b), 103 Stat. 2106 (1989).

In February 1990, HCFA published a proposed rule concerning provider-specific taxes and donations. HCFA, Proposed Rule, State Share of Financial Participation, 55 Fed. Reg. 4626 (Feb. 9, 1990). The rule would have provided FFP only for "net expenditures" for medical assistance, defined to mean the State's actual Medicaid payments, minus revenues generated by provider taxes and donations. *Id.* at 4627. Congress flatly rejected this proposal in the Omnibus Budget Reconciliation Act of 1990 ("OBRA 1990"). Pub. L. No. 101-508, § 4701, 104 Stat. 1388 (1990); *see* H. Conf. Rep. No. 101-964, *as reprinted in* 1990 U.S.C.C.A.N. 2374, 2676. OBRA 1990 added section 1902(t) to the Social Security Act ("SSA" or "the Act"), which provided that nothing in Title XIX authorized the Secretary to deny or limit payments to a State for medical assistance attributable to taxes, whether or not of general applicability. OBRA 1990,

§ 4701(b). OBRA 1990 also included a narrow exception to this general rule: under a new section 1903(i)(10) of the Act, FFP would be unavailable for provider costs attributable to a tax imposed only on hospitals, nursing facilities ("NFs"), and intermediate care facilities for the mentally retarded ("ICFs/MR"), where the facility received Medicaid payments on a cost basis. *Id.* Finally, OBRA 1990 extended the preexisting moratorium on regulations governing provider taxes and donations through December 31, 1991. *Id.* § 4701(a).

On September 12, 1991, HCFA published an interim final rule on Medicaid financing. HCFA, Interim Final Rule, State Share of Financial Participation, 56 Fed. Reg. 46,380. This rule purported to implement the new sections 1902(t) and 1903(i)(10) of the Act, but ignored the clear demarcations in the statutory scheme by denying FFP whenever there was any "linkage" between payments to the provider (hospital, NF, or ICF/MR) and the tax program, such as where an increase in provider payments "integrally is related to" the tax program. 56 Fed. Reg. at 46,387. A "clarification" of the rule, issued on October 31, 1991, preserved the amorphous "linkage" standard. HCFA, Interim Final Rule, State Share of Financial Participation, 56 Fed. Reg. 56,132, 56,139.

The rule never took effect because, once more, Congress rejected HCFA's action as exceeding the agency's authority. A November 1991 House Committee report noted that the "linkage" provisions gave CMS extremely broad discretion to issue disallowances, and that nothing in the Act "contemplates, much less authorizes, such an illogical and patently impractical result." H. Rep. No. 102-310, at 11. In November 1991, the House of Representatives passed a bill that, if enacted, would have extended the moratorium on the regulation of provider taxes for an additional year. H.R. Conf. Rep. 102-409, at 16 (1991), *as reprinted in* 1991 U.S.C.C.A.N. 1441, 1442.

Seeking to achieve a lasting solution, however, States negotiated with the Administration to draft substantive legislation, as an alternative to the moratorium. Alicia Pelrine, *The Art of the Deal*, J. OF AM. HEALTH POL'Y 23, 25-6 (May-June 1992). The resulting law repealed the provision of OBRA 1990 barring FFP for provider-tax expenditures included on a cost-based provider's cost report. Pub. L. No. 102-234, § 2(b)(2), 105 Stat. 1793, 1799 (1991). Instead, the law established a detailed framework requiring that provider taxes be broad-based and uniform, that no hold harmless result from payments made to providers, and that waivers of the broad-based and uniformity rules be authorized under standards to be adopted. *Id.* § 2(a). Since it comprehensively regulated provider-specific taxes, the law also amended section 1902(t) of the Act to delete reference to provider-specific taxes, although it retained the bar against denying or limiting medical assistance payments to States for costs attributable to generally applicable taxes. *Id.* § 2(b)(1).

The 1991 statute contemplated the issuance of regulations to implement its provisions and directed the Secretary to consult with the States in developing the regulations. *Id.* § 5(c). This was done, and regulations were issued on an interim final basis in November 1992, and ultimately in final form in August 1993. HCFA, Final Rule, Health Care-Related Taxes, 58 Fed. Reg. 43,156 (Aug. 13, 1993). The regulations essentially embodied the statutory provisions and, consistent with congressional intent, gave States clear and precise means of distinguishing permissible and impermissible taxes. Examples include the P1/P2 and B1/B2 statistical tests for determining if a tax was generally redistributive, the 6% "indirect guarantee" safe harbor, and the 75/75 indirect guarantee test for taxes that exceeded the 6% safe harbor. *Id.* at 43,181-2.

During the more than fifteen years since their enactment the Provider Tax Amendments, and the regulations that implemented them, have accomplished their purpose and

have worked as anticipated by the Congress and those involved in developing the federal-state agreement that produced the legislation. The provisions have neither stifled the use of all provider taxes, as feared by some at the time, nor opened the floodgates for provider taxes, as had been predicted by some others. Rather, the standards of the statute and the regulations have proved workable, allowing States to develop compliant tax programs with confidence. Where States have opted to employ taxes that deviated from the standards of the law, waivers have been sought, and the precise waiver standards embodied in the regulations have allowed HCFA and CMS to act consistently on waiver applications.

Significantly, there have been very few disputes over the meaning and application of the provider tax rules since their enactment. The *Hawaii* DAB case was the first Board decision involving a provider tax dispute other than a few early cases that involved the transition period to the new rules. In particular, there have been few significant issues over the application of the hold harmless provisions, for States understand that the law permits the use of provider tax proceeds to enhance Medicaid reimbursement for the taxed class, but that they may not structure those payments so as to return to the taxpayers the full amount of the tax collected or an amount varying based on the full amount, including the portion attributable to non-Medicaid activities.

II. The Hold Harmless Tests

The hold harmless provision, section 1903(w)(4) of the Act, is a particularly detailed portion of the Provider Tax Amendments. Consistent with the statute, when promulgating the regulation implementing the hold harmless, HCFA emphasized that it sought to apply "clear and specific rules" for identifying a hold harmless, because a more "subjective analysis would be administratively burdensome and virtually impossible to apply fairly." 58 Fed. Reg. at 43,166, 43,167. Thus, the hold harmless standards in both the Provider Tax

Amendments and their implementing regulations reflect Congress' decision to deny the agency a roving power to disallow funds whenever a State provides some benefit to a taxed provider, either through increased Medicaid payments or otherwise.

The Provider Tax Amendments set forth three hold harmless standards: the "positive correlation," "Medicaid payment," and "guarantee" tests. SSA § 1903(w)(4). The hold harmless regulatory provisions, at 42 C.F.R. § 433.68(f), add to the statutory framework the safe harbor indirect guarantee test. The three statutory standards and the quantitative indirect guarantee test offer both CMS and the States the benefit of transparent, predictable standards. CMS' proposed new interpretations would dismantle this framework by interpreting the "positive correlation," "Medicaid payment," and "direct guarantee" standards so expansively that the key features and limits of those tests would be obliterated.

Under the "positive correlation" test, a hold harmless exists if a non-Medicaid payment to the taxpayer by the State or other unit of government is positively correlated to either the taxpayer's tax amount, or the difference between the Medicaid payment and the tax amount. SSA § 1903(w)(4)(A); 42 C.F.R. § 433.68(f). This test focuses on whether a *non-Medicaid* payment serves to repay taxpayers "dollar (or part of a dollar)-for-dollar for their tax costs." 58 Fed. Reg. at 43,167. HCFA asserted in its 1993 rulemaking that it intended to use a statistical test to evaluate the positive correlation. *Id.* And as the Departmental Appeals Board held in the *Hawaii* decision, DAB No. 1981, at 20, the statutory term "positive correlation" by itself "certainly connotes something more than a mere relationship or association." Never before CMS's current proposed rulemaking has the agency asserted that a positive correlation under section 1903(w)(4)(A) may be established by vague "linkages" such as the timing of legislative enactment of a tax and of a non-Medicaid benefit.

The "Medicaid payment" test, like the positive correlation, involves a focused inquiry: whether all or a portion of a *Medicaid* payment to the taxpayer "varies based only upon the amount of the *total* tax paid." SSA § 1903(w)(4)(B) (emphasis supplied). Under this test, no hold harmless occurs unless the Medicaid payment varies in relation to the total (Medicaid and non-Medicaid) tax amount. In its 1993 final rule, HCFA acknowledged assertions in the comments that reimbursement of providers' costs attributable to the Medicaid portion of health-care related taxes is allowable, and that States are free to use provider tax revenues to compensate the provider for these allowable costs. 58 Fed. Reg. at 43,167. HCFA did not disagree with this point, nor could it, since section 1903(w)(4) provides that health care-related tax revenues may be used to reimburse providers for Medicaid expenditures. In the Provider Tax Amendments, Congress further expressed its intent to designate the Medicaid portion of provider tax liability as a reimbursable cost by repealing the provision of OBRA 1990 that had barred FFP for provider-tax expenditures included on a cost-based provider's cost report. Pub. L. 102-234, § 2(b)(2). The chief purpose of section 1903(w)(4)(B) is to ensure that States do not hold the provider harmless, through Medicaid payments, for the non-Medicaid portion of its tax liability.

Unlike the first two hold harmless tests, which focus on the relationship between tax and payment amounts, the "guarantee" provision examines whether taxpayers are assured that they will not be responsible for taxed amounts. SSA § 1903(w)(4)(C)(i); 42 C.F.R. § 433.68(f)(3). This follows from the dictionary definition and common understanding of "guarantee." *See* WEBSTER'S NEW COLLEGE DICTIONARY 493 (2001) (defining a "guarantee" as "1. Something that ensures a particular outcome or condition. . . . 2. A promise or assurance. . . ."). In developing regulations, HCFA identified two types of guarantees. A "direct guarantee" involves an explicit assurance in law that the taxpayer will be held harmless, in whole or in part.

See 57 Fed. Reg. at 55,129 ("[I]f an explicit guarantee exists, the tax would be impermissible and the two-prong test would not apply."); 58 Fed. Reg. at 43,167 (noting that, "[s]ince not all hold harmless situations are explicit," the indirect guarantee applies where there is no explicit assurance).

An "indirect guarantee" exists if the tax fails both parts of a two-pronged test. The first prong establishes the "safe harbor" of a tax that produces proceeds that do not exceed six percent of the total revenues of the taxpayers subject to the tax. 42 C.F.R. § 433.68(f)(3)(i). If the tax collections exceed this safe harbor, the tax is then subject to a second test: whether 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. *Id.* The premise of this "safe harbor" provision is that a tax imposed at no more than a normal rate for business taxes (in this case six percent was the median level of sales taxes in effect in the States at the time the regulation was adopted) would be presumptively valid, but if a higher rate were utilized and the revenue of the taxed class was substantially derived from Medicaid payments, then the tax would be deemed to contain an indirect guarantee of repayment constituting an impermissible hold harmless. 58 Fed. Reg. at 43,166.

In December 2006, Congress confirmed the validity of the indirect guarantee "safe harbor" test of the regulations by incorporating the provision into section 1903(w)(4)(C) of the statute. *See* Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432, § 403, 120 Stat. 2922, 2994-2995. This law also temporarily lowered the safe harbor from six percent to 5.5 percent. *Id.*

III. Comments on CMS Interpretations in the Preamble to the Proposed Rule

A. Positive Correlation Test (42 C.F.R. § 433.68(f)(1))

CMS asserts that "tax and payment amounts are positively correlated when they have a positive relationship with each other even when that relationship is not evidenced through a strict correlation in a mathematical sense." 72 Fed. Reg. at 13,729. This reverses the agency's statement in its 1993 final rule that "positive correlation" should be interpreted in its statistical sense. 58 Fed. Reg. at 43,167. CMS asserts that a positive correlation can be determined not just through a quantitative analysis of a series of tax and payment amounts, but also through (1) a finding that the same rate is used to impose a tax and to distribute a non-Medicaid payment, (2) a finding that the non-Medicaid payment is conditional on payment of the tax, or (3) other evidence that tax and payment programs are "linked," including the fact that a tax and a grant or credit program are enacted in the same legislative session. 72 Fed. Reg. at 13,729.

CMS's proposed interpretation of "positive correlation," particularly the notion that any form of "linkage" may be found to equal a hold harmless, defies the common understanding of the term "positive correlation" and removes the only identifying feature of this hold harmless test: an assessment of whether the tax amount and the payment amount increase or decrease in tandem. The "linkage" required to support a positive correlation under CMS's proposed new interpretation appears to encompass any causal or temporal connection as government policies between the tax and the payment. *Id.*

The Commenting States disagree with CMS's statement in the preamble that its 1993 interpretation of "positive correlation" led to confusion. 72 Fed. Reg. at 13,729. On the contrary, motivated by concerns that a more "subjective analysis would be administratively burdensome and virtually impossible to apply fairly," 58 Fed. Reg. at 43,167, the agency clearly

instructed at that time that a correlation exists where a non-Medicaid payment program ensures that a taxpayer is reimbursed dollar-for-dollar, or part-of-a-dollar-for-dollar, for its tax liability. *Id.* The interpretation that will propagate confusion is the proposed new one, which CMS acknowledges "interjects some degree of subjectivity" into the test. 72 Fed. Reg. at 13,729. Reinforcing the impression that it seeks to make these rules as opaque as possible, CMS asserts that it is "simply impossible to anticipate all hold harmless plans that could be created." *Id.* The fact that CMS is changing the hold harmless standard through statements in the preamble, rather than by amending its regulation, compounds the confusion for States seeking to comply with the rules.

CMS's proposed interpretation undermines the statutory requirement that CMS find, under this test, that "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." SSA § 1903(w)(4)(A) (emphasis added). CMS asserts that it may identify a correlation based on factors having nothing to do with the comparison of tax and payment amounts. Instead, evidence of "linked tax and payment programs" suffices, such as where the non-Medicaid payment is conditional on a provider's payment of its tax, or where the tax and a grant or credit program are enacted in the same legislative session.[2] 72 Fed. Reg. at 13,729.

If CMS imposes disallowances based on these vague linkages, then it will be enforcing a standard dramatically different from the one announced not only in the statute, but

---

[2] The Commenting States also note that some States do not compile or maintain legislative histories. Their legislatures do not issue official reports, and the text of a statute is considered to be the only embodiment of the legislature's intent. CMS's assertion that it can find a hold harmless based on state legislative history or intent is therefore at odds with those States' laws.

also in the almost identically worded implementing regulation. State personnel typically (and reasonably) rely on the text of regulations, rather than the regulatory history, when evaluating state policies to determine whether they comply with federal rules. The disconnect between the text of the positive correlation test and CMS's proposed "interpretation" is bad agency practice and will replace understanding with confusion.

Congress sixteen years ago forcefully rejected a HCFA interim final rule, worded similarly to the preamble of the current proposal, which would have established a hold harmless wherever a provider tax and a benefit to providers were "linked." *See supra* at 5. Under the rejected rule, a disallowance would have issued if "any level of State government reimburses these providers for the costs attributable to the [provider-specific] tax imposed." 56 Fed. Reg. at 46,387; *id.* at 56,139. Such reimbursement could be proven by identifying a "linkage between payment to the provider and the tax program," *id.* at 56,139, including by showing that revenues generated by the tax were used to enhance Medicaid payments to the taxpaying provider, or through legislative history "establishing a linkage" between the tax and a payment. *Id.* CMS violates Congress' clear purpose by seeking to restore the very sort of subjective standard that Congress rejected in 1991: a standard giving the agency free rein to find a hold harmless based on almost any combination of a provider tax and a non-Medicaid payment to taxed providers.

This is not to say that the relationship between a provider tax and a non-Medicaid payment must be constant over time to run afoul of the "positive correlation" provision. The Commenting States acknowledge that CMS may identify a positive correlation even where the relationship between the provider tax amount and the grant or credit amount varies from year to year. 72 Fed. Reg. at 13,729. As the Board noted in the *Hawaii* decision, in order to determine whether there is a positive correlation between tax amounts and payment amounts, two "sets of

scores" are needed. DAB No. 1981, at 20. CMS therefore may analyze one provider's or a set of providers' tax burden and grant or credit amounts in successive years, or it may analyze, within one year, multiple providers' tax amounts and grant / credit amounts. *Id.* at 21 n.7. Thus, the existing law and regulation affords CMS full opportunity to respond to a case where there is truly the kind of connection between a tax and a non-Medicaid payment that was meant to be proscribed. Other than to clarify that the non-Medicaid payment or similar benefit may be considered even if made to a patient of the taxed entity (see below), no change in the text or the interpretation of the first hold harmless provision is warranted.

B. Medicaid Payment Test (42 C.F.R. § 433.68(f)(2))

CMS proposes to construe 42 C.F.R. § 433.68(f)(2), the "Medicaid payment" test, as providing a hold harmless "when the payment is conditional on the tax payment." 72 Fed. Reg. at 13,730. CMS notes that this "clarification" does not preclude States that use cost-based payment mechanisms from including provider tax costs as one of the costs considered in setting individualized payment rates. Nonetheless, CMS asserts, the new interpretation does preclude States from "us[ing] rates that are based solely on the receipt of provider taxes, rather than on overall provider costs (such as supplemental payments conditioned on receipt of taxes)." *Id.*

CMS's proposed interpretation is irreconcilable with the last sentence in section 1903(w)(4), which states, "The provisions of this paragraph shall not prevent use of the tax to reimburse[] health care providers in a class for expenditures under this subchapter nor preclude States from relying on such reimbursement to justify or explain the tax in the legislative process." The law is established, and CMS has previously acknowledged, that providers' expenses for the Medicaid portion of provider taxes are allowable Medicaid expenditures. CMS's attempt to bar States from making Medicaid payments to providers (supplemental or

otherwise) measured by the Medicaid portion of tax liability is contrary to the explicit permission reserved to States in the provision quoted above.

CMS proposes to replace the term "amount of the total tax payment" with "the tax amount" in the Medicaid payment test. 72 Fed. Reg. at 13,729. The Commenting States strenuously object to this amendment. Under the Medicaid payment test, all or a portion of a Medicaid payment to the taxpayer must vary based only on the amount of the *total* tax. SSA § 1903(w)(4)(B); 42 C.F.R. § 433.68(f)(2). The word "total" is critical. The portion of a provider's health care-related tax payment attributable to Medicaid services is an allowable cost, and Medicaid reimbursement may be furnished for it. *See* SSA § 1903(w)(4); 58 Fed. Reg. at 43,167 ("A tax can be claimed as an allowable cost and included in the establishment of reimbursement rates."); *id.* ("It is true that it was not the intent of the statute to exclude Medicaid from recognizing mandatory taxes as an allowable cost in establishing reimbursement rates"). A Medicaid payment that varies based on the *Medicaid portion* of provider tax amounts is permissible; only a Medicaid payment varying based on *total* provider tax amounts (including the non-Medicaid portion) constitutes a hold harmless.

CMS should also retract its unwarranted assertion that a hold harmless exists under the "Medicaid payment" standard if a Medicaid payment is contingent on a provider's paying its tax. 72 Fed. Reg. at 13,730. In that event, CMS states, "the variation between a payment of zero and a positive payment would be based only on the payment of the tax amount." 72 Fed. Reg. at 13,730. A hold harmless exists if all or any portion of the Medicaid payment to a taxpayer varies based *only* upon the amount of the total tax paid. This is another way of stating that the total tax amount and the Medicaid payment are positively correlated. The fact that a provider must pay its taxes in order to receive a Medicaid payment does not establish a

correlation between the two amounts. To the contrary, many States authorize collection of delinquent taxes from any payments otherwise due to a taxpayer, including Medicaid payments. Collection of unpaid provider taxes by withholding amounts due for serving Medicaid patients is not a form of hold harmless, but would be impacted by the CMS statement that there is a hold harmless when a Medicaid payment is contingent upon payment of a tax.

CMS should restore the adjective "total" to the tax amount identified in the "Medicaid payment" provision. It should also abandon its indefensible position that a supplemental Medicaid payment based on the payment of provider taxes attributable to Medicaid services is improper.

C. Guarantee Test (42 C.F.R. § 433.68(f)(3))

In the preamble, CMS asserts that no "explicit promise or assurance of payment" is necessary to constitute a direct guarantee. *Id.* at 13,730. Instead, a direct guarantee occurs where payment is made available to the taxpayer or a "party related to the taxpayer . . . in the reasonable expectation that the payment would result in the taxpayer being held harmless for any part of the tax." *Id.* CMS states that the only element necessary to constitute a direct guarantee is "the provision for payment by State statute, regulation, or policy." *Id.* CMS asserts that the factor distinguishing direct from indirect guarantees is that under the indirect guarantee, the benefit to a provider is "through regular or enhanced payments for preexisting Medicaid obligations." *Id.*

CMS should retract its proposed interpretation of this test, which, like its statements about the "positive correlation" and "Medicaid payment," exceeds the agency's statutory authority. In conflict with section 1903(w)(4)(C)(i), CMS removes the key identifying feature of the direct guarantee test: the *assurance* that a taxpayer will be held harmless. The

interpretation also undermines the statutory scheme by rendering the "positive correlation" and "direct guarantee" tests coextensive.

The mere fact that a state statute provides by law for a payment, offset or waiver to a provider or a provider's patient, and that some person might have a "reasonable expectation" that the taxpayer would be held harmless as a result, cannot suffice to establish a direct guarantee. For example, in many states, nonprofit hospitals enjoy a statutory exemption from paying property taxes. A state might also decide to use revenues from a provider-specific tax on hospitals in part to establish a program of assistance to hospitals, including nonprofit hospitals, for maintenance and refurbishment of the physical plant. This does not mean that the grant or the exemption from a property tax constitutes a hold harmless for the provider-specific tax. As another example, some governmental units provide a property tax exemption for elderly property owners, including those who live in a nursing facility but own a house that is uninhabited. If the state imposes a nursing home provider tax, providers in the taxed class might "reasonably expect" that they could recover the cost of the tax by passing it on to their private pay patients, some of whom enjoy a property tax exemption. In each of these situations, however, the link between the benefit and the provider tax is so attenuated that without more there would be no basis for a finding of a "direct guarantee." Absent any evidence that the state or local government *intended*, through the property tax exemption, to hold a hospital or nursing facility harmless for provider tax amounts, the exemptions would appear to embody a public policy of support for charitable organizations or the elderly. But CMS's proposed interpretation, because it disregards the requirement of an explicit assurance, would command a finding of a "direct guarantee" in these situations.

CMS's current assertion that it may find a "direct guarantee" without any form of explicit assurance also contradicts CMS's own interpretation of this hold harmless provision in its 1993 rulemaking. *See* 58 Fed. Reg. at 43,167 (noting that the indirect guarantee test is necessary "[s]ince not all hold harmless situations are explicit").

Perhaps because it has declared irrelevant the obvious trait distinguishing the direct from the indirect guarantee, CMS contends for the first time in the preamble to the proposed rule that the two guarantees differ based on the kind of payment involved: that the indirect guarantee concerns regular or enhanced payments for preexisting Medicaid obligations, while the direct guarantee takes the form of a non-Medicaid payment. 72 Fed. Reg. at 13,730. There is no basis for this dichotomy. The direct guarantee clause is meant to address only a situation in which the State assures the return of the taxpayer's payment of any portion of the tax. The indirect guarantee clause, by contrast, is meant to provide a safe harbor when there is neither a direct guarantee nor a violation of the other two hold harmless provisions. If such a tax meets the safe harbor test, it is secure against a contention that it violates the hold harmless provision, whether through a Medicaid or a non-Medicaid payment.

CMS's expansive interpretations of the "positive correlation" and "direct guarantee" tests obscure the differences between these two distinct tests, and would enable the agency to find either of the two tests met wherever a non-Medicaid benefit might conceivably be used to defray provider tax costs. Further, under CMS's broad interpretation of the "Medicaid payment" provision, CMS can find a violation in virtually any situation in which provider tax revenues are used to make Medicaid payments to taxed providers. The effect of these proposed interpretations is effectively to omit the "indirect guarantee" test, whose importance Congress

has recently affirmed by incorporating the standard into the Social Security Act. *See* Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432, § 403.

IV. Comments on Proposed Amendments to 42 C.F.R. § 433.68(f)

A. Direct and Indirect Non-Medicaid Payment

CMS proposes to amend the first sentence of the "guarantee" subsection, 42 C.F.R. § 433.68(f)(3), to provide that a hold harmless exists where a State or other governmental unit "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 Fed. Reg. at 13,734. In addition, CMS asserts that when assessing whether a tax and credit / grant program constitutes a hold harmless under both the "positive correlation" and "direct guarantee" tests, it will interpret broadly the language providing for an indirect payment. Under CMS's interpretation, payments by the State to non-Medicaid patients in a taxed facility may be considered an indirect payment to the taxpayer. 72 Fed. Reg. 13,728.

The Commenting States do not object to CMS's proposed amendment to the "direct guarantee" test to clarify that payment to a taxpayer may be indirect. Nor do they disagree with CMS's assertion that, under the amended language, a grant or benefit to private-pay patients or residents could be considered an indirect payment to the taxpayer for purposes of the "direct guarantee."

With respect to the "positive correlation" test, the Commenting States would not object to CMS's amending the regulation by adding a subpart (i) to 42 C.F.R. § 433.68(f)(1) providing that for purposes of this test, a benefit conferred on private-pay patients of a provider shall be treated the same as a benefit conferred on "providers or others paying the tax."

Amending the regulation would, more effectively than an interpretation in the preamble, place States and providers on notice of this treatment of benefits to private-pay patients.

The Commenting States caution that CMS should not, in its analysis of the hold harmless, conflate the questions of (1) whether a "payment" is established, and (2) whether one of the three standards for a hold harmless is met. A mere "linkage" between a grant or a tax relief program for private-pay patients and a provider tax, absent specific evidence of a positive correlation or direct guarantee, is insufficient to establish a hold harmless.

B. Defining Tax and Payment Amounts for Hold Harmless Analyses

In the three hold harmless tests contained in subsection (f), CMS proposes to use the term "tax amount," rather than "amount of the tax," "total tax cost," or "total tax payment," when referring to the provider tax, and the term "payment amount" to refer to the amount of any credit or payment to the provider. 72 Fed. Reg. at 13,729. CMS proposes to this revision in order to obtain "maximum flexibility" in analyzing whether a hold harmless exists, by asserting that the terms "tax amount" and "payment amount [will] . . . encompass all of the meanings that could previously have been attributed to each of the prior terms." *Id.*

For the most part, the Commenting States do not object to the revisions, so long as they are not meant to embody the interpretations discussed above. However, the Commenting States do object to CMS's proposed revision of the "Medicaid payment" test since, as explained above at 15, the phrase "amount of the total tax payment" is essential to the rationale behind this hold harmless standard. 42 C.F.R. § 433.68(f)(2).

CONCLUSION

CMS seeks, through its proposed interpretations of the three hold harmless tests, to reinstate rules much like the agency's September 12 and October 31, 1991 rules, which

Congress forcefully rejected. These vague, subjective standards would have given the agency a roving power to find a hold harmless violation on the basis of undefined "linkages" between tax and payment programs. Similarly, CMS's proposed new interpretations deprive the States of notice of whether specific arrangements comply with the law. This contradicts the letter and purpose of the Provider Tax Amendments. The Commenting States respectfully request that CMS withdraw it proposed new, unauthorized and unwarranted interpretations in accordance with the foregoing Comments.

Respectfully submitted,

/s/

Charles A. Miller
Caroline M. Brown
Susannah Vance
Covington & Burling LLP
1201 Pennsylvania Avenue, N.W.
Washington, D.C. 20004-2401
(202) 662-5410

On behalf of the States of:

Alaska
Idaho
Illinois
Louisiana
Maine
Michigan
New Jersey
New Mexico
Ohio
Oklahoma
Oregon
Rhode Island
Tennessee
Wisconsin

and

Connecticut Department of Social Services
Kentucky Department for Medicaid Services
Maryland Department of Health and Mental Hygiene
Missouri Department of Social Services, Division of Medical Services
Pennsylvania Department of Public Welfare

Submitter : **Teresa Hursey** **Date: 05/22/2007**

Organization : **Illinois Hospital Association**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-2275-P-16-Attach-1.PDF

Illinois Hospital Association

OFFICERS

Chairman
Gary Barnett
Mattoon

Chair-Elect
James Skogsbergh
Oak Brook

Immediate Past Chairman
Raymond Grady
Evanston

Treasurer
Harry Wolin
Havana

Secretary
William Leaver
Rock Island

President
Kenneth Robbins
Naperville

TRUSTEES

John Bennett
Shelbyville

Richard Carlson
Springfield

Alan Channing
Chicago

Clifford Corbett
Morris

Kathleen DeVine
Chicago

Steve Drucker
Chicago

Michael Easley
Crystal Lake

Larry Goodman, M.D.
Chicago

William Hartley
Eldorado

James Hayes
Greenville

Forrest "Woody" Hester
Springfield

James Hill
Chicago

Gary Kaatz
Rockford

Colleen Kannaday
Blue Island

Norman LaConte
Peoria

James Leonard, M.D.
Urbana

Ronald McMullen
Alton

Peter Murphy
Chicago Heights

Mark Newton
Chicago

David Ochs
Pontiac

David Schertz
Rockford

Connie Schroeder
Pittsfield

May 22, 2007

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

RE: File Code CMS-2275-P; Proposed Rule on Medicaid Provider Taxes, published March 23, 2007, at 72 Fed. Reg. 13726

Dear Sir or Madam:

On behalf of its approximately 200 member hospitals, the Illinois Hospital Association ("IHA") appreciates this opportunity to comment on the above referenced proposed rule.

IHA's comments on this proposed rule focus on Section 433.68(f)(2), which would now provide that a taxpayer would be considered to be held harmless for the tax where the Medicaid payment is conditional on receipt of the tax amount.

IHA believes this change should be deleted because it is in direct conflict with Section 1903(w)(4) of the Social Security Act, which states:

> "The provisions of this paragraph [hold harmless restrictions] 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."

By prohibiting the State from conditioning the Medicaid payment on receipt of the tax, the proposed rule is preventing the State from using the tax to reimburse providers, as expressly permitted by the statute. Moreover, given the State's need to prudently manage the program, it is reasonable for the State to condition payment on the approval and receipt of the tax. By expressly conditioning the Medicaid payments on the tax amount, the State is explicitly explaining how the tax is being used for Medicaid reimbursement as part of the legislative process. To not do so would be fiscally irresponsible, since the State would be obligated to make payments without having a funding source to finance them. In many cases, CMS has taken several months to approve a State's proposed provider tax. If the State cannot condition payments on approval of the tax, this would effectively prevent states from being able to adopt provider tax programs – a result clearly not intended by Congress.

Headquarters
1151 East Warrenville Road
P.O. Box 3015
Naperville, Illinois 60566
630.276.5400

Springfield Office
700 South Second Street
Springfield, Illinois 62704
217.541.1150

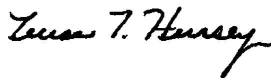
www.ihatoday.org

If CMS does adopt this proposed change, it should only apply to payments contained in state plan amendments adopted after the effective date of the final rule. This change should not be applied retroactively to provider taxes that are currently being used to finance payments authorized in existing approved Medicaid state plans. To apply this change to existing programs would jeopardize federal funding which states have relied on in establishing Medicaid payments – funding which is essential to preserving and promoting access to essential health care services for our most vulnerable residents – the poor, elderly and disabled. Thus, retroactive application of this proposed change would not only disrupt state budgets, but also would jeopardize essential access to health care services.

In summary, IHA respectfully urges CMS to delete the proposed change to Section 433.68(f)(2) of the rule that would prohibit a state from making a Medicaid payment conditional on the receipt of the provider tax amount. At a minimum, states should be given an adequate period of time to transition to this new rule; it should not apply to payments and taxes currently in effect. This means that this new prohibition should only apply to payments contained in state plan amendments submitted to CMS after the effective date of this proposed rule.

Thank you for the opportunity to provide these comments.

Sincerely,



Teresa Hursey
Vice President, Finance
Illinois Hospital Association

Submitter : **Mr. Robert Hedrick** **Date: 05/22/2007**

Organization : **North Carolina Providers Council**

Category : **Long-term Care**

Issue Areas/Comments

GENERAL

GENERAL

Dear Administrator Norwalk,

Please see the attached comments on CMS 2275-P; RIN 0938-AO80 - Proposed Rule on Medicaid Program s Health-Care Related Taxes.

Thank you,

Robert S. Hedrick, Executive Director
NC Providers Council
3722 Benson Dr., Suite 102, Raleigh, NC 27609
bob.hedrick@ncproviderscouncil.org
Office (919) 850-4592; Fax (919) 850-4593; Cellular (919) 621-9271

Provisions of the Proposed Rule

Provisions of the Proposed Rule

CMS-2275-P-17-Attach-1.DOC

The NC Providers Council strongly urges CMS to consider the impact of the proposed rule on existing Medicaid programs, as well as proposed amendments to those programs and to service recipients and delay implementation of these rules. Thank you for your consideration.

Sincerely,

/s

Robert S. Hedrick. Executive Director

State of California—Health and Human Services Agency

Department of Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

May 22, 2007

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

Dear Sir or Madam:

The California Department of Health Services (CDHS), on behalf of the State of California, appreciates this opportunity to comment on the proposed regulation changes. Please find enclosed California's comments in response to the Notice of Proposed Rule Making (NPRM) (CMS-2275-P) published at 72 Fed. Reg. 56 (March 23, 2007). The NPRM proposes amendments to 42 C.F.R. Part 433: Medicaid program; health-care related taxes.

CDHS's comments cover a number of issues concerning the overly broad interpretation of the proposed changes to the regulations as compared to the relatively minor changes to the language of regulations.

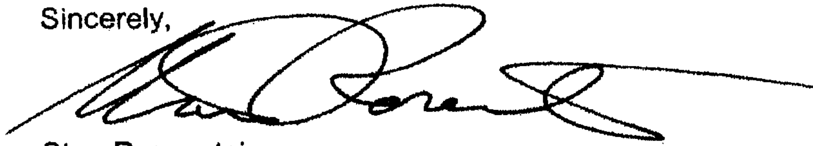
The preamble to the proposed regulations sets forth the intended interpretation of the proposed amendments to the regulations that is so expansive, and so at odds with the specific language of the hold harmless provisions, as to give the federal Centers for Medicare & Medicaid Services (CMS) complete discretion to find a hold harmless in almost any type of provider fee arrangement that has been used by states, including California, over the last many years.

California currently imposes "fees" on three classes of providers; Intermediate Care Facilities for the Developmentally Disabled; managed care organizations that serve Medicaid beneficiaries; and certain freestanding nursing facilities. Additionally, Governor Schwarzenegger's Health Care Reform Initiative proposes to impose "fees" on two additional classes of providers – hospitals and physicians. CMS's interpretation of the proposed changes to the regulations puts California's existing fee programs at risk and could completely derail the Governor's Health Care Reform Initiative.

Medical Care Services
1501 Capitol Avenue, P.O. Box 997419, MS 4000, Sacramento, CA 95899-7413
Telephone: (916) 440-7800 Fax: (916) 440-7805
Internet Address: www.dhs.ca.gov

If you have any questions, or if we can provide further information, please contact me at (916) 440-7800.

Sincerely,



Stan Rosenstein
Deputy Director
Medi-Cal Care Services

Enclosure

cc: Mr. Toby Douglas
Assistant Deputy Director
Medical Care Services
California Department of Health Services
1501 Capitol Avenue, MS 4000
P.O. Box 997413
Sacramento, CA 95899-7413

Ms. Karen Johnson
Chief Deputy Director
Health Care Programs
California Department of Health Services
1501 Capitol Avenue, MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413

Mr. Keith Berger
Executive Director
California Medical
Assistance Commission
770 L Street, Suite 1000
Sacramento, CA 95814

cc: Mr. Joe Munso
Deputy Secretary
Office of Program and Fiscal Affairs
California Health and
Human Services Agency
1600 Ninth Street, Room 460
Sacramento, CA 95814

Mr. Bob Sands
Assistant Secretary
Office of Program and Fiscal Affairs
California Health and
Human Services Agency
1600 Ninth Street, Room 460
Sacramento, CA 95814

Anthony Lewis, Esq.
Assistant Chief Counsel
Office of Legal Services
California Department of Health Services
1501 Capitol Avenue, MS 0010
P.O. Box 997413
Sacramento, CA 95899-7413

CMS's Proposed Regulations
Medicaid Programs; Health Care-Related Taxes
(CMS-2275-P)

COMMENTS FROM THE STATE OF CALIFORNIA

General Comments

Existing provider tax regulations set forth three hold harmless standards: the "positive correlation," the "Medicaid payment," and "guarantee" tests. The hold harmless regulatory provision, 42 C.F.R. § 433.68(f), adds to the statutory framework a mathematical "indirect guarantee" test, or "safe harbor." The three statutory standards and the quantitative indirect guarantee test provide both the Federal Centers for Medicare & Medicaid Services (CMS) and the states the benefit of transparent, predictable standards.

When promulgating the regulations that now implement the hold harmless, CMS (then the Health Care Financing Administration (HCFA)) made it clear that it sought to apply clear and specific rules for identifying a hold harmless, because a more subjective analysis would be administratively burdensome and virtually impossible to apply fairly. Thus, the regulations reflect Congress' decision to deny CMS the authority to subjectively disallow funds whenever a State provides some benefit to a taxed provider, either through increased Medicaid payments or otherwise. CMS's proposed new interpretations would dismantle this framework by interpreting the "positive correlation," "Medicaid payment," and "direct guarantee" standards so expansively that the key features and limits of those tests would be obliterated.

CMS's intended interpretation of the proposed changes to the regulations goes far beyond the relatively minor proposed changes to the current hold harmless provisions. If these changes are adopted, this broad interpretation would give CMS complete discretion to find a hold harmless in almost any type of provider tax arrangement, including those already approved by CMS for California. So, to the extent the proposed changes are meant to embody the interpretations set forth in the preamble, they must be rejected, because they are inconsistent with, and cannot be reconciled to, the statutory provisions that govern this area.

The current regulations can be thought of as reflecting a compromise – reached in the early 1990s between the view that no provider-related tax revenue should be used by states to support Medicaid payments and the view that Congress and HCFA should not interfere with the states' then-existing practices. HCFA and CMS have applied the current regulations over the years, and the states, including California, have generally come to understand what is barred and what is approvable. There simply does not appear to be any compelling reason to change these regulations now.

Further, CMS's intended interpretation of the proposed changes to the regulations could make each of California's three existing "fee" programs non-approvable because the fee revenue is used to fund the non-federal share of increased Medicaid payments that, in most cases, pay the cost of the fee back to the fee payer.

Finally, CMS's intended interpretation of the proposed changes to the regulations likely would result in completing derailing the Governor's proposed Health Care Reform Initiative (Initiative) because it will be funded, in part, by "fees" imposed on two classes of providers -- hospitals and physicians.

Positive Correlation Test

Under the "positive correlation" test, a hold harmless exists if a non-Medicaid payment to the taxpayer by the State or other unit of government is positively correlated to either taxpayer's tax amount, or the difference between the Medicaid payment and the tax amount. This test focuses on whether a non-Medicaid payment serves to repay taxpayers dollar (or part of a dollar)-for-dollar for their tax costs. In the NPRM, CMS asserts that tax and payment amounts are positively correlated when they have a positive relationship to each other even when that relationship is not evidenced through a strict correlation in a mathematical sense.

This reverses HCFA's statement in its 1993 final rule that "positive correlation" should be interpreted in its statistical sense. CMS now asserts that a positive correlation can be determined not just through a quantitative analysis of a series of tax and payment amounts, but also through (1) a finding that the same rate is used to impose a tax and to distribute a new Medicaid payment, (2) a finding that the non-Medicaid payment is conditional on payment of the tax, or (3) other evidence that tax and payment programs are "linked," including the fact that a tax and a grant or credit program are enacted in the same legislative session. Never before the current proposed rulemaking has HCFA or CMS asserted that a positive correlation under Section 1903(w)(4)(A) may be established by such vague "linkages" as the timing of the legislative enactment of a tax and of a non-Medicaid benefit.

CMS's proposed interpretation of "positive correlation," particularly the idea that any form of "linkage" may be found to equal a hold harmless, is inconsistent with the common understanding of the term "positive correlation" and removes the only identifying feature of this hold harmless test: an assessment of whether the tax amount and the payment amount increase or decrease in tandem. Additionally, this proposed interpretation is contrary to Congress' clear direction to HCFA in 1991 when it rejected its proposed interim final rule that would have established a hold harmless whenever a provider tax and a benefit to providers were "linked."

California disagrees with CMS's statement in the preamble that the 1993 interpretation of "positive correlation" led to confusion. On the contrary, California believes that the proposed interpretation of the federal rule, which CMS acknowledges interjects some

degree of subjectivity into the test, would result in confusion. Reinforcing the impression that it seeks to make these rules as unclear as possible, CMS asserts that it is simply impossible to anticipate all the hold harmless plans that could be created.

Finally, CMS's proposed interpretation undermines the statutory requirement that CMS find, under this test, that 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. CMS asserts that it may identify a correlation based on evidence of "linked tax and payment programs," such as where the non-Medicaid payment is conditional on a provider's payment of its tax, or where the tax and a grant or credit program are enacted in the same legislative session. Identifying these linkages does not satisfy the agency's duty under the statute to analyze the relationship between tax and payment amounts.

Medicaid Payment Test

The "Medicaid payment" test, like the positive correlation test, focuses on whether all or a portion of a Medicaid payment to the taxpayer "varies based only upon the amount of the total tax paid." Under this test, no hold harmless occurs unless the Medicaid payment varies in relation to the total (Medicaid and non-Medicaid) tax amount.

CMS proposes to construe 42 C.F.R. § 433.68(f)(2), the "Medicaid payment" test, as providing a hold harmless whenever the Medicaid payment varies based on the tax amount, when the payment is conditional on the tax payment.

CMS notes that this "clarification" does not preclude States that use cost-based payment mechanisms from including provider tax costs as one of the costs considered in setting individualized payment rates. Nonetheless, CMS asserts the new interpretation does preclude States from using rates that are based solely on the receipt of provider taxes, rather than on overall provider costs (such as supplemental payments conditioned on receipt of taxes).

CMS's proposed interpretation appears to be irreconcilable with the last sentence in Section 1903(w)(4), which states, "The provisions of this paragraph shall not prevent use of the tax to reimburse health care providers in a class for expenditures under this subchapter, nor preclude States from relying on such reimbursement to justify or explain the tax in the legislative process." The law is established, and CMS has previously acknowledged, that providers' expenses for the Medicaid portion of provider taxes are allowable Medicaid expenditures. CMS's attempt to bar States from making Medicaid payments to providers (supplemental or otherwise) measured by the Medicaid portion of tax liability is contrary to the explicit permission reserved to states in the provision quoted above.

CMS proposes to replace the term "amount of the total tax payment" with "the tax amount" in the Medicaid payment test. California strongly objects to this amendment.

Under the Medicaid payment test, all or a portion of a Medicaid payment to the taxpayer must vary based only on the amount of the total tax paid.

The word "total" is critical. The portion of a provider's health care-related tax payment attributable to Medicaid services is an allowable cost, and Medicaid reimbursement may be furnished for it. A Medicaid payment that varies based on the Medicaid portion of provider tax amounts is permissible; only a Medicaid payment varying based on total provider tax amounts (including the non-Medicaid portion) constitutes a hold harmless.

Under the current regulations, a hold harmless exists if all or any portion of the Medicaid payment to a taxpayer varies based only upon the amount of the total tax paid. This is another way of stating that the total tax amount and the Medicaid payment are positively correlated. The fact that a provider must pay its taxes in order to receive a Medicaid payment does not establish a correlation between the two amounts. On the contrary, many states authorize collection of delinquent taxes from any payments otherwise due to a taxpayer, including Medicaid payment.

Under the Governor's Initiative, California proposes to offset Medicaid payments if providers fail to pay their portion of the fee that is due. Collection of unpaid provider taxes by withholding amounts due for serving Medicaid patients is not a form of hold harmless, but would be impacted by the CMS statement that there is a hold harmless when a Medicaid payment is contingent upon payment of a tax.

To summarize, CMS should restore the adjective "total" to the tax amount identified in the "Medicaid payment" provision. It should also abandon its position that a supplemental Medicaid payment based on the payment of provider taxes attributable to Medicaid services is improper.

Guarantee Test

Unlike the first two hold harmless tests, which focus on the relationship between tax and payment amounts, the "guarantee" provision focuses on whether taxpayers are assured that they will not be responsible for the tax amounts paid.

When the existing regulations were developed, HCFA identified two types of guarantees. A "direct guarantee" is an explicit assurance in law that the taxpayer will be held harmless, in whole or in part. If an explicit guarantee exists, the tax would be impermissible and the two-prong test would not apply. HCFA then noted that because not all hold harmless situations are explicit, the indirect guarantee applies where there is no explicit assurance.

An "indirect guarantee" exists if the tax fails both parts of a two-pronged test. The first prong establishes the "safe harbor" of a tax that produces proceeds that do not exceed six percent of the total revenues of the taxpayers subject to the tax. If the tax collections exceed this safe harbor, the tax is then subject to a second test: whether 75 percent or more of the taxpayers in the class receive 75 percent or more of their total tax payments back in enhanced Medicaid payments or other state payments.

The premise of this "safe harbor" provision is that a tax imposed at no more than a normal rate for business taxes (in this case six percent was the median level of sales taxes in effect in the states at the time the regulation was adopted) would be presumptively valid, but if a higher rate were utilized and the revenue of the taxed class was substantially derived from Medicaid payments, then the tax would be deemed to contain an impermissible hold-harmless arrangement.

In December 2006, Congress signaled its approval of the indirect guarantee "safe harbor" test of the regulations by incorporating the provision into Section 1903(w)(4)(C) of the statute. This law also temporarily lowered the safe harbor from six percent to 5.5 percent.

In the preamble, CMS asserts that no explicit promise or assurance of payment is necessary to constitute a direct guarantee. Instead, a direct guarantee occurs where payment is made available to the taxpayer or a party related to the taxpayer in the reasonable expectation that the payment would result in the taxpayer being held harmless for any part of the tax. CMS states that the only element necessary to constitute a direct guarantee is the provision for payment by State statute, regulation, or policy. CMS asserts that the factor distinguishing direct from indirect guarantees is that under the indirect guarantee, the benefit to a provider is through regular or enhanced payments for preexisting Medicaid obligations.

CMS should retract its proposed interpretation of this test, which, like its statements about the "positive correlation" and "Medicaid payment" tests, appears to exceed the agency's statutory authority. In conflict with Section 1903(w)(4)(C)(i), CMS removes

the key identifying feature of the direct guarantee test: the assurance that a taxpayer will be held harmless.

California opposes CMS's statements that it may find a "direct guarantee" without identifying any evidence that the State has voiced an intent to hold taxpayers harmless. The mere fact that a state statute provides by law for a payment, offset or waiver to a provider or a provider's patient, and that some person might have a "reasonable expectation" that the taxpayer would be held harmless as a result, cannot be sufficient to establish a direct guarantee. The interpretation expressed in the preamble could put one or more of California's three health-care related tax programs at risk.

For example, in 2005, CMS approved the imposition of a "quality assurance fee" on specified freestanding nursing facilities in California. Because state law was enacted that required CDHS to seek federal approval to exempt certain facilities from paying the fee, the Department sought a waiver to impose a fee that is not broad based or uniformly imposed. CMS approved the waiver and a State Plan Amendment in June 2005, and the fee program was implemented retroactively to August 2004. Under CMS's proposed interpretation, this "fee" would require a finding of a "direct guarantee."

CMS's current assertion that it may find a "direct guarantee" without any form of explicit assurance also contradicts HCFA's interpretation of this hold harmless provision in the 1993 rulemaking where it was noted that the indirect guarantee test is necessary because not all hold harmless situations are explicit.

Perhaps because it has declared irrelevant the obvious trait distinguishing the direct from the indirect guarantee, CMS contends for the first time in the preamble to the proposed rule that the two guarantees differ based on the kind of payment involved: that the indirect guarantee concerns regular or enhanced Medicaid payments, while the direct guarantee takes the form of a non-Medicaid payment.

There is no basis for this distinction. The direct guarantee clause is meant to address only a situation in which the state assures the return of the taxpayer's payment of any portion of the tax. The indirect guarantee clause, by contrast, is meant to provide a safe harbor when there is neither a direct guarantee nor a violation of the other two hold harmless provisions. If such a tax meets the safe harbor test, it is secure against a contention that it violates the hold harmless provision, whether through a Medicaid or a non-Medicaid payment.

CMS's expansive interpretations of the "positive correlation" and "direct guarantee" tests obscure the differences between these two distinct tests, and would enable the agency to find either of the two tests met wherever a non-Medicaid benefit might conceivably be used to defray provider tax costs.

Further, under CMS's broad interpretation of the "Medicaid payment" provision, CMS can find a violation in virtually any situation in which provider tax revenues are used to

make Medicaid payments to taxed providers. The effect of these proposed interpretations is effectively to omit the "indirect guarantee" test, whose importance Congress has recently affirmed by incorporating the standard into the Social Security Act.