Appointment

From: CMS CMCS Scheduling (b)(6)
(b)(6)
Sent: 7/15/2019 7:35:02 PM
To: CMS CMCS Scheduling (b)(6)
(b)(6) ; Lynch, Calder
(CMS/OA) (b)(6)
(b)(6) Shields, Karen (CMS/CMCS)
(b)(6)
(b)(6) Deboy, Alissa (CMS/CMCS)
(b)(6)
(b)(6) ; Harris, Melissa
(CMS/CMCS) (b)(6)
(b)(6) ; Smith, Carrie
(CMS/CMCS) (b)(6)
(b)(6) ; Anderson, Debbie
(CMS/CMCS) (b)(6)
(b)(6) Gibson, Alexis (CMS/CMCS)
(b)(6)
(b)(6)
CC: Truffer, Christopher (CMS/OACT) (b)(6)
(b)(6) ; Fan, Kristin
(CMS/CMCS) (b)(6)
(b)(6) Cope, Tristan
(CMS/OACT) (b)(6)
(b)(6) ; Sumeracki, Jodie
(CMS/CMCS) (b)(6)
(b)(6) ; Delozier, Adrienne
(CMS/CMCS) (b)(6)
(b)(6) ; Howe, Rory
(CMS/CMCS) (b)(6)
(b)(6)

Subject: (b)(5) Follow Up (DEHPG Closed Session)
Attachments: 1. (b)(FMP SFY 19 options v6 clean.docx; 07162019 CLOSED DEH Clearance Agenda.docx
Location: Conference Room A / WebEx: 1-877-267-1577; ID: 994 976 725

Start: 7/16/2019 2:00:00 PM
End: 7/16/2019 2:15:00 PM
Show Time As: Tentative

Required Attendees: Lynch, Calder (CMS/OA); Shields, Karen (CMS/CMCS); Deboy, Alissa M. (CMS/CMCS); Harris, Melissa L. (CMS/CMCS); Smith, Carrie A. (CMS/CMCS); Anderson, Debbie (CMS/CMCS); Gibson, Alexis E. (CMS/CMCS)
Optional Attendees: Truffer, Christopher J. (CMS/OACT); Fan, Kristin A. (CMS/CMCS); Cope, Tristan P. (CMS/OACT); Sumeracki, Jodie M. (CMS/CMCS); Delozier, Adrienne M. (CMS/CMCS); Howe, Rory (CMS/CMCS) (Rory.Howe@cms.hhs.gov)

Agenda:

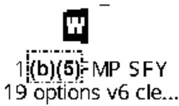
07162019
CLOSED DEH Cl...

Materials:

1. (b)(5) **Follow Up (paper)**
   Action Needed By: ASAP

Decision Requested: Next steps to bring the issue to resolution based on the options identified in the paper.

Summary: The state (b)(5) includes add on payments for hospitals in their SFY 2019 capitation rate setting based on the receipt of a hospital tax as the non-federal share. Plans are then instructed to use those additional funds to increase hospital payments. (b)(5) (b)(5) the payment arrangement violates the hold harmless provisions under tax law and is an impermissible cost included in the capitation rates. We identify the options for resolution in the attached paper.



1(b)(5)-MP SFY 19 options v6 cle...

Access Information

1. Please call the following number:
   WebEx: (b)(6)
2. Follow the instructions you hear on the phone.

Your WebEx Meeting Number: (b)(6)

(b)(5) FMP payments in the FY 2019 contracts

July 12, 2019

Issue

How can CMS move forward with the (b)(5) Fiscal Year 2019 rates given a large amount of the capitation payments are associated with Full Medicaid Pricing (FMP) adjustments?

Background on (b)(5) FMP

Starting in the rating period covering May 2017 through June 2018, the state expanded their managed care program statewide (previously only covering some regions of the state). (b)(5) (b)(5) (b)(5) These adjustments are included in the rates for all regions, even those previously covered under managed care.

The rating period that included state fiscal year 2018 began May 1, 2017; therefore, DEHPG/DMCP determined that the regulations at 42 CFR 438.6(c) (directed payments) and 42 CFR 438.6(d) (pass-through payments) did not yet apply (they went into effect with contract rating periods starting on or after July 1, 2017.) (b)(5) (b)(5) (b)(5) OACT finalized the May 2017 through June 2018 certification with the understanding that FMP would be considered a directed payment permissible under 42 CFR 438.6(c) in the next rating period.

The FMP payments are also included in fiscal year 2019 (the first rating period to fall under the regulations at 42 CFR 438.6(c) and 438.6(d)), which the state submitted in July 2018. After reviewing the language in the state's contract and rate certification, in September 2018, DMCP determined that these do not qualify as state-directed payments, because the state is not directing the managed care plans on how to make these payments to hospitals—only that these funds be used for hospital payments made during the rating period. DMCP determined that the plans retain discretion for the amount, timing, and mechanism for making the payments (this is consistent with page 3 of the [HYPERLINK "https://www.medicaid.gov/federal-policy-guidance/downloads/cib11022017.pdfhttps:/www.medicaid.gov/federal-policy-guidance/downloads/cib11022017.pdf"] on directed payments – Example 1 of a payment arrangement that is not subject to 438.6(c)). Appendix A includes the contract and rate certification language related to these payments.

The FMP amounts account (b)(5) for inpatient hospitals and (b)(5) (b)(5) for outpatient hospitals) or about 17 percent of projected total managed care payments for state fiscal year 2019. The adjustment factors range from 10 percent to 76 percent of the capitation rates by rate cell, although the adjustment impacts to the specific categories of service are significantly higher. In addition, the managed care plans pay a higher base rate to hospitals than were made under fee-for-service (about 30 percent higher), so the overall inpatient payments to hospitals are estimated to be about 15 percent higher than fee-for-service, which would make them above estimated Medicare rates and approximately equal to average commercial rates according to the state.

The source of the non-federal share of the FMP payments are from a hospital tax. (b)(5)

(b)(5)

(b)(5)

Hospital Tax - Hold Harmless Concerns

The hospital tax, called the Federal Reimbursement Allowance (FRA), generates approximately (b)(5) annually. The state uses the tax revenue as the non-federal share of various Medicaid payments, including the FMP payments. (b)(5) (b)(5) (b)(5) (b)(5) MHA's website, which explicitly states that "the pooling arrangement redistributes some FRA-funded payments so that participants in the FRA pooling arrangement are not financially harmed by the FRA program."

(b)(5) (b)(5). Regardless of state involvement (b)(5) (b)(5) the state Medicaid payments (b)(5) hold taxpayers harmless for the cost of the tax, which is prohibited by 42 CFR 433.68(f)(3). (b)(5)

(b)(5)

FMG is aware of a similar pooling arrangement that the state appears to have had in place relating to FFS payments (b)(5) Given the state's recent transition to managed care, (b)(5) (b)(5). CMS has never issued a disallowance relating to the FFS pooling arrangement or taken other action to end the possible FFS pooling arrangement. (b)(5) (b)(5) (b)(5) (b)(5) The disallowance does not address the pooling arrangement directly. Although the proposed disallowance was raised to prior Agency leadership on multiple occasions, CMS has never taken the disallowance.

Of note, the current draft, proposed Medicaid Fiscal Accountability Rule (MFAR) would explicitly identify this type of pooling arrangement as unallowable. CMS does not consider the relevant MFAR provision to be new policy, but instead a clarification of existing policy interpreting section 1903(w) of the Social Security Act, and 42 C.F.R. § 433.68(f).

(b)(4)

(b)(5)

Analysis

Between July 2018 and April 2019 CMS went through four rounds of questions with the state to understand the overall capitation rates, but also to get clarity on this payment arrangement and the financing of the payments. Given the ongoing concerns and the information CMS received throughout the course of the review, OACT sent a request to OGC on May 6, 2019 related to this payment arrangement requesting guidance on two issues:

1. If there is a concern that this payment arrangement violates the hold harmless provisions in tax law.

   (b)(5)

2. If these payments are actually pass-through payments, state directed payments or can be considered something in between.

   (b)(5)

Options

As CMCS believes this approach violates the hold harmless provisions in tax law, we cannot include these amounts in the capitation rates as it would be an impermissible cost. Therefore, CMCS has limited options for the SFY 19 rates. The state will be required to change their SFY 20 rates to a permissible directed payment.

1. Require the state to revise their rates, removing the FMP amounts (b)(5) given those payments violate the hold harmless provisions and would not be an allowable cost. The state could do this by either removing the amount and re-certifying the rates[2], or they could put the FMP amounts into a directed payment approach that does not violate the hold harmless provisions retroactively.

(b)(5)

2. CMS can issue a deferral and then disallowance for the entire amount of the SFY 19 capitation rates. Without the FMP amounts either being removed or changed to a permissible state directed payment, the rates would not be found as actuarially sound and therefore CMS could not provide FFP on those capitation rates.

(b)(5)

---

[2] (b)(5) (i.e., the base reimbursement rates before the addition of the direct Medicaid add-on amounts paid under FFS).

(b)(5)

(b)(5)

Next Steps

CMCS requests leadership discussion with the state to inform them they will need to change their rates in order to get the SFY 19 contracts approved.

Appendix A

Contract language

(b)(4)

Rate Certification Language

(b)(4)

Disabled and Elderly Health Programs Group Clearance Meeting
July 15, 2019
323H.01/Conference Room A – Dial (b)(6) **Meeting ID:** (b)(6)

Agenda

I. Closed Session – Managed Care Updates

1. (b)(5) **Follow Up (paper)**
   Action Needed By: ASAP
   Decision Requested: Next steps to bring the issue to resolution based on the options identified in the paper.
   Summary: The state (b)(5) includes add on payments for hospitals in their SFY 2019 capitation rate setting based on the receipt of a hospital tax as the non-federal share. Plans are then instructed to use those additional funds to increase hospital payments. (b)(5)
   (b)(5)
   the payment arrangement violates the hold harmless provisions under tax law and is an impermissible cost included in the capitation rates. We identify the options for resolution in the attached paper.

CMS00575cv1712

Message

From: Boston, Beverly (CMS/CMCS) (b)(6)
(b)(6)
Sent: 1/10/2023 7:12:07 PM
To: Howe, Rory (CMS/CMCS) (b)(6)
(b)(6) ; Fan, Kristin (CMS/CMCS)
(b)(6)
(b)(6) ; Arnold, Charlie
(CMS/CMCS) (b)(6)
(b)(6) Clark, Jennifer
(CMS/CMCS) (b)(6)
(b)(6) Goldstein, Stuart
(CMS/CMCS) (b)(6)
(b)(6) ; Cuno, Richard
(CMS/CMCS) (b)(6)
(b)(6) Endelman (he/him),
Jonathan (CMS/CMCS) (b)(6)
(b)(6)
CC: Maccarroll, Amber (CMS/CMCS) (b)(6)
(b)(6) ; Silanskis, Jeremy
(CMS/CMCS) (b)(6)
(b)(6) ; adams, lia (CMS/CMCS)
(b)(6)
(b)(6)
Subject: DUE WEDS 1/11: OGC-OL Passback: Status and Follow Up on Reactive Statement DUE COB TODAY: CIB Health Care Related Taxes and Hold Harmless Arrangements
Attachments: Internal QAs Healthcare Related Taxes CIB OGC OL REDLINES Jan 9 10am.docx; Healthcare Related Taxes CIB OGC OL REDLINES Jan 9 10AM .docx; 2023.01.09_Reactive CIB Healthcare related taxes and hold harmless Jan 9 1235PM_OL Comments.docx

Hello, **I am adding a SP link (below) for the reactive statement with OL comments/edits (attached) to be to aligned with the updated CIB and Q/As. Will these changes impact the OA briefing paper? We normally wait until we have clearance comments before going to OA, but I understand we are on a somewhat tight timeline.**

OC reconciled the comments. I did move the reconciled version of the CIB and Q/As to SharePoint (below). Please see attached with separate line edits/comments for full disclosure from OL and OGC. Please make edits in the reconciled version.

HC Related Taxes CIB

Q/As Taxes CIB

Reactive Statement - Tax CIB

Beverly

From: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>
Sent: Monday, January 9, 2023 4:31 PM
To: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>

Cc: Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Subject: RE: OGC-OL Passback: Status and Follow Up on Reactive Statement DUE COB TODAY: CIB Health Care Related Taxes and Hold Harmless Arrangements

Thanks, Beverly. I think some of the line edits are visible in the CIB, but many by OL are not visible. Is there a version with the line edits visible?

From: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Monday, January 9, 2023 3:34 PM
To: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>
Cc: Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Subject: OGC-OL Passback: Status and Follow Up on Reactive Statement DUE COB TODAY: CIB Health Care Related Taxes and Hold Harmless Arrangements

Hello,

Please see attached with OL and OGC comments. Can you take a look and let me know **when you'll be able to turn around clean versions**? As a reminder, next step is R2 CMS and the OCD will concurrently send it directly to Rachel in IOS, Sara Sills in OMB (Rory I did mention to Perrie that we shared and advanced copy with OMB), and Jessica Schubel in DPC to review.

Thanks

Beverly

From: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Friday, January 6, 2023 4:29 PM
To: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>
Cc: Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Subject: RE: Status and Follow Up on Reactive Statement DUE COB TODAY: CIB Health Care Related Taxes and Hold Harmless Arrangements

Looks good. I will circle back if there are any questions. Thank you all.

Beverly

From: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>
Sent: Friday, January 6, 2023 4:08 PM
To: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>

Cc: Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Subject: RE: Status and Follow Up on Reactive Statement DUE COB TODAY: CIB Health Care Related Taxes and Hold Harmless Arrangements

My edits are in and this is good to go. Thanks, all!

From: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Friday, January 6, 2023 2:47 PM
To: Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>
Cc: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Subject: RE: Status and Follow Up on Reactive Statement DUE COB TODAY: CIB Health Care Related Taxes and Hold Harmless Arrangements

Thanks Kristin,

Based on your comments would the below edits work? Please others review Kristin's comments in the attached and make edits here ➔ reactive that was drafted by OC **by COB today**.

State use of impermissible non-federal share sources often artificially inflate federal Medicaid expenditures. Further, these arrangements reimburse ~~reward~~ providers based on their ability to fund the state share and divert the focus of ~~disconnect~~ Medicaid payment from services, quality of care, health outcomes, and other program goals. Additionally, some redistribution arrangements may result in redirecting Medicaid payments away from Medicaid providers that serve a high percentage of Medicaid beneficiaries to providers that do not participate in Medicaid or have relatively lower Medicaid utilization.

Thanks
Beverly

From: Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>
Sent: Friday, January 6, 2023 2:19 PM
To: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>
Cc: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Subject: RE: Status and Follow Up on Reactive Statement DUE COB TODAY: CIB Health Care Related Taxes and Hold Harmless Arrangements

I made some suggestions.

From: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Friday, January 6, 2023 1:33 PM
To: Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>

Cc: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Subject: Status and Follow Up on Reactive Statement DUE COB TODAY: CIB Health Care Related Taxes and Hold Harmless Arrangements

Thanks Kristin,

Status update: OCD confirmed we are still aiming for 1/23. OCD is awaiting OGC comments (if any) on the CIB. Once the CIB clears Comms, the OCD will send it directly to Rachel in IOS, Sara Sills in OMB (Rory I did mention to Perrie that we shared and advanced copy with OMB), and Jessica Schubel in DPC to review.

In addition due COB today - Here is the reactive that was drafted by OC for the CIB. **Please let me know if you have edits to the reactive statement developed by OC.**

Thanks

Beverly

From: Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>
Sent: Wednesday, January 4, 2023 9:45 AM
To: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>
Cc: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Subject: RE: CIB Health Care Related Taxes and Hold Harmless Arrangements

Thanks Beverly. I defer to others but don't think the edits are helpful for the CIB. It was carefully crafted language. I would not recommend accepting these changes.

From: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Sent: Wednesday, January 4, 2023 8:46 AM
To: Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>
Cc: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Subject: CIB Health Care Related Taxes and Hold Harmless Arrangements

Good morning and HNY! 🎉

Looping others. All Comms clearance comments on the CIB are due from commenters on 1/5. Please hold the attached FCHCO comments until all other comments on the CIB are received. **I will need clean and redlined comments once all comments are received**.

In addition due 12pm tomorrow 1/5 - Here is the reactive that was drafted by OC for the CIB. Please let me know if you have edits to the reactive statement developed by OC.

Thank you

Beverly

From: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>
Sent: Tuesday, January 3, 2023 3:57 PM
To: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Cc: Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>
Subject: FW: FOR CLEARANCE: Internal Q&As for CIB Health Care Related Taxes and Hold Harmless Arrangements

Hi, Beverly and Lia. Would you mind making should make sure the attached track changes based on a few suggestions from Tim make it into the final version? Please let me know if you have any questions.

Thanks,
Rory

From: Howe, Rory (CMS/CMCS)
Sent: Tuesday, January 3, 2023 3:49 PM
To: Engelhardt, Tim (CMS/FCHCO) <Tim.Engelhardt@cms.hhs.gov>
Subject: RE: FOR CLEARANCE: Internal Q&As for CIB Health Care Related Taxes and Hold Harmless Arrangements

Hi Tim,

Happy New Year. I appreciate you taking the time to review and to comment. Thanks for catching the typo and for highlighting where we could be more precise to avoid misinterpretations. We'll update the draft CIB to address the comments/edit. Thanks again.

Rory

From: Engelhardt, Tim (CMS/FCHCO) <Tim.Engelhardt@cms.hhs.gov>
Sent: Tuesday, January 3, 2023 3:16 PM
To: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>
Subject: FW: FOR CLEARANCE: Internal Q&As for CIB Health Care Related Taxes and Hold Harmless Arrangements

Rory –

I understand the CIB was FYI-only, but I feel compelled to share with you a few things in the attached. I was only reading it to try to learn the policy, but there is a place in the CIB where a reader could easily take away the wrong message. And a typo.

Tim Engelhardt (he/him)
Medicare-Medicaid Coordination Office
Centers for Medicare & Medicaid Services
(b)(6)

INFORMATION NOT RELEASABLE TO THE PUBLIC UNLESS AUTHORIZED BY LAW: This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

From: CMS CLEARANCES <CLEARANCES@cms.hhs.gov>
Sent: Tuesday, January 3, 2023 1:35 PM

To: Worstell, Megan (CMS/OFM) <Megan.Worstell@cms.hhs.gov>; Czajkowski, John (CMS/OFM) <John.Czajkowski@cms.hhs.gov>; Plater, Morris (CMS/OFM) <Morris.Plater@cms.hhs.gov>; Stokes-Murray (He/Him), Heinz (CMS/OFM) <KHeinz.Stokes-Murray@cms.hhs.gov>; Tierney, Janet (CMS/OFM) <Janet.Tierney@cms.hhs.gov>; Kelsey, Ashley (CMS/OFM) <Ashley.Kelsey@cms.hhs.gov>; Carmichael, Wanda (CMS/OFM) <Wanda.Carmichael@cms.hhs.gov>; Benns, Antoinette (CMS/OFM) <Antoinette.Benns@cms.hhs.gov>; Richter (she/her), Liz (CMS/CM) <elizabeth.richter@cms.hhs.gov>; Rice, Cheri (CMS/CM) <Cheri.Rice@cms.hhs.gov>; Ahern, Robert (CMS/CM) <Robert.Ahern@cms.hhs.gov>; Mays, Beth (CMS/CM) <Beth.Mays@cms.hhs.gov>; Blackford (she/her), Carol (CMS/CM) <Carol.Blackford@cms.hhs.gov>; Pequigney, Susan (CMS/CM) <Susan.Pequigney@cms.hhs.gov>; Farran, Patti (CMS/CM) <Patti.Farran@cms.hhs.gov>; Beder, Victoria (CMS/CM) <Victoria.Beder@cms.hhs.gov>; Feaster, Simone (CMS/CM) <simone.feaster@cms.hhs.gov>; Uebersax, Julie (CMS/CM) <Julie.Uebersax@cms.hhs.gov>; Held, William (CMS/CM) <William.Held@cms.hhs.gov>; OToole, Meghan (CMS/OA) <Meghan.OToole1@cms.hhs.gov>; Labonte, Christiane (CMS/CM) <Christiane.Labonte@cms.hhs.gov>; Martin, Kristi (CMS/CM) <Kristina.Martin@cms.hhs.gov>; Turco, Molly (CMS/CM) <Molly.Turco@cms.hhs.gov>; Jacobs, Douglas (CMS/CM) <Douglas.Jacobs@cms.hhs.gov>; Hunter, Leah (CMS/CM) <Leah.Hunter@cms.hhs.gov>; CMS CPI Clearance Box <CPI_Clearance_Box@cms.hhs.gov>; Hart, Bradley (CMS/CPI); Lindstrom, Jennifer (CMS/CPI) <Jennifer.Lindstrom@cms.hhs.gov>; Mills, George (CMS/CPI) <george.mills@cms.hhs.gov>; Brentzel, Ingrid (CMS/CPI) <Ingrid.Brentzel@cms.hhs.gov>; Graham, John (CMS/CPI) <John.Graham@cms.hhs.gov>; Wilson-Coe, Tomiko (CMS/CPI) <Tomiko.Wilson-Coe@cms.hhs.gov>; Allen, Nakia (CMS/CPI) <nakia.allen-mcghee@cms.hhs.gov>; Ahmad, Namirah (CMS/CPI) <Namirah.Ahmad@cms.hhs.gov>; Barkai, Melissa (CMS/CPI) <Melissa.Barkai@cms.hhs.gov>; Coates, Nikita (CMS/CPI) <Nikita.Coates@cms.hhs.gov>; Mitchell, Dashe (CMS/CPI) <Dashe.Mitchell@cms.hhs.gov>; Tott, Karen (CMS/CPI) <Karen.Tott@cms.hhs.gov>; Stevenson, Bryant (CMS/CPI) <bryant.stevenson@cms.hhs.gov>; Oelschlaeger, Allison (CMS/OEDA) <Allison.Oelschlaeger@cms.hhs.gov>; Shatto, Andrew (CMS/OEDA) <Andrew.Shatto@cms.hhs.gov>; Hitchcock, Katherine (CMS/OEDA) <Katherine.Hitchcock@cms.hhs.gov>; Harper, Bernice (CMS/OEDA) <Bernice.Harper@cms.hhs.gov>; CMS Front Office - CCIIO Clearances <FrontOffice-CCIIOClearances@cms.hhs.gov>; Wu (he/him), Jeff (CMS/CCIIO) <Jeff.Wu@cms.hhs.gov>; Wilson, Lisa (CMS/CCIIO) <lisa.wilson@cms.hhs.gov>; Oconnor, Nancy (CMS/OPOLE) <Nancy.OConnor@cms.hhs.gov>; Rosta (she/her), Sara (CMS/CCIIO) <Sara.Rosta@cms.hhs.gov>; Arapi, Leslie (CMS/OPOLE) <Leslie.Arapi@cms.hhs.gov>; Frimpong, Janny (CMS/CCIIO) <Janny.Frimpong@cms.hhs.gov>; Brooks, Kiahana (CMS/CCIIO) <Kiahana.Brooks@cms.hhs.gov>; Cantwell, Kathleen (CMS/OSORA) <Kathleen.Cantwell@cms.hhs.gov>; Garcia, Vanessa (CMS/OSORA) <Vanessa.Garcia@cms.hhs.gov>; Jackson, Marilyn (CMS/OSORA) <Marilyn.Jackson@cms.hhs.gov>; Barnett Sherrill (She/Her), Alexis (CMS/OSORA) <Alexis.Sherrill@cms.hhs.gov>; Taylor, Isabel (CMS/OSORA) <Isabel.Taylor@cms.hhs.gov>; Palmer, Erin (CMS/OSORA) <erin.palmer@cms.hhs.gov>; Unruh, Patti (CMS/OSORA) <Patti.Unruh@cms.hhs.gov>; Khan, Farooq (CMS/OSORA) <Farooq.Khan@cms.hhs.gov>; Lafferty, Tiffany (CMS/OSORA) <Tiffany.Lafferty@cms.hhs.gov>; Parham, William (CMS/OSORA) <WILLIAM.PARHAM@cms.hhs.gov>; Jones, Martique (CMS/OSORA) <Martique.Jones@cms.hhs.gov>; Phan, Thomas (CMS/OSORA) <Thomas.Phan@cms.hhs.gov>; Edmondson-Parrott, Michele (CMS/OSORA) <michele.edmondsonparrott@cms.hhs.gov>; Miller, Ruth-Sam (CMS/OSORA) <Ruth.Miller@cms.hhs.gov>; Lilley, Edward (CMS/OSORA) <Edward.Lilley@cms.hhs.gov>; McLemore, Monica (CMS/OSORA) <Monica.McLemore@cms.hhs.gov>; Witherspoon, Tia (CMS/OSORA) <Tia.Witherspoon@cms.hhs.gov>; CMS OIT Correspondence <OITCorrespondence@cms.hhs.gov>; Howden, Catherine (CMS/OC) <Catherine.Howden@cms.hhs.gov>; Tross, Jason (CMS/OC) <Jason.Tross@cms.hhs.gov>; Wagner, Rachel (CMS/OC) <Rachel.Wagner@cms.hhs.gov>; Fortin-Garcia, Carolina (CMS/OC) <Carolina.Fortin-Garcia@cms.hhs.gov>; Boykin, Jibril (CMS/OC) <Jibril.Boykin@cms.hhs.gov>; Dinges, Enrico (CMS/OC) <Eric.Dinges@cms.hhs.gov>; Joy-Bush, Keya (CMS/OC) <keya.joy-bush@cms.hhs.gov>; Martin, Patrice (CMS/OC) <Patrice.Martin@cms.hhs.gov>; Mengel, Jonathan (CMS/OC) <Jonathan.Mengel@cms.hhs.gov>; Myers, Gregory (CMS/OC) <Gregory.Myers@cms.hhs.gov>; Smith, Aaron (CMS/OC) <Aaron.Smith@cms.hhs.gov>; Sokol, Lisa (CMS/OC) <Lisa.Sokol@cms.hhs.gov>; Thorn, Raymond (CMS/OC) <Raymond.Thorn@cms.hhs.gov>; Washington, April (CMS/OC) <April.Washington@cms.hhs.gov>; Trucil, Daniel (CMS/OC) <Daniel.Trucil@cms.hhs.gov>; Ryan, Lorraine (CMS/OC) <lorraine.ryan@cms.hhs.gov>; Schinderle, Elizabeth (CMS/OC) <elizabeth.schinderle@cms.hhs.gov>; Mahoney, Christine (CMS/OC) <Christine.Mahoney@cms.hhs.gov>; Brager, Mark (CMS/OC) <Mark.Brager@cms.hhs.gov>; Clemens, Kristen (CMS/OC) <Kristen.Clemens@cms.hhs.gov>; Reeves, Alison (CMS/OC) <Alison.Reeves@cms.hhs.gov>; Walker, Chantel (CMS/OC) <Chantel.Walker@cms.hhs.gov>; Chambers, Gwendolyn (CMS/OC) <Gwendolyn.Chambers@cms.hhs.gov>; Gross, Jessica (CMS/OC) <Jessica.Gross@cms.hhs.gov>; Alexander, Bruce (CMS/OC) <Bruce.Alexander@cms.hhs.gov>; Wallace, Mary (CMS/OC) <Mary.Wallace@cms.hhs.gov>; Aldana, Karen (CMS/OC) <Karen.Aldana@cms.hhs.gov>; Bradley, Tasha

(CMS/OC) <Tasha.Bradley1@cms.hhs.gov>; Toomey, Mary (CMS/OC) <Mimi.Toomey@cms.hhs.gov>; Perkins, Valerie (CMS/OC) <Valerie.Perkins@cms.hhs.gov>; Williams, Tamika (CMS/OC) <Tamika.Williams@cms.hhs.gov>; Patrick, Michele (CMS/OC) <Michele.Patrick@cms.hhs.gov>; Mazzone, Maria (CMS/OC) <Maria.Mazzone@cms.hhs.gov>; Pressley, Erin (CMS/OC) <Erin.Pressley@cms.hhs.gov>; Miner, Amy (CMS/OC) <Amy.Miner@cms.hhs.gov>; Harmatuk, Frances (CMS/OC) <Frances.Harmatuk@cms.hhs.gov>; Reilly, Megan (CMS/OC) <Megan.Reilly@cms.hhs.gov>; Gordon, Erin (CMS/OC) <Erin.Gordon@cms.hhs.gov>; Franklin, Julie (CMS/OC) <Julie.Franklin@cms.hhs.gov>; Winer, Rachel (CMS/OC) <Rachel.Winer@cms.hhs.gov>; Dinicolo, Kelly (CMS/OC) <Kelly.Dinicolo@cms.hhs.gov>; Shaham, Lauren (CMS/OC) <Lauren.Shaham1@cms.hhs.gov>; Walen, Alyssa (CMS/OC) <Alyssa.Walen@cms.hhs.gov>; Jenkins, Courtney (CMS/OC) <Courtney.Jenkins@cms.hhs.gov>; Broccolino, Michele (CMS/OC) <Michele.Broccolino@cms.hhs.gov>; Booth, Jon (CMS/OC) <Jon.Booth@cms.hhs.gov>; Hennessy, Amy (CMS/OC) <Amy.Hennessy@cms.hhs.gov>; Costello, Stefanie (CMS/OC) <Stefanie.Costello@cms.hhs.gov>; McIver, LaShawn (CMS/OMH) <LaShawn.McIver@cms.hhs.gov>; Finch, Wanda (CMS/OMH) <Wanda.Finch@cms.hhs.gov>; Gentry, Pamela (CMS/OMH) <Pamela.Gentry@cms.hhs.gov>; Peddicord-Austin, Ashley (CMS/OMH) <Ashley.Peddicord-Austin@cms.hhs.gov>; Young, Brian (CMS/OMH) <Brian.Young@cms.hhs.gov>; Fleisher, Lee (CMS/CCSQ) <Lee.Fleisher@cms.hhs.gov>; Ling, Shari (CMS/CCSQ) <Shari.Ling@cms.hhs.gov>; Schreiber, Michelle (CMS/CCSQ) <Michelle.Schreiber@cms.hhs.gov>; Iwugo, Jeneen (CMS/CCSQ) <jeneen.iwugo@cms.hhs.gov>; Spence, Ashley (CMS/CCSQ) <Ashley.Spence@cms.hhs.gov>; Jenkins, Courtney (CMS/OC) <Courtney.Jenkins@cms.hhs.gov>; Hakim, Alyson (Aly) (CMS/CMCS) <Alyson.Hakim@cms.hhs.gov>; Appleton, Paige (CMS/CCSQ) <Paige.Appleton@cms.hhs.gov>; Moody-Williams, Jean (CMS/CCSQ) <jean.moodywilliams@cms.hhs.gov>; Michael, Sean (CMS/CCSQ) <sean.michael@cms.hhs.gov>; Engelhardt, Tim (CMS/FCHCO) <Tim.Engelhardt@cms.hhs.gov>; Vitolo, Sara (CMS/FCHCO) <Sara.Vitolo@cms.hhs.gov>; Perry, Nicole (CMS/FCHCO) <Nicole.Perry@cms.hhs.gov>; Oconnor, Nancy (CMS/OPOLE) <Nancy.OConnor@cms.hhs.gov>; Hammarlund, John (CMS/OPOLE) <john.hammarlund@cms.hhs.gov>; Collura, Paul (CMS/OPOLE) <Paul.Collura@cms.hhs.gov>; Thomas, Pam (CMS/OPOLE) <Pam.Thomas@cms.hhs.gov>; Stupica-Dobbs, Kim (CMS/OPOLE) <Kimberly.Stupica-Dobbs@cms.hhs.gov>; Hannigan, John (CMS/OPOLE) <John.Hannigan@cms.hhs.gov>; Kerrigan, Maureen (CMS/OPOLE) <Maureen.Kerrigan@cms.hhs.gov>; Balch (she/her), Elissa (CMS/OPOLE) <Elissa.Balch@cms.hhs.gov>; Sutton, Erin (CMS/OPOLE) <erin.sutton2@cms.hhs.gov>; Spitalnic, Paul (CMS/OACT) <paul.spitalnic@cms.hhs.gov>; Cooper, Jill (CMS/OACT) <Jill.Cooper@cms.hhs.gov>; Croston, Diane (CMS/OACT) <Diane.Croston@cms.hhs.gov>; CMS OLClearances <OLClearances@cms.hhs.gov>; Woronoff, Arielle (CMS/OL) <Arielle.Woronoff@cms.hhs.gov>; Boulanger, Jennifer (CMS/OL) <Jennifer.Boulanger@cms.hhs.gov>; Keene, Danyail (CMS/OL) <Danyail.Keene@cms.hhs.gov>; Druckman, Jennifer (CMS/OL) <Jennifer.Druckman@cms.hhs.gov>; Oakes, Meghan (CMS/OL) <Meghan.Oakes@cms.hhs.gov>; Newlin, Manda (CMS/OL) <Manda.Newlin@cms.hhs.gov>; Stahlman, Mary Ellen (CMS/OL) <MaryEllen.Stahlman@cms.hhs.gov>; Martino, Maria (CMS/OL) <Maria.Martino@cms.hhs.gov>; Mote, Katelyn (CMS/OL) <Katelyn.Mote@cms.hhs.gov>; Khalid, Zunaira (CMS/OL) <Zunaira.Khalid@cms.hhs.gov>; Ryan, Dan (CMS/OL) <Dan.Ryan@cms.hhs.gov>; Upchurch, Talaiya (CMS/OL) <Talaiya.Upchurch@cms.hhs.gov>; Kirchgraber, Kate (CMS/OL) <Kate.Kirchgraber@cms.hhs.gov>; Mauser, Gayle (CMS/OL) <Gayle.Mauser@cms.hhs.gov>; Minor, Nevena (CMS/OL) <Nevena.Minor@cms.hhs.gov>; Estrada, Abuko (CMS/OL); Barry, Meg (CMS/CMCS) <meg.barry@cms.hhs.gov>; Dawson, Andrew (CMS/OL) <Andrew.Dawson@cms.hhs.gov>; Lewandowski, David (CMS/OL) <David.Lewandowski@cms.hhs.gov>; Miner, Imani (CMS/OL) <Imani.Miner@cms.hhs.gov>; Goto, Meinan (CMS/OL) <Meinan.Goto@cms.hhs.gov>; Greene, Mary (CMS/OAGM) <Mary.Greene@cms.hhs.gov>; Brown, Michelle (CMS/OAGM) <Michelle.Brown@cms.hhs.gov>; Amburgey, Louise (CMS/OAGM) <Louise.Amburgey1@cms.hhs.gov>; Waskiewicz, Beth (CMS/OAGM) <beth.waskiewicz@cms.hhs.gov>; Tatum, Kimberly (CMS/OAGM) <Kimberly.Tatum@cms.hhs.gov>; Calabro, Alice (CMS/OAGM) <Alice.Calabro@cms.hhs.gov>; Kelly, Ryan (CMS/OAGM) <Ryan.Kelly@cms.hhs.gov>; Hazelwood, Antoinette (CMS/OAGM) <Antoinette.Hazelwood@cms.hhs.gov>; Schmitz, Stefanie (CMS/OAGM) <Stefanie.Schmitz1@cms.hhs.gov>; Lanasa, Michele (CMS/OAGM) <Michele.Lanasa@cms.hhs.gov>; Eberhart, Christina (CMS/OAGM) <Christina.Eberhart2@cms.hhs.gov>; Dionne.Brown@cms.hhs.gov; Rippey (she/her), Catherine (CMS/OHI) <Catherine.Rippey@cms.hhs.gov>; Hamilton, Andrea (CMS/OHI) <andrea.hamilton@cms.hhs.gov>; Brauer (he/him), Randy (CMS/OHI) <Randy.Brauer@cms.hhs.gov>; Slade, James (CMS/OHI) <James.Slade@cms.hhs.gov>; Hernandez (she/her), Laura (CMS/OHI) <Laura.Hernandez@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>; Harris, Monica (CMS/CMCS) <Monica.Harris@cms.hhs.gov>; Harshman, Sara (CMS/CMCS) <Sara.Harshman@cms.hhs.gov>; Stegmaier, Jason (CMS/CMCS) <Jason.Stegmaier@cms.hhs.gov>; Whelan, Ellen-Marie (CMS/CMCS) <EllenMarie.Whelan@cms.hhs.gov>; Miller, Courtney (CMS/CMCS) <Courtney.Miller@cms.hhs.gov>; Janu, Shanna (CMS/CMCS) <Shanna.Janu@cms.hhs.gov>; Dorsey, Jennifer (CMS/CMCS) <jennifer.dorsey@cms.hhs.gov>;

Fowler (she/her), Liz (CMS/CMMI) <Liz.Fowler@cms.hhs.gov>; Tabe-Bedward, Arrah (CMS/CMMI) <arrah.tabebedward@cms.hhs.gov>; Rushton, Andrew (CMS/CMMI) <Andrew.Rushton@cms.hhs.gov>; Dziak, Kathleen (CMS/CMMI) <Kathleen.Dziak@cms.hhs.gov>; Cardin, Megan (CMS/CMMI) <Megan.Cardin@cms.hhs.gov>; OToole, Meghan (CMS/OA) <Meghan.OToole1@cms.hhs.gov>; Wells, Carrie (CMS/CMMI) <Carrie.Wells1@cms.hhs.gov>; Barberi, Jade (CMS/CMMI) <Jade.Russell@cms.hhs.gov>; Doherty, Theresa (CMS/CMMI) <Theresa.Doherty@cms.hhs.gov>; Anderson, Jessica (CMS/CMMI) <jessica.anderson@cms.hhs.gov>; McGinley, Katelynn (CMS/CMMI) <katelynn.mcginley@cms.hhs.gov>; Greene, Mary (CMS/OBRHI) <Mary.Greene1@cms.hhs.gov>; McClain, Rena (CMS/OBRHI) <Rena.McClain1@cms.hhs.gov>; Jackson, Michelle (CMS/CPI) <Michelle.Jackson@cms.hhs.gov>; Ratchford, Deneen (CMS/OAGM) <Deneen.Ratchford@cms.hhs.gov>; St. Louis, Aileah (CMS/OC) <Aileah.St.Louis@cms.hhs.gov>; Blum, Jonathan (CMS/OA) <Jonathan.Blum@cms.hhs.gov>; Ellis (she/her), Kyla (CMS/OA) <Kyla.Ellis@cms.hhs.gov>; Harris, Will (CMS/OA) <William.Harris@cms.hhs.gov>; Boulanger, Jennifer (CMS/OL) <Jennifer.Boulanger@cms.hhs.gov>; Katch (she/her), Hannah (CMS/OA) <Hannah.Katch@cms.hhs.gov>; OToole, Meghan (CMS/OA) <Meghan.OToole1@cms.hhs.gov>; Richardson (she/her), Erin (CMS/OA) <Erin.Richardson@cms.hhs.gov>; Woronoff, Arielle (CMS/OL) <Arielle.Woronoff@cms.hhs.gov>; Yao, Kristiana (CMS/OA) <Kristiana.Yao1@cms.hhs.gov>; CMS-CQISCOCMO@ees.hhs.gov; Ling, Shari (CMS/CCSQ) <Shari.Ling@cms.hhs.gov>; Wild, Richard (CMS/CCSQ) <Richard.Wild@cms.hhs.gov>; Nilasena, David (CMS/CCSQ) <David.Nilasena@cms.hhs.gov>; Wolfe, Ashby (CMS/CCSQ) <Ashby.Wolfe1@cms.hhs.gov>; Fisher, Barbara (HHS/OGC) <Barbara.Fisher@HHS.GOV>; Rainer, Melanie Fontes (OS/OCR) <Melanie.Rainer@hhs.gov>; Smalley, Elizabeth (HHS/ASPA) <Elizabeth.Smalley@hhs.gov>; Levin, Michael (HHS/ASPA) <Michael.Levin@hhs.gov>; HHSPress@hhs.gov; releases@hhs.gov
Cc: CMS CLEARANCES <CLEARANCES@cms.hhs.gov>; Dinges, Enrico (CMS/OC) <Eric.Dinges@cms.hhs.gov>
Subject: FOR CLEARANCE: Internal Q&As for CIB Health Care Related Taxes and Hold Harmless Arrangements

Please copy **Enrico Dinges** and on **ALL** responses pertaining to this item when replying to CMS Clearances.

Please see attached internal qas for review. The informational bulletin is FYI ONLY. Thank you.

Comments Due: 1:00 PM ET Thursday, January 5, 2023

All: For your review and input. Concurrent HHS/CMS review.

Title: Internal Q&As for CMCS informational bulletin on health care related taxes and hold harmless arrangements.
Agency/Office: CMCS

Subject/Description: CMS will release an informational bulletin on health care related taxes and hold harmless arrangements involving the redistribution of Medicaid payments. This informational bulletin responds in part to questions CMS has received regarding the statutory and regulatory requirements applicable to health care-related taxes, including in connection with proposals to implement or renew Medicaid managed care state directed payments (SDPs). There will be a reactive statement, listserv message, and internal questions-and-answers for this item.

COMMs Materials for Rollout: Internal Q&As

Deadline for COMMS Clearance comments: Thursday, January 5 by 1:00 PM

Requested Release date: 2/7/2023

INFORMATION NOT RELEASABLE TO THE PUBLIC UNLESS AUTHORIZED BY LAW:
This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in disciplinary action or prosecution to the full extent of the law.

Q: What is CMS announcing today?
CMCS is issuing an informational bulletin (CIB) to states reiterating certain federal requirements that pertain to health-care related taxes. Recently, CMS has discovered health care-related tax programs that appear to involve agreements among providers to redistribute their Medicaid payments to hold taxpayers harmless for the cost of the tax. The CIB reminds states that such arrangements are prohibited by the statute and regulations and re-emphasizes our goal of assisting states in ensuring appropriate sources of non-federal share financing.

Q: How do these hold harmless arrangements work?
In the arrangements, a state or other unit of government imposes a health-care related tax on certain health care providers, then uses the tax revenue to fund the non-federal share of state directed Medicaid payments back to the provider taxpayers. The taxpayers appear to have a pre-arranged agreement to redistribute the Medicaid payments to ensure that all taxpayers, when accounting for both the original Medicaid payment (from the state directly or through an MCO) and any redistribution payment from another taxpayer or taxpayers, receive all or any portion of their tax amount back—thus, holding the taxpayers harmless.

Q: Why is this CIB important?
In the past few years, it appears that health care-related tax programs with problematic hold harmless arrangements are starting to proliferate. CMS is aware of a few states with such problematic arrangements in place and a few additional states that appear likely to propose similar tax programs soon. These particular tax programs are often emerging in connection with state directed payment proposals under Medicaid managed care. The CIB aims to ensure that states clearly understand the existing requirements so that, as they develop state directed payment and other payment proposals, they can develop approvable non-federal share financing methodologies and make modifications as necessary to come into compliance with federal requirements.

Ensuring permissible non-federal share sources is critical to protecting Medicaid's sustainability through responsible stewardship of public funds. State use of impermissible non-federal share sources cancan inflate federal Medicaid expenditures. Further, these arrangements pay providers based on their ability to fund the non-federal share, and disconnect the Medicaid payment from Medicaid services, quality of care, health outcomes, or other Medicaid program goals. Of critical concern, it appears that the redistribution arrangements in this particular type of tax program are specifically designed to redirect Medicaid payments away from Medicaid providers that serve a high percentage of Medicaid individuals to providers that do not participate in Medicaid or have relatively lower Medicaid utilization.

INTERNAL CMS USE ONLY! INFORMATION NOT RELEASABLE TO THE PUBLIC UNLESS AUTHORIZED BY LAW: This information has not been publicly disclosed and may be privileged and confidential. This document must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

Q: Does CMS support states' adoption of health care-related taxes?

Yes, when the tax meets statutory and regulatory requirements. CMS approves hundreds of Medicaid non-federal share financing proposals that are funded by health care-related taxes that appear permissible every year.

Q: How will this impact/benefit Medicaid beneficiaries? How will this impact Medicaid providers?

The CIB reiterates existing statutory and regulatory requirements and does not establish new policy. However, impermissible non-federal share financing arrangements can have a negative impact on beneficiaries. For example, these particular arrangements may result in payments (including managed care state-directed payments), after the payment redistributions that provide higher payment to providers based on their ability to fund the state share instead of based on Medicaid utilization, quality, equity, health outcomes, or other Medicaid program goals. Additionally, the payment redistributions are specifically designed to redirect Medicaid payments away from Medicaid providers to lower volume or non-participating Medicaid providers.

Compared to permissible health care-related taxes, these problematic tax programs are more favorable to providers with relatively low Medicaid utilization. It is possible that some states may adjust existing tax programs or alter future tax programs to ensure compliance. Ultimately, we expect that such changes are beneficial to providers with relatively high Medicaid utilization and unfavorable to providers with relatively low Medicaid utilization that currently benefit from redistribution arrangements..

Q. Is today's action being taken in response to any particular state's arrangements relating to generating the non-federal share of Medicaid funding?

No, this action is not being taken in response to any particular state's Medicaid financing arrangements. However, as described above, CMS is aware of existing arrangements that appear problematic, and is concerned that additional states may be planning to implement similar arrangements. Recently, CMCS worked with one state and its hospitals to avoid implementing a problematic tax program and ensure compliance.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

CMCS Informational Bulletin

DATE: xx xx, xxxx

FROM: Daniel Tsai, Deputy Administrator and Director

SUBJECT: Health Care-Related Taxes and Hold Harmless Arrangements Involving the Redistribution of Medicaid Payments

Background

Recently, the Centers for Medicare & Medicaid Services (CMS) has been approached by several states with questions regarding the statutory and regulatory requirements applicable to health care-related taxes, including in connection with proposals to implement or renew Medicaid managed care state directed payments (SDPs). Many of these questions have focused on whether health care-related tax arrangements involving the redistribution of Medicaid payments among providers subject to the tax would comply with the statutory and regulatory prohibition on "hold harmless" arrangements—that is, arrangements in which the "State or other unit of government imposing the tax provides (directly or indirectly) for any payment, offset, or waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax"—as specified in section 1903(w)(1)(A)(iii) and (w)(4) of the Social Security Act (the Act) and implementing regulations. In response to these questions, this informational bulletin reiterates our longstanding position on the existing federal requirements that pertain to health-care related taxes and re-emphasizes our goal of assisting states in ensuring appropriate sources of non-federal share financing.

CMS recognizes that health care-related taxes are a critical source of funding for many states' Medicaid programs, including for payments to safety net providers. CMS supports states' adoption of health care-related taxes when they are consistent with federal requirements. CMS approves many state payment proposals annually that are supported by health care-related taxes that appear to meet federal requirements. CMS recognizes the challenges faced by states and health care providers in identifying sources of non-federal share financing and implementing Medicaid payment methodologies that assure payments are consistent with efficiency, economy, quality of care, and access, as required section 1902(a)(30)(A) of the Act.

Medicaid statute and regulations afford states flexibility to tailor health care-related taxes within certain parameters to meet their provider community needs and align with broader state tax policies and priorities for their Medicaid programs. CMS remains committed to providing states with technical assistance aiming to ensure that health care-related taxes used to finance the non-federal share of Medicaid expenditures meet the states' policy goals and comply with federal requirements. For example, CMS is authorized to waive the requirements that health care-related taxes be broad-based and/or uniform, when applicable conditions are met. CMS regularly works

with states to approve such waivers in furtherance of state goals while complying with federal requirements.

Although the applicable statutory and regulatory provisions afford states considerable flexibility in establishing health care-related taxes, such taxes must be imposed in a manner consistent with applicable federal statutes and regulations, including that they may not involve hold harmless arrangements, to avoid a reduction in the state's Medicaid expenditures eligible for federal financial participation. Occasionally, CMS encounters health care-related tax programs that appear to contain hold harmless arrangements, which are inconsistent with section 1903(w)(1)(A)(iii) and (w)(4) of the Act and 42 C.F.R. § 433.68(b)(3) and (f). Such arrangements are inconsistent with statutory and regulatory requirements and undermine the fiscal integrity of the Medicaid program. Recently, CMS has become aware of some health care-related tax arrangements that appear to contain a hold harmless arrangement that involves the taxpaying providers redistributing Medicaid payments after receipt to ensure that all taxpaying providers receive all or a portion of their tax costs back (typically ensuring that each taxpaying provider receives at least its total tax amount back).

In this informational bulletin, CMS is clarifying the federal requirements concerning hold harmless arrangements with respect to health care-related taxes. Further, we are encouraging states and providers to be as transparent as possible regarding any agreements in place or under development to ensure that all health care-related taxes meet federal requirements to avoid a statutorily required reduction in the state's Medicaid expenditures eligible for federal financial participation. CMS recommends that states that have concerns about the permissibility of a health care-related tax raise these concerns to CMS early in the process of developing the state's tax program to avoid issues surrounding the permissibility of the non-federal share of Medicaid expenditures.

Health Care-Related Taxes and Hold Harmless Arrangements

During standard oversight activities and the review of state payment proposals, particularly managed care state directed payments (SDPs) and fee-for-service payment state plan amendments (SPAs), CMS is increasingly encountering health care-related taxes that appear to contain hold harmless arrangements involving the redistribution of Medicaid payments. In these arrangements, a state or other unit of government imposes a health-care related tax, then uses the tax revenue to support the non-federal share of Medicaid payments back to the class of providers subject to the tax. The taxpayers appear to have entered into oral or written agreements (meaning explicit or implicit meeting of the minds, regardless of the formality or informality of any such agreement) to redirect or redistribute the Medicaid payments to ensure that all taxpayers receive all or a portion of their tax back, when considering each provider's retained portion of any original Medicaid payment (either directly from the state or from the state through an MCO) and any redistribution payment received by the provider from another taxpayer or taxpayers. These redistribution payments may be made directly from one taxpaying provider to another, or the funds may be contributed first to an intermediary redistribution pool.

In these hold harmless arrangements, there appear to be agreements among providers (explicit or implicit in nature) such that providers that furnish a relatively high percentage of Medicaid-covered services redistribute a portion of their Medicaid payments to providers with relatively lower (or no) Medicaid service percentage, relative to the health care-related tax those providers

paid. The redistributions occur so that taxpaying providers are held harmless for all or a portion of the health care-related tax. This may include the redistribution of Medicaid payments to providers that serve no Medicaid beneficiaries.

These taxes contain impermissible hold harmless arrangements as defined in section 1903(w)(4)(C)(i) of the Act and 42 CFR 433.68(f)(3) that lead to a reduction in medical assistance expenditures prior to the calculation of federal financial participation as required under section 1903(w)(1)(A) and (w)(1)(A)(iii) of the Act. Following is a detailed example of how a hold harmless arrangement involving Medicaid payment redistribution could work:

- A state imposes a hospital tax based on the volume of inpatient hospital services provided. The tax is broad-based, uniform, and is imposed on 10 hospitals.
- Six of the hospitals serve a high percentage of Medicaid beneficiaries, three serve a low percentage of Medicaid beneficiaries, and one hospital does not participate in Medicaid.
- The state uses the tax revenue as the source of non-federal share of Medicaid payments, which are made back to nine of the hospitals through SDPs. The tenth hospital, which does not participate in Medicaid, does not receive any SDPs directly from state-contracted MCOs.
- All ten hospitals enter into oral or written agreements (meaning an explicit or implicit meeting of the minds, regardless of the formality or informality of any such agreement) to redirect or redistribute the Medicaid payments that the nine Medicaid-participating hospitals receive. Under this arrangement, the six hospitals that furnish a high percentage of Medicaid-covered services receive Medicaid payments from MCOs, then redistribute a portion of their Medicaid payments to the remaining four hospitals with lower Medicaid service percentages (including to the one hospital that does not participate in Medicaid). The redistribution amounts are calculated to guarantee that all hospitals, including those redistributing their own payments and those receiving the redistribution amounts, receive most, all, or more than all of their total tax cost back.
- The agreement among the taxpaying hospitals results in a reasonable expectation that the taxpaying hospitals, whether directly through their Medicaid payments or due to the availability of the redistributed payments received from the six high Medicaid service volume hospitals (which may be first pooled and then redistributed), are held harmless for at least part of their health care-related tax costs.
- The high-percentage Medicaid hospitals are willing to participate because they still financially benefit from the tax program (even net of the redistribution payments they make to the lower Medicaid service volume hospitals), and the redistribution enables broad support for the tax program from all hospitals, ensuring constituent support for the state law authorizing tax program.
  financed

Section 1903(w)(4) of the Act describes what constitutes a hold harmless arrangement. Specifically, section 1903(w)(4)(C)(i) provides that a hold harmless provision exists where "[t]he State or other unit of government imposing the tax provides (directly or <u>indirectly</u>) for any payment, offset, or waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax." (emphasis added). Implementing regulations at 42 CFR 433.68(f)(3) specify that a hold harmless arrangement exists where "[t]he State (or other unit of government) imposing the tax provides for any <u>direct or indirect</u> payment, offset, or waiver such that the provision of the

payment, offset, or waiver directly or indirectly guarantees to hold taxpayers harmless for all or any portion of the tax amount" (emphasis added). In the preamble to the 2008 final rule amending the above-referenced regulation, CMS wrote that "[a] direct guarantee will be found when a State payment is made available to a taxpayer or a party related to the taxpayer with the reasonable expectation that the payment would result in the taxpayer being held harmless for any part of the tax (through direct or indirect payments).".[1]

The words "indirect" and "indirectly", included both in the Medicaid statute and in regulation (and underlined in the excerpts above), make clear that the state itself need not be involved in the actual redistribution of Medicaid payments for the purpose of holding taxpayers harmless for the arrangement to qualify as a hold harmless. We are referring here to indirect payments because indirect guarantees are already defined in the regulation at 42 CFR § 433.68 (f)(3)(i)(a). inIt is possible for a state to directly provide a payment within the meaning of section 1903(w)(4)(C)(i) of the Act that guarantees to hold taxpayers harmless for any portion of the costs of the tax, if or all the taxpayers receive the those payments at issue through an intermediary rather than directly from the state or its contracted MCO. As CMS further explained in preamble to the 2008 final rule, we used the term "reasonable expectation" to relate to a state's understanding of whether the taxpayer is being held harmless because "state laws were rarely overt in requiring that state payments be used to hold taxpayers harmless."[2] In the preamble we also gave an example of state laws providing grants to nursing home residents who experienced increased charges as a result of nursing facility bed taxes; even though no state law typically required residents to use the grant funds to pay the increased nursing home fees, these direct state payments to nursing home residents indirectly held the nursing facilities harmless for their health care-related tax costs because of the reasonable expectation that their residents would use the state payments to repay the nursing facilities for all or a portion of their tax costs.[3] It remains true that hold harmless arrangements typically are not overtly established through state law but can be based instead on reasonable expectations that certain actions will take place among participating entities that will result in taxpayers being held harmless for all or a portion of their health care-related tax costs.

Accordingly, an arrangement in which providers receive Medicaid payments from the state (or from a state-contracted MCO), then redistribute those payments such that taxed providers are held harmless for all or any portion of their cost of the tax, would constitute a prohibited hold harmless provision under section 1903(w)(4)(C)(i) of the Act and 42 CFR 433.68(f)(3). Section 1903(w)(1)(A)(iii) of the Act and 42 CFR 433.70(b) require that CMS reduce a state's medical assistance expenditures by the amount of health care-related tax collections that include hold harmless arrangements, prior to calculating federal financial participation.
Some states have cited challenges with identifying and providing details on redistribution arrangements because they may not be parties to the redistribution agreements. A lack of transparency involving health care-related taxes and Medicaid payments may prevent both CMS and states from having information necessary to ensure sources of non-federal share meet statutory requirements.

[1] 73 Federal Register 9685, 9694-95 (Feb. 22, 2008).
[2] 73 Federal Register 9694
[3] *Id.*

As part of the agency's normal oversight activities, CMS intends to inquire about potential redistribution arrangements and may conduct detailed financial management reviews of health care-related tax programs that appear to include redistribution arrangements or that CMS has information may include redistribution arrangements. Consistent with federal requirements, CMS expects states to make available all requested documentation regarding arrangements involving possible hold harmless arrangements and the redistribution of Medicaid payments, and states should work with their providers to ensure necessary information is available. Where appropriate, states may wish to examine their provider participation agreements and MCO contracts to ensure that providers, as a condition of participation in Medicaid and/or of network participation for a Medicaid managed care plan, agree to provide necessary information to the state. States may consult section 1902(a)(6) of the Act, 45 CFR 75.364, and 42 CFR 433.74 for requirements related to CMS' authority to request records and documentation related to the Medicaid program. In particular, 42 CFR 433.74(a) requires that states, "must also provide any additional information requested by the Secretary related to any . . . taxes imposed on . . . health care providers," and the "States' reports must present a complete, accurate, and full disclosure of all of their donation and tax programs and expenditures." 42 CFR 433.74(d) specifies that a failure to comply with reporting requirements may result in a deferral or disallowance of federal financial participation. CMS is available to provide technical assistance and work with states to ensure the permissibility of all of the sources of the non-federal share of Medicaid expenditures, including any health care-related taxes the state may impose.

Conclusion

CMS recognizes that health care-related taxes can be a permissible source of funding for the non-federal share of Medicaid expenditures. CMS is available to provide technical assistance to states, including by reviewing proposals and providing feedback to develop health care-related taxes that align with state policy goals and meet federal requirements. One key federal requirement is that a health care-related tax cannot have a hold harmless provision that guarantees to return all or a portion of the tax back to the taxpayer. Health care-related tax programs in which taxpayers enter into agreements (explicit or implicit in nature) to redistribute Medicaid payments so that taxpayers have a reasonable expectation that they will receive all or a portion of their tax cost back generally involve a hold harmless arrangement that does not comply with federal statute and regulations.

CMS will continue to approve permissible health care-related taxes that do not contain hold harmless arrangements and meet all other applicable federal requirements. These taxes often finance critical health care programs that pay for care furnished to Medicaid beneficiaries and shore up the health care safety net in our country. As always, CMS intends to work collaboratively with states by providing technical assistance as necessary to ensure the programmatic and fiscal integrity of the Medicaid program.
For questions or to request technical assistance, please contact Rory Howe at [HYPERLINK "mailto:rory.howe@cms.hhs.gov"].

REACTIVE MEDIA STATEMENT

The Centers for Medicare & Medicaid Services (CMS) released a Medicaid informational bulletin that reiterates its longstanding position on existing federal requirements regarding health-care related taxes. Recently, CMS has become aware of some health care-related tax programs that appear to involve impermissible "hold harmless" arrangements among providers to redistribute Medicaid payments to ensure taxpayers receive all or a portion of their tax back. The informational bulletin CMS has released will help ensure that states clearly understand existing requirements established in federal statute and regulations, to assist states in ensuring appropriate sources for the non-federal share of financing, which remains critical to protecting Medicaid's sustainability through responsible stewardship.

Additional Background:

- This informational bulletin responds in part to questions CMS has received regarding the statutory and regulatory requirements applicable to health care-related taxes, including in connection with proposals to implement or renew Medicaid managed care state directed payments (SDPs). Many of these questions have focused on whether health care-related tax arrangements involving the redistribution of Medicaid payments among providers subject to the tax comply with the statutory and regulatory prohibition on hold harmless arrangements, as specified in section 1903(w)(1)(A)(iii) and (w)(4) of the Social Security Act (the Act) and implementing regulations.

- CMS will continue to approve permissible health care-related taxes that do not contain hold harmless arrangements and meet all other applicable federal requirements. These taxes often finance critical health care programs that pay for care furnished to Medicaid beneficiaries and shore up the health care safety net in our country.As always, CMS remains committed to working with states on existing or possible arrangements that would involve health care-related taxes that align with state policy goals and meet federal requirements. These collaborations are key to avoiding impermissible tax programs.

INTERNAL CMS USE ONLY! INFORMATION NOT RELEASABLE TO THE PUBLIC UNLESS AUTHORIZED BY LAW: This information has not been publicly disclosed and may be privileged and confidential. This document must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TYLER DIVISION

STATE OF TEXAS; TEXAS HEALTH AND HUMAN SERVICES COMMISSION, *Plaintiffs*, v. CHIQUITA BROOKS-LASURE, in her official capacity as Administrator for the Centers for Medicare and Medicaid Services; THE CENTERS FOR MEDICARE AND MEDICAID SERVICES; XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; and the UNITED STATES OF AMERICA, *Defendants*.	Civ. Action No. ___________

ORIGINAL COMPLAINT

1. Every day, Texas's Medicaid program ensures access to high-quality medical care for nearly 5 million Texans. For decades, the program has been a bedrock part of the State's social safety net, and its enduring vitality depends on the joint collaborative efforts of the State and the federal government.

2. Unfortunately, for the second time in three years, the Centers for Medicare and Medicaid Services (CMS), which administers Medicaid at the federal level, has wielded its oversight role as a cudgel to force Texas to adopt its policy

preferences. In the process, it has shaken the structural foundation of Medicaid's operations in Texas.

3. This case implicates how Medicaid gets funded, which is always an important issue and recently has become a contentious one. As a general matter, Medicaid is jointly paid for by the federal and state governments. Texas finances a large share of its contributions to Medicaid through the collection of healthcare provider taxes. Such taxes are expressly permissible under the Social Security Act, but the Act imposes several notable conditions on those taxes. The most relevant to this suit is that States may not hold taxpaying providers harmless for the cost of such taxes. *See* 42 U.S.C. § 1396b(w); *see also* 42 C.F.R. § 433.68. If CMS concludes that such a hold harmless provision exists, the financial consequences for the State are severe: the amount of the State's requested reimbursement from the federal government must be "reduced by the sum of any revenues received by the State" through a "broad-based health care related tax" that operates as "a hold harmless provision." *Id.* § 1396b(w)(1)(A)(iii).

4. The Act provides three separate definitions of a hold harmless provision. *Id.* § 1396b(w)(4)(A)-(C). Only one is relevant to this case: a hold harmless provision exists if "[t]he State or other unit of government imposing the tax provides (directly or indirectly) for any payment, offset, or waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax." *Id.* § 1396b(w)(4)(C)(i).

5. This definition is straightforward: when *the State or other government unit* provides a payment, offset, or waiver that (directly or indirectly) guarantees to

hold a taxpayer harmless, that arrangement constitutes a prohibited hold harmless provision. Rather than apply that plain text, CMS has adopted the view that an agreement between two *private* providers to protect against financial loss constitutes "a hold harmless arrangement involving Medicaid payment redistribution" if there is a "reasonable expectation" that the taxpaying provider will receive a portion of its provider tax costs returned as part of a private agreement. Ex. A at 3-4. And CMS has done so not through notice-and-comment rulemaking but by issuing an informational bulletin purporting to give immediate force and effect to this extra-textual reading of the Social Security Act. The bulletin follows years of failed rulemakings and unsuccessful threats to compel Texas's compliance with the agency's preferred interpretation of the Act. And, perhaps most disturbingly, this expanded definition applies not just prospectively but also retroactively to payments that were made years ago, requiring Texas to monitor private-party arrangements on pain of the loss of billions of dollars in federal funding.

6. The bulletin is unlawful under the Administrative Procedure Act (APA) and should be set aside. It is inconsistent with the plain language of the Social Security Act and CMS's own regulations. It was not issued with an opportunity for notice and comment. And it is arbitrary and capricious because it contradicts CMS's prior position—that private arrangements do *not* fall within the ambit of a prohibited hold harmless provision—without even attempting to explain why that position was incorrect. In the interim, the bulletin is already causing the State irreparable harm.

CMS and the other federal defendants should not be permitted to enforce or rely on the bulletin pending a final resolution of its legality.

PARTIES

7. Plaintiff Texas is a sovereign State. *See* Tex. Const. art. I, § 1. Texas brings this suit on its own behalf and on behalf of its citizens *parens patriae* to ensure that federal officials comply with the statutory and regulatory limits on their power when making decisions that will affect millions of Texans. Texas has the authority and responsibility to protect the health, safety, and welfare of its citizens.

8. Plaintiff Texas Health and Human Services Commission (HHSC) is an executive branch agency organized under the laws of Texas. It is the state agency designated under 42 C.F.R. § 431.10 to administer Texas's Medicaid program. For ease of reference, HHSC will be referred to collectively with the State as "Texas."

9. Defendant CMS is a federal agency organized under the laws of the United States. It is responsible for federally administering Medicaid. Although HHSC has been informed that certain actions relating to this suit are being coordinated out of CMS's office in Baltimore, CMS maintains a regional office located in Texas for administering its operations in Arkansas, Louisiana, New Mexico, Oklahoma, and Texas.

10. Defendant United States Department of Health and Human Services (HHS) is a cabinet-level federal executive branch agency organized under the laws of the United States. It is responsible for administering federal healthcare policy and is the cabinet-level Department of which CMS is a part.

11. Defendant Xavier Becerra is the Secretary of HHS. He is sued in his official capacity.

12. Defendant Chiquita Brooks-LaSure is the Administrator for CMS. She is sued in her official capacity.

13. Defendant United States of America is the federal sovereign.

JURISDICTION AND VENUE

14. This Court has subject-matter jurisdiction under 28 U.S.C. § 1331 because this suit concerns the legality of actions taken by federal agencies and federal officers in their official capacities.

15. The Court is authorized to award the requested declaratory and injunctive relief under 5 U.S.C. §§ 702 and 706, 28 U.S.C. § 1361, 28 U.S.C. §§ 2201-2202, Federal Rules of Civil Procedure 57 and 65, and by the Court's general legal and equitable powers.

16. Venue lies in this district pursuant to 28 U.S.C. § 1391(e)(1)(B) because the United States, two of its agencies, and two of its officers in their official capacities are defendants. Plaintiff Texas resides in this judicial district, and a substantial part of the events or omissions giving rise to Texas's claims occurred in this district. Texas previously sued these same defendants in this Court to prevent CMS from arbitrarily revoking its approval of Texas's request to extend and amend the State's managed-care system, *see Texas v. Brooks-LaSure*, No. 6:21-cv-00191, 2021 WL 5154219, at *1 (E.D. Tex. Aug. 20, 2021), and the defendants did not challenge venue in that case. Moreover, the first federal audit, initiated by the HHS Office of the Inspector General

to ensure that a Texas jurisdiction is in compliance with the bulletin, is of Smith County. That action began roughly contemporaneously with CMS approving Texas's state directed payment programs (SDPs) to avoid sanctions in the last suit. The audit has occurred and will continue to occur in this judicial district and division.

BACKGROUND

I. Overview of Medicaid and Hold Harmless Provisions

A. Medicaid's cooperative federalism framework

17. Medicaid is designed as a cooperative federal-state program that has provided medically necessary healthcare to low-income families and individuals with disabilities since 1965. *See* 42 U.S.C. § 1396 *et seq.*; *Ark. Dep't of Health & Hum. Servs. v. Ahlborn*, 547 U.S. 268, 275 (2006). At the federal level, Medicaid is administered by the Secretary of Health and Human Services, who in turn exercises his authority through CMS. *Ahlborn*, 547 U.S. at 275. At the state level, participating States are required to designate a single agency to administer their Medicaid programs. *See* 42 U.S.C. § 1396a(a)(5). HHSC fills that role for the State of Texas.

18. A State that chooses to participate in the Medicaid program—as all States, including Texas have—must submit a state Medicaid plan to CMS for federal approval. 42 U.S.C. § 1396a. After CMS approves the state plan, "the state administers Medicaid with little to no federal oversight," *Texas v. Brooks-LaSure*, No. 6:21-cv-00191, 2022 WL 741065, at *2 (E.D. Tex. Mar. 11, 2022), and the participating State is entitled to receive reimbursement from the federal government for the federal share of specified covered services. 42 U.S.C. § 1396b; 42 C.F.R. § 430.30(a)(1).

19. The federal share of a participating State's Medicaid expenditures is primarily based on the federal medical assistance percentage (FMAP). *See* 42 U.S.C. § 1396d(b), 42 U.S.C. § 1396b(a). In Texas, that percentage is presently approximately 60%. The compensation to which a State is entitled can also include supplemental Medicaid payments such as payments for incentive arrangements, pass-through payments, and directed payment programs. 42 C.F.R. § 438.6. "Although the federal contribution to a State's Medicaid program is referred to as a 'reimbursement,' the stream of revenue is actually a series of huge quarterly advance payments that are based on the State's estimate . . . of future expenditures." *Bowen v. Massachusetts*, 487 U.S. 879, 883-84 (1988) (citing 42 U.S.C. § 1396b(d)).

B. The Social Security Act's prohibition on hold harmless provisions

20. To receive reimbursements from the federal government, States must provide assurances that they have adequate methods to pay the state share of Medicaid. *See* 42 U.S.C. § 1396b; 42 C.F.R. § 430.30.

21. Congress passed the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments in 1991, which addresses CMS's authority to restrict or reduce federal matching funds for Medicaid. Pub. L. No. 102-234, § 2, 105 Stat. 1793 (1991) (adding subsection 1903(w), codified at 42 U.S.C. § 1396b(w), to the Social Security Act).

22. The 1991 amendments require a reduction in the amount of patient-care costs for which the States may seek reimbursement—and which are used to calculate

the federal financial participation payment—when the State obtains revenues from certain sources. *See* 42 U.S.C. § 1396b(w)(1)(A).

23. Relevant here, the amendments require the amount of the State's requested reimbursement to be "reduced by the sum of any revenues received by the State" through a "broad-based health-care-related tax" that operates as "a hold harmless provision." *Id.* § 1396b(w)(1)(A)(iii). The amendments include three definitions of a "hold harmless provision." The first is when the State or local government entity "provides (directly or indirectly) for a payment . . . to taxpayers" that 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." *Id.* § 1396b(w)(4)(A). The second is when "[a]ll or any portion of the payment made under this subchapter to the taxpayer varies based only upon the amount of the total tax paid." *Id.* § 1396b(w)(4)(B). And the third, and the subject of the February 17 bulletin, is when the State or local government entity "provides (directly or indirectly) for any payment, offset, or waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax." *Id.* § 1396b(w)(4)(C)(i).

C. CMS's regulations implementing the 1991 amendments

24. In 1993, HHS promulgated a rule to implement these amendments. *See* Medicaid Program; Limitations on Provider-Related Donations and Health Care-Related Taxes; Limitations on Payments to Disproportionate Share Hospitals, 58 Fed. Reg. 43,156 (Aug. 13, 1993) (codified at 42 C.F.R. §§ 433, 447).

25. The regulations incorporate the Social Security Act's definition of a hold harmless provision into subsection (f) of 42 C.F.R. § 433.68 by "set[ting] out the three

ways of finding a 'hold harmless provision' for a state tax program." *Brooks-LaSure*, 2022 WL 741065, at *5 (setting out this history).

26. The regulation also "added detail on the third hold harmless definition" by adopting a two-part test—later formally adopted by Congress—for determining when the government entity's levy of an excessive amount of taxes on a healthcare provider rises to the level of a hold harmless "guarantee." *Id.* at *5-6; *see also* Medicaid Program; Limitations on Provider-Related Donations and Health Care-Related Taxes; Limitations on Payments to Disproportionate Share Hospitals 57 Fed. Reg. 55,129-30 (Nov. 24, 1992) (interim final rule).

27. Under that test, "[i]f the tax on the providers' revenue was at or below 6% (selected as the national average sales tax), the tax would be assumed permissible," but if "the tax was above 6%," "a numerical test would deem a hold harmless situation to exist when Medicaid rates are used to repay (within a 12-month period) at least 75 percent of providers for at least 75 percent of their total tax cost." *Brooks-LaSure*, 2022 WL 741065, at *5 (citing 57 Fed. Reg. at 55,142-55,143).

28. Twelve years elapsed until a new development, spurred by CMS's own internal adjudicative body, prompted CMS to again take regulatory action. In 2005, after years of litigation, HHS's Departmental Appeals Board rejected CMS's effort to retroactively disallow years of federal funding to five States based on an overbroad interpretation of what constitutes a hold harmless provision. Specifically, without basis in statute, CMS had determined that certain state programs providing grants to nursing homes or tax credits to patients constituted impermissible hold harmless

provisions under CMS's regulations. *See Brooks-LaSure*, 2022 WL 741065, at *6-7 (citing *In re: Hawaii Dep't of Human Servs.*, Docket No. A-01-40, 2005 WL 1540188 (Dep't Appeals Bd., Appellate Div. June 24, 2005)).

29. The Board held, however, that the programs at issue did not meet either the first or third definitions of a hold harmless provision. *Id.* As to the third definition, the Board explained that no language in the States' grant or credit programs offered an explicit or direct assurance of any payment to a taxpayer-provider, and it rejected CMS's argument that the third definition was merely a "broad catch-all provision." *Id.* at *6. Ultimately, the Board found that for a state taxing authority to guarantee a payment, offset, or waiver the Board expected to see a "legally enforceable promise" in "these States' laws." *Id.* at *7.

30. Following the Board's ruling, CMS's enforcement arm sought to alleviate the purported "confusion" that the ruling caused and "clarify" the tests for finding an impermissible hold harmless arrangement. *See, e.g.*, Medicaid Program; Health Care-Related Taxes, 73 Fed. Reg. 9,685, 9,686, 9,690 (Feb. 22, 2008) (final rule). CMS amended the regulatory definition of the third hold harmless provision to "cover[] the situation where a government provides for a certain financial measure 'such that' the measure guarantees" the taxpayer will be held harmless. *Brooks-LaSure*, 2022 WL 741065, at *8. This was a departure from the statutory definition in which Congress defined a hold harmless provision to include "certain financial measure[s] 'that guarantees' indemnification." *Id.* at *7. This change "deliberate[ly]"

"remove[d] the statute's tight grammatical link between *the government*, as the actor providing for something, and *a guarantee*, as the thing provided for." *Id.*

31. As a result of the agency's "loosen[ing]" of the required link between the state taxing authority and the guarantee itself, CMS has contended that the third definition "focus[es] on the 'reasonable expectation' [of the taxpayer] about the 'result' of a state payment, as opposed to what the state provided when making a payment." *Id.* (citing 73 Fed. Reg. 9,694-95).

D. CMS's failed 2019 amendment efforts

32. In 2019, CMS tried to stretch the definition of a hold harmless provision in section 1396b(w)(4)(C)(i) even farther to cover private, non-governmental arrangements. *See* Medicaid Program; Medicaid Fiscal Accountability Regulation, 84 Fed. Reg. 63,722, 63,742 (Nov. 18, 2019).

33. CMS's proposed rule conflicted with the agency's prior representations to providers across the country. In early 2019, Kristin Fan, then Director of CMS's Financial Management Group, told counsel for concerned providers that though CMS is "aware that there may be arrangements" between providers that CMS may "not particularly like," CMS "do[es] not have statutory authority to address" those arrangements. Fan also agreed that States should not be expected "to seek information about these agreements or providers to disclose these agreements to the state/local government in connection with CMS' questions." This exchange was widely circulated across the country.

34. In the proposed rule, issued only nine months later, CMS took a different approach entirely. The proposal said that the agency had "become aware of

impermissible arrangements that exist where a state or other unit of government imposes a health-care related tax, then uses the tax revenue to fund the non-federal share of Medicaid payments back to the taxpayers." 84 Fed. Reg. at 63,734. Critically, CMS clarified that it considered such arrangements to violate the law even if "a private entity makes the redistribution" to another private entity. *Id.* at 63,735. It reasoned that a purely private arrangement still "constitutes an indirect payment from the [S]tate or unit of government to the entity being taxed that holds it harmless for the cost of the tax." *Id.* That is because "[t]he taxpayers have a reasonable expectation to be held harmless for all or a portion of their tax amount." *Id.* at 63,734.

35. As a result, CMS proposed to amend 42 C.F.R. § 433.68(f)(3) to specify that CMS would consider the "net effect" of a particular arrangement—*i.e.*, whether the "net effect" is a "reasonable expectation" by the taxpayer that it will recoup all or a portion of its tax payment through Medicaid payments—to determine whether a hold harmless arrangement exists. *Id.* at 63,735.

36. CMS received more than 10,000 comments on the proposal, many of which faulted CMS for "lack[ing] statutory authority" and "creating regulatory provisions that were ambiguous or unclear and subject to excessive Agency discretion." This ultimately led CMS to "withdraw the proposed provisions." Medicaid Program; Medicaid Fiscal Accountability Regulation, 86 Fed. Reg. 5,105, 5,105 (Jan. 19, 2021).

37. One such commenter was Daniel Tsai—the author of the February 17 bulletin and CMS's current Deputy Administrator and Director for the Center for

Medicaid and CHIP Services—who was then serving as the Medicaid Director for the State of Massachusetts. Tsai explained that the proposed rule—including its "'net effect[]' test"—"introduce[d] new state obligations" and "significant administrative and operational burdens" that "represent[ed] an unprecedented federal overreach," "exceed[ed] CMS' statutory authority," contain[ed] "provisions [that] are highly susceptible to arbitrary and capricious application," "[was] not supported by the underlying statute," and "includ[ed] reporting on business dealings of private entities that are not available to the state." HHSC submitted a similar comment letter along those lines, as did many others.

II. Overview of Texas Medicaid[1] and the State's Funding Mechanisms

38. To allow flexibility from the default requirements of the Social Security Act, CMS may issue a waiver that exempts a State from those otherwise mandatory requirements. One common waiver is authorized by section 1115 of the Act, codified at 42 U.S.C. § 1315. Such a waiver allows a State to implement an "experimental, pilot, or demonstration project" that diverges from federal requirements so long as

[1] A more fulsome background of the Texas Medicaid system, including its section 1115 waiver, is available in Texas's First Amended Complaint from its earlier-filed lawsuit, which is expressly incorporated herein by reference. *See Texas v. Brooks-LaSure*, No. 6:21-cv-00191 (E.D. Tex. Aug. 31, 2021), ECF No. 54. To avoid burdening the Court, this complaint discusses only those aspects of Texas Medicaid necessary for resolving the parties' current dispute, which was first litigated in the context of Texas's motion to enforce the Court's preliminary injunction. *See id.*, Mot. to Enforce J., (Nov. 2, 2021), ECF No. 75; *id.*, Reply in Supp. of Mot. to Enforce J., (Nov. 22, 2021), ECF No. 84.

CMS00605cv1712

the project "is likely to assist in promoting the objectives" of Medicaid. 42 U.S.C. § 1315(a).

39. In 2011, Texas applied for and received a section 1115 waiver for a demonstration project called the Texas Healthcare Transformation and Quality Improvement Program. The waiver allowed Texas to transition its Medicaid program from a fee-for-service model to a managed-care model. Through that updated model, Texas contracts with health-insurance companies to deliver healthcare services through Medicaid. The State pays a monthly capitation payment to a managed care organization for each Medicaid recipient, which reduces the overall state and federal government Medicaid expenditures by encouraging recipients to take advantage of preventative care.

40. The Texas Legislature authorized another important change to Medicaid in 2013. In addition to furthering the transition to a managed-care model, as was discussed in the prior lawsuit, Texas law was amended to allow designated hospital districts, counties, and municipalities to "administer a healthcare provider participation program to provide additional compensation to certain hospitals located in the hospital district, county, or municipality by collecting mandatory payments from each of those hospitals to be used to provide the nonfederal share of a Medicaid supplemental payment program[.]" Tex. Health & Safety Code § 300.0001; *see* Act of May 24, 2013, 83d Leg., R.S., ch. 1369, 2013 Tex. Gen. Laws 3630 (codified at Tex. Health & Safety Code ch. 288); Tex. Health & Safety Code ch. 288–300A.

CMS00606cv1712

41. These mandatory payments are deposited into a Local Provider Participation Fund (LPPF), which is a dedicated-purpose account that local governments may use for certain statutorily authorized purposes, including intergovernmental transfers to HHSC to support specified Medicaid programs. HHSC uses these statutorily permitted local funds as the non-federal share of Medicaid funds that are then matched with federal funds.

42. The LPPFs are managed by local government entities and are subject to a host of relevant restrictions. If the government entity authorizes a healthcare provider participation program, it must require an annual mandatory payment to be assessed based upon the net patient revenue of each institutional healthcare provider located in the applicable local unit of government.[2] Tex. Health & Safety Code § 300.0151. Money deposited into the local provider participation fund is authorized for limited purposes, including the intergovernmental transfers from the local government to the State to provide the state share of Medicaid payments for statutorily specified Medicaid programs. *See* Tex. Health & Safety Code § 300.0103(b)(1). The levies imposed by the local unit of government must be broad-based and uniform, as required under federal law. *See id.* § 300.0151(b). All local governments authorized to collect mandatory payments in LPPFs are prohibited from assessing mandatory payments that exceed six percent of net patient revenue. *Id.*

---

[2] The Texas statutes which authorize hospital districts to collect and deposit mandatory payments into LPPFs explicitly state that such mandatory payments are not taxes for the purposes of Article IX of Texas Constitution. However, these payments are considered healthcare-related taxes for purposes of federal law. *See, e.g.*, 42 U.S.C. § 1396b(w)(3)(A); 42 C.F.R. § 433.55.

§ 300.0151(c). And consistent with the Social Security Act, Texas law specifically prohibits these programs from holding harmless any institutional healthcare provider. *Id.* § 300.0151(b).

43. CMS encouraged Texas to implement these funds, which have grown more important to the State over time. Collectively, the funds comprised about 17.7% of Texas's state share of Medicaid funding in the last fiscal year. HHSC expects this trend: when the funding mechanism was first piloted, it required express permission from the Legislature on a jurisdiction-by-jurisdiction basis. *E.g.*, 2013 Tex. Gen. Laws 3630. With the encouragement of CMS, the Texas Legislature has since made the authorization more general. Tex. Health & Safety Code §§ 300.0001, .0003.

44. As the statewide administrator of Texas Medicaid, HHSC ensures that the authority that administers each LPPF does not provide for any payment, offset, or waiver that directly or indirectly guarantees to hold the taxpaying providers harmless for any portion of their tax costs. But HHSC does not have statutorily conferred taxing or regulatory authority over the local government entities that manage those funds, nor does HHSC have authority to examine or consider any contractual arrangements that might exist between private businesses whose taxes contribute to those funds.

45. The taxes that flow into those funds are unrelated to the methodology for calculating the Medicaid reimbursements that HHSC disburses to healthcare providers. The State does not make any such reimbursements based on the amount that a provider is taxed by a local government. Instead, Medicaid payments to

providers are based exclusively on programmatic methodologies that consider, among other factors, what an estimated Medicare or average commercial payer would have paid for those same services.

46. CMS has approved SDPs that use LPPF to fund as the non-federal share. Those programs include:

- The Comprehensive Hospital Increase Reimbursement Program (CHIRP), which began on September 1, 2021, (but not approved by CMS until March 25, 2022) and replaced a prior directed payment program no longer in effect. CHIRP provides increased Medicaid payments to hospitals for inpatient and outpatient services to eligible recipients. On August 1, 2022, CMS renewed approval for CHIRP for the program period covering September 1, 2022, to August 31, 2023.

- The Quality Incentive Payment Program (QIPP), which is a performance-based payment program designed to incentivize eligible nursing facilities to improve the quality and innovation of their services. CMS has approved this program for six straight years (but delayed approval for the program period that began on September 1, 2021, until November 15, 2021). On August 1, 2022, CMS approved QIPP for the program period covering September 1, 2022, to August 31, 2023.

- The Texas Incentives for Physicians and Professional Services (TIPPS) program, which began on September 1, 2021 (but not approved by CMS until March 25, 2022), provides increased Medicaid payments to certain physician groups providing healthcare services to eligible Medicaid recipients. On August 1, 2022, CMS renewed approval for TIPPS for the program period covering September 1, 2022, to August 31, 2023.

- The Rural Access to Primary and Preventive Services (RAPPS) program, which began on September 1, 2021 (but not approved by CMS until March 25, 2022), is designed to incentivize rural health clinics that provide primary and preventive care services to eligible Medicaid recipients in rural areas of Texas. On August 1, 2022, CMS renewed approval for RAPPS for the program period covering September 1, 2022, to August 31, 2023.

- The Directed Payment Program for Behavioral Health Services (DPP BHS), which began on September 1, 2021 (but not approved by CMS until November 15, 2021), is designed to promote and improve access to

behavioral health services, coordination of care, and successful care transitions for eligible Medicaid recipients. On August 1, 2022, CMS renewed approval for DPP BHS for the program period covering September 1, 2022, to August 31, 2023.

47. The directed payment programs are complex, and Texas must have its directed-payment-program proposals, called "preprints," approved annually by August to process the payments the following September. Texas typically submits the preprints to CMS for approval in March. In total, CMS has approved pre-prints that contemplate the use of LPPFs at least nine times since the funds were first introduced in 28 local jurisdictions. CMS has also issued federal financial participation for the Delivery System Reform Incentive Payment (DSRIP) program and the Uncompensated Care (UC) program, which have used LPPF funds at least four times per year since 2016.

III. CMS's Initial Encouragement of LPPFs and Sudden About-Face

48. CMS has been involved in the development of LPPFs in Texas from the outset of their existence. It was at CMS's encouragement that the Texas Legislature began authorizing LPPFs for certain jurisdictions. Later, in 2018 and 2019, CMS and Texas had lengthy discussions about the structure of LPPFs. At the time, Texas and CMS were working to resolve a disallowance that had been issued by CMS related to funds transferred from government entities in Dallas and Tarrant Counties. (Texas challenged the disallowance, and litigation is ongoing.) CMS reviewed the structure of the proposed LPPFs in Dallas and Tarrant Counties and allowed Texas to substitute funds derived from the LPPFs operated by the hospital districts in those counties for the disallowed funds.

CMS00610cv1712

49. Texas has long understood that its LPPFs do not run afoul of the Social Security Act's hold harmless prohibition and structured its regulatory regime accordingly. That understanding was gained in part based on CMS's assurances. In early 2019, HHSC first became aware of the possibility that business agreements might exist between private entities. HHSC officials promptly contacted CMS for guidance. CMS assured HHSC that, so long as neither the State nor a unit of local government was providing a guarantee, there was no prohibition on private business arrangements. This assurance was consistent with the email discussed above from Kristin Fan that was circulated to providers across the country around that same time.

50. Texas continued to rely upon that assurance in setting up its team that monitors local funds used as the non-federal share in the Medicaid program, including funds that are transferred to HHSC from a LPPF. Unfortunately, since the withdrawal of the 2019 proposed rule, CMS has reneged on its word and twice unsuccessfully sought to force HHSC to police private agreements.

51. During negotiations over the extension of the State's demonstration project (which was set to expire in September 2022), CMS attempted to insert special terms and conditions imposing many of the same requirements from the withdrawn proposed rule. Because those terms would have been inconsistent with the Social Security Act, Texas refused to agree to the requested terms and conditions.

52. On January 15, 2021, CMS informed Texas that its extension application was approved for a ten-year period ending on September 30, 2030. Just

three months later, on April 16, 2021, CMS reversed course and rescinded that approval. Texas challenged CMS's decision, and this Court issued a preliminary injunction obligating "defendants to treat Texas's demonstration project (Waiver Number 11-W-00278/6) as currently remaining in effect as it existed on April 15, 2021." *Brooks-LaSure*, 2021 WL 5154219, at *15.

53. As a result of that preliminary injunction, defendants were prohibited from implementing the rescission letter. The Court's orders made clear that CMS was required to treat the demonstration project as remaining in effect and to cooperate with Texas in negotiating various terms, including negotiating the approval of Texas's SDPs. *Brooks-LaSure*, 2022 WL 741065, at *10; *see also, e.g.*, *Texas v. Brooks-LaSure*, No. 6:21-cv-00191, 2021 WL 5154086, at *1-2 (E.D. Tex. Aug. 12, 2021).

54. Despite the Court's instructions, CMS attempted to impose the rejected LPPF-related terms by holding approval of five SDPs hostage until Texas would agree to CMS's terms to police private arrangements. That effort failed, too, but only after Texas returned to this Court to compel CMS to promptly issue a final decision on those SDPs. *Brooks-LaSure*, 2022 WL 741065, at *10. Even then, CMS would not withdraw its demand until this Court threatened to impose sanctions. *See id.*; Notice of Compliance with Order, *Texas v. Brooks-LaSure*, No. 6:21-cv-00191, (E.D. Tex. Mar. 25, 2022), ECF No. 100 (confirming that CMS approved the SDPs).

55. Ultimately, under threat of sanction by this Court, CMS approved the state directed payment programs, which was the only remaining issue in the prior lawsuit, and the case was dismissed.

IV. OIG Audits and the February 17 Bulletin

56. On November 29, 2021, the HHS Office of the Inspector General (OIG) announced an audit workplan of "States' Use of Local Provider Participation Funds as the State Share of Medicaid Payments." The choice of wording was unusual: OIG did not announce a review of provider taxes categorically, or even provider taxes operated by units of local government. Instead, OIG specifically identified a review of "Local Provider Participation Funds," which is the term that Texas (and a limited number of other States) uses in state statutes authorizing this method of finance for units of local government.

57. On March 25, 2022, at approximately the same time that CMS finally agreed to the state directed payment programs contemplated by the 2021 waiver extension, OIG notified Texas that the State was selected for OIG's audit of LPPFs and held an entrance conference with Texas on April 14, 2022. After collecting information from Texas about the operation of LPPFs in this State, OIG selected Smith County, the home county for this Court, for a detailed review. OIG officials contacted Smith County and asked for information regarding private business agreements to which Smith County is not a party. The officials informed Texas that the audit would take approximately 12 months to complete, and that OIG would issue its report, including any findings, in the summer of 2023.

58. On February 17, 2023, the Deputy Administrator and Director of the Center for Medicaid and CHIP Services at CMS issued a bulletin announcing a retroactive change in CMS's definition of a hold harmless arrangement. *See* Ex. A. Without the notice and comment that CMS acknowledged was necessary when it

issued the 2019 proposed rule change, the bulletin pronounced that an agreement between private providers to redistribute Medicaid payments constitutes "a hold harmless arrangement involving Medicaid payment redistribution" if there is a "reasonable expectation" that the taxpaying providers will receive a portion of their provider tax costs returned as part of a private agreement. *Id.* at 3.

59. CMS described how, in its view, "taxpayers appear to have entered into oral or written agreements" to redirect or redistribute their Medicaid payments "to ensure that all taxpayers receive all or a portion of their tax back." *Id.* at 3. Notwithstanding the acknowledged absence of state participation in such agreements, CMS concluded they were impermissible because "[t]he redistributions occur so that taxpaying providers are held harmless for all or a portion of the health care-related tax." *Id.*

60. Without pointing to any statutory authority, the bulletin further stated CMS "intends to inquire about potential redistribution arrangements and may conduct detailed financial management reviews of healthcare-related tax programs that appear to include redistribution arrangements or that CMS has information may include redistribution arrangements." Ex. A at 5. Henceforth, States are expected "to make available *all requested documentation* regarding arrangements involving possible hold harmless arrangements and the redistribution of Medicaid payments" as part of CMS's "oversight activities and review of state payment proposals[.]" *Id.* (emphasis added).

61. CMS threatened to "take enforcement action as necessary" if an audit uncovers "impermissible financing practices." *Id.* And without regard to whether the requested documentation exists, CMS ominously warned that a State's failure to supply requested documentation regarding redistribution arrangements "may result in a deferral or disallowance of federal financial participation." *Id.*

62. After the bulletin was issued, OIG moved up the expected timeframe for completion of its report on Smith County to May 2023. On March 1, 2023, OIG sent a letter to HHSC indicating its intent to conduct new audits of local provider participation funds in Amarillo, Tarrant, and Webb counties. The "objective" of the second audit "is to determine whether the State agency adhered to the hold-harmless provisions in Federal regulations."

63. On March 9, 2023, OIG notified Texas that it had changed the original audit objective of the Smith County LPPF audit (referenced in paragraph 57) from the broad examination of whether LPPF funds were permissible and in accordance with state and federal law to the much narrower objective utilized in the new audit of the three additional local government entities.

V. Immediate and Long-Term Effects of the Bulletin on Texas

64. This bulletin, if allowed to be implemented, will have an immediate impact on not just HHSC's ability to provide vitally needed healthcare services to Texans but also on Texas's sovereign interest in enforcing its laws.

65. Relying on the text of both the Social Security Act and CMS's existing regulations, the Texas Legislature has never deemed it necessary to create a

CMS00615cv1712

regulatory body with authority to examine contractual agreements that might exist between two private businesses. Nor has the Legislature ever seen fit to provide HHSC with such authority. As a result, to comply with the bulletin, HHSC will have to arrogate power to itself that it lacks under state law.

66. Beyond that injury to its sovereignty, Texas faces significant monetary costs to comply with the bulletin: it would be required to establish and operate a regulatory entity with sufficient resources to examine the contractual arrangements and financial management of every private hospital that exists in a jurisdiction with a LPPF. Ex. A at 5 (States are expected "to make available all requested documentation regarding arrangements involving possible hold harmless arrangements and the redistribution of Medicaid payments."). That is the only way Texas could accurately determine what private contractual relationships exist and whether those contracts are related to their provider tax payments. Texas would then need to take decisive action to halt private contractual agreements that fall within the scope of the bulletin's definition of a hold harmless arrangement. Ex. A at 5 (States must "take steps to curtail these practices if they exist.").

67. HHSC estimates that to achieve compliance, it will need to expend tens of millions of dollars and hire many new staff. There are 304 privately-owned hospitals located in jurisdictions that currently have a LPPF, 27% of which are not-for-profit organizations. Texas hospitals are extremely complex organizations, which have innumerable private contracts with various types of entities that Texas would

be required to examine to determine whether each contract constituted hold harmless arrangements under the bulletin's vague definitions.

68. Because current law only requires HHSC to monitor agreements involving local government entities, HHSC currently employs only about a dozen compliance staff aimed at ensuring no impermissible hold harmless provisions exist. HHSC would need to hire hundreds of additional staff to "curtail" any actions that might be inconsistent with the bulletin: those staff would include professionals like auditors, financial examiners, financial analysts, and attorneys who could competently interpret the thousands (potentially millions) of contracts or other business arrangements at each hospital and the billions of dollars of revenues and expenditures that are associated with the running of those hospitals.

69. HHSC would also need to investigate private associations or individual citizens who may have financial or other contractual relationships with any Medicaid provider that is assessed a mandatory payment as part of a LPPF. And at that juncture, HHSC would risk transgressing the First Amendment, which protects the free-association rights of individuals and nonprofit organizations—including nonprofit hospital associations.

70. The last several years have been challenging for Texas Medicaid: the pandemic, combined with CMS's past conduct that precipitated Texas's earlier lawsuit, have put providers and patients on edge. CMS's latest salvo threatens to undermine the work that HHSC has done to restore confidence in the Texas Medicaid Program and is destabilizing to the safety net that Texans enrolled in the Medicaid

program rely on to provide them life-saving care. LPPFs fund nearly a fifth of Texas's state share of Medicaid expenditures. Moreover, LPPFs are typically operated by hospital districts and other local government entities—meaning that CMS's current effort to shut off Medicaid funding is aimed at the very local government entities that are charged with creating an aspect of the entire social-safety net that serves emergent or acute medical needs. In Texas, most hospital associations are non-profits and, to comply with the bulletin, HHSC would be compelled to examine them to evaluate any financial relationship they might have with hospitals located in jurisdictions that operate LPPFs. Texas hospitals cannot afford, and the Texans they serve cannot afford, the type of uncertainty in future funding that has resulted from the bulletin.

CLAIMS

Count I

The February 17 Bulletin Exceeds CMS's Statutory Authority and is Not in Accordance with Law (5 U.S.C. § 706)

71. Plaintiffs incorporate by reference all preceding paragraphs.

72. Under the APA, a court must "hold unlawful and set aside agency action" that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law" or "in excess of statutory . . . authority, or limitations, or short of statutory right." *See* 5 U.S.C. § 706(2)(A), (C).

73. The February 17 bulletin defines a hold harmless arrangement to reach agreements solely between private healthcare providers. Defendants lack statutory and regulatory authority to issue a definition of a hold harmless arrangement that

contradicts the plain language of the Social Security Act and CMS's own agency rules. *See* 42 U.S.C. § 1396b(w)(4); *see also* 42 C.F.R. § 433.68(f)(3).

74. The Social Security Act's definition of a prohibited hold harmless provision does not encompass private agreements exclusively between private providers. Instead, the Act requires that a) *the State or other unit of government* imposing the tax provide the payment, offset, or waiver, and b) the payment, offset, or waiver guarantees to hold taxpayers harmless for any portion of the tax. 42 U.S.C. § 1396b(w)(4)(C)(i). The redistribution agreements between private providers that CMS described in the February 17 bulletin are not hold harmless arrangements because they do not involve "[t]he State or other unit of government imposing the tax" acting to hold taxpayers harmless. *Id.* § 1396b(w)(4)(C)(i).

75. The bulletin also elevates a legally unenforceable "expectation" to the level of a guarantee, which is contrary to the plain meaning of the term "expectation." There is no indication that Congress intended for "guarantee" to have any definition other than its plain meaning.

76. Defendants did not act in accordance with the law and exceeded their statutory and regulatory authority when promulgating and relying upon the February 17 bulletin. Accordingly, the bulletin should be set aside.

Count II

The February 17 Bulletin Did Not Comport with the Requirements of Notice-and-Comment Rulemaking (5 U.S.C. § 553)

77. Plaintiffs incorporate by reference all preceding paragraphs.

78. The February 17 bulletin is a substantive or legislative rule that required notice-and-comment rulemaking under the APA. *See* 5 U.S.C. § 553. The bulletin is not exempt from the APA's notice-and-comment requirements as the bulletin is not an interpretive rule, general statement of policy, or the rule of agency organization, procedure, or practice. *See id.* § 553(b)(A).

79. "Agencies have never been able to avoid notice and comment simply by mislabeling their substantive pronouncements." *Azar v. Allina Health Servs.*, 139 S. Ct. 1804, 1812 (2019). "On the contrary, courts have long looked to the *contents* of the agency's action, not the agency's self-serving *label*, when deciding whether statutory notice and comment demands apply." *Id.*

80. CMS acknowledged that defining hold harmless arrangements to include agreements to which neither the State nor local government entities were a party is a substantive rule requiring notice-and-comment rulemaking when it initiated such a process in 2019. That conclusion was proven correct by the thousands of comments submitted to CMS discussing not only its lack of statutory authority but also the real-world obligations that the proposed rule would impose on both private parties and the States.

81. Moreover, the bulletin easily meets the definition of a legislative rule requiring notice and comment. Specifically, courts "evaluate two criteria to distinguish policy statements from substantive rules: whether the rule (1) impose[s] any rights and obligation and (2) genuinely leaves the agency and its decision-makers

free to exercise discretion." *Texas v. United States*, 809 F.3d 134, 171 (5th Cir. 2015) ("*DAPA*") (quotation marks omitted).

82. Here, the bulletin imposes rights and obligations and does not leave CMS and its decisionmakers free to exercise discretion regarding the scope of the Social Security Act's hold harmless prohibition: because of the bulletin, "an arrangement in which providers receive Medicaid payments from the state (or from a state-contracted managed care plan), then redistribute those payments such that taxed providers are held harmless for all or any portion of their cost of the tax, would constitute a prohibited hold harmless provision under" the Social Security Act. Ex. A at 5.

83. CMS is *required* to "reduce a state's medical assistance expenditures by the amount of healthcare-related tax collections that include hold harmless arrangements, prior to calculating federal financial participation." *Id.* The bulletin is therefore substantive because it imposes more than "derivative, incidental, or mechanical burdens" and it "change[s] the substantive standards by which" CMS determines how to enforce the Social Security Act and its implementing regulations. *DAPA*, 809 F.3d at 176; *Texas v. EEOC*, 933 F.3d 433, 443-46 (5th Cir. 2019).

84. The February 17 bulletin is invalid because CMS failed to use the proper notice-and-comment procedures required by the APA. *See* 5 U.S.C. §§ 553, 706.

Count III

The February 17 Bulletin Is Arbitrary and Capricious (5 U.S.C. § 706)

85. Plaintiffs incorporate by reference all preceding paragraphs.

86. Federal administrative agencies are required to engage in reasoned decision-making. "Not only must an agency's decreed result be within the scope of its lawful authority, but the process by which it reaches that result must be logical and rational." *Allentown Mack Sales & Serv., Inc. v. NLRB*, 522 U.S. 359, 374 (1998). And when an agency reverses "prior policy," it must provide a "detailed justification" for doing so. *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515-16 (2009) (plurality op.).

87. The February 17 bulletin is arbitrary and capricious because it fails to acknowledge CMS's change in position. In 2019, CMS acknowledged the absence of statutory or regulatory authority to police, or require States to police, private provider agreements under the Social Security Act. The bulletin reaches the exact opposite conclusion, with no explanation (or even acknowledgement) of that change in position. The bulletin therefore cannot survive arbitrary-and-capricious review.

88. "[A]gencies must typically provide a 'detailed explanation' for contradicting a prior policy, particularly when the prior policy has engendered serious reliance interests." *BST Holdings, L.L.C. v. OSHA*, 17 F.4th 604, 614 (5th Cir. 2021) (quoting *Fox*, 556 U.S. at 515); *see DHS v. Regents of the Univ. of Cal.*, 140 S. Ct. 1891, 1913 (2020) (applying this principle even when there were serious questions as to the legality of the rule to be rescinded). The February 17 bulletin fails to discuss the reliance interests of States like Texas that have never needed to police redistribution agreements between private providers, and which now lack the structural and financial systems necessary to comply with CMS's edict.

89. The bulletin also fails to discuss Medicaid recipients' need for access to care that is funded by LPPFs. CMS well knows that Texas relies on $3 billion from LPPFs as part of the non-federal share of Medicaid payments. Withholding federal matching funds for this large amount of funding based on the State's inability to immediately comply with the bulletin, as CMS has threatened, Ex. A at 5-6, would devastate Texas's Medicaid finances, significantly destabilize the State's Medicaid provider network, and jeopardize the availability of options for quality healthcare for all Texans, including Medicaid recipients.

90. Moreover, agency action may be set aside as arbitrary and capricious if the agency fails to "comply with its own regulations." *See Environmental, LLC v. FCC*, 661 F.3d 80, 85 (D.C. Cir. 2011). The bulletin is inconsistent with CMS's implementing regulations, that specify that a hold harmless provision exists where "[t]he State (or other unit of government) imposing the tax provides for any direct or indirect payment, offset, or waiver such that the provision of the payment, offset, or waiver directly or indirectly guarantees to hold taxpayers harmless for all or any portion of the tax amount." *See* 42 C.F.R. § 433.68(f)(3). CMS's bulletin therefore conflicts not just with the text of the Social Security Act but with the agency's own regulations, and should be set aside on this basis, too.

91. Based on these and other flaws, the bulletin should be set aside as arbitrary and capricious.

Count IV

Alternatively, the 2008 Rule Is Not in Accordance with Law (5 U.S.C. § 706)

92. Plaintiffs incorporate by reference all preceding paragraphs.

93. CMS has taken the position that the February 17 bulletin was supported by the preamble to the 2008 rule. This is legally incorrect as a rule's preamble cannot impose obligations that are inconsistent with the rule's text. *See Entergy Servs., Inc. v. FERC*, 375 F.3d 1204, 1209 (D.C. Cir. 2004). It also misreads the preamble.

94. If the Court disagrees, however, then the 2008 rule is contrary to CMS's statutory authority and should be set aside for the reasons discussed above.

95. Although any claim challenging the process by which the 2008 rule was adopted is time-barred, 28 U.S.C. § 2401(a); *Wind River Mining Corp. v. United States*, 946 F.2d 710, 715 (9th Cir. 1991); *Texas v. United States*, 749 F.2d 1144, 1146 (5th Cir. 1985), Texas may still challenge the legality of the rule if it has been applied to Texas within the last six years, *Dunn-McCampbell Royalty Int., Inc. v. Nat'l Park Serv.*, 112 F.3d 1283, 1287 (5th Cir. 1997).

96. CMS has applied or attempted to apply its (incorrect) interpretation of the 2008 Rule multiple times since 2021: when CMS demanded the interpretation be applied as a condition of the extension of Texas's section 1115 waiver in 2021, when CMS refused to approve Texas's directed payment programs until Texas agreed to the interpretation in 2022, and now when CMS demands documents based on the interpretation of the rule in 2023.

DEMAND FOR JUDGMENT

Plaintiffs request that the Court:

a. Declare unlawful and set aside the February 17 bulletin;

b. Issue preliminary and permanent injunctive relief enjoining defendants from enforcing or implementing the February 17 bulletin against Texas;

c. Compel defendants to conduct any Medicaid audit and oversight activities against Texas in accordance with the Social Security Act and its implementing regulations and without reliance on the February 17 bulletin;

d. Award Texas the costs of this action and reasonable attorney's fees; and

e. Award such other and further relief as the Court deems equitable and just.

Dated: April 5, 2023.

Respectfully submitted.

KEN PAXTON
Attorney General of Texas

BRENT WEBSTER
First Assistant Attorney General

CHRISTOPHER H. HILTON
Chief, General Litigation Division
Texas Bar No. 24087727
Christopher.Hilton@oag.texas.gov

LEIF A. OLSON
Chief, Special Litigation Division
Texas Bar No. 24032801
Leif.Olson@oag.texas.gov

MUNERA AL-FUHAID
Special Counsel
Texas Bar No. 24094501
Munera.Al-Fuhaid@oag.texas.gov

OFFICE OF THE ATTORNEY GENERAL
P.O. Box 12548 (MC-059)
Austin, Texas 78711-2548
(512) 936-1700

JUDD E. STONE II
Solicitor General

/s/ Lanora C. Pettit
LANORA C. PETTIT
Principal Deputy Solicitor General
Lead Counsel
Texas Bar No. 24115221
Lanora.Pettit@oag.texas.gov

MICHAEL R. ABRAMS
Assistant Solicitor General
Texas Bar No. 24087072
Michael.Abrams@oag.texas.gov

WILLIAM F. COLE*
Assistant Solicitor General
Texas Bar No. 24124187
William.Cole@oag.texas.gov

*Application for admission forthcoming

Counsel for Plaintiffs

CMS00625cv1712

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TYLER DIVISION

STATE OF TEXAS; TEXAS HEALTH AND HUMAN SERVICES COMMISSION, *Plaintiffs*, v. CHIQUITA BROOKS-LASURE, in her official capacity as Administrator for the Centers for Medicare and Medicaid Services; THE CENTERS FOR MEDICARE AND MEDICAID SERVICES; XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; and the UNITED STATES OF AMERICA, *Defendants*.	Civ. Action No. ___________

Original Complaint

Exhibit A

Centers for Medicare and Medicaid Services Bulletin Feb. 17, 2023

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMCS Informational Bulletin

DATE: February 17, 2023

FROM: Daniel Tsai, Deputy Administrator and Director

SUBJECT: Health Care-Related Taxes and Hold Harmless Arrangements Involving the Redistribution of Medicaid Payments

Background

Recently, the Centers for Medicare & Medicaid Services (CMS) has been approached by several states with questions regarding the statutory and regulatory requirements applicable to health care-related taxes, including in connection with proposals to implement or renew Medicaid managed care state directed payments (SDPs) under 42 C.F.R. § 438.6(c). Many of these questions have focused on whether health care-related tax arrangements involving the redistribution of Medicaid payments among providers subject to the tax would comply with the statutory and regulatory prohibition on "hold harmless" arrangements—that is, arrangements in which the "State or other unit of government imposing the tax provides (directly or indirectly) for any payment, offset, or waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax"—as specified in section 1903(w)(1)(A)(iii) and (w)(4) of the Social Security Act (the Act) and implementing regulations. In response to these questions, this informational bulletin reiterates our longstanding position on the existing federal requirements that pertain to health-care related taxes and re-emphasizes our goal of assisting states in ensuring appropriate sources of non-federal share financing.

CMS recognizes that health care-related taxes are a critical source of funding for many states' Medicaid programs, including for payments to safety net providers. CMS supports states' adoption of health care-related taxes when they are consistent with federal requirements. CMS approves many state payment proposals annually that are supported by health care-related taxes that appear to meet federal requirements. CMS recognizes the challenges faced by states and health care providers in identifying sources of non-federal share financing and implementing Medicaid payment methodologies that assure payments are consistent with federal requirements.

Medicaid statute and regulations afford states flexibility to tailor health care-related taxes within certain parameters to meet their provider community needs and align with broader state tax policies and priorities for their Medicaid programs. CMS remains committed to providing states with technical assistance aiming to ensure that health care-related taxes used to finance the non-federal share of Medicaid expenditures meet the states' policy goals and comply with federal requirements. For example, CMS is authorized to waive the requirements that health care-related

taxes be broad-based and/or uniform, when applicable conditions are met. [1] CMS regularly works with states to approve such waivers in furtherance of state goals while complying with federal requirements.

Although the applicable statutory and regulatory provisions afford states considerable flexibility in establishing health care-related taxes, such taxes must be imposed in a manner consistent with applicable federal statutes and regulations, including that they may not involve hold harmless arrangements, to avoid a reduction in the state's Medicaid expenditures eligible for federal financial participation. Occasionally, CMS encounters health care-related tax programs that appear to contain hold harmless arrangements, which contravene section 1903(w)(1)(A)(iii) and (w)(4) of the Act and 42 C.F.R. § 433.68(b)(3) and (f). Such arrangements are inconsistent with statutory and regulatory requirements and undermine the fiscal integrity of the Medicaid program. Recently, CMS has become aware of some health care-related tax programs that appear to contain a hold harmless arrangement that involves the taxpaying providers redistributing Medicaid payments after receipt to ensure that all taxpaying providers receive all or a portion of their tax costs back (typically ensuring that each taxpaying provider receives at least its total tax amount back).

In this informational bulletin, CMS is reiterating the federal requirements concerning hold harmless arrangements with respect to health care-related taxes. Further, states and providers should be transparent regarding any explicit or implicit agreements in place or under development to ensure that all health care-related taxes meet federal requirements to avoid a statutorily required reduction in the state's Medicaid expenditures otherwise eligible for federal financial participation. CMS recommends that states that have questions or concerns about the permissibility of a health care-related tax raise these concerns to CMS early in the process of developing the state's tax program to avoid issues surrounding the permissibility of the non-federal share of Medicaid expenditures. CMS also intends to work with states that may have existing questionable arrangements to ensure compliance with federal statutory and regulatory requirements.

Health Care-Related Taxes and Hold Harmless Arrangements

During standard oversight activities and the review of state payment proposals, particularly managed care SDPs and fee-for-service payment state plan amendments (SPAs), CMS is increasingly encountering health care-related tax programs that appear to contain hold harmless arrangements involving the redistribution of Medicaid payments. In these arrangements, a state or other unit of government imposes a health-care related tax, then uses the tax revenue to support the non-federal share of Medicaid payments back to the class of providers subject to the

---

[1] For non-broad based and/or non-uniform health care related taxes, these conditions are: that the tax be imposed on a permissible class or class, that the tax be generally redistributive, that the tax be not directly correlated with Medicaid payments, and that the tax lack a hold harmless arrangement. See section 1903 (w)(3)(E)(ii) for the requirement that the tax demonstrate that it is 'generally redistributive" and "not directly correlated with Medicaid payments." For the statistical test demonstrating that the tax is "generally redistributive" see 42 CFR § 433.68 (e)(1) for waivers of the broad based requirement only and 42 C.F.R. § 433.68 (e)(2) for waivers of the uniformity requirement whether or not the tax is broad-based. See section 1903 (w)(4) and implementing regulations at 42 C.F.R. § 433.68 (f) for the hold harmless requirements. See section 1903 (w)(7) and 42 C.F.R. § 433.56 for a list of permissible classes upon which states may impose health care-related taxes.

tax. The taxpayers appear to have entered into oral or written agreements (meaning explicit or implicit meeting of the minds, regardless of the formality or informality of any such agreement) to redirect or redistribute the Medicaid payments to ensure that all taxpayers receive all or a portion of their tax back, when considering each provider's retained portion of any original Medicaid payment (either directly from the state or from the state through a managed care plan[2]) and any redistribution payment received by the provider from another taxpayer or taxpayers. These redistribution payments may be made directly from one taxpaying provider to another, or the funds may be contributed first to an intermediary redistribution pool.

In these hold harmless arrangements, there appear to be agreements among providers (explicit or implicit in nature) such that providers that furnish a relatively high percentage of Medicaid-covered services redistribute a portion of their Medicaid payments to providers with relatively low (or no) Medicaid service percentage. The redistributions occur so that taxpaying providers are held harmless for all or a portion of the health care-related tax. This may include the redistribution of Medicaid payments to providers that serve no Medicaid beneficiaries.

These tax programs appear to contain impermissible hold harmless arrangements as defined in section 1903(w)(4)(C)(i) of the Act and 42 C.F.R. § 433.68(f)(3) that require a reduction in medical assistance expenditures prior to the calculation of federal financial participation as required under section 1903(w)(1)(A) and (w)(1)(A)(iii) of the Act. Here is a detailed example of a hold harmless arrangement involving Medicaid payment redistribution:

- A state imposes a hospital tax based on the volume of inpatient hospital services provided. The tax is broad-based, uniform, and is imposed on 10 hospitals.
- Six of the hospitals serve a high percentage of Medicaid beneficiaries, three serve a low percentage of Medicaid beneficiaries, and one hospital does not participate in Medicaid.
- The state uses the tax revenue as the source of non-federal share of Medicaid payments, which are made back to nine of the hospitals through SDPs. The tenth hospital, which does not participate in Medicaid, does not receive any SDPs directly from state-contracted managed care plans.
- Nine hospitals enter into oral or written agreements (meaning an explicit or implicit meeting of the minds, regardless of the formality or informality of any such agreement) to redirect or redistribute the Medicaid payments that the eight of the nine Medicaid-participating hospitals receive. Under this arrangement, five of the six hospitals that furnish a high percentage of Medicaid-covered services receive Medicaid payments from the managed care plans, then redistribute a portion of their Medicaid payments to the remaining four hospitals with lower Medicaid service percentages (including to the one hospital that does not participate in Medicaid). The redistribution amounts are calculated to guarantee that the nine participating hospitals, including those redistributing their own payments and those receiving the redistribution amounts, receive most, all, or more than all of their total tax cost back.
- The agreement among the taxpaying hospitals results in a reasonable expectation that the taxpaying hospitals, whether directly through their Medicaid payments or due to the

[2] The term managed care plan is used here and throughout this guidance to include managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs) as defined in 42 C.F.R. § 438.2.

availability of the redistributed payments received from five of the six high Medicaid service volume hospitals (regardless of whether the funds were first pooled and then redistributed), are held harmless for at least part of their health care-related tax costs.

- The high-percentage Medicaid hospitals are willing to participate because they still financially benefit from the tax program (even net of the redistribution payments they make to the lower Medicaid service volume hospitals), and the redistribution enables broad support for the tax program from all hospitals, ensuring constituent support for the state law authorizing the tax program.

Section 1903(w)(4) of the Act describes what constitutes a hold harmless arrangement. Specifically, section 1903(w)(4)(C)(i) provides that a hold harmless provision exists where "[t]he State or other unit of government imposing the tax provides (directly or indirectly) for any payment, offset, or waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax." Implementing regulations at 42 C.F.R. § 433.68(f)(3) specify that a hold harmless arrangement exists where "[t]he State (or other unit of government) imposing the tax provides for any direct or indirect payment, offset, or waiver such that the provision of the payment, offset, or waiver directly or indirectly guarantees to hold taxpayers harmless for all or any portion of the tax amount" (emphasis added). In the preamble to the 2008 final rule amending the above-referenced regulation, CMS wrote that "[a] direct guarantee will be found when a State payment is made available to a taxpayer or a party related to the taxpayer with the reasonable expectation that the payment would result in the taxpayer being held harmless for any part of the tax (through direct or indirect payments)."[3]

The word "indirect" in the regulation, highlighted in the excerpt above, makes clear that the state or other unit of government imposing the tax itself need not be involved in the actual redistribution of Medicaid payments for the purpose of making taxpayers whole for the arrangement to qualify as a hold harmless. It is possible for a state to indirectly provide a payment within the meaning of section 1903(w)(4)(C)(i) of the Act that guarantees to hold taxpayers harmless for any portion of the costs of the tax, if some or all of the taxpayers receive those payments at issue through an intermediary (for example, a hospital association or similar provider affiliated organization) rather than directly from the state or its contracted managed care plan. As CMS further explained in preamble to the 2008 final rule, we used the term "reasonable expectation" because "state laws were rarely overt in requiring that state payments be used to hold taxpayers harmless."[4] In the preamble, we also gave an example of state laws providing grants to nursing home residents who experienced increased charges as a result of nursing facility bed taxes; even though no state law typically required residents to use the grant funds to pay the increased nursing home fees, these direct state payments to nursing home residents indirectly held the nursing facilities harmless for their health care-related tax costs because of the reasonable expectation that their residents would use the state payments to repay the nursing facilities for all or a portion of their tax costs.[5] It remains true that hold harmless arrangements typically are not overtly established through state law but can be based instead on reasonable expectations that certain actions will take place among participating entities that will result in taxpayers being held harmless for all or a portion of their health care-related tax costs.

---

[3] 73 Federal Register 9685, 9694-95 (Feb. 22, 2008).
[4] 73 Federal Register 9694
[5] *Id.*

Accordingly, an arrangement in which providers receive Medicaid payments from the state (or from a state-contracted managed care plan), then redistribute those payments such that taxed providers are held harmless for all or any portion of their cost of the tax, would constitute a prohibited hold harmless provision under section 1903(w)(4)(C)(i) of the Act and 42 C.F.R. § 433.68(f)(3). Section 1903(w)(1)(A)(iii) of the Act and 42 C.F.R. § 433.70(b) require that CMS reduce a state's medical assistance expenditures by the amount of health care-related tax collections that include hold harmless arrangements, prior to calculating federal financial participation.

Some states have cited challenges with identifying and providing details on redistribution arrangements because they may not be parties to the redistribution agreements. A lack of transparency involving health care-related taxes and Medicaid payments may prevent both CMS and states from having information necessary to ensure sources of non-federal share meet statutory requirements. States have an obligation to ensure that the sources of non-federal share of Medicaid expenditures comport with federal statute and regulations. As a result, states should make clear to their providers that these arrangements are not permissible under federal requirements, learn the details of how health care-related taxes are collected, and take steps to curtail these practices if they exist.

As part of the agency's normal oversight activities and review of state payment proposals, CMS intends to inquire about potential redistribution arrangements and may conduct detailed financial management reviews of health care-related tax programs that appear to include redistribution arrangements or that CMS has information may include redistribution arrangements. As part of their obligation to ensure state sources of non-federal share meet federal requirements, we expect states to have detailed information available regarding their health care-related taxes. Consistent with federal requirements, CMS expects states to make available all requested documentation regarding arrangements involving possible hold harmless arrangements and the redistribution of Medicaid payments. States should work with their providers to ensure necessary information is available. Where appropriate, states should examine their provider participation agreements and managed care plan contracts to ensure that providers, as a condition of participation in Medicaid and/or of network participation for a Medicaid managed care plan, agree to provide necessary information to the state. States may consult section 1902(a)(6) of the Act, 45 C.F.R. § 75.364, 42 C.F.R. § 433.74, and 42 C.F.R. part 438 for any requirements related to CMS' authority to request records and documentation related to the Medicaid program. In particular, 42 C.F.R. § 433.74(a) requires that states, "must also provide any additional information requested by the Secretary related to any . . . taxes imposed on . . . health care providers," and the "States' reports must present a complete, accurate, and full disclosure of all of their donation and tax programs and expenditures." 42 C.F.R. § 433.74(d) specifies that a failure to comply with reporting requirements may result in a deferral or disallowance of federal financial participation. If CMS or an outside oversight agency, such as the state auditing agency or the HHS Office of Inspector General discovers the existence of impermissible financing practices related to health care-related taxes CMS will take enforcement action as necessary. CMS is available to provide technical assistance and work with states to ensure the permissibility of all of the sources of the non-federal share of Medicaid expenditures, including any health care-related taxes the state may impose.

Conclusion

CMS recognizes that health care-related taxes can be a permissible source of funding for the non-federal share of Medicaid expenditures. CMS is available to provide technical assistance to states, including by reviewing proposals or existing arrangements and providing feedback to develop or modify health care-related taxes to align with state policy goals and federal requirements. One key federal requirement is that a health care-related tax cannot have a hold harmless provision that guarantees to return all or a portion of the tax back to the taxpayer. Health care-related tax programs in which taxpayers enter into agreements (explicit or implicit in nature) to redistribute Medicaid payments so that taxpayers have a reasonable expectation that they will receive all or a portion of their tax cost back generally involve a hold harmless arrangement that does not comply with federal statute and regulations.

CMS will continue to approve permissible health care-related tax programs that do not contain hold harmless arrangements and meet all other applicable federal requirements. These taxes often finance critical health care programs that pay for care furnished to Medicaid beneficiaries and shore up the health care safety net in our country. As always, CMS intends to work collaboratively with states by providing technical assistance as necessary to ensure the programmatic and fiscal integrity of the Medicaid program. For questions or to request technical assistance, please contact Rory Howe at rory.howe@cms.hhs.gov.

Appointment

From: Howe, Rory (CMS/CMCS) (b)(6)
(b)(6)
Sent: 10/4/2017 7:40:31 PM
To: Kumar, Neal J. (CMS/OL) (b)(6)
(b)(6) ; Davidson, Timothy G.
(CMS/CMCS) (b)(6)
(b)(6) Cuno, Richard (CMS/CMCS)
(b)(6)
(b)(6) Golden, James
(CMS/CMCS) [James.Golden@cms.hhs.gov]; Anderson, Debbie (CMS/CMCS) [debbie.anderson@cms.hhs.gov];
Delozier, Adrienne (CMS/CMCS) (b)(6)
(b)(6) ; Conover, Lillian
(CMS/CMCS) (b)(6)
(b)(6) ; Fan, Kristin (CMS/CMCS)
(b)(6)
(b)(6) Freeze, Janet G.
(CMS/CMCS) [Janet.Freeze@cms.hhs.gov]; Howe, Rory (CMS/CMCS) (b)(6)
Group (b)(6) Lane, Robert
(CMS/CMCS) (b)(6)
(b)(6) Boston, Beverly
(CMS/CMCS) (b)(6)
(b)(6) ; CMS CMCS_GAO/OIG
(b)(6)
(b)(6) McGreal, Richard R.
(CMS/CMCHO) [richard.mcgreal@cms.hhs.gov]; Mccullough, Francis T. (CMS/CMCHO)
[Francis.McCullough@cms.hhs.gov]; CMS CMCHOSID (b)(6)
(b)(6) ; Vlahodimos, Rena
G. (CMS/CMCHO) [Rena.Vlahodimos@cms.hhs.gov]; Walsh, Karen (CMS/CMCS) (b)(6)
Administrative Group (b)(6)
Habit, Sandra (CMS/OL) (b)(6)
(b)(6) Sendros (he/him),
Dennis (CMS/CPI) (b)(6)
(b)(6) CMS OIG Calendar
(b)(6)
(b)(6) Brandt, John (CMS/OL)
[John.Brandt@cms.hhs.gov]; Ojeda, Danielle (CMS/CCIIO) (b)(6)
(b)(6)
CC: Giles, John (CMS/CMCS) [John.Giles@cms.hhs.gov]

Subject: FW: FW: In-person Meeting: Exit Conference on Hold Harmless Requirements (A-03-16-00202)
Attachments: A-03-16-00202 draft Report in Brief for discussion.docx
Location: S1-06-11 and webex call-in information below

Start: 10/5/2017 3:00:00 PM
End: 10/5/2017 4:00:00 PM
Show Time As: Tentative

-----Original Appointment-----
From: Kumar, Neal J. (CMS/OL)
Sent: Tuesday, September 19, 2017 8:54 AM

To: Kumar, Neal J. (CMS/OL); Golden, James (CMS/CMCS); Anderson, Debbie (CMS/CMCS); Delozier, Adrienne M. (CMS/CMCS); Conover, Lillian A. (CMS/CMCS); Fan, Kristin A. (CMS/CMCS); Freeze, Janet G. (CMS/CMCS); Howe, Rory (CMS/CMCS); Lane, Robert (CMS/CMCS); Boston, Beverly A. (CMS/CMCS); CMS CMCS_GAO/OIG; McGreal, Richard R. (CMS/CMCHO); Mccullough, Francis T. (CMS/CMCHO); CMS CMCHOSID; Vlahodimos, Rena G. (CMS/CMCHO); Walsh, Karen S. (CMS/CMCHO); Habit, Sandra C. (CMS/OL); Sendros, Dennis (CMS/OL); CMS (b)(6) Calendar; Brandt, John (CMS/OL); Ojeda, Danielle (CMS/OL)
Cc: Giles, John (CMS/CMCS)
Subject: In-person Meeting: Exit Conference on Hold Harmless Requirements (A-03-16-00202)
When: Thursday, October 5, 2017 11:00 AM-12:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: S1-06-11 and webex call-in information below

Report in brief is attached:

A-03-16-00202
draft Report in Br...

DO NOT DELETE OR CHANGE ANY OF THE TEXT BELOW THIS LINE

Neal Kumar has scheduled this WebEx meeting.

In-person Meeting: Exit Conference on Hold Harmless Requirements (A-03-16-00202)
Host: Neal Kumar

Access Information
1. Please call the following number:
   WebEx (b)(6)
2. Follow the instructions you hear on the phone.

Your WebEx Meeting Number: (b)(6)

=================================

To join from a Cisco VoIP enabled CMS Region or from CMS Central Office

1. Dial ext (b)(6)

Enter Meeting Number: Use Meeting WebEx Number provided above.

=================================

To join this meeting online
1. Go to (b)(6)
2. If requested, enter your name and email address.
3. If a password is required, enter the meeting password: This meeting does not require a password.
4. Click "Join".
5. Follow the instructions that appear on your screen.

++
This meeting may be recorded by the host. If you have questions, please contact the host.
++

Hosts, need your host access code or key? Go to the meeting information page:
(b)(6)

Delivering the power of collaboration
(b)(6)

Message

From: Hebert, Krista (CMS/CMCS) (b)(6)
(b)(6)
Sent: 3/14/2023 6:06:05 PM
To: Katch (she/her), Hannah (CMS/OA (b)(6)
(b)(6) Briskin, Perrie
(CMS/CMCS) (b)(6)
(b)(6) Tesfaye, Eden (CMS/OA)
(b)(6)
(b)(6)
CC: Tsai, Daniel (CMS/CMCS) (b)(6)
(b)(6); Costello, Anne Marie
(CMS/CMCS) (b)(6)
(b)(6)
Subject: RE: RE: [INTERNAL] ACBL Mtg (b)(6)
Attachments: NC HASP Preprint - 2.28.2023.pdf; NC HASP Preprint Attachment - 2.28.2023.docx; NCDHHS Draft Pre-Print: Healthcare Access & Stabilization Program (HASP); Status of North Carolina Section 1115 Requests.docx

Hi Hannah and Eden,

See below points for Thursday's call with NC. Also attaching a few papers for additional background on SDP and 1115 in case it's helpful.

- Unwinding: NC team needs to remain focused on finishing the unwinding work with our team on the renewal mitigation plan. Reaffirm that we will support NC with implementation of expansion. Ensuring that unwinding goes well is critical to the successful implementation of expansion.
- State Directed Payments: NC shared a draft preprint/proposal for SDP with us, (b)(5) (b)(5). To our knowledge, they are funding through a flat tax, not a hold harmless. We'd like to discuss the direction.
- 1115 Waivers: North Carolina has 2 pending 1115 amendments. Topics for each pending amendment include: (1) expanding the Healthy Opportunities Pilot (HOP), removing most duals with significant BH needs and requiring enrollment into tailored BH/IDD plans; (2) expanding Medicaid eligibility to parents/caretaker relatives of foster care youth and expanding eligibility for the Children and Families Specialty Plan. (b)(5) (b)(5) (b)(5)

Of note, Jay (NC SMD) is at AHIP this week, and Dan/Anne Marie will try to catch him there too. Let me know if you want this in another format or need any additional details.

Best,
Krista

From: Katch (she/her), Hannah (CMS/OA) <Hannah.Katch@cms.hhs.gov>
Sent: Monday, March 13, 2023 5:00 PM
To: Briskin, Perrie (CMS/CMCS) <Perrie.Briskin@cms.hhs.gov>; Hebert, Krista (CMS/CMCS) <krista.hebert@cms.hhs.gov>
Subject: RE: [INTERNAL] ACBL Mtg w/Sec. Kinsley and Gov. Cooper

Can you help with this prep document? I can format it etc. But would be great if CMCS could share the relevant info – e.g. what are the things you want ACBL to ask/offer?

-----Original Appointment-----
From: CMS Administrator <CMSAdministrator@cms.hhs.gov>
Sent: Monday, March 13, 2023 4:54 PM

To: CBL (she/her), Administrator (CMS/OA); Tsai, Daniel (CMS/CMCS); Ellis (she/her), Kyla (CMS/OA); Tesfaye, Eden (CMS/OA); Hebert, Krista (CMS/CMCS); Briskin, Perrie (CMS/CMCS); Katch (she/her), Hannah (CMS/OA)
Subject: [INTERNAL] ACBL Mtg w/Sec. Kinsley and Gov. Cooper
When: Thursday, March 16, 2023 11:00 AM-11:30 AM (UTC-05:00) Eastern Time (US & Canada).
Where: Zoom: (b)(6)

CMS Administrator is inviting you to a scheduled ZoomGov meeting.

Join ZoomGov Meeting
(b)(6)

Meeting ID: (b)(6)
Password: (b)(6)

One tap mobile
(b)(6) US (San Jose)
(b)(6) US (New York)

Dial by your location
(b)(6) (San Jose)
(New York)
(b)(6) US Toll-free
Meeting ID: (b)(6)
Find your local number: (b)(6)

Join by SIP
Password: (b)(6)
(b)(6)

This meeting may be recorded. The host is responsible for maintaining any official recordings/transcripts of this meeting. If recorded, this meeting becomes an official record and shall be retained by the host in their files for 3 years or if longer needed for agency business. If a recording intends be fully transcribed or is being captured for the purpose of creating meeting minutes, the host shall retain the record in their files for 3 years or if no longer needed for agency business, whichever is later.

<u>**Status of North Carolina's pending section 11115 requests**</u>
March 14, 2023

<u>**Issue:**</u> Status of North Carolina Pending 1115 Requests

<u>**Background:**</u> North Carolina has 2 pending amendments to its section 1115 demonstration, "North Carolina Medicaid Reform Demonstration," described below.

Amendment 1: Received and determined complete on February 2, 2022. The amendment requested to and CMS is approving:

- Requiring enrollment into Tailored Behavioral Health/ Intellectual or Development Disabled Plans for certain individuals in residential settings;
- Removing most dual eligibles with significant behavioral health and I/DD needs from the demonstration;
- Expanding eligibility for Healthy Opportunities Pilots (HOP) services to most full-benefit beneficiaries.
- Lengthening the time that the state can use of HOP Capacity Building Funds; and
- Providing more flexibility on HOP timelines for value-based payments.

There are several elements the state requested that SDG is not approving at this time:

(b)(5)

Current Status: CMCS is working towards imminent approval of this amendment. To ensure a smooth transition for the vulnerable BH I/DD population, CMS will include STCs which seek to ensure beneficiaries are not negatively impacted by limiting choice under the demonstration.

Amendment 2: Received and determined complete on February 6, 2023. This amendment requested two things:

- Permanently expand Medicaid eligibility to parents and caretaker relatives of children/youth while the child was in foster care.
    - This population would be almost entirely covered by the Medicaid expansion adult group.

      (b)(5)
- Expand eligibility for the Children and Families Specialty Plan to include additional Medicaid-eligible beneficiaries.
    - Still under CMS review but SDG has not identified significant concerns with this request.
    - The state is not seeking to implement until 12/2024 and therefore is not seeking urgent approval of this element.

CMS00638cv1712

Current Status: SDG will continue to work with the state on a longer timeframe for the second request given the state's implementation timeline.

CMS00639cv1712