DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
2500 Security Blvd. Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

April 21, 2023

Dear Mr. Richardson:

The Centers for Medicare & Medicaid Services (CMS) is providing this letter to reiterate concerns regarding the State of Missouri's Federal Reimbursement Allowance (FRA) hospital tax program and to encourage the state to take immediate action to ensure its FRA tax arrangement meets federal requirements. As currently structured, the state's FRA tax program appears to include a prohibited "hold harmless" arrangement that involves hospitals pooling Medicaid payments and redistributing those Medicaid payments across its hospitals so that FRA-taxpaying hospitals are not financially harmed by the FRA tax. It appears that the redistributed Medicaid payments typically benefit hospitals that serve low percentages of Medicaid beneficiaries or no Medicaid beneficiaries at all. In some cases, this means that federal Medicaid dollars are being used to pay the FRA tax bill for hospitals that do not participate in the Medicaid program.

CMS recognizes the importance of FRA tax revenue to Missouri's Medicaid program. Since 2020, CMS has regularly offered technical assistance to the state and provided multiple opportunities to make practical modifications to its FRA tax arrangement so that the state could continue collecting its FRA tax without a reduction in federal funds. Essentially, the state could ensure compliance by working with its providers and/or legislature to stop the redistribution of approximately $55 million in annual Medicaid payments, which are redistributed from hospitals that serve a high percentage of Medicaid patients to hospitals with a low percentage of (or no) Medicaid patients. CMS remains hopeful that the state will take appropriate administrative and/or legislative action to modify its FRA tax program to ensure compliance with federal requirements, and therefore, avoid CMS recovery of federal funds associated with the FRA tax. If the state desires, CMS stands ready to partner with the state through rapid technical assistance to remedy the impermissible tax arrangement. Should the state not take appropriate action to ensure its FRA tax complies with federal statute and regulations, CMS intends to initiate a disallowance of federal financial participation as required by section 1903(w)(1)(A)(iii) of the Social Security Act. CMS intends to take this action no earlier than 60 days following issuance of this letter.

As currently structured, the tax appears to contain a hold harmless arrangement, which would violate section 1903(w)(1)(A)(iii) and 1903(w)(4) of the Act and implementing regulations in 42 C.F.R. § 433.68(b)(3) and (f). CMS understands the state's FRA tax program to operate as follows. Missouri imposes a tax on net patient revenues separately on inpatient and outpatient hospital services. These revenues provide the state with the source of funding for the non-federal share of Medicaid payments for hospital services and increased managed care capitation rates that support increased payments to hospitals. A voluntary FRA pool program operated by the Missouri Hospital Association (MHA) then appears to redistribute Medicaid payments among

the participating hospitals using a formula that ensures hospitals paying more in tax than they receive in Medicaid payments are not harmed by the tax. Such an arrangement appears to ensure that participating hospitals are held harmless for all or a portion of their FRA tax, which would violate section 1903(w)(4) of the Act and implementing regulations in 42 C.F.R. § 433.68(f)(3).

In a document entitled, "Rapid Response Review- Assessment of Missouri Medicaid Program" issued by the Missouri Department of Social Services on February 11, 2019, there is a flowchart entitled "Exhibit 12: Missouri Hospital Association FRA Funding Pool." According to the flow chart, providers that receive more in Medicaid payments funded by the FRA than the provider pays in tax transfer some of the provider's FRA-funded Medicaid payments to the pool operated by the MHA. If a provider receives less in Medicaid payments funded by the FRA than it pays in tax, the provider receives a payment from the pool consisting of amounts from the pooled Medicaid payments from other providers. The goal is to "net out the FRA paid with the payments received" or, in other words, to guarantee that no taxpayer is financially harmed by the cost of the tax.

CMS is also aware of multiple documents previously publicly available on MHA's website that describe the hold harmless arrangement relating to the FRA tax program that appears to occur through pooling and redistribution. For example, the MHA described the pooling arrangement and indicated that it "…redistributes some FRA-funded payments so that participants in the FRA pooling arrangement are not financially harmed by the FRA program. By insulating pool participants against financial loss, the pooling arrangement enables industry concurrence with the state's use of provider taxes, which generates more funding than likely would be possible under alternative scenarios." [1]

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)." [2]

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

[1] https://web.mhanet.com/media-library/missouris-hospital-provider-tax-pooling-arrangement/
[2] 73 Federal Register 9685, 9694-95 (Feb. 22, 2008)

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."[3] In the preamble, CMS 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.[4]

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. In these hold harmless arrangements, including what appears to be the case with Missouri's FRA tax program, agreements exist 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. This may include the redistribution of Medicaid payments to providers that serve no Medicaid beneficiaries.

To date, Missouri has been unable to provide assurance that there is not an arrangement to redistribute Medicaid payments to hold taxpayers harmless for the cost of the FRA tax. Instead, the state has continued to assert that the Missouri Partnership Plan (MPP) signed in 2008 by Missouri and CMS authorizes the hold harmless arrangement that appears to exist relating to the FRA program. This assertion does not take into account that CMS has obtained more information about the FRA pooling and redistribution arrangement since 2008, that the state's FRA tax program may have changed significantly since that time, and that the MPP did not authorize (and could not have authorized) the state to collect revenue for a health care-related tax program that includes a hold harmless arrangement without a reduction to the state's Medicaid expenditures as required by section 1903(w)(1)(A)(iii) of the Act.

Further, CMS has provided the state clear, repeated notice of its concerns regarding the apparent hold harmless arrangement, including in July 20, 2020, and July 15, 2022 letters to the state and additional email and verbal communication. As discussed in these letters, CMS understood that the state would ensure that the pooling arrangement would end for contract rating periods after June 30, 2021 and that all hospital payments would be financed and paid in accordance with all applicable federal requirements. However, based on various recent communications between CMS and the state, it appears the state does not intend to ensure that the FRA pooling arrangement has ended consistent with CMS's understanding articulated in the July 20, 2020 letter.

As indicated in our July 15, 2022 letter, CMS is committed to ensuring the non-federal share of Medicaid expenditures complies with all applicable federal requirements, including section

[3] 73 Federal Register 9694
[4] *Id.*

1903(w)(4) of the Act and federal regulations at 42 C.F.R. § 433.68(f)(3). In that July 15, 2022 letter and prior communication with the state including a July 20, 2020 letter, CMS reiterated concerns that CMS the state's FRA tax program appeared to contain a hold harmless arrangement, which would violate section 1903(w)(4) of the Act and implementing regulations in 42 C.F.R. § 433.68(f)(3). The July 2022 letter also indicated that CMS intended to conduct a focused review of Missouri's FRA program related to expenditures reported to CMS on the Form CMS-64, the results of which are described in this letter.

CMS initiated this review in February 2023, obtained additional information from the state, and asked follow-up questions relating to the state's August 25, 2022 reply letter to CMS's July 2022 letter. While CMS appreciates the state's August 25, 2022 response to our July 15, 2022 letter and additional information provided on March 10, 2023 and March 21, 2023, CMS remains concerned that Missouri's FRA program does not appear to meet federal requirements. Further, the state did not provide certain requested information on provider pooling and redistributions that are integral to the state's FRA program. Section 1902(a)(6) of the Act, 45 C.F.R. § 75.364, 42 C.F.R. § 433.74 include requirements related to CMS's 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.

CMS takes its responsibility for financial oversight of the Medicaid program seriously to ensure its long-term health and financial stability. CMS remains committed to ensuring that the non-federal share of Medicaid expenditures comply with all applicable federal requirements, including those related to health care-related taxes in section 1903(w)(4) of the Act and federal regulations at 42 C.F.R. § 433.68(f)(3). If the FRA-related hold harmless arrangements described above no longer exist or if Missouri has initiated action to end those arrangements, such as informing providers to cease the pooling and redistribution of Medicaid payments, please provide a detailed description of any actions taken by the state and/or participating hospitals to this end.

As noted above, should the state not take appropriate action to ensure its FRA tax complies with federal statute and regulations, CMS intends to initiate a disallowance of federal financial participation as required by section 1903(w)(1)(A)(iii) of the Act. CMS intends to take this action no earlier than 60 days following issuance of this letter.

CMS remains committed to providing additional technical assistance on this issue and is available to continue discussions with Missouri to ensure its sources of non-federal share meet all applicable federal requirements, and if possible, avoid a recovery of FFP by ensuring state's tax meets federal requirements.

Should you require further details or have any questions regarding this matter, please contact XXXX@cms.hhs.gov.

Sincerely,

Timeline on Key Missouri/Texas/Tax Activity from 2002-2021

2002 - CMS and Missouri sign a 2002 agreement Missouri called the "Missouri Partnership Plan" (MPP), which references the pooling/redistribution arrangement and indicates that CMS will approve the state's tax waiver submissions if "there is no explicit hold harmless in state law, regulation, or policy."

2003 – HHS OIG releases an audit report on Missouri's FRA tax program, and the pooling arrangement is directly addressed. The report highlights a concern that the pooling results in Medicaid payments not being used for statutory purposes, but asserts that the OIG is not making a recommendation on the hold harmless provision because there are no regulations precluding the pooling arrangement.

2007 - HHS OIG audit releases an audit of Missouri's FRA tax that does not address the pooling arrangement. However, it includes findings that the state's FRA tax in 2004 was impermissible for non-hold harmless related reasons and because the state appeared to violate the terms of the MPP. CMS has not yet closed out the audit findings.

February 22, 2008 - CMS Publishes Final Rule on Health Care-Related Taxes – Asserting that state laws are rarely overt in requiring that state payments be used to hold taxpayers harmless, CMS clarified the hold harmless definition by stating 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)." This clarification was in response to an unfavorable DAB decision on CMS disallowances in five states that provided grants to nursing home residents who experienced increased charges as a result of nursing facility bed taxes, with an expectation that the residents would use the grant funds to pay the facility for the increased nursing home tax cost holding the nursing facilities harmless. (See Attachment A)

2008 - CMS and Missouri re-sign the MPP.

September 2008 - The Provider Review Board (PRRB) issued a decision on whether Missouri payments redistributed through the pooling were treated properly by hospitals for Medicare cost reporting and payment purposes. Notably, the decision stated, "In December 2002, CMS ultimately concluded after a lengthy review and discussions with the State of Missouri that the FRA tax did not violate the hold-harmless provisions of 42 C.F.R. §433.68(f)." (See Attachment B)

2009 - The Administrator issued a decision reversing the September 2008 PRRB decision and correcting the record that, "…while not having a conclusive bearing on this case, it would not be accurate to state…that CMS concluded that the [Missouri pooling] arrangement did not violate the Medicaid hold harmless rule." (See Attachment C)

2010 and 2011 – US district and circuit court decisions uphold the 2009 Administrator ruling. The rulings discuss some specifics of the pooling arrangement (including calling the hospital plaintiff's suggestion that there is no consequential relationship between the state FRA tax it pays and the pooling "disingenuous"). However, the rulings only address the issue as it relates to

Medicare cost reporting (for Medicare payment purposes) and not compliance with Medicaid hold harmless provisions at 1903(w) and implementing regulations.

August 7, 2018 - HHS DAB upholds September 1, 2016 CMS disallowance of impermissible financing arrangements in Dallas and Tarrant counties in Texas. Soon after, the state and CMS begin to discuss corrective action to replace impermissible financing arrangements.

October 16, 2018 - CMS asks Texas for information on replacement financing arrangements in Dallas and Tarrant County, and including specific questions asking about possible agreements between private parties relating to the Local Provider Participation Funds (LPPFs). *(See CMS questions in Attachment D)*

November 2018 – The HHS OIG audit releases an audit of seven states' tax programs, including Missouri. Although the tax generally covers the hold harmless provisions, there is no mention of the Missouri pooling arrangement. Internal comments from FMG to the OIG (through OL) on the draft report do not include anything about the Missouri pooling arrangement. Although the report includes general mentions of the direct hold harmless provision (which is at issue with redistributions), the report and recommendation to CMS focus mostly on the 6% indirect hold harmless threshold.

November 19, 2018 – Texas indicates that the replacement financing in Dallas and Tarrant counties will come from LPPFs, which are derived from taxes on hospitals imposed by Dallas and Tarrant counties. Additionally, the state confirms that it is exploring similar models across the state. Finally, the state provides assurances that there are no agreements in place among the hospitals, the state, and counties. *(See State responses in Attachment D – note key response highlighted in yellow)*

December 20, 2018 - CMS sends letter to Texas stating that the LPPF in Dallas and Tarrant Counties **appear**, based on information provided by the state, to be broad-based, uniform, and lack a hold harmless. CMS also indicates that it may enforce compliance if CMS later discovers the arrangements are out of compliance with tax requirements. *(See Attachment E – 2nd paragraph)*

December 27, 2018 - CMS receives answers from seventeen additional counties and hospital districts concerning LPPFs. The answers again indicate no agreements exist among participants.

April 10, 2019 – Barbara Eyman exchanges emails with Kristin Fan, then FMG Director, in which Barbara recaps a March 2019 conversation between she and Kristin. Kristin indicated that the discussion was raised as an informal inquiry and hypothetical and that Barbara did not represent that she was acting as a representative for a particular state or states. This conversation did not represent formal Agency guidance or action on the topic and did not relate to a state proposal before CMS or a specific CMS review. Additionally, it pre-dated CMS's discussion of the Texas and Missouri arrangements with OGC and CMCS/CMS leadership, which were the first time the agency had reviewed the MO/TX arrangements closely from the Medicaid perspective following the 2008 tax rule.

April 16, 2019 – OACT and FMG meet to discuss OACT concerns with Missouri's managed care proposal to extend gray area payments. The proposal is funded in part using the FRA tax and OACT expressed concerns that it identified a contract between the plans and the hospital association detailing that the payments are, in part, designed to repay the hospital tax.

May 3, 2019 - CMS discovers through independent research the existence of agreements that detail pooling arrangements among providers designed to hold taxpayers harmless. *(See Attachment F – p. 14-17 – hold harmless arrangement explicitly described on p.17)*

May 21, 2019 – CMS sends an email to Texas pointing to the third-party PowerPoint detailing the redistribution arrangement and communicating that "CMS is concerned that this arrangement is designed to hold all hospitals harmless from the cost of the tax in contravention to 42 CFR 433.68 (f)." *(See Attachment G – Question #1)*

June 28, 2019

- Texas submitted SPA 19-0020 to make Medicaid Direct GME payments to privately owned and operated teaching hospitals. To qualify for payments under the SPA, a provider must execute an undefined agreement with the state.
- CMS also sends questions to Texas regarding concerns about the possible redistribution arrangements and other LPPF concerns.

August 2, 2019 – In response to CMCS leadership expressing concerns that the FRA tax program contains a hold harmless arrangement. Missouri sends a letter to CMS articulating why it does not believe the FRA pooling arrangement constitutes a prohibited hold harmless arrangement.

August 20, 2019 - Texas confirms that it is aware of pooling arrangements, but does not provide requested detail on the arrangements. Additionally, it inaccurately suggests that CMS verbally approved the pooling arrangements. FMG is not aware of any verbal communication with Texas regarding the arrangement (Texas might have been referring to the Barbara Eyman email, though Barbara did not indicate she was representing Texas and it was not raised in the context of a particular state proposal or CMS review of health care-related taxes) *(See Attachment G – Question and Response #1)*

August 23, 2019 – At the request of CMCS and with all available document and background on the Missouri arrangement to FMG at the time (the MPP, PRB hearings, 2008 rule, 8/2/19 letter from MO, etc.), OGC provides a memo to FMG reaffirming OGC's support of its recent, informal read that the Missouri pooling arrangement, if confirmed, is a violation of the hold harmless provisions. (See Attachment H)

March 2020 – After obtaining CMS Administrator concurrence with CMCS's analysis that the Texas LPPF program appears to contain a hold harmless arrangement, OA schedules time with senior Texas officials to communicate the concerns and indicate that CMS may soon initiate compliance enforcement action. The call, however, does not occur due to the emerging COVID-19 Public Health Emergency.

July 29, 2020 - CMS sends the State of Missouri a letter reiterating CMCS's hold harmless concerns communicated in 2019 and documenting a commitment from the State of Missouri on a call held on July 19, 2020 in which the State had committed to end the pooling of managed care payments by June 30, 2021. (See Attachment I)

August 24, 2020 – CMCS sends talking points to the Administrator to prepare for an August 25, 2020 call between OA and Texas that relates to the proposed Medicaid Fiscal Accountability Rule (MFAR). The talking points clearly communicate to Texas CMS's concerns that the LPPF appears to contain a hold harmless arrangement and that CMS's analysis would stand whether or not MFAR would have been finalized. It is unclear if the August 25, 2020 call occurred or what was conveyed to the state.

December 2020/January 2021 – OA agrees to send a letter to Texas reiterating CMS' concerns that the LPPF tax program including a hold harmless arrangement and urging Texas to take any necessary legislative action to end the hold harmless arrangements. The draft letter also indicated that CMS intended to initiate deferrals for the quarter ended March 31, 2021. OA initially agreed to send the letter to Texas, but ultimately, chose not to release the letter prior to the Administration change.

Attachment A – 2008 Final Tax Rule - 73 Federal Register 9685, 9694-95 (Feb. 22, 2008)

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)." 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."

<u>Excerpt from 2008 Final Rule</u>

Comment: Several commenters stated that the term ''reasonable expectation'' under the guarantee test in § 433.68(f)(3) is too broad and/or subjective.

Response: In the preamble to the proposed rule we stated that ''A direct guarantee will be found when a state payment is made available to a taxpayer or a party related to a taxpayer (for example as a nursing home resident is related to a nursing home), in the reasonable expectation that the payment would result in the taxpayer being held harmless for any part of the tax'' (72 FR 13730). We chose to use the term reasonable expectation because we recognized that state laws were rarely overt in requiring that state payments be used to hold taxpayers harmless. For example, state laws providing grants to nursing home residents who incur increased rates as a result of bed taxes on nursing homes, rarely required the residents receiving the grants to actually use the money to pay the increased nursing home fees. Accordingly, arguments have been made that such grants do not actually guarantee to hold the nursing homes harmless for the tax. We disagree. Because the residents must pay the increased rates passed on to them as a result of the tax and because the state has made money available to those residents to pay those increased rates, it is reasonable to expect that the payments going to the nursing home residents will promptly be sent to the nursing home as resident fee payments. This would result in a hold harmless for the nursing home. The only way to avoid this conclusion would be for the resident to leave the facility and/or not pay the rate increase. Therefore, we do not believe the use of the term reasonable expectation is overly broad or vague.

Texas LPFFs/HCPPPs, etc. Questions

1. Is the LPPF/HCPPP model being used for multiple of supplemental payments within the same county/hospital district (e.g., UC, DSRIP, UHRIP, DSH)? If so, are providers assessed a percentage fee on each type of supplemental payment or is there a maximum cap that providers may be assessed that covers all supplemental payments received? Please explain the mechanics of this process.

   Dallas County

   Funds included in the Dallas County Local Provider Participation Funds, per the authorizing legislation at Chapters 298A of the Texas Health and Safety Code, respectively, can be used for a number of specified purposes, including UC, UHRIP, and other similar waiver payment programs. The LPPF in Dallas cannot be used for DSH or DSRIP. Providers are assessed based on a uniform percentage of net revenues, with a statutory maximum of 6 percent. The percentage used for the assessment is set by the board of the hospital district after a public hearing where the amounts and uses are discussed. The board does not set separate assessment percentages for different supplemental payments.

   Tarrant County

   Per the Local Provider Participation Funds authorizing legislation (Chapters 298A of the Texas Health and Safety Code), Tarrant County provider taxes are used to support uncompensated care payments and UHRIP payments. Funds are not used to support DSH payments or DSRIP payments.

   Private providers are taxed at a uniform rate, not to exceed 6 percent. The tax is broad-based: all private hospitals within Tarrant County are taxed. The actual rate is determined by the Board of the Tarrant County Hospital District (TCHD), upon request by private hospitals.

2. For the counties in the state that do not have a LPPF/HCPPP established and utilize it, how many use a financing model similar to the previous Dallas/Tarrant county model? Will these counties be moving to a LPPF/HCPPP model in the future? If not, will these counties utilize a different model? If so, how will this model be structured?

   Per discussion with CMS, this question will be answered at a later date.

3. Are these assessments considered property taxes or an assessment on net patient revenues for hospital services?

   Dallas County

   The mandatory payments required into the LPPF are an assessment on net patient revenues from hospital services.

   Tarrant County

LPPF taxes are assessed on net patient revenues.

4. Just to confirm, for each LPPF/HCPPP:
    a. Are all private hospitals subject to the assessment?

    Dallas County

    Yes. All nonpublic hospitals located in the district that provide inpatient hospital services are subject to the assessment.

    Tarrant County

    Yes. All nonpublic hospitals located in the district that provide inpatient hospital services are subject to the assessment.

    b. Are all private hospitals subject to the assessment at the same rate?

    Dallas County

    Yes.

    Tarrant County

    Yes. It is uniform.

    c. Do any hospitals pay the assessment but do not receive payments funded by the assessment?

    Dallas County

    Yes, hospitals that do not see Medicaid patients (in particular some rehabilitation hospitals and long term acute care hospitals).

    Tarrant County

    Yes, the following hospitals pay the assessment but do not receive Medicaid UC payments. (The assessment is also used to support UHRIP payments, however, we do not have information as to which hospitals pay the assessment but do not receive UHRIP payments.)

Baylor Surgical Hospital at Fort Worth

Baylor Emergency Medical Center

Baylor Institute for Rehabilitation at Fort Worth

Baylor Orthopedic and Spine Hospital at Arlington

Cook Children's Northeast Hospital

Healthsouth City View Rehabilitation Hospital

Healthsouth Rehabilitation Hospital of Arlington

Healthsouth Rehabilitation Hospital of Fort Worth

Healthsouth Rehabilitation Hospital of the Mid-Cities

Kindred Hospital - Fort Worth

Kindred Hospital - Mansfield

Kindred Hospital - Tarrant County Arlington

Kindred Hospital - Tarrant County Fort Worth

Methodist Southlake Hospital

Ethicus Hospital DFW LLC

LifeCare Hospitals of Fort Worth

Mesa Springs

Millwood Hospital

Sundance Hospital

Texas General Hospital

Wellbridge Hospital of Fort Worth

Texas Health Harris Methodist Hospital Southlake

Texas Health Heart & Vascular Hospital Arlington

Texas Health Specialty Hospital Fort Worth

Texas Rehabilitation Hospital of Fort Worth

Texas Rehabilitation Hospital of Arlington

USMD Hospital at Arlington

USMD Hospital at Fort Worth

d. Do all hospitals subject to the assessment receive at least the total assessment amount in the form of Medicaid payments funded by the assessment? If so, please identify these LPPFs/HCPPPs.

Dallas County

See response to 4(c). Some hospitals subject to the assessment do not receive any Medicaid payments funded by the assessment. In any event, those hospitals that do receive payments funded by the assessment do not receive Medicaid payments based

on the amount of the assessment paid. It is certainly possible that a hospital could be required to pay an assessment in excess of Medicaid payments received.

Tarrant County

No. Some hospitals subject to the assessment do not receive any Medicaid payments funded by the assessment. In addition, some hospital pay an assessment greater than the amount received in UC payments.

5. Some LPFFs/HCPPPs appear to have a low number of providers subject to the assessment, which raises concerns regarding whether the arrangements comport with section 1903(w)(4) of the Social Security Act and implementing regulations that prohibit hold harmless arrangements. For example, it appears that Rusk County has an LPFF/HCPPP in which only one provider is assessed. Please explain how the provider is not guaranteed to receive its entire assessment back in the form of Medicaid payments.

   Per discussion with CMS, this question will be answered at a later date.

6. Are there any agreements, written or otherwise, regarding the LPFF/HCPPP among providers, counties, the state, and/or any other entities? If so, please identify, describe, and provide executed copies of the agreements.

   Dallas County

   The Dallas County Hospital District does not have agreements with providers, counties, the state, or any other entities regarding the LPPF.

   Tarrant County

   TCHD does not have any agreements with LPPF hospitals. TCHD Rules governing the program are attached.

   There are no agreements among private providers or other entities regarding the LPPF in either county.

7. On a quarterly basis, the state certifies on its Form CMS-64 that "the required amount of state and/or local funds were available and used to match the state's allowable expenditures included in this report [the quarterly CMS-64], and such state and/or local funds were in accordance with all applicable federal requirements for the non-federal share match of expenditures." How is the state monitoring these LPFF/HCPPP arrangements to ensure the state's share of Medicaid expenditures meets the requirements of section 1903 of the Social Security Act and that the state's quarterly certification is accurate?

HHSC is developing the process for collecting the information from the local governmental entities that administer provider participation programs to inform reporting on the CMS-64.11. However, given the limitations of the CMS-64.11 form, HHSC would welcome the opportunity to talk with CMS about how best to report the required information when there are multiple governmental entities that use the provider fees for a variety of authorized purposes, including transferring to HHSC as the non-federal share of certain Medicaid supplemental programs.

8. Is the state reporting LPPF/HCPPP fees on the CMS-64.11 form? If not, please explain.

   Please see response to #7 above.

5/21/2019

Questions for Texas on LPPF

1. In a presentation entitled, "The Present and Future of Medicaid" by David Salisbury at the HFMA Lone Star Summer Institute on August 17, 2017, slide 17 mentions an arrangement known as a "Community Benefit Payment." According to the presentation, hospitals that receive more in reimbursements because of the tax would make such a payment to hospitals that receive less in reimbursement than they pay because of the tax. The amount of the payment is set at 105 percent of the mandatory payment and the net gain hospital must make the payment within 30 days after the net hospital pays the assessment. CMS is concerned that this arrangement is designed to hold all hospitals harmless from the cost of the tax in contravention to 42 CFR 433.68 (f). Can the state please inform CMS:
   A. Do such "Community Benefit Payments" currently exist?

The state has been told that some sorts of arrangements between private entities exist. The state seeks no involvement and has not been involved in any such arrangements. The state does not regulate such private arrangements because it does not have the authority to do so. HHSC is willing to discuss with CMS what form of monitoring could occur to ensure that local government involvement in these arrangements does not occur.

In December, HHSC contacted CMS to inform them that there were oral agreements among private providers. CMS subsequently sent a letter to HHSC stating that the LPPF models as described appear to be consistent with regulatory requirements. Since that time, the state has had two conversations with stakeholders to discuss CMS's position on written mitigation agreements and one phone call with CMS, which was made at the request of stakeholders to find out CMS's position about such written agreements. The purpose of all the conversations has been to ensure both CMS and the stakeholders that HHSC is operating transparently.

   B. What role does the State of Texas play in facilitating such payments?

The State of Texas plays no role in facilitating such payments.

The State's only role is in ensuring that intergovernmental transfers from units of government are not derived from an impermissible tax or donation. HHSC takes this monitoring role seriously. For example, recently HHSC has been actively monitoring its Medicaid financing program by requiring providers and governmental units to complete surveys describing their funding arrangements for participation in supplemental and directed payment programs.

HHSC is in the process of preparing a rule to require LPPFs to report to HHSC mandatory payments and expenditures from an LPPF fund, as well as other information. The rule proposal will be published in August. Legislation and forthcoming rules contain serious consequences for entities that fail to provide necessary information. If a governmental entity operating an LPPF fails to provide the required quarterly information, HHSC will not accept any transfer of LPPF funds.

   C. If it is aware of their existence, has the State of Texas sent any guidance to hospitals related to them? If so, please describe.

HHSC does not have purview to regulate any such agreements between private entities. As previously mentioned, HHSC is willing to discuss with CMS what form of monitoring could occur to ensure that local government involvement in these arrangements is not occurring and will not occur in the future.

D. Regardless of whether the state is aware of the existence of such payments, does the state have appropriate oversight monitoring mechanisms of its Medicaid financing program in place that would detect and prohibit such arrangements if they existed?

As previously stated, HHSC does not have purview to regulate any such agreements between private entities. As previously mentioned, HHSC is willing to discuss with CMS what form of monitoring could occur to ensure that local government involvement in these arrangements is not occurring and will not occur in the future.

Moreover, HHSC requests CMS to identify which section of federal law it believes is being violated. Based on our review, HHSC cannot affirm CMS's belief that arrangements such as the one described in the referenced presentation violate federal law. Subsection 433.68(f) sets out three hold harmless tests, none of which are met. For a hold harmless to occur under a health care related tax, one of the following three activities must occur:

> (f)(1) The State (or other unit of government) imposing the tax provides for a direct or indirect non-Medicaid payment to those providers or others paying the tax and the payment amount is positively correlated to either the tax amount or to the difference between the Medicaid payment and the tax amount. A positive correlation includes any positive relationship between these variables, even if not consistent over time.

Here, there is no indication that any unit of government imposing a mandatory payment has provided for a direct or indirect non-Medicaid payment, the amount of which is positively correlated to the mandatory payment amount or to the difference between the Medicaid payment and the mandatory payment amount.

> (f)(2) All or any portion of the Medicaid payment to the taxpayer varies based only on the tax amount, including where Medicaid payment is conditional on receipt of the tax amount.

No part of the Medicaid payment varies based only on the amount of the mandatory payment. Consistent with the guidance in the final rule's preamble, the state's payment methodology for Medicaid supplemental payments is designed in a manner that recognizes the volume or nature of the covered services provided to Medicaid individuals, and is not related to the amount of the mandatory payment made by the provider (73 Fed. Reg. 9692). In other words, no "portion of the Medicaid payments made by the state to providers…varies based upon the [mandatory payment]…" (73 Fed. Reg. 9693).

> (f)(3) The State (or other unit of government) imposing the tax provides for any direct or indirect payment, offset, or waiver such that the provision of that payment, offset, or waiver directly or indirectly guarantees to hold taxpayers harmless for all or any portion of the tax amount.

There is no indication that the state or the local governments imposing the mandatory payments provide for any direct or indirect payment, offset, or waiver such that the provision of a payment, offset, or waiver directly or indirectly guarantees to hold providers harmless for all or any portion of the mandatory payment amount.

CMS's guidance in the final rule's preamble provides, "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). A direct guarantee does not need to be an explicit promise or assurance of payment. *Instead, the element necessary to constitute a direct guarantee is the provision for payment by State statute, regulation, or policy* (73 Fed. Reg. 9694 (emphasis added); see also 72 Fed. Reg. 13730). No state statute, regulation, or policy exists that would implicate a guarantee in violation of 42 C.F.R. 433.68(f)(3).

The indirect guarantee portion of the regulation in 42 C.F.R. 433.68(f)(3)(i) sets out a two-prong test related to the amount of revenues produced by the health care-related tax and the relation of that amount to the revenues received by the providers. It does not appear that CMS is suggesting that this test is at issue.

Under (f)(1) and (f)(3), a hold harmless may only exist if the unit of government imposing the tax is involved in the supposed arrangement. As stated previously, the state is not and has not been involved in any such arrangements. The money at issue under the purported agreements is neither controlled nor directed by the state. HHSC can inquire with the local governments that receive the mandatory payments to ensure that they are not involved either. If no local governments are involved, then (f)(1) and (f)(3) cannot be the source of the violation. HHSC requests further information to understand CMS's position with respect to (f)(2).

In short, the purported agreements described by CMS above would comply with 42 C.F.R. 433.68. Had CMS wished to prohibit these kinds of agreements, it could have attempted to do so when it amended the regulation in 2008. Moreover, at the time the current regulation became effective, CMS was aware that these kinds of agreements existed. HHS OIG reviewed similar actions regarding the Missouri DSH program in 2003 and determined that "because the agreements were voluntary between the hospital provider and the MHA/MSC, and because there are no regulations precluding the arrangement, we are not making any recommendations for recovery of the pooled payments in excess of DSH limits." HHSC has reasonably relied on this opinion and current regulations to inform its oversight responsibility.

E. Any other information the state may have regarding "Community Benefit Payments."

No other information to add.

2. In the current legislative section how many LPPFs has the Texas legislature approved? Of those, how many consist of more than one county grouped together to form an LPPF?

During the 86th legislative session, ten bills relating to LPPFs became law. Only House Bill 4289 permits a local government to create a health care provider participation district with one or more other local governments. A district may then authorize a health care provider participation program and must require a mandatory payment to be assessed on each nonpublic hospital that provides inpatient hospital

services. The state is not aware of any governmental units having been formed pursuant to House Bill 4289.

Further, HHSC would not accept funds from such a governmental unit until it has completed its discussions with CMS on the issue. HHSC and CMS held a conference call about the issue of jurisdictions joining together on April 2, 2019. CMS identified concerns to HHSC and HHSC agreed to provide a document with reasoning as to why joining jurisdictions together should be legal. HHSC submitted this information to CMS on April 15, 2019. HHSC has not received any comments or objections from CMS.

3. CMS remains concerned that LPPFs do not qualify as units of government. Section 1903 (w)(6)(A) of the Act stipulates that the state may use revenue from local sources to fund the non-Federal share of Medicaid expenditures only if the units of government within the State derive that revenue from state or local taxes or certify it as the non-Federal share of expenditures. If LPPFs do not qualify as units of government, they cannot transfer revenue derived from taxes to the state to fund the non-Federal share of Medicaid. Please provide any additional evidence the state has that supports its claim that LPPFs qualify as units of government as stipulated by the Act.

HHSC is concerned that CMS is confusing the issue of a local governmental entity operating an LPPF with multiple governmental entities joining together to operate an LPPF. As stated in Question 2, no jurisdictions have yet attempted to join to form a new governmental entity and HHSC prefers to continue to work with CMS to understand the legal boundaries of such an action.

However, regarding all currently existing and authorized LPPFs, CMS is correct that an LPPF is not a unit of government. But HHSC does not claim that an LPPF is a unit of government. An LPPF is not an entity; it is an account a local unit of government creates at a financial institution. An LPPF cannot exist without a local unit of government to operate it. All units of government authorized to operate an LPPF were created pursuant to state law and existed prior to the creation of the LPPF, many of them for years. Local units of government assess mandatory payments akin to property taxes that are paid into the LPPF. The assessments are broad-based and uniform and therefore a legitimate revenue source for the nonfederal share.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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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, 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 critically important 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 payment methodologies that pay appropriately for services furnished to Medicaid beneficiaries.

The 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 the state's priorities for its Medicaid program. 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. There are statutory and regulatory flexibilities afforded states in how they design health care-related tax programs. 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 still 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 existing 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 to 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 costs back, when considering each provider's retained portion of any original Medicaid payment (either directly from the state of 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 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. The redistributions occur so that taxpaying providers are held harmless for all or a portion of the cost of a health care-related tax. This may include the redistribution of Medicaid payments to providers that serve no Medicaid beneficiaries.

These taxes appear to 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 would 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. Here is a detailed example (b)(5) hold harmless arrangement involving Medicaid payment redistributio (b)(5)

- 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. (b)(5)
- 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 hospital (b)(5) irst pooled and then redistributed), are held harmless for at least part of their health care-related tax costs. (b)(5)
- 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.
- Any increased payments the hospitals receive as a result of the distribution arrangements are federal dollars and there is no net increase paid for with state funds.

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 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 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).".[1]

The word "indirect" in the regulation, highlighted in the excerpt above, makes clear that the state 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. The word "indirect" appears twice in the regulation. 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). A state can 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 even if some of the taxpayers that are held harmless receive the payment 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" because "state laws were rarely overt in requiring that state payments be used to hold taxpayers harmless."[2] We 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 hospitals 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.

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,

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

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, 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 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 rory.howe@cms.hhs.gov.

Requesting Additional Information regarding Nevada's Hospital Tax Program

To ensure that Nevada's hospital tax program meets federal requirements, CMS is requesting assurances that Nevada's hospital tax program does not involve arrangements among providers to redistribute Medicaid payments to ensure that no provider is harmed financially as a result of a health care-related tax. This would constitute a hold harmless under Section 1903(w)(4) of the Social Security Act and 42 CFR § 433.68(f).

Federal Financial Participation (FFP) is not available for Medicaid programs where the state's share of the Medicaid payments for those programs are financed through health care-related taxes and there is a "hold harmless arrangement" in place. CMS and the State must ensure that sources of non-federal share comply with section 1903(w) of the Social Security Act and implementing regulations at 42 CFR Part 433.

CMS is requesting more information regarding the state's tax program, including whether pooling and/or redistribution practices that would constitute a hold harmless arrangement are occurring.

Please provide the following information to assist in our review of whether the state's non-federal share source complies with section 1903(w)(4) of the Act and 42 C.F.R. § 433.68(f)(3):

1. A comprehensive description of how the tax program (including any payment redistributions among providers) works, including at the provider level.

2. Copies of agreements relating to the tax program or payment redistributions in place between or among participating providers and/or the state and localities and a complete description of how the agreements work, including at the provider level.

3. As an alternative to providing the agreements in #2, attestations from each participating provider or from the state (attesting on behalf of each provider) that the providers do not participate in arrangements, through written agreements or otherwise (including non-written agreements or understandings that result in reasonable expectations for participating parties), which involve participating providers transferring, redirecting, redistributing (irrespective of state or local government involvement) Medicaid or other payments to other providers, directly or indirectly (irrespective of whether the state or units of local government are compelling or sanctioning provider participation).

4. If all participating providers or the state are able to provide the attestation(s) in #3, a comprehensive description of the process used by the state and providers to ensure the accuracy of the attestation(s) that the arrangements described in #3 have either stopped or were never in effect.

CMS is open to state ideas regarding how it can provide information to CMS to support that its hospital tax program does not likely include a hold harmless arrangement. For example, the state could hold a meeting with its providers. Please find below an example of state talking points that could be used for such a meeting:

In recent discussions with CMS, they wanted assurance that Medicaid funds were not being redistributed by providers for the purpose of making taxpayers whole from paying the assessment in a "hold harmless" arrangement. The following is a summary of CMS' interpretations of existing federal statutes and rules that we are sharing with you for the purposes of providing CMS with the assurance they require from the State as part of the approval process for the directed payment programs recently submitted.

CMS reminds the state and providers that Section 1903 (w)(1)(A)(iii) of the Social Security Act (the Act) states that a state's amount of medical assistance expenditures shall be reduced by the amount of a health care-related tax if there is in effect a hold harmless arrangement.

Section 1903 (w)(4) describes what constitutes a hold harmless arrangement. Specifically, Section 1903 (w)(4)(C) states that, "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."

Implementing regulations at 42 CFR 433.68(f)(3) state that a hold harmless arrangement exists where a state imposing a health care-related 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.

CMS recognizes that the statute clearly permits health care-related taxes and supports states' adoption of these financing strategies. However, the taxes must be imposed in a manner consistent with applicable federal statute and regulations and cannot include a direct or indirect hold harmless arrangements.

In the preamble to the 2008 final rule amending the above referenced provision, 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 in the reasonable expectation that the payment would result in the taxpayer being held harmless for any part of the tax." 73 FR 9685, 9695 (Feb. 22, 2008) (confirming proposed rule preamble statement in 72 FR 13726, 13730 (Mar. 23, 2007)).

CMS stated that the addition of the word "or indirectly" in the regulation indicates that the state itself need not be involved in the actual redistribution of Medicaid funds for the purpose of making all taxpayers whole in order for the arrangement to qualify as a hold harmless.

As CMS further explained in the same preamble, they used the term "reasonable expectation" because "state laws were rarely overt in requiring that state payments be used to hold taxpayers harmless." 73 FR at 9694. Therefore, hold harmless arrangements are not always overtly established through state law, but can be based instead only on reasonable expectations of certain actions among participating entities.

As a result, an arrangement in which hospitals receive Medicaid payments from the State, then pool and redistribute those payments with an aim of holding all providers harmless for the cost of the tax would constitute a hold harmless under Section 1903 (w)(4) of the Act and 42 CFR § 433.68 (f) and would lead to a reduction of the state's medical assistance expenditures as specified by Section 1903 (w)(1)(A)(iii) and 42 CFR § 433.70 (b).

If there are any oral or written agreements to redirect or redistribute Medicaid payments related to the tax in any way including to hold another tax paying entity harmless from all or a portion of the assessment, you must let us know in writing within the next five business days.

If you are unsure of whether an agreement will result in a hold harmless arrangement, you may contact XXXXX for assistance.

XXXX must certify to CMS that it provided an opportunity for all taxpayers to be made aware of this information and requested disclosure of any such agreement as part of the approval process for the submitted XXXXX preprints. At the lapse of the 5 days XXXX will notify CMS of whether any such arrangements were disclosed and certify that this meeting took place.

Nevada Department of Health and Human Services

DIVISION OF HEALTH CARE FINANCING AND POLICY

Missouri Federal Reimbursement Allowance (FRA) Tax Questions

As indicated in our July 15, 2022 letter, CMS is committed to ensuring the non-federal share of Medicaid expenditures complies with all applicable federal requirements, including section 1903(w)(4) of the Social Security Act and federal regulations at 42 CFR 433.68(f)(3). In that July letter and prior communication with the state including a July 20, 2020 letter, CMS reiterated concerns that CMS the state's Federal Reimbursement Allowance (FRA) tax program appeared to contain a hold harmless arrangement, which would violate section 1903(w)(4) of the Act and implementing regulations in 42 CFR 433.68(f)(3). The July 2022 letter also indicated that CMS intended to conduct a focused review of Missouri's FRA program related to expenditures reported to CMS on the Form CMS-64. We appreciate the state's August 25, 2022 response to our July 15, 2022 letter. After review of the information shared in conjunction with the letter, CMS remains concerned that Missouri's FRA program does not appear to meet federal requirements. Therefore, we are requesting information and supporting documentation to determine if the FRA is in compliance with all federal statutory and regulatory requirements for FRA tax amounts reported on the CMS-64 for the quarter ending December 31, 2022.

<u>Please provide the following information and documentation relating to FRA amounts reported to CMS on the Form CMS-64 for the quarter ended December 31, 2022</u>:

1. The state law(s) that authorize the FRA and that direct the disposition of the revenue raised.

2. A list of each State Directed Payment Preprint and State Plan payment provision for which the non-federal share includes FRA tax revenue.

3. For each provider paying the FRA tax:
    a. Provider name
    b. The applicable FRA tax rate or rates
    c. The basis for the tax rate (e.g., hospital net patient revenues, discharges, etc.)
    d. Amount of FRA tax paid for the quarter ended 12/31/2022
    e. Total amount received in Medicaid payments funded by FRA tax revenue through the State Directed Payments and/or State Plan payments.
    f. Amount(s) paid or contributed to the Missouri Hospital Association FRA Funding Pool
    g. Amount(s) received from the Missouri Hospital Association FRA Funding Pool

4. Please confirm that the FRA assessment is imposed on the two permissible classes, inpatient hospital services and outpatient hospital services, and no other items or services. The term "permissible class" is defined in section 1903(w)(7) of the Social Security Act and 42 CFR 433.56(a).

5. Each permissible class the state taxes under the FRA is subject to the indirect guarantee hold harmless test as specified in 42 CFR 433.68(f)(3)(i)(A) and (B). The state should calculate the test for each permissible class separately. For example, inpatient hospital

services and outpatient hospital services should be calculated separately. Please confirm the total amount of health care-related tax or taxes is less than or equal to 6% of the taxpayers' net patient revenue for inpatient hospital services, and for outpatient hospital services. If the state cannot confirm that the total amount of health care-related tax or taxes is less than or equal to 6% of the taxpayers' net patient revenue for inpatient hospital services, and for outpatient hospital services, please confirm that 75% or more of providers being taxed in the class do not receive 75% or more of their tax cost back in Medicaid or other state payments.

6. 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.

   In a document entitled, "Rapid Response Review- Assessment of Missouri Medicaid Program" issued by the Missouri Department of Social Services on February 11, 2019, there is a flowchart entitled "Exhibit 12: Missouri Hospital Association FRA Funding Pool." The document is included as an attachment to this email. According to the flow chart, providers that receive more in Medicaid payments funded by the FRA than the provider pays in tax transfer some of the provider's FRA-funded Medicaid payments to the pool operated by the MHA. If a provider receives less in Medicaid payments funded by the FRA than it pays in tax, the provider receives a payment from the pool consisting of amounts from the pooled Medicaid payments from other providers. The goal is to "net out the FRA paid with the payments received" or, in other words, to guarantee that no taxpayer is financially harmed by the cost of the tax. Is the description found in the PowerPoint issued by the State of Missouri an accurate description of how the pooling arrangement worked for the quarter ended December 31, 2022 with regard to the FRA?

7. Please provide any documentation the state has concerning the operation of these pooling arrangements (including the redistribution of payments) and how they work. This would include any copies of contracts, agreements, letters, call or meeting notes, or other similar materials discussing the arrangements, involving the state, hospitals, the Missouri Hospital Association (MHA), managed care organizations, and/or other parties.

8. If a hospital is a "pool contributor" and receives more in payments than it pays in tax, does it always pay all of the difference into the pool? Do "pool receivers" that pay more in tax than they receive in payments always receive the entire amount back from the pool, or only some of it? How are those payment amounts determined?

9. Please provide any additional detail on the memorandum of understanding (MOU) between the Missouri Hospital Association and Managed Care Organizations, as described in the Rapid Response document, regarding an agreement to attempt to ensure individual hospitals are not financially harmed by the FRA using Medicaid managed care payments. If available to the state, please provide a copy of this MOU as it was in effect during the quarter ended December 31, 2022, and as it is currently in effect, if the MOU instrument is not the same for the periods. Are these expectations reflected in any contract between the state and the MCOs? If so, please provide copies of the relevant MCO contracts, identifying the relevant provisions.

10. Has the state communicated with its providers regarding the statutory and regulatory prohibition of hold harmless arrangements involving provider payment redistributions, including as articulated by CMS in its July 20, 2020 and July 15, 2022 letters? If so, please describe the nature and substance of the communications, providing copies, if available.

11. Please describe what oversight the state conducts to ensure that the state and providers comply with federal requirements related to the financing of the non-federal share of Medicaid expenditures.

12. Based on the responses to these questions regarding possible redistribution arrangements, CMS may ask additional questions and/or make additional requests for information from the state and/or providers, if necessary.

Missouri NF Rebase SPA 22-0025
State Response to Informal Inquiry from CMS – email from Fredrick Sebree dated 3/16/2023

The email from Fredrick Sebree has been restated below. The questions are followed by the State's response.

Email from Fredrick –

Good morning,

MO 22-0025 has been presented to leadership and the SPA is good to go but our tax team wanted to touch base on the NFRA. Below are a few questions/confirmations:

1. To confirm, the Nursing Facility Reimbursement Allowance (NFRA) does not have any redistributions. Is that correct?

   State Response: The nursing facilities do have a private redistribution arrangement in which the State is not involved. Pursuant to the State's longstanding Partnership Plan agreement with CMS, the NFRA is "recognized as a permissible funding source" subject to an annual demonstration that the redistribution meets the "B1/B2 standard of 1.0 or above contained in the federal regulations at 42 C.F.R. 433.68(e), after taking into account the redistribution arrangement." MHD has shared with CMS the results of the redistribution on an annual basis, which establishes that the B1/B2 standard is met. The most recent demonstration was provided to CMS on 8/22/2022. A copy of the Partnership Plan, Addendum A, and the most recent demonstration of the redistribution are attached.

2. Is the NFRA broad-based and uniform? Are any providers excluded? Are any providers taxed at different rates?

   State Response: The NFRA is broad based and uniform. No providers are excluded. All providers are taxed at the same rate.

3. Using the most recent data available, how much does the state anticipate raising from the NFRA?

   State Response: For SFY 2023, the State anticipates to assess approximately $162.7 million in NFRA.

4. For the purposes of the 6% test, what percentage of net patient revenue for the permissible class is raised by all taxes on the services of nursing facilities, including the NFRA?

   State Response: For SFY 2023, the estimated percentage of NFRA assessments to net patient revenues is approximately 5%.

ADDENDUM A
TO MEDICAID PARTNERSHIP PLAN

MISSOURI-SPECIFIC
TRANSITION AGREEMENT

This Missouri Specific Agreement between the Centers for Medicare and Medicaid Services ("CMS"), an agency of the United States Department of Health and Human Services, and the State of Missouri, through the Director of the Department of Social Services ("DSS" or "the State"), is entered into contemporaneously with the Medicaid Partnership Plan (MPP). This Missouri specific transition agreement entered into between CMS and DSS is intended to facilitate the MPP by reducing audit and financial management burdens related to past activities and focusing such resources on the ongoing operations of the MPP.

I. Treatment of health-care related taxes:

(A) All existing and new health care related taxes must meet all Federal Medicaid statutory and regulatory requirements.

(B) Inpatient and Outpatient Hospital Services Taxes. The tax on inpatient hospital services and the tax on outpatient hospital services, which are considered separate health care-related taxes for purposes of compliance with section 1903(w), will continue to be recognized as permissible funding sources, subject to annual demonstrations described in paragraph II. For purposes of imposing and collecting the taxes, the State will utilize the methodology described in Attachment 1 of this Addendum to ensure that only the inpatient hospital service revenues are assessed under the inpatient hospital service tax and that only outpatient hospital service revenues will be assessed under the outpatient hospital service tax.

(C) The State's tax on nursing facility services will continue to be recognized as a permissible funding source subject to paragraph I(A) and subject to an annual demonstration of the redistribution arrangement described in paragraph II of this Addendum.

(D) The State's tax on MO HealthNet managed care organizations will expire on September 30, 2009 in compliance with the transition period allowed under the Federal Deficit Reduction Act of 2005.

(E) The State's tax on outpatient prescription drugs will be recognized as a permissible funding source provided that the tax structure is imposed in a broad based and uniform manner with no hold harmless provisions and, if applicable, subject to an annual demonstration of the redistribution arrangement described in paragraph II of this Addendum.

(F) Any new health-care related taxes enacted by the State must be expressly approved by CMS.

(G) Section 403 of the Tax Relief and Health Care Act of 2006 (Pub. L. 109-432) revised the percentage threshold from 6 percent of net patient service revenue to 5.5 percent under the first prong of the indirect hold harmless test. The State will be expected to comply with this provision as of its effective date of January 1, 2008.

II. In those instances where providers subject to an otherwise valid health-care related tax have an agreement for redistribution of Medical Assistance payments received from the State, the redistribution arrangement will be subject to CMS review and approval. CMS will accept the taxes as a valid state funding source if: 1) there is no explicit hold harmless in state law, regulation, or policy, and 2) the tax program structure at issue meets the B1/B2 standard of 1.0 or above contained in the federal regulations at 42 CFR 433.68(e), after taking into account the redistribution arrangement. Such demonstration must be provided on an annual basis for each health care-related tax program to which redistribution is applicable.

A. Any change in the taxes or tax structures will subject the tax to a new review by CMS under the MPP. Such changes include any change to the tax rate(s), tax base or any other aspect of the taxing structure. Such changes must be included in the annual B1/B2 analysis to be submitted to and approved by CMS before the tax can be recognized as a permissible funding source for the non-Federal share of MO HealthNet expenditures.

B. For purposes of applying the B1/B2 standard to the tax on inpatient hospital services and the tax on outpatient hospital services, facilities can be treated individually or by commonly controlled industry systems in similar geographic locations. Separate analyses shall be performed for the tax on inpatient hospital services and the tax on outpatient hospital services.

C. Submission of the B1/B2 Demonstration Pursuant to the MPP. DSS represents that it is not involved in any way in the redistribution of Medical Assistance payments among providers and does not have access to the information involving redistribution. Therefore, the B1/B2 analyses required to be submitted pursuant to this paragraph shall be prepared in the first instance by the entity or entities that administers a redistribution program. However, the State shall work with such entity to supply and verify the data used as the MO HealthNet statistic, and the State shall be responsible for submitting the B1/B2 analyses to CMS. CMS shall direct any questions regarding the B1/B2 analysis to the State, except that questions as to the redistribution arrangement or the amounts redistributed shall be forwarded to and answered by the provider entities. The State will work with the providers to assure access to records and documentation as necessary to facilitate CMS' review of the analysis.

D. In any circumstance in which the assessed health care providers are required by federal laws, regulations or policies to identify revenues or costs of patient care, the State shall assure that the redistribution of medical assistance payments shall not be taken into account in determining revenues or costs (an assessed health care provider must consider as Medicaid patient care revenues the full amount received from the Missouri program, and may not consider redistribution to be a cost of patient care).

III. Certified Public Expenditures (CPE)

To the extent that the State continues to use certified public expenditures (CPEs) as a source of non-federal share, the State shall (a) use a cost reimbursement methodology; (b) require each provider that certifies expenditures to submit annually a cost report, according to a protocol approved by CMS, that reflects the provider's costs of serving MO HealthNet participants during the year; (c) reconcile payments in each year to the finalized cost report for that year; and (d) provide the results of such reconciliation to CMS and credit the Federal government with any overpayment amount.

Dennis G. Smith

For the Centers for Medicare
And Medicaid Services

Dennis G. Smith, Director
Center for Medicaid and State Operations

Date: April 10, 2008

Deborah E. Scott

For the State of Missouri
Department of Social Services

Deborah E. Scott, Director
Department of Social Services

Date: April 8, 2008

PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2009-D42

PROVIDER -
Kindred Hospital-Kansas City
Kindred Hospital-St. Louis

Provider Nos.: 26-2011; 26-2010
(respectively)

vs.

INTERMEDIARY -
Wisconsin Physician Services
(formerly Mutual of Omaha)

DATE OF HEARING -
September 25, 2008

Cost Reporting Periods Ended -
August 31, 2000; August 31, 2001
August 31, 2002; August 31, 2003

CASE NOs: See Attachment 1

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ISSUE:

Whether the Intermediary's adjustments treating the Management Services Corporation (MSC) pool payments the Providers received as provider refunds, which were offset against the allowable provider tax expense, were proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§ 1395-1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and interpretive guidelines published by CMS. See 42 U.S.C. §1395h; 42 C.F.R. §§413.20 and 413.24.

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. § 413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. § 405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. § 1395oo(a); 42 C.F.R. § 405.1835.

Medicare reimbursement is governed by 42 U.S.C. § 1395x(v)(1)(A). The statute provides that the reasonable cost of any service "shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." The implementing regulation at 42 C.F.R. § 413.9(a) provides that "reasonable costs" includes "all necessary and proper costs incurred in furnishing the services subject to principles relating to specific items of revenue and cost." In determining what constitutes a reasonable cost, 42 C.F.R. § 413.98 provides for reductions due to purchase discounts, allowances, and refunds of various expenses:

> (a) Discounts and allowances received on purchases of goods or services are reductions of the costs to which they relate. Similarly, refunds of previous expense payments are reductions of the related expense.

* * * * *

> (b)(3)*Refunds.* Refunds are amounts paid back or a credit allowed on account of an over collection.
>
> (c) *Normal accounting treatment – Reduction of costs.* All discounts, allowances, and refunds of expenses are reductions in the costs of goods or services purchased and are not income. If they are received in the same accounting period in which the purchases were made or expenses were incurred, they will reduce the purchases or expenses of that period. However, if they are received in a later accounting period, they will reduce the comparable purchases or expenses in the period in which they are received.

Providing additional guidance about purchase discounts, allowances, and refunds, the CMS Provider Reimbursement Manual ("PRM") 15-1, section 2302.5 defines "Applicable Credits," that offset or reduce expense items listed on a cost report as follows:

> Those receipts or types of transactions which offset or reduce expense items that are allocable to cost centers as direct or indirect costs. Typical examples of such transactions are: purchase discounts, rebates, or allowances; recoveries or indemnities on losses; sales of scrap or incidental services; adjustments of overpayments or erroneous charges; and other income items which serve to reduce costs.

The issue in these cases concerns the Providers' Medicare cost report treatment of the payments they received from a privately-administered pooling arrangement in which certain Missouri hospitals participated.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

A. Statement of the Case

In 1992, the Missouri Hospital Association ("MHA" or the "Association") created a voluntary Medicaid pool arrangement on behalf of Missouri hospitals who chose to participate. The pooling arrangement provided for the distribution of funds among participating hospitals to pay for care provided to patients who are uninsured and who are eligible to be Medicaid beneficiaries. Hospitals first paid the FRA tax directly to the State by check or requested that the tax be deducted from their Medicaid reimbursement. The State then issued checks payable to the hospitals for their Medicaid reimbursement. Under the Association's pooling arrangement, the Association's Management Services Corporation ("MSC") was authorized by participating hospitals to endorse and deposit these checks into separate bank accounts maintained by each participating hospital and such funds are in turn transferred to an MSC bank account (the "MSC pool" or "pool"). MSC then reallocated this revenue to hospitals participating in the pool pursuant to an agreed-upon payment methodology. Each hospital received a net payment from MSC equal to their Medicaid claims (including any uninsured add-on payment and upper payment limit payment) less the MSC's administrative fee and contributions for MCE

scholarship and Missouri poison control network, plus an adjustment for participation in the pool (either an additional amount for revenue received from the pool, or a deduction for the amount of Medicaid revenue paid into the pool). This payment detail was included on monthly account statements issued by MSC to each participating hospital.

While the FRA State tax is mandatory, the MSC pooling arrangement is voluntary and not all hospitals participate. Participating hospitals sign a private contract that authorizes MSC to accept voluntary contributions on behalf of the hospitals and to redistribute such voluntary payments to other participating hospitals pursuant to a pre-established methodology. The State of Missouri has no control over the contractual relations between MSC and participating hospitals, or over the payments made to or from the MSC pool. The State of Missouri has no authority over the means or methodology applied by MSC for receiving Medicaid payments and redistributing such payments to participating hospitals.

The providers are Medicare-certified long-term acute care hospitals located in the State of Missouri that were subject to the FRA tax and have been participants in the MSC pooling arrangement since its inception. The Providers entered into separate contracts with MSC for this purpose. The Providers have received regular statements from MSC listing their payments to and from the MSC pool. On their Medicare cost reports, the Providers reported both their FRA tax payments and the payments they received from the MSC pool. The Providers claimed the amount of provider FRA tax each hospital paid to the State as an allowable expense on their cost reports. The Providers listed payments received from the MSC pool as revenue on their cost reports by reporting MSC pool payments as a reduction of their Medicaid contractual allowance adjustment.

B. Procedural History

The Providers' appeals cover fiscal year ends ("FYE") from 2000 to 2003.

2000

Wisconsin Physicians Service (formerly Mutual of Omaha) (the "Intermediary") audited Kindred – Kansas City's FYE August 31, 2000 cost report and issued an NPR dated September 19, 2003. On the original NPR, the Intermediary made no adjustments with regard to FRA tax expense or the pool payments.

On May 6, 2004, the OIG released a report on its review of 17 Missouri hospitals that purportedly received the largest MSC pool payments from the Association. See "Review of the Classification of Missouri Provider Tax Refunds on Hospitals' Medicare Cost Reports," May 2004, A-07-02-04006 (the "OIG Report"). The OIG found that 15 of the 17 hospitals recorded the pool payments as Medicaid revenue, rather than as a reduction of the FRA tax expense. The OIG concluded that CMS should instruct the Intermediary to reopen these hospitals' cost reports and make adjustments to reclassify the pool payments as tax refunds, to be offset against the FRA tax expense.

At the instruction of CMS, per the OIG report, the Intermediary reopened the Kindred Hospital – Kansas City FYE August 31, 2000 cost report and issued a revised NPR dated

September 15, 2004. Adjustment No. 4 to the revised NPR disallowed $1,714,610 "to reflect the non allowable FRA tax." Adjustment No. 5 to the revised NPR disallowed $2,267 in expenses claimed related to the administration of the Association's pool. The Intermediary issued a second revised NPR to the same cost report dated October 21, 2004. Adjustment No. 4 to the second revised NPR allowed $570,033 to "correct the allowable expense for FRA [tax] for previous excess revenue offset." The Providers determined that these adjustments have a total Medicare reimbursement impact of $484,728, the amount at issue in appeal PRRB No. 05-0717.

Kindred Hospital – Kansas City appealed these determinations (PRRB No. 05-0717) in a letter to the Board dated February 14, 2005. The Board acknowledged this appeal in a letter dated February 24, 2005.

2001-2003

At the instruction of CMS, per the OIG report, the Intermediary audited additional cost reports of the Providers and issued the NPRs listed in the chart below. As with Kindred Hospital – Kansas City's NPR for FYE August 31, 2000, these NPRs disallowed FRA tax expense by the amount of pool payments received to decrease FRA tax per a calculation based on review of State of Missouri documentation.

Kindred Provider	PRRB Appeal No.	NPR Date	Adj. No.	Costs Disallowed	Medicare Reimbursement Impact
Kansas City	05-0718	August 20, 2004	18	$1,205,030	$628,271
Kansas City	06-0165	June 10, 2005	4	$749,288	$408,361
Kansas City	06-0166	May 12, 2005	23	$1,377,838	$618,798
St. Louis	06-0121	April 27, 2005	9	$913,069[1]	$428,724
St. Louis	06-1729	March 9, 2006	6	$978,649	$667,316

The Provider appealed the disallowances to the Board and met the jurisdictional requirements of 42 C.F.R. §§ 405.1835 - 405.1841. The Board agreed to hear these six cases concurrently.

The Providers were represented by Jason M. Healy, Esquire, and Kevin M. Madagan, Esquire, of Reed Smith LLP. The Intermediary was represented by Ms. Stacey Hayes and Mr. Terry Gouger of Wisconsin Physicians Service.

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[1] The Intermediary used a summary schedule of MHA invoices to determine total provider tax and total pool payments. From that schedule they determined net allowable tax, subtracting total pool payments from total provider tax. During 2002, specifically on a June 20 invoice and a July 5 invoice, there were negative payments from the pool (or take backs) in the amounts of $234,535 and $17,403 respectively. These negative payments effectively reduced pool payments. However, the amounts were incorrectly noted on the Intermediary summary schedule as a pool payments received, therefore understating allowable provider tax. The Providers argue that a reduction in the amount of offset ($251,938) is needed to correct the adjustment. This is in the nature of a mathematical error in the Intermediary's adjustment – separate from the substantive basis for that adjustment.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends it properly reduced the Providers' FRA tax assessment (expenses) by the pool payments received from the Missouri Hospital Association. The Intermediary contends that the MSC pool payments are related to the FRA tax payments in such a way as to justify offsetting the pool payments as refunds of FRA tax expense. The Intermediary relies on an OIG report and its witness to contend that the sole purpose of the MSC pooling arrangement is to mitigate the impact of the FRA tax, thus serving as a return or refund. Both the Intermediary and the OIG believe that the State and MHA agreed to refund or at least mitigate the impact of the FRA tax in an effort to increase the State of Missouri's federal financial participation (FFP).

The Intermediary contends that it properly offset the MSC pool payments as returns or refunds of the FRA tax assessment citing Section 1861(v)(1)(A) of the Social Security Act which defines reasonable costs as, " . . . the cost actually incurred," implying that the FRA taxes paid were not actual costs incurred by hospitals that received MSC pool payments. The Intermediary further supports its adjustments under the authority of 42 C.F.R. §413.98(a) which states that "'refunds' of previous expense payments are reductions of the related expense."

The Intermediary also asserts that the MSC pool payments could be considered "applicable credits" which, under PRM § 2302.5, are "transactions that offset or reduce expense items that are allocable to cost centers as direct or indirect costs." An example of an "applicable credit" is "other income items which serve to reduce costs." The Intermediary argues that an MSC payment is an "other income item" because the payment serves to reduce the FRA tax. The Intermediary believes that Montefiore Medical Center (New York, N.Y.) v. BlueCross BlueShield Association/Empire Medicare Services, PRRB Decision No. 2006-D29, (June 5, 2006) (holding that rental income constituted a related income reducing costs) supports this argument.

PROVIDERS' CONTENTIONS:

The Providers argue that it was improper for the Intermediary to treat MSC pool payments the Providers received as provider tax refunds and to offset these funds as a reduction to the allowable provider tax expense. The Providers argue that paying the mandatory FRA tax and making voluntary payments to or receiving payments from the MSC pool are separate, unrelated transactions. The Providers contend that the MSC payments from the pool are "other revenue," and can never qualify as refunds, credits, or returns of the FRA tax paid. The Providers also contend that the transfers of funds via the MSC pool between hospitals qualify as donations or contributions to fund care provided to Medicaid and uninsured patients. Other revenue is not a "refund" of expenses to be offset against allowable expenses. Therefore, there is no basis to offset the revenue the Providers received from the MSC pool against the allowable provider tax expense the Providers incurred. Likewise, the Providers assert that, as voluntary contributions or donations, the payments from the MSC pool could not be properly offset against the Providers' FRA tax expense.

The Providers assert that payments from the MSC pool are not tax refunds for at least four reasons. First, the Missouri statute, Mo. Rev. Stat. § 208.461(1), precludes a refund of FRA taxes. Second, MSC is a private entity without authority to tax or issue a tax refund. Third, MSC is an agent of the Providers and other hospitals participating in the pooling arrangement under private contracts between the hospitals and MSC. MSC is not an agent of the State of Missouri. Fourth, the State-issued IRS Form 1099 reflects revenue amounts for tax purposes and the lack of any MSC pool payments on the State-issued Form 1099 confirms that an MSC pool payment is not a tax refund. The Providers further argue that the FRA tax and MSC pooling arrangement are not related so that the Intermediary or the OIG could conclude that an MSC payment constitutes a tax refund. Rather than upholding the reimbursement principle that Medicare pays its fair share of the costs of services to program beneficiaries, the Providers contend that the Intermediary has violated this principle by offsetting payments from the MSC pool against the FRA tax expense – an unrelated expense that shares none of the underlying characteristics of the MSC pool.

The Providers also contend that, under generally accepted accounting principles ("GAAP"), and Medicare reimbursement rules, payments from the MSC pool are not to be offset against the FRA tax expense. The Providers contend that the MSC pool payments are not some type of refund or credit; rather, payments from the MSC pool are properly considered "other revenue" in accordance with the American Institute of Certified Public Accountants ("AICPA") Audit and Accounting Guide for Health Care Organizations §10.07, because such payments are part of the ongoing major or central operations of the hospital. The Providers state that payments from the MSC pool are not "other revenue which serve to reduce costs" under the Provider Reimbursement Manual (PRM) §2302.5. Therefore, such payments cannot be deemed credits under the PRM. The Providers argue that, as "other revenue," PRM § 2302.5 directs that payments from the MSC pool should not be offset against the FRA tax expense because those pool payments are not an income item which serve to reduce costs. The Providers assert that the MSC pool payments are generated from a voluntary contractual arrangement among certain Missouri hospitals to help fund hospital services for Medicaid and uninsured patients. As such, payments from the MSC pool are not a reduction or a refund of the expense incurred by the Providers to pay the FRA tax.

The Providers argue that this reporting treatment is consistent in principle with guidance provided by a national accounting firm to MSC regarding how hospitals participating in the MSC pooling arrangement should treat the pool payments for financial accounting purposes, and consistent with the Providers' Medicare cost reporting treatment of payments from the MSC pool as a reduction in the Medicaid contractual allowance. Whether reported as the Providers have or as the accounting firm recommended, the payments from the MSC pool are revenue, consistent with the proper statement of revenues versus expenses under GAAP.

The Providers contend that the transfers of funds between hospitals also qualify as donations or contributions to fund care provided to Medicaid and uninsured patients. MSC pool payments, whether contributed to the pool or received from the pool, are the

result of this voluntary arrangement between the hospitals – an arrangement to which the State is not a party. Therefore, the Providers assert that these payments can be considered donations or unrestricted grants from one hospital to another. The Providers refer to PRM § 600 in support of their position that payments from the MSC pool should not be deducted or offset against the FRA tax expense.

The Providers label the OIG argument as unconvincing when considered alongside a previous review of the Missouri FRA hospital tax and MSC pooling arrangement conducted by CMS over a ten year period. In that review, CMS ultimately concluded the pooling arrangement was *not* being used to hold hospitals harmless from the FRA tax. Conversely, the Providers contend that, in their own review, the OIG ignored federal laws governing acceptable health care related taxes as well as the relevant facts in order to reach the opposite conclusion. The Providers assert that the OIG's vague references to unwritten "agreements" to help so-called "loser" hospitals that in some unspecified way made the payments from the MSC pool conditional lack merit. The Providers state that the contracts between the Providers and MSC confirm that these payments are unconditional and that participation in the pooling arrangement is voluntary. In sum, the Providers contend that the OIG Report cannot be used as a basis to support the Intermediary's adjustments.

The Providers also challenge the Intermediary's ability to recoup Medicare reimbursement on a retroactive basis when these hospitals reported their costs consistent with prior years, as audited by the Intermediary, received no notice of a change in policy, and were unfairly chosen for cost report reopening when many other Missouri hospitals were not. The Providers argue that they fully disclosed their treatment of the FRA tax expense and Medicaid pool payments to the Intermediary for eight years. They state that they relied upon the Intermediary's audit of their Medicare cost reports during those eight years without adjustment to offset such costs. The Providers also indicate that they received no prior notice of the new policy from the OIG report regarding the need to offset FRA tax expense with pool payments received. The Providers assert that it was inequitable for the Intermediary to single out only 17 Missouri hospitals to disallow legitimate FRA tax expense when well over 100 Missouri hospitals participated in the MSC pooling arrangement.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of Medicare law and guidelines, the parties' contentions and the evidence presented at the hearing, the Board finds that the Intermediary incorrectly treated the MSC pool payments the Providers received as refunds of the FRA tax and improperly offset such payments against the allowable FRA tax expense for the following reasons:

A. MSC Pool Payments Are Not Tax Refunds

The MSC pool payments are not refunds of the FRA tax. Missouri Statute §208.461(1) makes no provision authorizing a refund of FRA taxes. The only way under State law to

change the amount of FRA tax assessed on a hospital is for the hospital to petition the State before the tax is due.

The Board finds that payments from the MSC pool are not "refunds of previous expense payments" as contemplated under 42 C.F.R. § 413.98(a) ("'Refunds' of previous expense payments are reductions of the related expense."). The creation of the FRA tax and the MSC pooling arrangement at approximately the same time does not necessarily support the conclusion reached by the the Intermediary or the OIG that an MSC pool payment constitutes a tax refund that should be used to offset the FRA tax. The Board finds that the MSC pool payments derive from private contracts and that hospitals may voluntarily choose to participate in the MSC pooling arrangement. Not all Missouri hospitals subject to the mandatory FRA tax participate in the voluntary MSC pooling arrangement and, accordingly, the Board finds that the FRA tax and the pooling arrangement are independent of one another. Further, the Board was not persuaded by the Intermediary's argument that participation in the pooling arrangement was conditional. The contracts between participating hospitals and MSC express terms to the contrary.

Moreover, under 42 C.F.R. § 413.98(b)(3), refunds are "amounts paid back or a credit allowed on account of an overcollection." The Board finds no evidence of an overcollection (a prerequisite to qualifying a payment as a refund under section 413.98(b)(3)) in these cases.

The Board also finds that a payment from the MSC pool does not qualify as a tax refund because MHA and MSC are private entities. A tax refund may only be issued by a governmental authority or its representative and neither MHA nor MSC is a governmental authority or such representative. Neither of these entities can collect a tax or issue a tax refund. In addition, if a tax refund were issued at all by the State, it would be reflected on the State issued IRS Form 1099. The OIG report states that the pool payments were not reflected on the 1099s. The absence of MSC payments on the State issued IRS Form 1099 is evidence that the State played no role in making payments from the MSC pool.

The Intermediary's own witness testified that only Medicaid reimbursement is contributed by hospitals into the MSC pool. There is no basis to conclude that Medicaid reimbursement going into the MSC pool converted to tax refunds coming out of the MSC pool. The Board also finds it inconsistent that the OIG's report concluded under PRM §2122.1 that payments *into* the MSC pool may not be claimed by hospitals as tax expenses,[2] yet the report concludes that any payments *from* the MSC pool constitute tax refunds. Funds going into the MSC pool that are not tax expenses for cost reporting purposes are not transformed into tax refunds for cost reporting purposes when coming out of the MSC pool. The FRA tax expense is an unrelated expense that shares none of the underlying characteristics with payments from the MSC pool.

The Board agrees with the Providers that, unlike in Montefiore Medical Center (New York, N.Y.) v. BlueCross BlueShield Association/Empire Medicare Services, PRRB

[2] Exhibit P-4 page 14, footnote 3.

Hearing, Dec. No. 2006-D29 (June 5, 2006), there is no direct link between the expense (FRA tax) and the revenue (MSC pool payments) to warrant an offset of expense. In Montefiore, the Board found that rental income generated from renting apartments to employees should be prorated and offset against the operating and capital expenses of the apartments, rather than against the apartment operating expenses alone. The Board believes that the independent nature of the MSC pooling arrangement and the different underlying characteristics of the FRA tax and MSC pool payments make Montefiore inapplicable to the facts and circumstances of this case. The applicable Medicare principles and the relevant facts in the instant cases show that a direct expense-revenue relationship or link similar to the one in Montefiore does not exist in these cases.

B. MSC Pool Payments Are Not Credits, Give-Backs or Returns

The Board finds that the MSC pool payments are not credits or returns. In making this argument, the Intermediary asserts that the MSC pool payments could be considered an "other income item" under the definition of "applicable credits" which, under PRM §2302.5, are transactions that offset or reduce expense items that are allocable to cost centers as direct or indirect costs:

> 2302.5 Applicable Credits.--Those receipts or types of transactions which offset or reduce expense items that are allocable to cost centers as direct or indirect costs. Typical examples of such transactions are: purchase discounts, rebates, or allowances; recoveries or indemnities on losses; sales of scrap or incidental services; adjustments of overpayments or erroneous charges; and *other income items which serve to reduce costs.*
>
> (Emphasis added.)

Only "other income items *which* serve to reduce costs" qualify as applicable credits, not all "other income" items. The MSC pool payments are part of a funding mechanism for the state-wide care provided to Medicaid and uninsured patients. Consequently, the Board finds that a hospital's payment into the MSC pool does not constitute an allowable expense. Therefore the hospital's receipt of a payment from the MSC pool cannot result in the reduction of that expense. As a result, a payment from the MSC pool cannot be an income item which serves to reduce costs.

C. MSC Pool Payments Qualify as Other Revenue or Donations

The Board agrees the payments from the MSC pool are properly characterized as "other revenue" or as donations for financial accounting and Medicare cost reporting purposes. According to the AICPA Audit and Accounting Guide for Health Care Organizations §10.07, "other revenue" is derived from "services other than providing health care services or coverage to patients, residents, or enrollees."[3] Although reporting the payments from the MSC pool as "other revenue" or donations is different from the

[3] Exhibit P-17, page 264.

manner in which the Providers reported these payments, it is consistent in the sense that these are transactions which do not offset the FRA tax expense.

Revenues from operations are derived from activities that constitute an entity's ongoing major or central operations. The Board finds that MSC pool payments are derived as a result of the provision of services to Medicaid and uninsured patients. The Board, therefore, finds that this revenue is properly reported as "other revenue" and should not be used as an offset to the FRA tax expense.

The Board finds that even if MSC pool payments may qualify as donations under PRM §600, for the fiscal years at issue, PRM §600 requires that donations are not to be offset against expense, stating as follows:

> Unrestricted grants, gifts, and income from endowments should not be deducted from operating costs in computing reimbursable costs. Grants, gifts, or endowment income designated by a donor for paying specific operating costs for cost reporting periods beginning before October 1, 1983, should be deducted from the particular operating cost or group of costs. Restricted grants, gifts, and income from endowments designated for cost reporting periods beginning October 1, 1983, should not be deducted from the particular operating costs or group of costs.

Under the Financial Accounting Standards Board Statement Pronouncement No. 116, a contribution or gift is "an unconditional transfer of cash or other assets to a not-for-profit entity or a settlement or cancellation of its liabilities in a voluntary nonreciprocal transfer by another entity acting other than as an owner." The OIG and Intermediary assert that a hospital's participation in the pool redistribution is conditioned on their own self-benefit (namely, the additional Medicaid revenue generated from the FRA tax), which would prohibit a payment from the MSC pool as qualifying as a gift or donation. However, the Board can find no evidence in the record to support a finding that hospitals participating in the MSC pooling arrangement make conditional payments into the MSC pool.

D. MSC is a Separate and Unrelated Entity to the State

The Board notes that the Intermediary and OIG contend that the State and MHA colluded to create the FRA tax and MSC pooling arrangement, and that an additional unwritten agreement was negotiated and existed between these two entities. Even if this were true, those issues are not relevant to the Board's decision. Accordingly, the Board reaches no conclusions relative to the intermediary's speculation about motive. The Board finds persuasive the fact that before the OIG conducted its review, CMS concluded a ten-year review of the same FRA hospital tax and MSC pooling arrangement. In December 2002, CMS ultimately concluded after a lengthy review and discussions with the State of Missouri that the FRA tax did not violate the hold-harmless provisions of 42 C.F.R. §433.68(f).[4] These provisions specify that health care related taxes are permissible if they do not hold providers harmless for their tax costs. The argument posited by the

[4] Exhibit P-4, page 14.

Intermediary and the OIG is that hospitals agree to participate in the MSC pooling arrangement because they are held harmless from the FRA tax as a result. Use of the term "mitigate" by the Intermediary and the OIG as an alternative to "hold harmless" does not bring the analysis out from under the applicable federal laws and regulations governing acceptable health care related taxes. Nor is it plausible to ignore the Medicaid rules governing the FRA tax in connection with the Medicare reimbursement rules upon which the Intermediary relies to offset that tax. The OIG's insistence that they used a "form over substance" analysis to reach their conclusions is troubling and equally unconvincing. In sum, this is not an analysis that can be detached from the laws governing State health care related taxes and the specific facts of both the Missouri FRA hospital tax and the MSC pooling arrangement.

The MSC and hospital contracts clearly state that the purpose of the MSC pooling arrangement is to pool funds to enhance the ability of Missouri hospitals to provide health care services to beneficiaries of the Missouri Medicaid Program and to the uninsured. The subset of Missouri hospitals participating in the pooling arrangement voluntarily agreed to a redistribution of their Medicaid reimbursement from the State by directing their agent, the MSC, to administer the pool. The evidence submitted supports these representations.

DECISION AND ORDER:

The Intermediary's decision to treat payments the Providers received from the MSC pool as provider tax refunds, and offset such payments against allowable FRA tax expense, was inconsistent with the facts, Medicare laws, and program guidance. The Intermediary's adjustments are reversed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esq., Chairman
Yvette C. Hayes
Michael D. Richards, C.P.A.
Keith E. Braganza, C.P.A.
John Gary Bowers, C.P.A.

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: September 29, 2009

Attachment 1

Kindred Hospitals

Provider and Case number Summary

Provider Name	Provider#	Case#	FYE
Kindred Hospital – Kansas City	26-2011	05-0717	8/31/00
		05-0718	8/31/01
		06-0165	8/31/02
		06-0166	8/31/03
Kindred Hospital – St. Louis	26-2010	06-0121	8/31/02
		06-1729	8/31/03

CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Kindred Hospital - Kansas City **Kindred Hospital - St. Louis**	**Provider Cost Reimbursement Determination for Cost Reporting Periods Ended: 08/31/00, 08/31/01 08/31/02, 08/31/03**
Provider **vs.**	
Wisconsin Physician Services (formerly Mutual of Omaha)	**Review of:** **PRRB Dec. No. 2009-D42** **Dated: September 29, 2009**
Intermediary	

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in §1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). The parties were notified of the Administrator's intention to review the Board's decision. Comments were received from the Intermediary requesting reversal of the Board's decision. Comments were also received from the Provider requesting affirmation of the Board's decision.[1] Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue is whether the Intermediary's adjustments treating the Management Services Corporation (MSC) pool payments the Providers received as provider refunds, which were offset against the allowable provider tax expense, were proper.

The Board held that the Intermediary's decision to treat payments the Providers received from the MSC pool as provider tax refunds, and offset such payments

[1] The Center for Medicare Management submitted untimely Comments after the prescribed commenting period, and thus, those comments were not considered.

against allowable FRA tax expense, was inconsistent with the facts, Medicare laws, and program guidance. The Board reversed the Intermediary's adjustments.

The Board found that the MSC pool payments are not refunds of the Federal Reimbursement Allowance Program (FRA) tax since the only way under State law to change the amount of FRA tax assessed on a hospital is for the hospital to petition the State before the tax is due.

The Board stated that payments from the MSC pool are not "refunds of previous expense payments" as contemplated under the regulation at 42 C.F.R. §413.98(a) ("Refunds of previous expense payments are reductions of the related expense.") The Board points out that the creation of the FRA tax and the MSC pooling arrangement at approximately the same time does not necessarily support the conclusion reached by the Intermediary or the Office of the Inspector General that an MSC pool payment constitutes a tax refund that should be used to offset the FRA tax.

The Board found that payments from the MSC pool does not qualify as a tax refund because the Missouri Hospital Association (MHA) and MSC are private entities. According to the Board, a tax refund may only be issued by a governmental authority or its representative and neither MHA, nor MSC, is a governmental authority or representative of such.

The Board found that the MSC pool payments are not credits or returns. In making this argument, the Board states that MSC pool payments are part of a funding mechanism for the state-wide care provided to Medicaid and uninsured patients. Hence, such payments to hospitals into the MSC pool do not constitute an allowable expense. Therefore the hospitals that receive payments from the MSC pool cannot result in the reduction of that expense, since MSC pool payments cannot be an income which serves to reduce costs.

Instead, the Board found that payments from the MSC pool are properly characterized as "other revenue" or as donations for financial accounting and Medicare cost reporting purposes. The Board stated that "other revenue" is derived from "services other than providing health care services or coverage to patients, residents or enrollees." Therefore, since only "other income items which serve to reduce costs" qualify as applicable credits, and not "all other income", such as the non cost-reducing revenue at issue qualify as credits, give-backs or returns, the MSC pool payments in this case do not offset FRA tax expenses.

SUMMARY OF COMMENTS

Providers Comments

The Providers requested affirmation of the Board's decision. The Providers stated that the Board correctly held that MSC pool payments are not refunds of the FRA tax. The Providers asserted that Missouri Statute 208.461(1) provides no provision authorizing a refund of FRA taxes, except under limited circumstances not involved here. Therefore, payments from the MSC pools are not "refunds of previous expense payments" as contemplated under 42 C.F.R. §413.98(a), and the FRA tax and the pooling arrangement are independent of one another. MSC pool payments are derived from private contracts and hospitals may voluntarily choose to participate in the MSC pooling arrangement.

The Providers stated that MSC pool payments are not credits, give-backs or returns, as contemplated under PRM §2302.5 because only "other income items which reduce costs" qualify as an applicable credit, not all other income items as asserted by the Intermediary. Since the MSC pool payments are part of a funding mechanism for state-wide care provided to Medicaid and uninsured patients, a hospital's payment to the MSC pool could not constitute an expense, and another hospital's receipt of a payment from the MSC pool could not result in the reduction of an expense. Therefore, a payment from the MSC pool cannot be an income item which serves to reduce costs.

According to the Providers, a payment from the MSC pool is properly characterized as "other revenue" for financial accounting and Medicare cost reporting purposes. These payments are unrelated to, and should not be used as an offset to, the FRA tax expense.

Intermediary Comments

The Intermediary requested reversal of the Board's decision. The Intermediary argued that the MSC pool payments serve to reduce the FRA tax burden. Therefore, the Intermediary's adjustments made to offset the FRA tax expense were appropriate. According to the Intermediary, the statute defines reasonable costs as: "the cost actually incurred" and the regulations allow for reductions of expenses when related funds are received. Furthermore, the manual instruction allows the offset of an expense by the receipt of "other income" items which serve to reduce costs.

The Intermediary pointed to the Office of the Inspector General's (OIG) report, dated May 6, 2004, which concluded that the MSC pool payments should be offset against

the FRA tax expense because the pool was established to mitigate the provider tax imposed by the State.

The Intermediary stated that the purpose of the MSC pool is for "enhancing the ability of Missouri hospitals to provide health care services to beneficiaries of the Missouri Medicaid Program and to the uninsured." However, it is the FRA tax itself which results in increased Medicaid funding, which enhances Medicaid beneficiaries. The MSC pool is simply a redistribution system that does not restrict how the funds may be used. The redistribution formula considers the FRA tax to determine which hospitals contribute funds to the pool, as well as the hospitals which receive funds from the pool. The OIG report concluded that the contributions to the pool were not "unconditional." Thus, the contributions cannot be considered to be donations.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

Section 1861(v)(1)(A) of the Social Security Act establishes that Medicare pays for the reasonable cost of furnishing covered services to program beneficiaries, subject to certain limitations. This section of the Act also defines reasonable cost as "the cost actually incurred, excluding there from any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." The Act further authorizes the Secretary to promulgate regulations establishing the methods to be used and the items to be included in determining such costs. Consistent with the statute, the regulation at 42 C.F.R. §413.9 states that all payments to providers of services must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries. The implementing regulation at 42 C.F.R. §413.9(a) provides that "reasonable costs" includes "all necessary and proper costs incurred in furnishing the services subject to principles relating to specific items of revenue and cost."

In determining what constitutes a reasonable cost, 42 C.F.R. §413.98 provides for reductions due to purchase discounts, allowances and refunds of various expenses:

> (a) Discounts and allowances received on purchases of goods or services are reductions of the costs to which they relate. Similarly, refunds of previous expense payments are reductions of the related

> expense.
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> ****
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> (b)(3) Refunds are amounts paid back or a credit allowed on account of an over collection.
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> (c) All discounts, allowances and refunds of expenses are reductions in the costs of goods or services purchased and are not income. If they are received in the same accounting period in which the purchases were made or expenses were incurred, they will reduce the purchases or expenses of that period. However, if they are received in a later accounting period, they will reduce the comparable purchases or expenses in the period in which they are received.

Providing additional guidance about purchase discounts, allowances, and refunds, the CMS Provider Reimbursement Manual (PRM) 15-1, Section 2302.5 defines "Applicable Credits," that offset or reduce expense items listed on a cost report as follows:

> Those receipts or types of transactions which offset or reduce expense items that are allocable to cost centers as direct or indirect costs. Typical examples of such transactions are: purchase discounts, rebates, or allowances; recoveries or indemnities on losses; sales of scrap or incidental services; adjustments of overpayments or erroneous charges; and other income items which serve to reduce costs.[2]

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[2] The Administrator notes that the term "other income" is generally defined as income activities that are not undertaken in the ordinary course of a firm's business, while the term "other revenue" is generally defined as revenue from sources other than regular sources. Hence, the use of the term "other income" or "other revenue" appears interchangeable. See also Transcript of Oral Hearing (Tr.) at 173. (Provider Witness: "A. Well since the payments from the pool which is coming from the MSC cannot be identified with an individual patient and an individual service provided they really can't be designated as patients services and really related to other revenue or other income.")

This particular case involves the Providers' Medicare cost report treatment of the payments they received from a privately-administered pooling arrangement in which certain Missouri hospitals participated.

In 1992, the MHA created a voluntary Medicaid pool arrangement on behalf of Missouri hospitals that chose to participate. The pooling arrangement provided for the distribution of funds among participating hospitals with the purpose of enhancing the ability of Missouri hospitals to provide health care services to patients who are uninsured and to Medicaid beneficiaries. The hospitals first paid the FRA tax directly to the State by check or requested that the tax be deducted from their Medicaid reimbursement.

Under the MHA's pooling arrangement, the MSC was authorized by participating hospitals to endorse and deposit the checks issued by the State to the respective hospitals into separate bank accounts maintained by each participating hospital and such funds were in turn transferred to an MSC bank account (the MSC pool).[3] Generally the State payments included Medicaid DSH (add-on) payments in addition to payments for Medicaid claims.[4] The MSC then reallocated this revenue to hospitals participating in the pool pursuant to an agreed-upon payment methodology. According to the agreement, each hospital received a net payment from MSC equal to their Medicaid claims net payment (after reduction for FRA assessment payment) and including any uninsured add-on payment and upper payment limit payment, i.e., Medicaid DSH payment) less the MSC's administrative fee and contributions for scholarship and poison control network, plus an adjustment for participation in the pool (either a payment received from the pool, or a deduction for the amount of the Medicaid revenue paid into the pool).[5] This payment detail, which, inter alia, showed the FRA assessment, were included on monthly account statements issued by MSC to each participating hospital.[6]

While the FRA State tax is mandatory, the MSC pooling arrangement is voluntary and not all hospitals participate. Participating hospitals sign a private contract that authorizes MSC to accept and deposit a hospital's State payment contributions on behalf of the hospitals and to redistribute such voluntary payments to other

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[3] See, Agreement between the Providers and MHA, Providers' Final Position Paper at Exhibit, P-16, No.13.

[4] See, e.g., Intermediary Exhibits I-13, I-14, I-15 (Intermediary Workpapers and MSC remittance advices)

[5] See, e.g., Provider Exhibit P-14-2 Schedule A Calculation Worksheet at 00138.

[6] See, e.g., Intermediary Exhibits I-13, I-14, I-15 (MSC remittance advices)

participating hospitals pursuant to a pre-established methodology. The Providers' Agreement with MHA[7] explains how the pool funds are created, stating:

> Hospital authorizes MSC, as agent, to withhold certain funds received by MSC from Hospital that have been paid to Hospital by the program for the purpose of redistributing said funds or a portion thereof to other hospitals to enhance such hospitals' ability to provide health care to Medicaid beneficiaries and the uninsured. This amount is separate and apart from amounts withheld pursuant to paragraph 2.c. of this Agreement. Such separate funds managed on behalf of Hospital are not the property of MSC in accordance with this Agreement and will be consolidated with like funds from other hospitals. Such consolidation of funds will constitute the Pool.

The Providers in this case are Medicare-certified long-term acute care hospitals located in the State of Missouri that were subject to the FRA tax and have been participants in the MSC pooling arrangement. The Providers entered into separate contracts with MSC for this purpose. The Providers have received regular statements from the MSC listing their payments to, and from, the MSC pool. On their Medicare cost reports, the Providers reported both their FRA tax payments and the payments they received from the MSC pool. The Providers respectively claimed the amount of provider FRA tax each hospital paid to the State as an allowable expense on their cost reports. The Providers listed payments received from the MSC pool as Medicaid revenue on their cost reports by reporting MSC pool payments as a reduction of their Medicaid contractual allowance adjustment.

The Providers' appeals cover fiscal years ending (FYE) from 2000 to 2003. The Intermediary audited the Provider's [Kindred Hospital – Kansas City] FYE August 31, 2000 cost report, and issued an NPR, dated September 19, 2003. On the original NPR, the Intermediary made no adjustments with regard to FRA tax expense, or the pool payments.

On May 6, 2004, the OIG released a report on its review of 17 Missouri hospitals that purportedly received the largest MSC pool payments from the Missouri Hospital Association or MHA.[8] The OIG found that 15 of the 17 hospitals recorded the pool payments as Medicaid revenue, rather than as a reduction of the FRA tax expense. The OIG concluded that CMS should instruct the Intermediary to reopen these

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[7] See, Providers' Final Position Paper at Exhibit P-16, No. 3.

[8] See "Review of the Classification of Missouri Provider Tax Refunds on Hospitals' Medicare Cost Reports," May 2004, A-07-02-04006 (the "OIG Report").

hospitals' cost reports and make adjustments to reclassify the pool payments as tax refunds, to be offset against the FRA tax expense.

At the instruction of CMS, and pursuant to the OIG report, the Intermediary reopened the Provider's [Kindred – Kansas City] FYE August 31, 2000 cost report, and issued a revised NPR dated September 15, 2004. Adjustment No. 4 to the revised NPR disallowed $1,714,610 "to reflect the non allowable FRA tax." Adjustment No. 5 to the revised NPR disallowed $2,267 in expenses claimed related to the administration of the Association's pool. The Intermediary issued a second revised NPR for the same cost report, dated October 21, 2004. Adjustment No. 4 to the second NPR allowed $570,033 to "correct the allowable expense for FRA tax for previous excess revenue offset." The Provider determined that these adjustments have a total Medicare reimbursement impact of $484,728, the amount at issue in appeal PRRB No. 05-0717. For FYEs 2001 through 2003, at the instruction of CMS, and pursuant to the OIG report, the Intermediary audited additional cost reports of the Providers and issued several NPRs. As with the Provider's NPR for FYE August 31, 2000, these NPRs offsetting the FRA tax expense by the amount of pool payments received to decrease FRA tax.

After consideration of the law, regulations, policy guidelines and the administrative record, the Administrator finds that the Intermediary correctly treated the MSC pool payments the Providers received as a reduction of the costs of the FRA tax and properly offset such payments against the allowable FRA tax expenses.

The history of the Missouri FRA program shows that the State and the Missouri Hospital Association originally proposed, in 1990, a voluntary contribution program. Under this proposal, hospitals would be compensated for some of the uncompensated care costs with the understanding that hospitals would contribute some of the funds back to the State to be used to pay the State share of the uncompensated care payments necessary to draw matching Federal dollars and underwrite some of the State's costs of operating the basic Medicaid program. The "FRA Briefing Book"[9] explained that: "Under the voluntary contribution program, there were no losers. All hospitals received payments in excess of their contribution."

However, in 1992, the Federal government enacted "The Medicaid Voluntary Contribution and Provider- Specific Tax Amendments of 1991" (Pub. Law 102-234). The Public Law 102-234 required the phasing out of the Voluntary Contribution program and established alternative criteria for Medicaid provider assessment or tax programs. As a result, the State of Missouri enacted the Federal Reimbursement Allowance (FRA) law, which in complying with the Federal law, imposed a

[9] Provider Exhibit P-14-4.

uniformed and broad based tax. This tax did not rely heavily on disproportionate share hospitals contributions and was originally based on patient days, which was later based on operating revenue. Moreover, because of these changes, the State concluded that all hospitals would receive disproportionate share payments. As the FRA Briefing Book explained:

> The [DSH] payments were based on a hospital's Medicaid contractual adjustment and 15 percent of a hospital's Medicare contractual adjustment. The inclusion of 15 percent of the Medicare contractual adjustment allowed the payments to hospitals to be structured in such a way that extreme variation in payments could be avoided. **MHA's objective in reviewing the [DSH] payment was to have this component of the FRA payment system offset the FRA assessment.** **** *Under the provisions of Public Law 102-234 some hospitals became "losers", meaning that their FRA disproportionate share payments did not exceed their FRA assessments.*

The MHA thus initiated the "Hold Harmless" pool, an arrangement that saw further increased participants due to the Omnibus Budget Reconciliation Act of (OBRA) 1993 attempts to contain the growth of the Medicaid program. These provisions limited the Medicaid disproportionate share payments to no more than the costs of serving Medicaid patients and the costs of the uninsured, thus requiring the State's removal of the 15 percent of the Medicaid contractual adjustment in the formula for determining State of Missouri "FRA-based [DSH] payments. When the 15 percent of Medicaid contractual adjustment was removed from the [DSH] payment, it was no longer possible to avoid wide variations in payments among hospitals….. Under OBRA '93 the number of losers increased and the amount of losses increased."[10] Correspondingly, the number of hospitals that volunteered to join the pooling arrangement significantly increased. The Missouri Hospital Association explained:

> The enactment of Public Law 102-234 created a dilemma for Missouri's hospitals. The law's requirement of a broad-based and

[10] The FRA Briefing Book at 00165 The FRA Briefing Book also showed the "Impact on the FRA on the State Medicaid Appropriations: FY 1996" showing hospital DSH payments of $360 million and Hospitals tax payment of $316 million (which allows Federal matching of $475 million). Id. 00165. See also Provider Exhibit P-1 showing "How FRA Works" State fiscal year 2002, showing Hospital Assessments of $463 million, $678 million of Federal matching with the resultant expenditures of a total of $1,112 million including $311 million for DSH, $249 million for direct payments, $311 million for hospital care, $181 million for managed care, $57 million for 1115 waiver.

> uniform assessment forced some hospitals to pay a tax substantially in excess of any benefit they would derive from the program. A review of the federal law led to the conclusion that hospitals could engage in a pooling arrangement to mitigate the impact of a broad-based, uniform assessment. Under the pooling arrangement, funds are withheld from hospitals that are winners under the program. Winners are defined as hospitals with certain designated Medicaid payments in excess of their FRA assessments. The withheld funds are transferred to the hospitals that are losers. Losers are defined as hospitals with an FRA assessment in excess of their designated Medicaid payments. This pooling arrangement is voluntary, and not all hospitals participate.
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> ***
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> In July 1996, because of concerns of the Health Care Financing Administration about the uniformity of the tax, the DSS converted the FRA based on patient days to an assessment based on net-patient service revenue minus Medicaid net patient-service revenue. With this change in taxing methodology, the number of hospitals paid from the pool increased from 51 to 71. (The 71 hospitals include those that received a pool payment to cover their nursing home assessment.) In SFY 1999, the state began to include Medicaid net patient revenue and other revenue in its assessment calculation. In SFY 2004, 79 hospitals received payments from the pool.[11]

In sum, under the FRA program, the State assessed a provider tax for use in the Medicaid financing formula, which allowed the State to increase matching Federal funding and provide higher reimbursement to Medicaid providers. The MHA, long a partner with the State in developing sources of revenue for providing uncompensated and Medicaid care, created the redistribution arrangement on behalf of the Providers to mitigate the impact of the provider tax.[12] As a result of the FRA tax assessment program and changes in the Federal law which affected the Medicaid DSH formula and the State's ability to directly mitigate the tax burden, certain Missouri hospitals elected to participate in the redistribution arrangement managed by the Missouri Hospital Association. This pool arrangement allowed for a distribution of the increased funding that occurred as a result of the FRA tax based on the provider's tax burden. The pooling arrangement created a redistribution methodology under which payment in excess of a hospital's FRA tax assessment would be redistributed to those

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[11] See Intermediary Exhibit I-4, "Missouri Hospital Association-FRA History and Background."

[12] See, Intermediary Final Position Paper at 7.

Missouri providers that did not receive Medicaid reimbursement in excess of their FRA tax assessment.

The objective for establishing the system that returned funds to the providers was to "offset" or ease the severity of the FRA tax assessment and diminish the effects of changes in law that resulted in wide disparity in the impact of the tax, an objective, which, in practice, was achieved. This objective, in practice, can be seen in the computation formula of the remittance advices which shows the FRA obligation of the respective participant and the amount of its Medicaid DSH add-on payment. The pool payment is shown when the tax burden was not sufficiently eased by the DSH payment for that period.[13] The remittance advices show the pool participation payment was linked to the amount of the FRA tax assessed on the individual hospital and the amount of its Medicaid DSH payment. The MHA/MSC remittance advices recorded the Medicaid add-on (DSH) payment, the FRA tax withheld, and the pool payment to the provider for that period.[14] The pool contributors and pool receivers were directly linked to, and determined by, the amount of the tax assessment and the amount of the DSH payment.[15]

Generally, the providers that received a payment from the pool were assessed a FRA tax that exceeded the Medicaid add-on (DSH) payment amount. Those providers with a tax assessment amount less than the Medicaid add-on payment amounts were not adversely affected by the hospital provider tax and were not awarded an additional payment from the pool.[16] Thus, for providers receiving a payment from the pool, these payments were specifically designed to reduce the tax assessment burden determined by the State.

Based on the foregoing, the Administrator finds that the record shows an integral nexus and link between the FRA tax assessment program and the pooling arrangement payments. As the history of the FRA program shows, the State and the

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[13] See, e.g., Intermediary Exhibits I-13, I-14, I-15 (MSC remittance advices), Intermediary Exhibit I-17. Attachment 1.

[14] See Id. As noted above in Provider Exhibit P-1, the total amount of DSH payment expenditures by the State was less than the amount of the FRA assessments. Thus, it is reasonable that the pool participation payment to an individual hospital may not result in a dollar for dollar recovery of the tax burden incurred, but rather reduce the tax burden.

[15] See, also e.g. Provider Final Position Paper, at 10. ("The reasons the hospitals needed to join in this voluntary association was that the State's distribution mechanism of the additional Medicaid funds realized from the FRA tax assessment and the resulting Federal match was not equitable to all hospitals.")

[16] See, e.g., Intermediary Exhibits I-13, I-14, I-15 (MSC remittance advices), Intermediary Exhibit I-17-Attachment 1.

Missouri Hospital Association were long partners in working together to seek financing for Medicaid and uncompensated care individuals. Because of Federal law changes, the State's Medicaid DSH payment to a respective provider could no longer be guaranteed to directly track a provider's FRA assessment. The FRA tax amount was assessed broadly based on all revenue (both operating and other) and unrelated to the Medicaid DSH payment. No longer did the FRA tax assessment weigh more heavily on the hospitals receiving significant DSH payments therefore causing the MHA's establishment of the pool to accomplish what State law no longer could. But for the FRA tax assessment and the Federal limitations placed on such tax funds and Federal limitations placed on the mitigation of the burden by DSH payments, the pooling arrangement at issue in this case would not have been created by the Missouri Hospital Association. Likewise, the record shows that the FRA tax assessments and the payments of funds derived directly and indirectly from that tax through the DSH payments drove the pools payment methodology.

Therefore, the Administrator finds that payment from the pool must be used to offset the tax assessment. The reasonable cost rules require that a provider be reimbursed the costs actually incurred. In this case, the actual costs incurred are properly determined with respect to the tax assessments once the related pool payment is recognized and offset. Similarly, the regulation at 42 C.F.R. §413.98(a)[2003] states that refunds of previous expense payments (such as FRA taxes) are reductions (offsets) of the related expense, just as other income (the pool payment) should be used to reduce the related cost (the FRA tax assessment) under §2302.5 of the PRM.. A reduction to the amount "paid from the pool" is required under reasonable cost principles which allows only the costs actually incurred under §2302.4 of the PRM as the "other income" received from the pool was because of the FRA tax assessment.[17]

In addition, contrary to the Providers' assertion, the payments to the pool cannot be considered donations or unrestricted grants from one hospital to another hospital. The Administrator finds inter alia, that the contribution was not unconditional and, thus, cannot be considered a donation. The record shows that the pool itself, not the individual hospital, calculated the contribution amount based on a formula. The contributions by the hospitals were driven or conditioned by the underlying mechanism whereby the hospital was assured that it would have some relief overall from the FRA tax assessments if needed. Overall, the pool also ensured cooperative

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[17] As stated previously, "For services reimbursed on the basis of actual cost, the Medicare program's clear intent is to pay the "net cost of covered services." Inherent in the definition of "net costs" is the concept that expenses must be reduced by any related income earned … form cannot prevail over substance…." See, Montefiore Medical Center (New York, N.Y.) v. BlueCross BlueShield Association/Empire Medicare Services, PRRB Hearing, Dec. No 2006-D29; Intermediary Exhibit I-7.

compliance and agreement with the tax assessment that allowed for the matching Federal funds benefits and increased Medicaid payments overall. Thus, the payment to the pool cannot be considered unconditional and, hence, a donation.

Further, the OIG Report released May 6, 2004, also found that other funds paid from the pool as the "pool redistribution amounts" also known as "payment from the pool" were not included in the IRS Form 1099 released annually by the Missouri Medicaid Department of Social Services. The Administrator finds that, while treated as Medicaid revenue by the Providers, there was no evidence that the pool payment was shown as Medicaid revenue through the IRS Form 1099 reporting process. This is further cumulative evidence that the "payment from the pool" was not Medicaid operating revenue as originally claimed and, but rather a payment to offset the burden of the FRA tax and, consequently, a payment that reduced the costs incurred from the tax under reasonable cost rules and principles.[18]

In sum, the Administrator finds that the Intermediary properly revised the Providers' Medicare cost reports to identify improper classification of payments and ensure the integrity of the Medicare Trust Fund by treating the Providers' MSC pool payments as offsets against the Providers' allowable tax expense.[19]

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[18] The Administrator notes that the Board found, based on the OIG Report, that CMS determined after ten years of review, that the arrangement under Medicaid rules did not violate the hold harmless provision of 42 CFR 433.68(f). However, the OIG Report stated that: "CMS and the State ultimately arrived at a compromise for Medicaid purposes in December 2002. As part of the agreement, the State agreed to change its financing formula." Thus, while not having a conclusive bearing on this case, it would not be accurate to state based on the OIG Report summary, that CMS concluded that the arrangement did not violate the Medicaid hold harmless rule.

[19] The Administrator notes that such offsets should only include positive pool payments from the fund to the Providers and not pool contributions. See Tr. at 80-84.

DECISION

The decision of the Board is reversed in accordance with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 11/20/09

/s/
Michelle Snyder
Acting Deputy Administrator
Centers for Medicare & Medicaid Services

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

Charles Greenberg
Director of Hospital Finance and Waiver Programs
Health and Human Services Commission
4900 N. Lamar Boulevard
Austin, Texas 78751

Dear Mr. Greenberg:

On September 21, 2018, the Centers for Medicaid & CHIP Services (CMCS) sent questions to the State of Texas requesting information about how the state is financing the non-federal share of several Medicaid payments. In light of previously expressed CMS concerns regarding the state's financing and the August 7, 2018 decision from the Department of Health and Human Services' Departmental Appeals Board, CMCS has requested this information to ensure the state is financing its Medicaid program consistent with federal requirements and is exercising program oversight necessary for ongoing compliance. Please provide a response within 30 days of receipt of this letter.

On November 16, 2018, the state provided information regarding health care-related taxes in Dallas and Tarrant counties that have replaced impermissible financing. Based on CMCS' review of this information, the Dallas and Tarrant county taxes appear to meet the broad-based and uniformity requirements at section 1903(w) of the Social Security Act (the Act) and implementing regulations at 42 CFR part 433. Further, the use of such funds to finance certain Medicaid payments, as described in the information provided, does not appear to constitute a hold harmless arrangement prohibited by section 1903(w) of the Act and implementing regulations. To the extent CMS discovers at a later date that these financing arrangements do, in fact, violate federal statute and regulation, CMS may take action to enforce compliance.

We appreciate the action taken to replace impermissible arrangements in Dallas and Tarrant counties. We hope that this progress will now allow the State and CMCS to timely address the permissibility of other financing arrangements throughout the state and related state oversight. In its November 16, 2018 response, the state indicated it would respond at a later date to CMS requests regarding these additional concerns. Recently, the state notified CMS that it plans to conduct a state-wide survey to obtain information regarding the financing mechanisms in other local jurisdictions. We understand that the state is initiating this survey during the week of December 10, 2018.

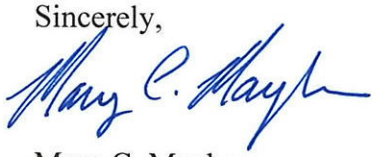
In addition, the state provided CMS an analysis of a proposed structural change that you believe could alleviate any concerns beginning October 1, 2019. CMS is now reviewing the information the state provided and will respond as soon as possible.

Thank you again for the recent information. We look forward to obtaining the remainder of the information previously requested on September 21, 2018, including the state's detailed plan and timeline outlining corrective action for any impermissible financing arrangements that may be currently in use. CMS recognizes that corrective action may require consideration by the Texas legislature, which will convene in January and only meets every two years. Therefore, we are asking that the State submit this information and plan within 30 days of receipt of this letter, which CMS will view as evidence of a good faith effort by the state to resolve these outstanding concerns. Such a good faith effort will be taken into consideration as CMS weighs the need for further compliance action, including but not limited to further deferrals or disallowances in counties where CMS has completed a financial management review (FMR) or initiating new FMRs.

Please be reminded that CMS expects all financing arrangements in Texas to comply with statute and regulations and remains committed to working with the state to ensure compliance.

CMS continues to be available to provide technical assistance to the state as necessary. Please contact Kristin Fan should you have any questions or need assistance.

Sincerely,



Mary C. Mayhew
Deputy Administrator, Director

cc: Bill Brooks, Associate Regional Administrator, Dallas

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the General Counsel
Centers for Medicare &
Medicaid Services Division

August 23, 2019

NOTE TO RORY HOWE

Re: Missouri Federal Reimbursement Allowance (FRA) Tax Program

You have asked whether the contents of an August 2, 2019 letter from the Director of the Missouri Department of Social Services to the Center for Medicaid and CHIP Services (CMCS) Acting Director (state's letter) affects our previously expressed agreement that CMS reasonably could conclude that the Federal Reimbursement Allowance (FRA) health care-related tax program in Missouri includes a hold harmless arrangement under 42 C.F.R. §433.68(f)(3), because the state imposes the tax and provides for payments that directly guarantee to hold the taxpayers harmless for all or any portion of the tax amount. As discussed below, the state's letter does not affect our position.[1]

42 C.F.R. §433.68(f)(3) provides, in relevant part, that a hold harmless arrangement exists where the state imposing the tax provides for any direct or indirect payment such that the provision of the payment directly guarantees to hold taxpayers harmless for all or any portion of the tax amount.[2] In preamble to a 2008 final rule amending this provision, CMS affirmed its explanation in preamble to the proposed rule that "[a] direct guarantee will be found when a State payment is made available to a taxpayer or a party related to the taxpayer in the reasonable expectation that the payment would result in the taxpayer being held harmless for any part of the tax." 73 FR 9685, 9695 (Feb. 22, 2008) (confirming preamble statement in 72 FR 13726, 13730 (Mar. 23, 2007)).

As we understand it, Missouri imposes a tax of less than 6 percent of revenue, separately for inpatient and outpatient hospital services. These taxes support fee-for-service (FFS) add-on payments for hospital services and increased managed care capitation rates that support increased payments for hospital services. There is a voluntary "FRA pool" program operated by the Missouri Hospital Association (MHA) into which participating hospitals pay amounts from their stream(s) of payments that are supported by the FRA tax. The MHA then applies an FRA pool payment methodology to redistribute these amounts among the participating hospitals using a formula that we understand takes into account the hospitals' volume of care furnished to Medicaid beneficiaries and the uninsured. Although the MHA-published "FRA Tutorial" document that you supplied[3] asserts that "[f]or various reasons, the amount of the tax paid by each hospital bears no direct relationship to the amount of FRA-funded payments it receives for treating Medicaid and uninsured patients," in the same paragraph, the MHA explains that the

[1] We are also attaching the state's letter to the transmittal e-mail for this Note.

[2] The regulation also provides that a hold harmless arrangement exists where the provision of the payment indirectly guarantees to hold taxpayers harmless. Whether there is an indirect guarantee is determined under a two-prong test, which the subject Missouri tax appears to satisfy because it is less than 6% of taxpayer revenues. *See* 42 C.F.R. §433.68(f)(3)(i)(A).

[3] We are also attaching the "FRA Tutorial" document to the transmittal e-mail for this Note.

FRA pool program collects and redistributes "only what is needed to ensure that no pool participant pays more in FRA tax than it received in FRA-funded payments," FRA Tutorial, at 2. This is consistent with a publicly available statement by the MHA Vice President of Governmental Relations 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. By insulating pool participants against financial loss, the pooling arrangement enables industry concurrence with the state's use of provider taxes, which generates more funding than likely would be possible under alternative scenarios.[4]

Notably, these characterizations of the FRA tax program by the MHA are also consistent with the state's own statements, including a state program assessment that describes the MHA-operated FRA pool program as an "attempt to make the tax closer to budget neutral for hospitals" involving "efforts to compensate hospitals for their costs attributable to the FRA assessment."[5] A graphic depiction of the FRA fund flows reflects that an "[i]ntention of [the] voluntary MHA pooling arrangement is participation of all FRA paying hospitals," and explains that, "[t]o net out the FRA paid with the payments received, MHA reimburses providers that receive less in FRA-funded payments than they pay [in FRA taxes.]"[6]

We understand CMCS-Financial Management Group to believe that, because of the MHA-operated voluntary FRA pool program, the state's payment of FFS add-ons and increased capitation rates supported by the FRA tax to increase hospital payments directly guarantees to return to the taxpaying hospitals all or a portion of their tax amounts. The state counters that it is not involved in the MHA-operated FRA pool program in any way; the state is not a party to the FRA pool agreement (which takes the form of a memorandum of understanding (MOU) between the MHA and each participating hospital) and "in no way directed either party as to [the] terms [of the MOU]." "The non-involvement of the State," argues Missouri, "in itself should satisfy CMS that there is no hold harmless violation." State's letter, at 1.

We do not think it is dispositive that the state itself is not directly involved in setting the terms of, or administering, the FRA pool. In preamble to the proposed rule that preceded the February 2008 final rule on health care-related taxes, CMS stated that a direct guarantee would be found "when a state payment is made available to a taxpayer or a party related to a taxpayer (for example as a nursing home resident is related to a nursing home), in the reasonable expectation that the payment would result in the taxpayer being held harmless for any part of the tax." 72 FR at 13730. In final rule preamble, CMS explained that it chose the term "reasonable expectation" because "state laws were rarely overt in requiring that state payments be used to hold taxpayers harmless." 73 FR at 9694. By its own statements, Missouri is aware of the availability of the FRA pool program to hospitals subject to the FRA tax, and shares (or at least is aware of) an

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[4] Daniel Landon, "Missouri's Hospital Provider Tax Pooling Arrangement," https://web.mhanet.com/article/4387/Missouri8217sHospital-Provider-Tax-Pooling-Arrangement.aspx?articlegroup=2663, June 1, 2016 (accessed Aug. 19, 2019).

[5] Missouri Department of Social Services, "Rapid Response Review – Assessment of Missouri Medicaid Program FINAL REPORT," p. 22, https://dss.mo.gov/mhd/mt/docs/mhd-rapid-response-review.pdf, Feb. 11, 2019 (accessed Aug. 19, 2019).

[6] *Id.*

"intention" that all such hospitals should participate in the FRA pool so that they can be reimbursed if their increased Medicaid payments supported by the FRA tax are insufficient to compensate them for their FRA tax costs. Although we do not know whether all hospitals subject to the FRA tax in fact participate in the FRA pool, we would expect that any hospital that does not participate receives sufficient Medicaid payments for inpatient and outpatient hospital services that the hospital is reasonably confident that it receives its tax cost back without need for the FRA pool's redistribution mechanism. There appears to be a "reasonable expectation" that the taxpaying hospitals – whether directly through their Medicaid payments or due to the availability of the FRA pool program – are held harmless for at least part of their FRA tax costs.

We believe the foregoing suggests a significant probability that the agency would prevail in the event of an administrative or judicial challenge to a final agency determination that the Missouri FRA arrangement constitutes an impermissible hold harmless under 42 C.F.R. §433.68(f)(3). We note that the agency's position could be marginally stronger after publication of the forthcoming Medicaid Fiscal Accountability Rule (MFAR) proposed rule, CMS-2393-P, the most recent draft of which includes a proposed clarification of existing CMS policy that,

> [a] direct guarantee will be found to exist where, considering the totality of the circumstances, the net effect of an arrangement between the State (or other unit of government) and the taxpayer results in a reasonable expectation that the taxpayer will receive a return of all or any portion of the tax amount. The net effect of such an arrangement may result in the return of all or any portion of the tax amount, regardless of whether the arrangement is reduced to writing or is legally enforceable by any party to the arrangement.[7]

To the extent this proposed change to regulation text clarifies current CMS policy that is itself adequately supported by existing statutes and regulations – which we believe to be the case – the publication of this clarification in the MFAR proposed rule effectively will constitute guidance and will further illuminate CMS' understanding of the existing statute and regulations even before an MFAR final rule is issued or takes effect. However, to the extent an adjudicator concludes that the "clarification" in fact represents a substantive change from the requirements of the current statute and regulations, the final rule must take effect before the new interpretation would carry any force, and it likely would not apply to retroactive periods. With respect to the "net effect" standard in the draft MFAR proposed rule, we note that the Departmental Appeals Board previously has endorsed this standard in upholding CMS' finding of an impermissible hold harmless under a similar test applicable to provider-related donations (and also endorsed CMS' examination of "reasonable expectations" concerning the existence of a hold harmless). *See* Texas Health & Hum. Servs. Comm'n, DAB No. 2886 (Aug. 7, 2018).[8]

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[7] Draft proposed 42 C.F.R. §433.68(f)(3).

[8] With regard to the closing point in the state's letter about the applicability of 42 C.F.R. §438.6 and the characterization of the payment arrangement between the state and the managed care plans as a "directed payment," my colleague, Sherry Lynn Burke, is working with the Division of Managed Care Plans in connection with CMS' response.

Please contact me at Jeremy.Vogel@hhs.gov or (202) 205-8778 if you have any questions or concerns.

Jeremy Vogel
Attorney, CMS Division

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

July 29, 2020

Todd Richardson, Director
MO HealthNet Division
Department of Social Services
Broadway State Office Building
PO Box 6500
Jefferson City, Missouri 65102-6500

Dear Director Richardson:

Thank you for your letter dated August 2, 2019 communicating your position as to why the Federal Reimbursement Allowance program in Missouri does not violate federal hold harmless provisions. I appreciate your feedback and continued engagement on this important issue.

As you are aware, during the most recent actuarial review of Missouri's Medicaid managed care capitation rates, the Centers for Medicare & Medicaid Services (CMS) became aware that Missouri is using revenues derived from its Federal Reimbursement Allowance (FRA) tax program as the source of the non-federal share for its rates. Consistent with our July 19, 2019 telephone conversation, CMS is concerned that those funds may constitute an impermissible source of the non-federal share.

As we understand the arrangement, Missouri imposes a tax of less than 6 percent of net patient revenues on hospital services (inpatient and outpatient). These revenues provide the state with the source of funding for the non-federal share of payments for hospital services and increased managed care capitation rates that support increased payments to hospitals. A voluntary FRA pool program operated by the Missouri Hospital Association (MHA) then redistributes tax collections among the participating hospitals. While we appreciate the information provided in your August letter, we remain concerned that this pool arrangement appears to ensure that participating hospitals are held harmless for all or a portion of their FRA tax, which would violate section 1903(w)(4) of the Social Security Act and implementing regulations in 42 CFR 433.68(f)(3).

As discussed in our July 2020 phone conversation, you indicated that the state will ensure that the current pooling arrangement ends by the end of the contract rating period ending June 30, 2021 and that all hospital reimbursement is financed and paid in accordance with all applicable federal requirements. We appreciate the state's commitment and, accordingly, do not intend at this time to utilize our limited financial review resources to conduct an in-depth examination of the pooling arrangement to quantify any possible overpayments through contract rating year 2020 (ending June 30, 2020). However, please note that nothing precludes CMS from

recovering the federal portion of any overpayments from Missouri, including for contract years through 2020, should CMS or another oversight entity (such as the Department of Health and Human Services Office of Inspector General or the Single State Auditor) quantify overpayment amounts relating to Missouri's Full Medicaid Pricing arrangement or FRA tax.

CMS is also in the process of publishing additional guidance on state directed payments, parts of which are expected to further clarify some provisions of guidance published in the November 2017 Informational Bulletin on state-directed payments. Therefore, CMS requests that the state revise future contracts and rate certifications to transition the increased funding for Medicaid hospital stays under the current Full Medicaid Pricing arrangement into a state-directed payment. CMS is committed to providing technical assistance on this topic as discussed during recent calls between our staff.

I want to again thank you for your commitment to resolving longstanding concerns and for your collaborative approach in finding a workable solution moving forward that ensures the Full Medicaid Pricing arrangement and FRA tax meet federal requirements. Should you have additional questions, please contact Rory Howe for tax issues at 410-786-4878, and Alissa DeBoy for managed care issues at 410-786-1699.

Sincerely,

Calder Lynch
Deputy Administrator and Director

INITIAL DOCUMENT AND INFORMATION REQUEST
(10/1/20 – 09/30/21)
Please refer to Control No. EC-FM-2023-FL-01-D in all correspondence.
Please submit the requested materials by March 22, 2023.

Section 1902(a)(6) of the Social Security Act (the Act), 45 C.F.R. § 75.364, 42 C.F.R. § 433.74, and 42 C.F.R. part 438 include 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.

Please provide the following documentation:

1. State, units of local government, cities, and counties' laws, regulations, guidelines and instructions to local governments and providers on the subject of health care-related taxes. Specifically:
    a. All state, units of local government, cities, and counties' laws that authorize the Local Provider Participation Funds (LPPFs) health care-related taxes.

    b. States policies and procedures related to intergovernmental transfers including intergovernmental transfers funded by LPPFs.

    c. Written procedures from the state or units of local government, cities and counties for assessing, collecting, and expending LPPF tax revenues.

2. A list of Medicaid payments where the source of the non-federal share is financed by LPPFs revenue.
    a. Also, include with the list the location of the state's approved Medicaid payment methodology.

3. A list of units of local government including but not limited to cities, counties, and hospital districts that use LPPFs as the source of non-federal share for the Medicaid payments identified in request number 2.

4. A list all providers and their locations including amounts of all revenues collected using LPPFs for Federal Fiscal Year 2022. The list of providers and their locations should also include their respective cities and counties that the local government entities imposed LPPF taxes. Also include the following:
    a. The amounts each provider received in Medicaid payments funded by LPPFs in the State Directed Payment Preprints.
    b. Indicate the total number of LPPFs currently in operation in the State of Florida.
    c. Indicate what providers are in which LPPF.

d. The tax amounts that each provider paid into the LPPF.
e. The total amount of tax collected by each LPPF.
f. The total amount of tax collected by all LPPFs. If possible, please provide all this information in Excel format.
g. The basis, i.e. hospital net patient revenues, discharges, upon which the governmental entity levies taxes in the LPPF.
h. The tax rate or rates that each provider is charged in the LPPF.
i. The permissible class or classes upon which the LPPF taxes are imposed as defined at Section 1903 (w)(7) of the Act and 42 C.F.R. 433.56.
j. An indication, for each LPPF, if the tax imposed is broad-based as described at Section 1903 (3)(w)(B) of the Act, uniform as described at Section 1903 (w)(C) of the Act, or has a waiver of the broad-based and uniformity provisions as described at Section 1903 (w)(3)(E)(i) of the Act and implementing regulations at 42 C.F.R. 433.72.
k. For each permissible class taxes, the 6% test as described by 42 C.F.R. 433.68 (f)(3)(i)(A). The State should calculate the test for each permissible class separately. The State should calculate the test as follows: add together all of the health care-related taxes operating within the state, including those imposed by units of local government, and then dividing that by the net patient revenue of the entire permissible class.
l. A list of programs funded by the LPPF as well as their authorities including, but not limited to state directed payments, state plan supplemental payments, and payments made under a Section 1115 demonstration.
m. For each provider included in an LPPF tax, a comparison of the amount that the provider is taxed with the amount of payments, including Medicaid payments, funded by the LPPF.
n. For each locality as applicable, a description of any purpose for which LPPF revenue is used other than for the non-federal share of Medicaid payments.

5. The universe of paid expenditures using intergovernmental transfers funded by LPPFs for each Medicaid payment in request number 2. This universe should include date of payment, date of service, provider name and location, provider Medicaid number, and payment amount.

Please respond to the following questions:

6. Does all or any portion Medicaid payments to the providers vary based solely on the amount of the total tax payment?

7. Recently, CMS has become aware that other states have similar hospital tax arrangements in connection with which there appear to be pre-arranged agreements to redirect Medicaid payments away from Medicaid providers serving a high percentage of Medicaid beneficiaries to hospitals that do not participate in Medicaid or that serve a low percentage of Medicaid beneficiaries. Florida's LPPF tax structure and media reports indicate that the Florida LPPF arrangement may be similar to other states' arrangements that appear to violate federal requirements. To date, Florida's Agency

for Health Care Administration (AHCA) has been unable to provide assurance that there is not an arrangement to redistribute Medicaid state directed payments.

Such arrangements could constitute a prohibited hold harmless arrangement as described at section 1903(w)(4) of the Social Security Act and federal regulation at 42 C.F.R. § 433.68 (f). Is the state aware of any agreements or arrangements involving the redistribution of Medicaid payments among providers, including those with the purpose to ensure health care providers are not financially harmed by the health care-related tax associated with the LPPF tax program?

8. If yes, please provide us with any information that you may have, including copies of any written agreements or other documents describing how the redistribution works.

9. Has the state communicated with its providers regarding such redistribution arrangements? If so, please describe the communications.

10. Has the state communicated with its providers regarding the federal requirements prohibiting hold harmless arrangements? If so, please describe the communications.

11. Has the state communicated with any third parties regarding the redistribution arrangements? If so, please describe the communications.

12. If the state is not aware of any redistribution arrangements, have providers informed the state that such redistribution arrangements are not in place?

13. The state certifies to CMS on its quarterly Form CMS-64 that its sources of non-federal share meet applicable federal statutory and regulatory requirements. Please describe what oversight the state conducts to ensure the use of LPPF revenue as a source of non-federal share meets federal requirements?

14. Based on the responses to these questions regarding possible redistribution arrangements, CMS may ask additional questions and/or make additional requests for information from the state. Additionally, CMS intends to communicate directly with individual health care providers to obtain additional information regarding the LPPF tax program and possible redistribution arrangements. CMS intends to keep AHCA apprised of any direct communication with providers.

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

Financial Management Group
Division of Financial Operations East

February 22, 2023

Thomas J. Wallace
Deputy Secretary for Medicaid
Agency of Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32308

Re: Notification of Financial Management Review - Use of Local Provider Participation Funds as a Source of the non-Federal Share, Control Number EC-FM-2023-FL-01-D

Dear Mr. Wallace:

The purpose of this letter is to notify you that the Centers for Medicare & Medicaid Services (CMS) will perform a Financial Management Review (FMR) which will take place over the next several months. The review will focus on Florida's use of revenues derived from its Local Provider Participation Program (LPPF) tax program as a source of the non-federal share of Medicaid payments. In conjunction with the September 29, 2022 approval of the Medicaid Managed Care State Directed Payments (SDP) for Federal Fiscal Year (FY) 2022, (FL_Fee.IPH.OPH4_Renewal_20211001-20220930), CMS issued a companion letter to the state identifying concerns that the LPPF tax program may not comply with certain health care-related tax requirements in section 1903(w)(4) of the Social Security Act and implementing regulations in 42 CFR 433.68(f)(3). The companion letter also informed Florida of CMS's intent to conduct the FMR described in this letter during FY 2023.

As we understand the LPPF arrangement, twenty-one cities or counties impose health care-related taxes on gross or net inpatient and/or outpatient hospital service revenue at a rate of less than six percent. These revenues provide the state with the source of funding for the non-federal share of payments for hospital services that support increased payments to hospitals. Recently, CMS has become aware that other states have similar hospital tax arrangements in connection with which there appear to be pre-arranged agreements to redirect Medicaid payments away from Medicaid providers serving a high percentage of Medicaid beneficiaries to hospitals that do not participate in Medicaid or that serve a low percentage of Medicaid beneficiaries. Florida's LPPF tax structure and media reports indicate that the Florida LPPF arrangement may be similar to other states' arrangements that appear to violate federal requirements. To date, Florida's

Agency for Health Care Administration (AHCA) has not provided CMS with an assurance that there is not an arrangement to redistribute Medicaid state directed payments.

The objective of this FMR is to examine whether the state's source of non-federal share, including the LPPF tax program, complies with Federal statute and regulations. At this time, we expect this review will be performed remotely, however, if there is a need for any on-site work related to this review, we will advise you and coordinate any on-site activity.

We will review the LPPF tax program associated with fiscal quarters beginning October 1, 2021 and ending September 30, 2022. Attached to this letter is a preliminary information request list. This list is not all-inclusive, and we may request additional information necessary as the review progresses. Of note, we also anticipate requesting additional information directly from individual health care providers throughout the course of the review. Please provide the requested materials and responses by March 22, 2023. We request all information be provided to us in electronic format via email or through the use of a secure network, BOX. CMS will grant state staff providing requested documentation access to BOX. CMS has obtained contractor support to assist us with this review. The contractor is the National Opinion Research Center (NORC). The NORC team will be involved with all aspects of this review.

We plan to conduct an entrance meeting and start our review work during the week of March 6, 2023. Please respond to this letter with your availability during this period and provide a liaison to coordinate with us on this review. We will contact your staff to coordinate meetings, obtain information, and to hold any discussions relating to this review as it progresses. At the completion of the review, we will schedule an exit conference and provide the state the chance to respond to any potential findings or observations prior to development of a draft report. We will consider the state's input in preparation of the draft report. We anticipate the issuance of the draft report to the state by the end of calendar year 2023. The state will then have 30 days to formally respond to the draft report. Afterwards a final report will be issued that will incorporate the state's response to any findings, observations, and recommendations including CMS comments to the state's response.

If you have any questions or concerns about our review, please contact Ricardo Holligan, Branch Chief, at 212-616-2424, email Ricardo.Holligan@cms.hhs.gov, or Sidney Staton, Financial Analyst, 850-878-3486, email Sidney.Staton@cms.hhs.gov. Please refer to control number EC-FM-2023-FL-01-D in all correspondence. Additionally, please include our contractor, NORC, at MedicaidFMR@norc.org in all email correspondence relating to this review. We appreciate your assistance in this review.

Sincerely,

Robert Lane
Director
Division of Financial Operations East

Preamble

PARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 433 and 447

[MB-062-IFC]

RIN 0938-AF42

Medicaid Program; Limitations on Provider-Related Donations and Health Care-Related Taxes; Limitations on Payments to Disproportionate Share Hospitals

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule establishes in Medicaid regulations limitations on Federal financial participation (FFP) in State medical assistance expenditures when States receive funds from provider-related donations and revenues generated by certain health care-related taxes. The le also adds provisions that establish ts on the aggregate amount of ments a State may make to proportionate share hospitals for which FFP is available.

This interim final rule implements provisions of the Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991.

DATES: *Effective date:* These interim final rules are effective December 24, 1992. However, the statutory requirements at sections 2(c)(1) and 3(e)(1) of Public Law 102-234 have an effective date of January 1, 1992, and are effective on that date regardless of the effective date of this interim final rule.

COMMENT DATE: Written comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on January 25, 1993.

ADDRESSES: Mail comments to the following address:

Health Care Financing Administration, Department of Health and Human Services, Attention: MB-062-IFC P.O. Box 26676, Baltimore, Maryland 21207.

If you prefer, you may deliver your written comments to one of the following addresses:

oom 309-G, Hubert H. Humphrey Building, 200 Independence Avenue, SW, Washington, DC 20201, or

Room 132, East High Rise Building, 6325 Security Boulevard, Baltimore, Maryland 21207.

Due to staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code MB-062-IFC. Written comments received timely will be available for public inspection as they are received, beginning approximately three weeks after publication of this document, in room 309-G of the Department's offices at 200 Independence Avenue, SW, Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: 202-690-7890).

Organizations and individuals desiring to submit comments on the reporting requirements discussed under the section on "Paperwork Burden" of this preamble should direct them to the Health Care Financing Administration at one of the addresses cited above, and to the Office of Information and Regulatory Affairs, Attention: Laura Oliven, Office of Management and Budget, New Executive Office Building (Room 3002), Washington, DC 20503.

FOR FURTHER INFORMATION CONTACT:

Theresa Pratt (Donations and Taxes) (410) 966-9635

Betty Kern (Disproportionate Share Payments) (410) 966-4560

SUPPLEMENTARY INFORMATION:

I. Background

Title XIX of the Social Security Act (the Act) authorizes Federal grants to the States for Medicaid programs to provide medical assistance to persons with limited income and resources. Medicaid programs are administered by the States in accordance with Federal regulations. State Medicaid agencies conduct their programs according to a Medicaid State plan approved by the Health Care Financing Administration (HCFA). To carry out the mandates of the Medicaid program, the State agency pays providers for medical care and services provided to eligible Medicaid recipients. Providers that wish to participate in the Medicaid program must agree to comply with certain requirements specified in a provider agreement.

While Medicaid programs are administered by the States, they are jointly financed by the Federal and State governments. The Federal government pays its share of medical assistance expenditures to the State on a quarterly basis according to a formula described in sections 1903 and 1905(b) of the Act. The amount of the Federal share of medical assistance expenditures is called Federal financial participation (FFP). The State pays its share of medical assistance expenditures in accordance with section 1902(a)(2) of the Act.

The Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 (Pub. L. 102-234), enacted December 12, 1991, amended section 1903 of the Act to specify limitations on the amount of FFP available for medical assistance expenditures in a fiscal year when States receive certain funds donated from providers and revenues generated by certain health care-related taxes. This law also amended section 1923 of the Act to establish limits on the amount of FFP for expenditures made to hospitals that serve a disproportionate number of Medicaid recipients and other low-income individuals. These hospitals are referred to as disproportionate share hospitals.

This interim final rule interprets and implements the provisions of Public Law 102-234. The two issues that are affected by this law (provider-related donations and health care-related taxes, and disproportionate share hospital payments) are addressed separately in this preamble.

II. Provider-Related Donations and Health Care-Related Taxes

Section 1902(a)(2) of the Act requires States to share in the cost of medical assistance expenditures, and permits both State and local governments to participate in the financing of the non-Federal portion of expenditures under the Medicaid program. This section specifies the minimum percentage of the State's share of the non-Federal costs, and requires that the State share be sufficient to assure that the lack of adequate funds from local government sources will not prevent the furnishing of services equal in amount, duration, scope, and quality throughout the State. Section 1903 of the Act requires the Secretary to pay each State an amount equal to the Federal medical assistance percentage of the total amount expended as medical assistance under the State's plan.

Public Law 102-234 amended section 1903 of the Act by adding a new subsection (w) regarding the receipt of provider-related donations and health care-related taxes by a State as the State's share of financial participation under Medicaid. In general, under section 1903(w) of the Act, a reduction in FFP will occur if a State receives donations made by, or on behalf of, health care providers unless the donations are bona fide donations or meet outstationed eligibility worker donation requirements, as specified in

the law. The law also specifies the types of health care-related taxes a State is permitted to receive without a reduction in FFP. Such taxes are broad-based taxes which apply in a uniform manner to all health care providers in a class, and which do not hold providers harmless for their tax costs. However, the law permits States which have received, by specific date prior to the enactment of this law, provider-related donations and health care-related taxes that are not permitted by this law, to continue to receive them during the State's transition period without a reduction in FFP.

Public Law 102–234 specifies that the Secretary may not restrict the use of funds derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the State share of Medicaid, unless the transferred funds are derived from donations or taxes that would not otherwise be recognized for Federal matching purposes. This provision applies regardless of whether the unit of government transferring the money is also a health care provider.

Funds transferred from another unit of State or local government which are not restricted by the statute are not considered a provider-related donation or health care-related tax. Consequently, until the Secretary adopts regulations changing the treatment of intergovernmental transfer, States may continue to use, as the State share of medical assistance expenditures, transferred or certified funds derived from any governmental source (other than impermissible taxes or donations derived at various parts of the State government or at the local level).

Prior to the enactment of Public Law 102–234, regulations at 42 CFR 433.45 delineated acceptable sources of State financial participation. The major provision of that rule was that public and private donations could be used as a State's share of financial participation in the entire Medicaid program. As mentioned previously, the statutory provisions of Public Law 102–234 do not include restrictions on the use of public funds as the State share of financial participation. Therefore, the provisions of § 433.45 that apply to public funds as the State share of financial participation have been retained but redesignated as § 433.51 for consistency in the organization of the regulations.

The provisions of Public Law 102–234 apply to all 50 States and the District of Columbia, but not to any State whose entire Medicaid program is operated under a waiver granted under section 1115 of the Act. The exemption is currently limited to Arizona. The provisions apply to donations to State or local governments from providers and related entities and to revenues generated by health care-related taxes, regardless of whether these funds were directly or indirectly received by the Medicaid agency or some other department of the State or local government, and regardless of whether the State uses these funds as the State share of medical assistance expenditures for FFP purposes. However, the provisions do not apply to the treatment of donations from entities not related to providers or the receipt of revenues generated by generally applicable taxes or other non-health care-related taxes.

A discussion of the specific provisions of Public Law 102–234 relating to treatment of provider-related donations and health care-related tax revenues and the implementing regulatory provisions follows.

General Rule

Section 1903(w)(1) of the Act provides that, effective January 1, 1992, before calculating the amount of FFP, certain revenues received by a State will be deducted from the State's medical assistance expenditures. The revenues to be deducted are as follows:

- Donations made by health providers and entities related to providers (except for bona fide donations and, subject to a limitation, donations made by providers for the direct costs of outstationed eligibility workers);
- Impermissible health care-related taxes; and
- Until October 1, 1995, permissible health care-related taxes that exceed a specified limit.

It is important to note that the new statutory requirements apply to all impermissible provider-related donations and health care-related tax revenues received by State or local governments, without consideration of the use of the funds. If a State levies a tax on hospitals that is impermissible under section 1903(w) of the Act, and deposits the revenues in an account designated for some purpose other than Medicaid funding, the statute requires that the funds be offset from Medicaid expenditures even though the State is not using the revenues as its share of Medicaid expenditures for FFP purposes. For this purpose, the statute treats the State, and units of local government within the State, as a single entity. The fact that the funds were not received directly by the Medicaid agency does not alter the statute's requirements that the funds be reduced from the State's claimed expenditures.

Section 1903(w)(2)(A) of the Act defines "provider-related donations" as any donations or other voluntary payments (in-cash or in-kind) made directly or indirectly to a State or unit of a local government by a health care provider, an entity related to a health care provider, or an entity providing goods or services under the State plan and paid as administrative expenses. Section 1903(w)(2)(B) defines "bona fide provider-related donations" as provider-related donations that have no direct or indirect relationship (as determined by the Secretary) to payments made under title XIX to that provider, to providers furnishing the same class of items and services as that provider, or to any related entity, as established to the satisfaction of the Secretary. The statute also gives the Secretary the authority to specify, by regulation, types of provider-related donations that will be considered to be bona fide provider-related donations.

Section 1903(w)(3)(A) of the Act defines "health care-related taxes" as those taxes that are related to: (1) Health care items or services; (2) the provision of such items or services; (3) the authority to provide health care items or services; or (4) the payment for such items or services.

In accordance with section 1903(w) of the Act, we are defining the term "permissible health care-related taxes" to mean those health care-related taxes which are broad-based taxes, uniformly applied to a class of health care items, services or providers (as specified in section 1903(w)(7)(A) of the Act), and which do not hold a taxpayer harmless for the costs of the tax, or a tax program for which HCFA has granted a waiver. Health care-related taxes that do not meet these requirements are "impermissible health care-related taxes."

As specified in section 1903(w)(1)(C)(i) of the Act, these provisions apply to revenues received by a State on or after January 1, 1992 (except for certain donations and taxes permitted under a transition period, which are subject to a limit). Revenues received by States prior to January 1, 1992 are not subject to these statutory provisions. In addition, since these provisions restrict the receipt of taxes and donations, they do not apply to expenditures that are made on or after January 1, 1992, that are funded by these pre-January 1, 1992 revenues.

We are revising subpart B in 42 CFR part 433 to incorporate the statutory provisions of section 1903(w) of the Act

ing to States' receipt of provider-ed donations and health care-related taxes. Under revised subpart B, we are adding §§ 433.50 through 433.74. Section 433.50, entitled Basis, scope, and applicability, includes a provision that this subpart apply to the 50 States and the District of Columbia, but not to any State whose entire Medicaid program is operated under a waiver granted under section 1115 of the Act (section 1903(w)(7)(D) of the Act).

In § 433.52, General definitions, we are incorporating the statutory definitions of an entity related to a health care provider, provider-related donations and health care-related taxes. The statutory language provides the Secretary with the authority to specify when an entity or individual has a similar, close relationship to the provider for purposes of determining when an entity is related to a health care provider. Therefore, under the definition in this section, an entity related to a health care provider means (a) an organization, association, corporation, or partnership formed by or on behalf of a health care provider; (b) an individual with an ownership or control interest in the provider, as ned in section 1124(a)(3) of the Act; n employee, spouse, parent, child, sibling of the provider, or of a person with an ownership or control interest in the provider, as defined in section 1124(a)(3) of the Act; or, (d) a supplier of health care items or services or a supplier to providers of health care items or services. We have added this provision to make clear that businesses, i.e., laundry or meal services, who provide services to health care providers would be considered a related entity and subject to the provisions of this law.

Additionally, provider-related donations are defined under this section as a donation made directly or indirectly to a State or unit of local government by or on behalf of a health care provider, an entity related to a health care provider, or an entity providing goods or services to the State for administration of the State's Medicaid plan. Under this definition, donations made by a health care provider to an organization, which in turn donates money to the State, will be considered to be an indirect donation to the State by the health care provider. Thus, the statutory requirements pertaining to provider-related donations ould apply.

We realize that many organizations eceive nominal donations from providers and that States receive donations from many organizations. We have, therefore, determined that, if the organization receives less than 25 percent of its revenues from donations from individual providers and/or provider-related entities, the donation made to the State will be presumed to not be a provider-related donation and therefore is not affected by this interim final rule. However, if the donations from providers to an organization are subsequently determined to be indirect donations to the State or unit of local government for administration of the State's Medicaid program, then such donations will be considered to be provider-related. Therefore, the State may only receive these donations, without a reduction in FFP, if the statutory requirements pertaining to bona fide donations are met.

If the organization receives more than 25 percent of its revenues from donations from individual providers and/or provider-related entities, the organization will be considered as acting on behalf of health care providers or related entities. We specifically seek public comments on the percentage limit established for making this determination.

The amount of the organization's donations to the State during a State fiscal year that will be considered health care related will be based on the percentage of revenues the organization received from providers during that period. For example, if an organization received 30 percent of its revenues from providers, then 30 percent of the donation made by the organization to the State would be considered provider related. Therefore, the State may receive these donations, without a reduction in FFP, only if the statutory requirements pertaining to bona fide donations are met.

After consultation with State representatives, we want to emphasize that there is no limitation on donations from sources other than health care providers, related entities, or suppliers of administrative goods or services. Thus, States may continue to receive, without a reduction in FFP, contributions from charitable organizations that are not health care providers or acting on behalf of health care providers or related entities. Further, such donations may be permissible when made on behalf of health care providers or related entities when they satisfy the requirements of bona fide provider-related donations.

Section 433.53 contains requirements for State plans regarding State financial participation. In § 433.54, we define bona fide donations in accordance with section 1903(w)(2)(B) of the Act. A bona fide donation is a provider-related donation that has no direct or indirect relationship to Medicaid payments to that provider, to providers furnishing the same class of items and services as that provider, or to any related entity as established by the State to the satisfaction of the Secretary. Provider-related donations are determined to have no direct or indirect relationship to Medicaid payments if the donations are not returned to the individual provider, provider class, or related entity under a hold harmless provision or practice. A hold harmless practice exists if HCFA determines that any of the following applies: (1) The State or other unit of local government receiving the donation provides (directly or indirectly) for a payment (other than under title XIX) to the donating providers, and the amount of such payment is positively related either to the amount of the provider-related donation or to the difference between the amount of the donation and the amount of payment received under the State plan; (2) All or any portion of the payment made under title XIX to the donor, the provider class or any related entity varies only based upon the amount of the total donation received; or (3) The State or other unit of local government receiving the donation provides for any payment, offset, or waiver that guarantees to return any portion of the donation to the provider.

In defining the conditions under which a State or local government receiving a provider-related donation is determined to hold providers harmless for such donations, we have adopted the same statutory tests of hold harmless that apply to health care-related taxes. We believe that use of the same tests establish continuity and consistency in the treatment of funding sources addressed in this interim final rule. Moreover, although we considered developing a separate test for determining when States' payments are related to provider donations, we believe the tests designated in the law for determining when States' payments hold taxpayers harmless for their tax costs are equally useful for this purpose.

As mentioned above, section 1903(w)(2)(B) of the Act authorizes the Secretary to specify types of provider-related donations that will be considered to be bona fide provider-related donations. We believe this provision provides HCFA with the necessary discretion to determine the types of provider-related donations that will be considered bona fide. In making this determination, we have attempted to strike a meaningful balance between those donations that are presumably bona fide—assuming there is no hold

harmless effect—and those that cannot be presumed to be bona fide.

For a donation to be considered bona fide, the State must demonstrate, to HCFA's satisfaction, that it meets the requirements for bona fide donations specified in § 433.54. In considering the types of provider-related donations that would be presumed bona fide, we assessed the potential administrative burden to the States in requiring them to obtain "advance approval" from HCFA for each donation received. We believe an "advance approval" requirement for all provider donations could impose a significant burden on States.

To this end, we have determined that the types of provider-related donations that we will presume to be bona fide are those voluntary payments, including, but not limited to, gifts, contributions, presentations, or awards made by or on behalf of individual health care providers to the State, county, or any other unit of local government, that do not exceed $5,000 in any one year. In the case of a provider which is an organizational entity rather than a single individual, donations of $50,000 or less annually are presumed to be bona fide. However, if the donations are subsequently determined to have a direct or indirect relationship to Medicaid payments or a hold harmless provision or practice, they will no longer be considered to be bona fide.

We selected the levels of $5,000/$50,000 as the cutoff for presumption of donations as bona fide for several reasons. First, we wanted to establish a cutoff for this presumption at a sufficient level that ordinary charitable activity on the part of providers would be acceptable. We believe this activity would ordinarily not exceed the cutoff levels of $5,000/$50,000. Second, we wanted to minimize the administrative burden on the States and HCFA. Lower values would require more justification on the part of the States, and increased review activity by HCFA, on donations that are likely to meet the bona fide criterion. Third, we wanted to be able to detect and effectively control any potentially abusive situations. We believe that the levels in these interim final regulations meet these objectives. However, we invite comments from States, providers, and other interested parties on the specific cutoff figures specified in these regulations.

We want to make clear that at any time a State receives an inordinate number of individual or organizational donations that are at or under the monetary limits necessary for presumption of bona fide, HCFA may exercise its authority to perform an audit of such donations to determine if the provider-related donation is indeed bona fide.

When HCFA makes a determination that a donation presumed to be bona fide is not bona fide based on the criteria set forth, HCFA will deduct this amount from the State's medical assistance expenditures before calculating FFP. This decision and offset will apply to any similar donations previously received by the State and for all subsequent fiscal years in which a similar donation is received.

A donation from an individual provider or any health care organizational entity exceeding the monetary cap will require explicit authorization from HCFA prior to being considered bona fide. We want to make clear that, in the case of provider donations that are not presumed to be bona fide, States may seek HCFA approval at any time. HCFA will review the quarterly reports required by § 433.74. If, at the time the State submits its quarterly report to HCFA, it has not obtained authorization for the donations it received during that period, the authorization can be requested at that time. If HCFA determines provider-related donations are not bona fide, HCFA will deduct this amount from the State's medical assistance expenditures before calculating FFP for the year of receipt and for any subsequent fiscal year in which such a donation is received by the State.

After consultation with State representatives, we have determined that it will be the responsibility of the State to obtain the necessary certification of the fund source from the donating entity in establishing that a provider-related donation is bona fide.

A tax is considered a health care-related tax if it meets any of the three criteria specified in section 1903(w)(3)(A)(i) of the Act. Under these criteria, which are codified in § 433.55, a tax is considered to be health care related if—

- The tax is imposed on the provision of, or the authority to provide, health care services (e.g., a licensing fee);
- The tax is imposed on the payment for health care services (e.g., a tax on payments made by health insurance plans for the provision of health care items or services); or
- The tax is related to health care items or services. Under this criterion, a tax is considered to relate to health care items or services if at least 85 percent of the burden of such tax falls on health care providers. For example, if a tax is imposed at equal rates on physicians and attorneys, and 85 percent of the burden falls on physicians, the tax is considered to be health care related.

One additional criterion imposed by section 1903(w)(3)(A)(ii) of the Act must be considered in determining whether a tax is health care related. Under this section, if the tax is not limited to health care items or services, but the treatment of individuals or entities providing or paying for those health care items or services is different than the tax treatment provided to other individuals or entities, the tax on health care items or services is considered to be health care related. For example, if a tax is imposed on physician and attorney services, but they are taxed at different rates, the tax on physician services is considered to be a separate health care-related tax on physician services.

Further, in determining if the treatment of a tax applicable to health care providers is different from the treatment of other taxpayers, HCFA will take into account any State credits or rebates to any of the payers. For example, if a tax is imposed at the same rate on physician and attorney services, but the attorneys receive tax credits for payment of this tax, this would be considered as taxation at different rates. Thus, the tax would be considered a health care-related tax, and would be subject to the provisions of the law relating to health care-related taxes.

If a State's tax program does not meet any of the above criteria, taxes imposed under the tax program are not health care-related taxes and, therefore, are not subject to the remaining statutory and regulatory provisions.

Section 433.55(e) specifies that health care insurance and HMO premiums are not payments for "health care items and services." We included this provision to make clear that, for purposes of defining the term "health care-related tax," we will not consider individual and group payments for such premiums as payments for health care items and services. Payments for health care insurance and HMO enrollment premiums are made to the insurer or HMO, for their use and to ensure coverage. Such payments may or may not be used to purchase or provide health care items or services for that individual or group.

It is important to note that any mandatory payment, fee, or assessment that is imposed by a State or local government unit, and which is related to health care items or services, providers of those items or services, or payments for health care services, is considered to be a health care-related tax and subject to the provisions of these regulations. Consequently, any health care-related taxes, regardless of their purpose, must meet several requirements in order to

avoid a reduction in FFP. These requirements are specified in § 433.68. This section requires that health care-related taxes are permissible only if they are broad-based, uniformly imposed, and do not hold taxpayers harmless for their tax costs. In order for a tax to be considered broad based, it must apply to all items and services within a class of items and services specified in section 1903(w)(7)(A) of the Act.

In § 433.56, we incorporate the classes of health care services and providers specified in section 1903(w)(7)(A) of the Act. After consultations with State representatives, we believe there is a general understanding that, since the class definition is determined by the type of service provided, only the revenues or activities of the provider pertaining to that class of service need be covered by the tax. Accordingly, a tax imposed on inpatient hospital services, or the providers thereof, need not cover revenues or activities of hospitals not related to inpatient hospital services, such as a separate ng certified as a nursing facility (NF) a research laboratory.

For purposes of these interim final regulations, each of the following will be considered as a separate class of health care items or services. Taxes that pertain to each class must apply to all items and services within the class, regardless of whether the items or services are furnished by or through a Medicaid-certified or licensed provider.

- Inpatient hospital services.
- Outpatient hospital services.
- NF services (other than services of intermediate care facilities for the mentally retarded (ICF/MRs)).
- Intermediate care facility services for the mentally retarded, and similar services furnished by community-based residences for the mentally retarded, under a waiver under section 1915(c) of the Act, in a State in which, as of December 24, 1992, at least 85 percent of such facilities were classified as ICF/MRs prior to the grant of the waiver.
- Physicians' services.
- Home health care services.
- Outpatient prescription drugs.
- Services of health maintenance organizations (HMOs) and health insuring organizations (HIOs).

It is important to note that inpatient spital services include all services efined as inpatient hospital services, such as inpatient psychiatric services. Additionally, based on our consultations with States representatives, we are adding the following additional class of items and services:

- Other health care items and services not listed above on which the State has enacted a licensing or certification fee.

The additional class that we have added includes any licensing or certification fee on medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. The State revenues from the fees collected must be established so that they do not exceed the State's cost of operating the licensing or certification program. If the fee exceeds the estimated projected cost of operating the licensure or certification program, the entire program will be barred from the class. Such fees, whether enacted prior to or subsequent to the enactment of Public Law 102-234, would be permissible to the extent they are broad based and uniform and do not hold taxpayers harmless for the cost of the fee. It should be noted, that if this class is not added, licensing or certification fees will be excluded because the law defines as impermissible any tax imposed on classes other than those designated classes of items and services. We believe that taking a disallowance with respect to broad-based and uniform licensing or certification fees on items or services not listed in the statute which do not hold taxpayers harmless would be inconsistent with the intent of the law.

It should also be noted that a licensing or certification fee on health care items and services not listed above which was in existence prior to the enactment of Public Law 102-234, and which does not meet the broad-based and uniform requirements of the law, will only be permissible during a State's transition period, unless the State requests, and HCFA approves, a waiver of these requirements, and the payers are not held harmless.

Section 1903(w)(7)(A)(iv) of the Act includes, within the list of health care items and services on which permissible taxes may be enacted, services of intermediate care facilities for the mentally retarded (ICF/MRs). In incorporating this class in the regulation, we have clarified this provision to include within that class of facilities certain group homes for the mentally retarded that provide services under a waiver, similar to ICF/MR services. We added these homes because, in some States, many former ICF/MRs were converted to group homes under the waivers. These facilities could easily be converted back to ICF/MRs. Because of the ability of these facilities to be converted, and because of our desire to ensure that taxes are as broad-based as possible, we have added these group homes to the ICF/MR class.

In implementing the provision in the statute that permits expansion of the list of permissible classes, we could have chosen to provide a limited expansion of the list at this time. This decision would act as a strong control on the enactment of new tax programs. On the other hand, a second option was to provide an extensive expansion of the list, on the theory that such taxes would be permissible up to the limits prescribed in the statute, as long as they were broad based and uniform. In limiting the expansion to licensing fees for purposes of this interim final rule, we chose a middle ground approach to permit only ordinary fee programs designed to cover the costs of licensing providers and to clarify that States include as providers of ICF/MR services, certain group homes that provide these services under a waiver. This option was selected because of our desire to permit these ordinary State functions to occur, but not to encourage the development of new tax programs that could have adverse effects on Federal funding, particularly after October 1, 1995, when the cap on health care-related taxes expires.

However, we intend to remain flexible for purposes of the final rule in deciding whether and/or how to expand the list to include other legitimate classes. The statute constrains this flexibility by not providing any waiver authority regarding additional classes and by requiring that any additional classes of health care items and services must be established by regulation. We intend to review this issue carefully before publishing a final rule. Therefore, we request public comments on whether we should define additional specific classes of health care items and services. We also particularly request comments on which additional classes should be added to the list, and what criteria could be used by the Secretary in evaluating what classes should be added in the future. An example of criteria that could be considered for defining additional classes of items or services include State licensure and certification requirements and requirements that the tax apply to a sufficient mix of patients to ensure that the tax is generally redistributive.

It should be noted that there is nothing in the statute that precludes States from imposing a tax on more than one of the classes listed above. When a State imposes a tax on more than one class of items or services, the effect of the tax will be measured in the aggregate. This is particularly important

when determining if taxpayers are held harmless for the costs of the tax. The specific provisions relating to hold harmless are discussed later in this preamble.

Section 433.57 specifies the general rules regarding revenues from donations and taxes, in accordance with section 1903(w) of the Act. Under this section, effective January 1, 1992, HCFA will deduct from a State's expenditures for medical assistance, before calculating FFP, funds from provider-related donations and revenues generated by health care-related taxes received by a State or unit of local government, if the donations and taxes are not (1) Permissible provider-related donations, (2) permissible health care-related taxes, or (3) during a specified transition period, donations and taxes that meet certain requirements.

Rules Regarding Revenues From Donations and Taxes During a Transition Period

Section 1903(w)(1)(C)(ii) of the Act provides for a transition period during which, under certain circumstances, States may receive, without a reduction in FFP, revenues from provider-related donation programs and impermissible health care-related tax programs in effect prior to the enactment of Public Law 102-234. However, in order for the tax or donation program to be continued after the transition without a reduction in FFP, the law requires that the tax and donation programs meet specific requirements.

Specifically, section 1903(w)(1)(C)(ii) of the Act provides that donations received prior to the expiration of a State's transition period are eligible for Federal matching if the donations are received under a donation program that was in effect on September 30, 1991, described in State plan amendments or related documents submitted to the Secretary by September 30, 1991, or substantiated by written documentary evidence, and if the program was applicable to State fiscal year 1992. States may demonstrate that their donations are applicable to State fiscal year 1992 through State plan amendments, written agreements, State budget documents, or other documentary evidence in existence on September 30, 1991.

Section 1903(w)(1)(C)(iii) of the Act provides that for States whose donation programs remain eligible for Federal matching funds in State fiscal year 1992, the total amount of donations in State fiscal year 1993 cannot exceed the total amount of donations received in the corresponding period plus 5 days after the end of the period of State fiscal year 1992.

Section 1903(w)(1)(D) of the Act provides that tax revenues received from impermissible taxes during a State's transition period are eligible for Federal matching funds if the tax was in effect as of November 22, 1991, or if the legislation or regulations imposing these taxes were enacted or adopted as of November 22, 1991.

Section 1903(w)(1)(E) of the Act provides that, when calculating the total amount of donations and taxes permitted during the transition period for the portion of State fiscal year 1992 that occurs in calendar year 1992, and for State fiscal year 1993, the total amount of impermissible donations and taxes permitted cannot exceed 25 percent of the non-Federal share of medical assistance expenditures minus the total amount of revenues from permissible broad-based health care-related taxes received in that year (or portion thereof). For States with a State base percentage greater than 25 percent, the total amount of impermissible donations and taxes permitted during the transition period cannot exceed the product of the State base percentage and the non-Federal share of Medicaid expenditures, minus the total amount of revenues from permissible broad-based health care-related taxes received in that year.

Section 1903(w)(1)(F) of the Act specifies the duration of the different transition periods for States. Under this provision, the transition period expires on October 1, 1992 for States with a fiscal year beginning on or before July 1. This applies to the majority of States. For States whose fiscal years begin after July 1, the transition period extends until January 1, 1993. In addition, regardless of when their fiscal year ends, States without a regularly scheduled legislative session in 1992 or 1993, and States with a provider-specific tax enacted on November 4, 1991 are eligible to receive Federal matching funds for otherwise impermissible donations and tax programs before July 1, 1993, subject to the conditions described above.

To interpret how States are to implement the transition period provisions in Public Law 102-234, we are adding § 433.58, Revenues from provider-related donations and health care-related taxes during a State's transition period, and § 433.60, Limitations on level of FFP for State expenditures from provider-related donations and health care-related taxes during a transition period. Sections 433.58 (a) and (b) delineate the general rule concerning the transition period and specify each State's transition period as provided for in section 1903(w)(1)(F) of the Act. Section 433.58(d) describes the criteria that must be met in order for a donation to be permissible during the State's transition period. We have included bona fide donations and donations for outstationed eligibility workers in this section of the regulations to ensure that all donations that are permissible during a State's transition period are clearly identified. It is important to note that these provisions governing permissible donations received during the transition period are not solely transition period-related provisions, and are addressed again in § 433.68, which specifies the criteria for permissible provider-related donations after the transition period.

Under § 433.58(d), to be permissible for purposes of FFP, donations received during a State's transition period must be one of the following:

- Bona fide donations (as defined in § 433.54, General definitions).
- Donations made by a hospital, clinic, or similar entity (such as a Federally-qualified health center) for the direct costs of State or local agency personnel who are stationed at that facility to determine the eligibility (including eligibility redeterminations) of individuals for Medicaid and/or to provide outreach services to eligible (or potentially eligible) Medicaid individuals. We want to emphasize that outreach activities for potentially eligible Medicaid individuals include the costs associated with the initial receipt and processing of Medicaid applications, regardless of whether the State or local worker actually determined eligibility. Direct costs of outstationed eligibility workers refers to the costs of training, salaries, and fringe benefits associated with each outstationed worker and similar allocated costs of State or local agency support staff. Such direct costs include the prorated cost of pamphlets and materials distributed by the outstationed eligibility workers at these sites. For example, if a State purchased pamphlets and other materials to be distributed for outreach activities totalling $100,000 and outstationed eligibility workers at these sites used 15 percent of these materials, the "pro rata share" that the State would be permitted to record in computing the amount of permissible donations from providers would be $15,000. Costs such as State agency overhead costs and the cost of advertising campaigns, as well as the costs of provider space, are not allowable for this purpose. After

consulting with States, we want to make clear that since we do not consider extensive outreach campaigns, such as television and other mass media promotions, within the context of outstanding, we believe that donations that otherwise meet the statutory requirements for charitable contributions or bona fide provider donations could be used for this purpose.

• Other provider-related donations, if the following conditions are met:

+ The donation program was in effect on September 30, 1991, described in State plan amendments or related documents submitted to HCFA by that date, or substantiated by written documentary evidence that was in existence as of that date; and

+ The donation program is applicable to State fiscal year 1992.

In implementing these provisions, States must demonstrate that the above criteria are met through written documentary evidence, as specified in § 433.58k(e). Paragraph (e) specifies that HCFA will consider as acceptable documentation such items as:

• Reference to the donation program a State plan amendment or related documents, including a satisfactory response, as determined by HCFA, to a HCFA request for additional information;

• State budget documents identifying the amounts States expected to receive in donations;

• Written agreements with the parties donating the funds; and/or

• Other written documentation that identify amounts that States planned to receive in donations from specified organizations during the period.

It is important to note that, to be acceptable, the written documentary evidence must have been in existence on September 30, 1991.

During the transition period, donations (other than bona fide donations and donations for outstationed eligibility workers) that may be received, without a reduction in FFP, by a State in fiscal year 1992 (subject to the limitation imposed during the transition period) are those that the State can document that it intended to receive during that period. Under § 433.58(f), for any portion of State fiscal year 1993 that occurs during the transition period, the State may receive, without a reduction in FFP, the amount of donations that it received in the corresponding period in State fiscal year 1992 (including the 5 days after the end of that period).

It is important to note that in no case may the amount of donations and health care-related taxes permitted during a State's transition period in State fiscal year 1993, exceed the product of 25 percent or, if higher, the State base percentage, and the entire State fiscal year non-Federal share of Medicaid expenditures (including certain administrative costs) less revenues received from broad based health care-related taxes. There is no limit on the amount of bona fide donations a State may receive without a reduction in FFP. Effective October 1, 1992, the amount of donations for outstationed eligibility workers that a State may receive without a reduction in FFP may not exceed 10 percent of a State's medical assistance costs (Federal and State), exclusive of the costs of family planning activities.

Section 433.58(g) provides that, subject to certain limitations, States may receive revenues from tax programs during the State's transition period, without a reduction in FFP, if:

• The health care-related taxes are broad-based and uniformly imposed, and the taxpayer will not be held harmless; or

• The health care-related taxes are imposed under:

+ A tax program that was in effect as of November 22, 1991; or

+ Legislation or regulations that were enacted or adopted as of November 22, 1991.

In addition, we have identified the following circumstances under which a State may modify health care-related tax programs in existence as of November 22, 1991, without a reduction in FFP: (1) If the modification only extends to a tax program that is scheduled to expire before the end of the State's transition period, or makes technical changes that do not alter the rate of the tax or the base of the tax (e.g., the providers on which the tax is imposed) and do not otherwise increase the proceeds of the tax; or (2) If the modification only decreases the rate of the tax, without altering the base of the tax. These provisions were included in the regulations as a result of questions from States concerning what types of modifications can be made to existing impermissible tax programs. As a result, during a State's transition period, only modifications to impermissible tax programs in existence on November 22, 1991, that meet one of the specific circumstances or provisions described above, will be permitted without a reduction in FFP.

Section 433.60, Limitations on level of FFP in State expenditures from provider-related donations and health care-related taxes during the transition period, specifies limits and formulas for calculating the maximum amount of provider-related donations and health care-related taxes that a State may receive without a reduction in FFP during a State fiscal year in the State's transition period, in accordance with section 1903(w)(1)(E) of the Act.

It is important to note that Pub. L. 102-234 applies to all donations from providers and related entities and to all health care-related taxes. The governing factor for the treatment of the tax or donation program (i.e., for determining applicability in State transition periods and the amount of the transition cap) is whether or not the provider-related donation program was in effect on September 30, 1991, or, if the tax program was enacted or adopted as of November 22, 1991. The duration or the purpose of the program is irrelevant. Consequently, all provider-related donations and health care-related taxes in existence as described above are used to calculate the limit. Under § 433.60, the maximum amount of provider-related donations and health care-related taxes that a State may receive, without a reduction in FFP, during a State fiscal year in the State's transition period is expressed as a percentage of the State's total Medicaid expenditures (including all of the State's Medicaid program administrative costs). Specifically, the State's total medical assistance expenditures for its fiscal year is multiplied by the greater of 25 percent or the State base percentage.

The specific percentage to be applied for a State in any fiscal year is the greater of 25 percent or the "State base percentage." The State base percentage is calculated by dividing the amount of all provider-related donations and health care-related taxes (whether or not they are permissible) estimated to be received in State fiscal year 1992 by the State's share of the total amount estimated to be expended under the State plan during such State fiscal year. This percentage is multiplied by the total non-Federal share of Medicaid expenditures (including all of the administrative costs) in that fiscal year to determine the actual dollar limit.

The statute provides special rules for the calculation of the amount of health care-related taxes to be included in the numerator of the formula for taxes that were not in effect for the entire fiscal year, but were enacted as of November 22, 1991. In this case, the amount of revenues to be included would be estimated as if the tax (or increase) were in effect for the entire fiscal year. In accordance with the statute, a subsequent decrease in the tax would not be taken into consideration in calculating the numerator. The law

requires HCFA to estimate the State fiscal year 1992 non-Federal share of Medicaid expenditures based on the best available data.

During the transition period, the 25 percent limit (or if higher, the State base percentage) will limit the amount of revenues States may receive from provider-related donations and health care-related taxes, and will apply to the sum of revenues received by States from—

- Provider-related donations, other than bona fide donations and donations for outstationed eligibility workers; and
- Health care-related taxes, including permissible taxes and impermissible taxes still eligible for use during the transition period.

Revenues received from these sources in excess of the 25 percent cap (or the State base percentage) will be deducted from Medicaid expenditures before FFP is calculated. For example, assume a State with a July 1, fiscal year received provider-related donations in State fiscal year 1992 and collected $250,000 in provider-related donations in the September 1991 quarter. The transition period for this State extends through September 30, 1992. Assume further that the State base percentage for this State is 30 percent and its estimated State fiscal year 1993 Medicaid expenditures is $6 million. The State's limit for State fiscal year 1993 would be determined by multiplying its State base percentage by the State's share of total medical assistance expenditures (including administrative costs) for State fiscal year 1993 (i.e., $6 million multiplied by 30 percent would yield a State fiscal year 1993 limit of $1,800,000).

Given these assumptions, the amount the State can receive in provider-related donations based on the State's estimated fiscal year 1993 medical assistance expenditures is $250,000 (the amount it collected in the preceding corresponding period plus 5 days). Since the amount of provider-related donations the State is permitted to receive in this example is less than the State's limit for total donations and taxes for the year, this State may collect the remaining amount, without a reduction in FFP, from permissible and qualifying impermissible health care-related taxes.

Conversely, if the $250,000 in provider-related donations represented an amount greater than 30 percent of the State's medical assistance expenditures estimated for the entire State fiscal year 1993, then the excess amount would be deducted from the State's medical assistance expenditures before determining the amount of FFP that would be available.

Rules Regarding Revenues From Donations and Taxes After a State's Transition Period

Beginning on the day after a State's transition period has ended, Public Law 102-234 denied FFP for most donations from health care providers and limits Federal matching funds for health care-related taxes. To incorporate these statutory provisions, we are adding new §§ 433.68 through 433.70, which delineate the rules and limitations regarding revenues from provider-related donations and health care-related taxes.

Section 433.66 specifies permissible provider-related donations after the transition period. This section provides that, except for provisions relating to donations for outstationed eligibility workers (which are effective on October 1, 1992), beginning on the day after a State's transition period ends, a State may receive revenue from provider-related donations, without reduction in FFP, only in accordance with the requirements specified in that section. Section 433.66(b) provides that in order to be permissible, provider-related donations must meet one of the following requirements:

- The donations must be bona fide donations, as defined in § 433.54. Note that after a State's transition period ends, the amounts permitted as bona fide donations would not be subject to the 25 percent cap or, if higher, the State base percentage; or
- The donations must be made by a hospital, clinic, or similar entity (such as a Federally-qualified health center) for the direct costs of State or local agency personnel who are stationed at the facility to determine the eligibility (including eligibility redeterminations) of individuals for Medicaid and/or to provide outreach services to eligible (or potentially eligible) Medicaid individuals. Direct costs of outstationed eligibility workers refers to the costs of training, salaries, and fringe benefits associated with each outstationed eligibility worker and similar allocated costs of State or local agency support staff. Such direct costs include the prorated cost of pamphlets and materials distributed by the outstationed eligibility workers at these sites. Costs such as State agency overhead costs and the cost of advertising campaigns, as well as provider space, are not allowable for this purpose. Beginning October 1, 1992, these donations are subject to the 10 percent limit described in § 433.67(a)(2).

As mentioned earlier in the preamble, since we do not consider extensive outreach campaigns within the context of outstationing, donations that otherwise meet the statutory requirements for charitable contributions or bona fide provider donations could be used for this purpose. Section 433.67, Limitations on level of FFP for revenues from permissible provider-related donations, specifies limits applicable to such donations in accordance with section 1903(w)(1)(A) and (B) of the Act. As mentioned earlier in the preamble, during a State's transition period, bona fide donations and, prior to October 1, 1992, the amounts permitted as donations for outstationed eligibility workers are not subject to the 25 percent cap or, if higher, the State base percentage. Under § 433.67(a)(1), there is no limit on the amount of bona fide provider-related donations that a State may receive without a reduction in FFP, as long as the bona fide donations meet the requirements of § 433.66(b)(1).

In addition, § 433.67(a)(2) provides that, effective October 1, 1992, regardless of when a State's transition period ends, the maximum amount of donations for outstationed eligibility workers that a State may receive without a reduction in FFP may not exceed 10 percent of a State's medical assistance administrative costs (Federal and State), exclusive of the costs of family planning activities. The 10 percent limit for provider-related donations for outstationed eligibility workers is not included in the limit in effect through September 30, 1995, for health care-related taxes as described in § 433.70.

Section 433.67(b) specifies that HCFA will deduct from a State's medical assistance expenditures, before calculating FFP, any provider-related donations that do not meet the requirements of § 433.66(b)(1), and provider-related donations for outstationed eligibility workers in excess of the limits specified in § 433.66(a)(2).

Section 433.68, Rules regarding revenues from health care-related taxes after the transition period, provides, in general, that revenues from broad-based health care-related taxes that are applied uniformly to providers, and which do not hold providers harmless for the costs of the tax, may be received by States without a reduction in FFP, subject to the limits specified in § 433.70. Revenues from health care-related taxes not meeting these statutory requirements are deducted from medical assistance expenditures before FFP is calculated.

As mentioned earlier in this preamble, any licensing fee, assessment or other

andatory payment which is related to health care items or services, or to the provision of, the authority to provide, or payment for the health care items or services, as defined in § 433.55, is considered to be a health care-related tax. The term "tax" does not include a criminal or civil fine or penalty, unless the fine or penalty was imposed instead of a tax.

Under § 433.68(c), in order for a health care-related tax to be considered to be broad-based, it must:

- Be imposed at least on all items or services in the class furnished by all non-Federal, non-public providers in the State, or all non-Federal, non-public providers in a class. If imposed by a unit of local government, the tax must extend to all items, services or providers (or to all within a class) in the area over which the unit of government has jurisdiction; and
- Be imposed uniformly throughout the jurisdiction.

In accordance with section 1903(w)(7)(A) of the Act, we define classes of health care items, services and providers, in § 433.56. After consulting with State representatives, ve believe it is necessary to emphasize nat, for purposes of determining if a tax on a class of health care-related items or services is broad based, a class includes all providers of a particular class of service located in a State or, in the case of a tax imposed by a unit of local government, the area over which the unit has jurisdiction. A tax need not cover out-of-State providers who provide service to State residents, or any out-of-State business of an in-State provider of health care-related items or services.

Under § 433.68(d)(1), a tax is considered to be uniformly imposed if it meets any one of the following criteria:

- If the tax is a licensing fee or similar tax imposed on a class of health care items or services, or providers of those health care items or services, the tax must be the same amount for every item and service or for every provider providing those items or services within the class.
- If the tax is a licensing fee or similar tax imposed on a class of health care items or services, or providers of those items or services, on the basis of the number of beds in the provider, the amount of the tax must be the same for each bed of each provider in the class.
- If the tax is imposed on provider revenues or receipts with respect to a class of items or services or providers of those health care items or services, the tax must be imposed at a uniform rate for all items and services, and providers of those items or services in the class on all the gross revenues or receipts, or on net operating revenues. We have defined net operating revenue to mean gross charges of facilities, less any amounts deducted for bad debts, charity care, and payer discounts.
- The tax is imposed on items or services on a basis other than those listed above, e.g., an admission tax, and the State establishes to the satisfaction of the Secretary that the amount of the tax is the same for each provider of such items or services in the class.

Conversely, under § 433.68(d)(2), a tax is not considered to be imposed uniformly if it meets either one of the following two criteria:

- The tax provides for any credits, exclusions, or deductions, even if made to third parties such as patients, that result in the return to providers, directly or indirectly through third parties, of all or a portion of the tax paid, and it results, directly or indirectly, in a tax program—
  - + In which the net impact of the tax and payments is not generally redistributive; and
  - + In which the amount of the tax is directly correlated to payments under the Medicaid program.
- The tax holds providers harmless for the cost of the tax.

A tax will, however, still be considered to be uniform if it excludes Medicaid or Medicare revenues.

Section 433.68(d)(3) specifies that, if a tax does not meet the criteria in 433.68(d)(1), but the State establishes that the tax is imposed uniformly in accordance with the procedures for a waiver specified in § 433.72, the tax will be treated as a uniform tax.

Section 433.68(f) specifies that a provider will be considered to be held harmless under a tax program if any of the following conditions applies:

- The State (or other unit of government) imposing the tax provides, directly or indirectly for a non-Medicaid payment to those providers or others paying the tax and the amount of the payment is positively correlated either to the amount of the tax or to the difference between the Medicaid payment and the total tax cost.
- All or any portion of the Medicaid payment to the taxpayer varies based only on the amount of the tax payment.
- The State (or other unit of local government) imposing the tax provides, directly or indirectly, for any payment, offset, or waiver that guarantees to hold taxpayers harmless for all or a portion of the tax.

Section 433.70, Limitations on level of FFP for revenues from health care-related taxes after the transition period, specifies limits and formulas for calculating the maximum amount of health care-related taxes that a State may receive without a reduction in FFP during a State fiscal year after the State's transition period, in accordance with sections 1903(w)(1)(A)(iv) and 1903(w)(5) of the Act. Under § 433.70(a)(1), subsequent to the end of a State's transition period, and extending through September 30, 1995, the maximum amount of permissible health care-related taxes that a State may receive without a reduction in FFP during a State fiscal year (or portion thereof) is expressed as a percentage of the total State share of Medicaid Program expenditures in that fiscal year (including all of the State's medical assistance administrative costs). Specifically, the State's total medical assistance expenditures (reduced by the amount of impermissible provider-related donations and impermissible health care-related taxes) are multiplied by the greater of 25 percent or the State base percentage, as described in our regulations. As mentioned earlier in the preamble, the 10 percent limit for donations from providers for outstationed eligibility workers described in § 433.67(a)(2) is not included in the limit in effect through September 30, 1995, for health care-related taxes.

Section 433.70(a)(2) provides that, beginning October 1, 1995, there is no limitation on the amount of health care-related taxes that a State may receive without a reduction in FFP, as long as the taxes meet the requirements specified in these regulations.

Section 433.70(b) provides the formula for calculating the amount of FFP when a State receives health care-related taxes that do not meet the definition specified in § 433.68, and when a State receives health care-related taxes in excess of the limit described in § 433.70(a)(1).

Section 1903(w)(3)(E)(i) of the Act provides for a waiver of the broad-based and uniform requirements. In accordance with this section, we are adding a new § 433.72, Waiver provisions applicable to health care-related taxes. Under this section, a State may submit to HCFA a request for a waiver of the broad-based tax and/or the uniformity requirements specified in the regulations. A request for a waiver should be submitted subsequent to enactment of the State law implementing the tax. A waiver will be effective the first day in the quarter in which the request is received even if the additional information necessary to complete an evaluation of the waiver request is submitted subsequent to that

quarter. We have included a special provision whereby a State may apply for a waiver of a tax program that was in effect prior to October 1, 1992. Such waiver requests must be submitted to HCFA within 90 days after publication of these interim final rules. If a State submits a waiver request for a tax that was in effect prior to October 1, 1992, the waiver may be granted effective no earlier than January 1, 1992 or, if later, the date of enactment of the tax.

In order for HCFA to approve a waiver request, the State must demonstrate that its tax program meets all of the following requirements:

- The net impact of the tax and any payments made to the providers by the State under the Medicaid program is generally redistributive in nature.
- The amount of the tax is not directly correlated to medical assistance payments.
- The tax program meets the hold harmless provisions specified in this regulation.

The following example illustrates how the requirements relating to health care-related taxes contained in Pub. L. 102-234 would be applied.

Assume that a State imposes a tax of 5 percent on gross revenues of hospitals and gas stations. The tax generates $100 million in revenues during the State fiscal year, of which $90 million is paid by the hospitals and is deposited into the State General Fund.

The fact that this tax includes hospitals does not in and of itself subject it to the provisions of Pub. L. 102-234. Nor is the dedicated use of the tax revenue a consideration in determining the applicability of the statutory requirements. Rather, in determining whether or not the provisions of the law apply to this tax program, it must first be determined, in accordance with section 1903(w)(3)(A) of the Act, if the tax program is considered "health care-related."

The tax described in this example applies to both health care items and services and non-health care items and services. Therefore, we would determine if this tax is considered to be health care-related in accordance with section 1903(w)(3)(A)(ii) of the Act (i.e., a tax is considered to be health care-related if the treatment of the tax for health care items and services is different from the treatment of the non-health care entity). Since the tax in our example is a flat rate based on gross receipts, this tax would not be deemed health care-related based on section 1903(w)(3)(A)(ii) of the Act.

We then need to determine if this tax is health care-related in accordance with section 1903(w)(3)(A)(i) of the Act (i.e., if 85 percent of the burden of the tax falls on health care providers). Since 90 percent of the tax revenue in this example is generated from providers of health care services, the tax paid by the provider is considered to be a health care-related tax under section 1903(a)(w)(3)(A)(i) of the Act.

If, in this example, the hospitals paid $80 million in tax revenue and the gas stations paid $40 million, the tax would not be considered health care-related, and would not be subject to the remaining provisions of the law.

Once it is determined that a tax is health care-related, additional analysis of the tax program must be done to determine if States may receive this revenue, subject to the limitations previously described in this rule, without a reduction in FFP. The tax revenue would be deducted from Medicaid expenditures, before calculation of FFP, unless the tax met three independent criteria. The tax must be broad-based, applied uniformly, and must not hold taxpayers harmless for their tax costs.

In order for a health care-related tax to be considered to be broad-based in accordance with section 1903(w)(3)(B) of the Act, it must be imposed at least on all items or services in the class furnished by all non-Federal non-public providers in a class. If the tax is imposed by a unit of local government, the tax must extend to all items, services, or providers (or to all within a class) in the area over which the unit of government has jurisdiction.

In the example, since the tax extends to all hospital services, it would be considered broad based. Further, since the tax is imposed at a flat rate on gross revenue, it satisfies the requirement that it is imposed uniformly.

We wish to point out that in the example above, the tax would still be considered to be broad based if the State included only all non-Federal non-public providers in the class. Moreover, the tax would still be considered imposed uniformly if it excluded Medicare or Medicaid revenues. However, if the tax did not apply to all hospital services, and/or provided a credit, deduction, or exclusion, other than those mentioned in the preceding paragraph, the State may submit an application to the Secretary requesting that the tax be treated as broad-based and/or uniform. The criteria for determining whether a tax is "generally redistributive" even though it is not broad-based and/or uniform are included in § 433.68(e)(1) and (2) of the regulations.

To illustrate, assume that the tax in the example above was imposed only on hospitals which have more than 500,000 total patient days per year. If the State can demonstrate that the requirements defined in § 433.68(e)(1) are met, a wavier of the broad-based requirement as described in section 1903(w)(3)(B) the Act could be granted. Under the waiver, although the tax would not be paid by all hospitals, the revenue would not be offset from medical assistance expenditures before calculating FFP.

Assume differently that the tax was imposed on all health care items or services in a class, but the State granted a $2,000 tax credit for each 100 Medicaid patient days per year. If the State can demonstrate that the requirements in § 433.68(e)(2) are met, a waiver of the uniformity provisions in section 1903(w)(3)(C) of the Act could be granted. Under the waiver, although the tax law contains a tax credit for certain hospitals, the revenue would not be offset from Medical Assistance expenditures before calculating FFP.

It is important to note that the potential availability of waivers is limited to the broad-based and the uniformity criteria. The hold harmless requirement may not be waived under this provision.

Even if a tax is deemed under waiver authority to be a broad-based health care-related tax that is applied uniformly, it must also be determined if a hold harmless provision exists as described in section 1903(w)(4) of the Act. If, in any of the illustrations above, it were determined that a hold harmless provision as described in § 433.68(f) exists, the waiver would be denied and the tax revenue would be subtracted from the State's Medical assistance expenditures before calculating FFP.

We elected not to establish a separate appeals process for waiver disapprovals. If a State believes that a waiver disapproval results in a disallowance of claims for FFP issued in accordance with 42 CFR 430.42 (Disallowance of claims for FFP), the State may appeal the waiver disapproval when it appeals the disallowance. The appeals process will be handled by the Departmental Appeals Board (DAB) in the context of any disallowance that results from the denial of the waiver.

Generally Redistributive

Section 433.68(e) provides the criteria under which HCFA will determine whether a tax is not broad based or uniform is "generally redistributive". In interpreting this statutory requirement, which appears at section 1903(w)(3)(E)(ii) of the Act, we have attempted to balance our desire to give

States some degree of flexibility in designing tax programs with our need to preclude use of revenues derived from taxes imposed primarily on Medicaid providers and activities.

For purposes of these regulations, we have interpreted the term "redistributive", as used in the statute, to mean the tendency of a State's tax and payment program to derive revenues from taxes imposed on non-Medicaid services in a class of items or services (or providers of these services), and to use these revenues as the State's share of Medicaid payments. To the extent that a tax is imposed more heavily on providers with low Medicaid utilization than high Medicaid providers, the tax would be considered redistributive.

In order to apply the "generally redistributive" test to a tax program that is not broad based or uniform, § 433.68(e) provides States with two quantitative tests to measure the degree to which a tax is "redistributive", in reference to a tax that is broad based and uniform. The tests will be calculated by States and the results subject to verification by HCFA. The first test applies to those situations in which a tax is uniform, but not broad based. That is, the test would be used for a tax that does not apply to all services or providers of those services in a class, but all services or providers subject to the tax are taxed uniformly. This test would be used, for example, in the case of a tax on inpatient hospital revenue that exempted rural hospitals.

The test would be calculated by the State by comparing the proportion of the tax applicable to Medicaid as proposed by the State, to the proportion of the tax applicable to Medicaid if it were broad based. For example, in the case of a tax applied to inpatient hospital revenue, but which exempts rural hospitals, the State would calculate in proportion of the tax revenue applicable to Medicaid under the tax as imposed, and under the tax if all providers were subject to the tax. In this example, the proportion of the tax would equal the Medicaid share of the hospital revenues.

The regulatory provision at § 433.68(e) would require the State to calculate the proportion of the tax applicable to Medicaid under a broad-based tax (designated as P1), and the proportion applicable to Medicaid under the tax as imposed by the State (called P2). The test of how redistributive the tax is would be measured by dividing P1 by P2. Note that if P1/P2 equalled one, the new tax would be exactly as redistributive as the broad-based tax, i.e., the tax would have the same proportion of tax applicable to Medicaid. If the value of P1/P2 were greater than one, the non-broad-based tax would be more redistributive than the broad-based one, i.e., less of the tax burden would fall on Medicaid services. If the value of P1/P2 were less than one, the non-broad-based tax would be less redistributive than the broad-based one. A value of P1/P2 of 0.5 would represent a tax that doubled the proportion applicable to Medicaid.

Under § 433.68(e), when the State demonstrates to the Secretary's satisfaction that P1/P2 is greater than 1, the waiver request will be approved automatically. HCFA will review other waiver requests only if the State demonstrates to the Secretary's satisfaction that the proportion of the tax applicable to Medicaid in the broad-based tax (P1), when divided by the proportion of the tax applicable to Medicaid under the waiver (P2), is at least equal to 0.95 but is not greater than 1. HCFA will approve such waiver requests if the value of P1/P2 is at least equal to 0.95 but is not greater than 1, and the tax excludes or provides credits or deductions only to one or more of the following providers of items and services within the class to be taxed:

- Providers that furnish no services within the class is the State;
- Providers that do not charge for services within the class;
- Rural or sole community hospitals; or
- Physicians practicing primarily in medically underserved areas.

Our intention is to define rural and sole community hospitals in accordance with the definitions already established by the Medicare program. A sole community hospital is defined in 42 CFR 412.92(a). An urban area is defined in 42 CFR 412.62(f)(ii). Based on these definitions already established in our regulations, we are defining a rural hospital as any hospital located outside of an urban area. In addition, we are defining physicians in medically underserved areas in accordance with section 1302(7) of the Public Health Service Act.

The second test, although similar to the first, would apply in situations in which the State is requesting a waiver of the uniformity requirement, whether or not the tax is broad-based. Under this test, the State would calculate two linear regressions, one for the tax program for which waiver is requested, and one for the tax if it were applied uniformly and as a broad-based tax. (A linear regression is a statistical technique in which ordinary least squares are used to fit a straight line to paired data coordinates.)

Under the test specified in § 433.68(e), a State seeking waiver of the uniformity requirements must demonstrate that its tax program meets the generally redistributive test by the following procedure:

- For the tax program for which the State is seeking a waiver, the State must calculate a linear regression using as the dependent variable each provider's percentage proportion of the total statewide tax paid by all providers in a 12-month period and as each provider's independent variable, the "Medicaid Statistic". By the term "Medicaid Statistic, we mean the number of the provider's taxable units applicable to the Medicaid program. If, for example, the State imposed a tax based on charges, the amount of the provider's Medicaid charges in a 12-month period would be its Medicaid Statistic. If the tax were based on days, the number of the provider's Medicaid days in a 12-month period would be its Medicaid Statistic. For purposes of this test, it is not relevant that a tax program exempts Medicaid from the tax.
- The State must calculate a linear regression as above, but under the assumption that the tax is broad based and uniformly applied.
- The slope (i.e., the X coefficient) of the linear regression applicable to the hypothetical broad-based uniform tax (called B1) is divided by the slope of the linear regression applicable to the tax for which a waiver is sought (called B2).
- When the State demonstrates to the Secretary's satisfaction that B1/B2 is greater than 1, HCFA will automatically approve the waiver request.
- HCFA will review other waiver requests only if the State demonstrates to the Secretary's satisfaction that the value of B1/B2 is at least equal to 0.95 but is not greater than 1. HCFA will approve such waiver requests if the value of the B1/B2 is at least equal to 0.95 but not greater than 1, and the tax excludes or provides credits or deductions only to one or more of the following providers of items and services within the class to be taxed:
  - + Providers that furnish no services within the class in the State;
  - + Providers that do not charge for services within the class;
  - + Rural or sole community hospitals; or
  - + Physicians practicing primarily in medically underserved areas.
  - + Physicians in primarily medically underserved areas.

While we believe that the intent of the waiver provision is to provide States with some degree of discretion in their tax programs, we do not believe its

intent is to provide States with the ability to design programs in which the tax burden is shifted significantly to Medicaid providers or activities. We also believe States should have some additional flexibility in the case of rural or sole-community hospitals or physicians in health underserved areas because of their importance to recipient access to services.

We seek public comments on the tests, as well as the specific numerical values in the tests, specified in this interim final rule.

Hold Harmless

Section 1903(w)(4) of the Act specifies three conditions under which a State or local government is determined to hold taxpayers harmless for their tax costs. If any of these criteria is met, a tax program would be determined to have a hold harmless provision and the tax is impermissible. This section also provides that States are not, however, precluded from using a tax to reimburse health care providers for medical assistance expenditures, or precluded from relying on this reimbursement to justify or explain the tax.

Taken together, we have interpreted the hold harmless provisions to mean that while States may use revenue from otherwise permissible taxes to increase payment rates to the providers subject to the tax, States may not make Medicaid or other payments to providers that result in taxpayers being repaid dollar for dollar for their tax costs. If such payments were permitted, there would be no restraint on States' ability to use provider taxes as the source of the non-Federal share of Medicaid payments.

The first criterion, included in the regulations at § 433.68(f)(1), would determine a hold harmless to exist when a State or local government directly or indirectly provides for any non-Medicaid payment to taxpayers and the amount of the payment is positively correlated either to the amount of the tax or to the difference between the amount of the tax and the amount of the Medicaid payment. Examples of the types of situations which might fall under the criteria are:

- A State imposes a tax on NF charges. The revenue from the tax is used for two purposes. Some of the funds are used by the State as the State share of Medicaid rate increases to facilities. The remaining portion of the tax receipts are given to private pay patients in the form of grants to compensate them for the tax added to their nursing home bills. If the tax is considered to be levied on the nursing home, the State is using non-Medicaid funds to compensate nursing homes, indirectly, for the cost of the tax imposed on private charges. If the tax is considered to be levied on the third party, the State is directly providing for a non-Medicaid payment to a private pay patient that is positively correlated to the amount of the tax.
- A State imposes a tax on hospital revenues. The State uses the tax revenues in two ways. First, it uses part of the funds as the State share of disproportionate share hospital payment adjustments. Second, it repays hospitals whose DSH payment adjustments were insufficient to cover their tax costs. In this case, since the State is directly repaying taxpayers for the difference between their tax costs and the enhanced Medicaid payments, a hold harmless situation would exist.

The second criterion, as specified in the statute, provides another general test for determining when hold harmless situations exist. This provision would deem a hold harmless situation to exist when all or any portion of a State's Medicaid payment to a taxpayer varies only based upon the total tax paid. While this provision does not preclude States from using revenues from permissible taxes imposed on classes of health care items and services to increase general payment rates for those services, the provisions would deem a hold harmless situation to exist when the rate increase to a provider is related only to the amount of the tax paid by the provider.

The third criterion in the statute provides that a hold harmless is determined to exist when the State or local government imposing the tax provides for any direct or indirect payment, offset or waiver that guarantees to hold taxpayers harmless for any portion of their tax costs. We have interpreted this provision to mean that use of any State payment, or offset or waiver or other taxes or mandatory payments that would have been paid by the taxpayer, in a way that is guaranteed to repay the taxpayer for all or part of the cost of health care-related taxes, is a hold harmless situation. The third statutory criterion would also consider as a hold harmless any sort of explicit guarantee, for example, in a State law authorizing a health care-related tax, that assures repayment of tax costs. For example, if a State imposes a health care-related tax, but provides a credit against property taxes equal to the tax imposed on providers not participating in Medicaid, a hold harmless situation would exist.

We are also concerned about the application of the hold harmless provisions in cases in which States impose taxes on classes of items and services (such as ICFs/MR) which are predominantly furnished to Medicaid recipients. In these cases, repayment of the Medicaid share could be tantamount to a guarantee of repayment of the entire tax cost and would result in a hold harmless situation. If HCFA did not address this situation, it would be possible for States to levy excessive amounts of taxes on ICFs/MR and other high Medicaid providers, and use Medicaid rates to repay them for their tax costs. We specifically seek public comments on both the thresholds and policy of this test. This specific hold harmless test will be effective December 24, 1992.

In applying the "guarantee" requirement to this situation, we have adopted a two-prong test for determining when hold harmless situations exist when States impose disproportionate health care-related taxes. However, if an explicit guarantee exists, the tax would be impermissible and the two-prong test will not apply. If an explicit guarantee does not exist, the two-prong test will apply.

Under the first prong of the test, if the health care-related tax is applied at a rate that is less than or equal to 6 percent of the revenue received by the taxpayer (which we consider to be the average level of taxes applied to other goods and services in the States), the tax would be presumed to be permissible under this test. If an explicit guarantee does not exist and if the tax is applied at a rate that is in excess of 6 percent of the revenue received by the taxpayer, we will apply the second prong of the test to determine if an inexplicit guarantee exists in violation of the hold harmless provision.

Under the second prong, 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. We have selected this level because we think it strikes a reasonable balance between our need to assure that States do not use Medicaid rates to repay providers for tax costs in a way not permitted under the statute, and our desire to permit States flexibility in the design of their tax and payment programs. It is our belief that this requirement will largely affect only those tax programs placed on ICFs/MR, but may not impact on every State. We would not expect the 75/75 criterion to affect taxes on classes of providers in which at least 25 percent of providers do not participate in Medicaid at any significant level. If, as of December 24,

1992, a State has enacted a tax in excess of 6 percent that does not meet these requirements, HCFA will not disallow funds received by the State resulting from the tax if the State modifies the tax to comply with this requirement by April 1, 1993. If by April 1, 1993, the tax is not modified, funds received by States on or after April 1, 1993, will be disallowed. HCFA has selected this date to permit States time to come into compliance with the requirement.

In implementing this provision, the test will be applied to all providers in the class (or classes) subject to the tax. The test will be determined by comparing Medicaid rates to providers before the imposition of the tax to the Medicaid payment rates paid to providers after the tax.

To illustrate how this test would be applied, a State, upon request from HCFA, would be required to supply the following information for each provider subject to the tax:

- The average Medicaid rate paid to the facility in the period prior to the imposition of the tax;
- The average Medicaid rate paid to the facility within twelve months of the imposition of the tax; and
- The number of rate units (i.e. days, discharges, charges) in the year prior to imposition of the tax.
- The payment for each provider to which the tax cost would be compared would be calculated by multiplying the difference in the rates (#2–#1) by the measure of utilization (#3).

This test would compare each provider's tax payment to its Medicaid rate increase over a 12-month period. By using prior year's utilization, the test would not be affected by increases in utilization subsequent to the tax. If a State's tax and payment program were determined to violate the numerical test, all of the revenue received by the State from the taxpayers would be disallowed. In applying the hold harmless provision to State tax programs, HCFA will not apply any numerical test before the effective date of these regulations. Offsets from FFP made under this test will only be made after the effective date of the regulations.

Reporting Requirements

Section 4 of Public Law 102–234 amended section 1903(d) of the Act to require that each State submit information related to provider-related donations received and health care-related taxes collected by the State or units of local government during the Federal fiscal year. In a new § 433.74, Reporting requirements, we are requiring that, beginning with the first quarter of Federal fiscal year 1993, each State must submit to HCFA quarterly summary information on the source and use of provider-related donations (including all bona fide and "presumed to be bona fide" donations) received and health care-related taxes collected. Each State must also provide any additional information requested by the Secretary related to any other donations made by, any taxes imposed on, health care providers. Each State must provide this information with its regular quarterly budget and expenditure reporting, in accordance with the forms and procedures established by HCFA in section 2800 of the State Medicaid Manual. States' reports must present a complete, accurate, and full disclosure of all of their donation and tax programs and expenditures. If a State fails to comply with these reporting requirements, future grant awards will be reduced by the amount of FFP HCFA estimates is attributable to the sums raised by tax and donation programs as to which the State has not reported properly, until such time as the State complies with the reporting requirements. Deferrals and/or disallowances of equivalent amounts may also be imposed with respect to quarters for which the State has failed to report properly. Unless otherwise prohibited by law, FFP for those expenditures will be released when the State complies with all reporting requirements.

Information on the source and use of provider-related donations received and health care-related taxes collected for State fiscal year 1992 was obtained in a request made on May 6, 1992, to the States for purposes of calculating applicable State transition period limits. Instead of continuing this type of reporting process, we have incorporated this reporting into the States' normal budget and expenditure reporting processes and cycles. If, subsequent to a State's initial report, a State determines that it inadvertently omitted estimates for either donation programs applicable to State fiscal year 1992 (for which documentation existed showing the program was in effect as of September 30, 1991) or for tax programs enacted as of November 22, 1991, a State must submit this information to HCFA within 90 days after publication of these interim final rules. HCFA will then analyze this data and recalculate the applicable State's transition period limit.

While we are requiring States to only report summary information on a quarterly basis, States must maintain, in readily reviewable form, supporting documentation that provides a detailed donation and tax program being reported, along with the source and use of all donations received and taxes collected. This information must be made available to Federal reviewers upon request.

Consultation With States

Section 5(c) of Public Law 102–234 required HCFA to consult with the States before issuing regulations to implement the legislation. We have met this requirement by conducting a series of meeting with representatives of the National Governors Association, the National Council of State Legislatures, the National Association of Counties, the National Association of State Budget Officers, and the American Public Welfare Association. During these meetings, HCFA received written and oral input from these groups concerning the issues involved in developing these rules. To the extent possible, their views and ideas have been accommodated in the rules.

We also met with representatives of hospital organizations, including the American Hospital Association, the American Public Hospital Association, and the National Association of Children's Hospitals and related institutions, concerning the issues involved in implementing the statute. Again, to the extent possible, their views and ideas have been accommodated in the rules. These organizations were helpful in providing the perspective of hospitals concerning the donations and taxes and DSH payment requirements.

III. Disproportionate Share Hospitals

General Rule

Among the hospitals that agree to provide services to Medicaid recipients are certain hospitals that, because of their geographic location or various other reasons, serve a larger number of Medicaid recipients and other low-income individuals than other hospitals. These hospitals are referred to as disproportionate share hospitals (DSHs). Because DSHs provide services to a large population of Medicaid recipients and other low-income individuals, they are faced with special financial needs.

Section 1902(a)(13)(A) of the Act requires States to assure that their Medicaid payment rates take into account the situation of hospitals serving a disproportionate number of low-income patients with special needs.

Section 1923 of the Act contains a Federal definition of DSHs, delineates specific requirements that DSHs must

and specifies formulas for States to use to make payment adjustments to DSHs. Under section 1923 of the Act, States are free to establish their own criteria for determining whether a hospital qualifies as a DSH, subject to certain statutorily imposed minimums specified in section 1923(b) of the Act. In accordance with section 1923(c) of the Act, States are also free to choose one of three payment formulas to calculate the amount of the payment adjustment each DSH receives.

Prior to the enactment of Public Law 102–234, DSH payment adjustments were not subject to Federal limitations. Section 1902(h), in part, prohibited the Secretary from imposing an upper payment limit for DSHs. As a result, DSH payments have substantially increased. Therefore, the Congress found it necessary to impose limits on these payments.

Section 3 of Public Law 102–234 established limits on the amount of Federal financial participation (FFP) available for expenditures made to DSHs. Prior to enactment of this legislation, there were no imposed legal limits on Medicaid DSH payments. The provisions of section 3 of Public Law 102–234 affecting DSH payments apply to all 50 States and the District of Columbia, but not to any State whose entire Medicaid program is operated under a waiver granted under section 1115 of the Act.

Specifically, section 3(a) of Public Law 102–234 deleted the prohibition on an upper payment limit for DSHs from section 1902(h) of the Act. Section 3(b) of Public Law 102–234 added subsection (f) to section 1923 of the Act which imposes two restrictions on DSH payments. One restriction is applicable from January 1, 1992 through September 30, 1991. A second restriction goes into effect on October 1, 1992.

The first DSH restriction, effective from January 1, 1992 through September 30, 1992, places a moratorium on DSH plans. Section 1923(f)(1) of the Act provides that States may receive FFP for DSH payments during the moratorium period only if the payments were made in accordance with one of the following:

A State plan in effect by September 30, 1991.

A State plan amendment submitted to HCFA by September 30, 1991.

A State plan amendment or modification submitted to HCFA between October 1, 1991 and November 26, 1991, if the amendment or modification was intended to limit the State's definition of DSHs to those hospitals with Medicaid inpatient utilization rates or low-income utilization rates (as defined in section 1923(b) of the Act) at or above the statewide arithmetic mean. A DSH payment methodology established and in effect as of September 30, 1991, or in accordance with State law enacted or State regulations adopted as of September 30, 1991.

A State plan amendment that increases DSH payments to comply with the minimum payment requirement described in section 1923(c)(1) of the Act, which provides for a payment adjustment based on the formula used in the Medicare program.

The second DSH restriction, effective October 1, 1992, establishes both national and State limits on DSH payments. The national limit is established at 12 percent of the total amount of medical assistance expenditures paid under Medicaid State plans during the Federal fiscal year. For the calculation of this limit, State administrative costs, by law, are excluded from medical assistance expenditures for this purpose.

In general, the State limit is similarly set at 12 percent of a State's medical assistance expenditures (excluding administrative costs). However, each State's DSH limit is based on the fiscal year 1992 DSH expenditures. Section 1923(f)(4)(C) of the Act defines a State base allotment as the total amount of DSH payment adjustments eligible for Federal matching during Federal fiscal year 1992 or $1 million, whichever is greater. States with DSH payments during Federal fiscal year 1992 above the 12 percent limit are defined in section 1923(f)(4)(A) of the Act as "high-DSH States." In accordance with section 1923(f)(2)(B) of the Act, States that are designated as "high-DSH States" will have DSH payment adjustments limited to the State base allotment.

States with aggregate DSH payments below the 12 percent limit are referred to as "low-DSH States." Section 1923(f)(2)(A) of the Act provides that these States are permitted to increase DSH payments to the extent their Medicaid programs grow, and to the extent that the sum of all States' DSH limits do not exceed the national 12 percent limit. The preliminary national DSH limit and the preliminary State-specific DSH limits are calculated prospectively, before the beginning of the Federal fiscal year (i.e., October 1). These preliminary limit calculations will be updated and published in the Federal Register by April 1 of each year and subsequently reconciled to actual expenditures by April 1 of the following year. The preliminary Federal fiscal year 1993 limits will be updated and published by April 1, 1993, and the final Federal fiscal year 1993 limits will be published April 1, 1994.

In calculating both the preliminary and final limits, DSH expenditures will be capped at 12 percent in accordance with the statutory requirements. If, in any year, DSH expenditures exceed 12 percent, HCFA will proportionally reduce the State DSH allotments for all States (that is, both high-DSH and low-DSH States) to ensure that the cap does not exceed the 12 percent statutory limit.

Section 3(b)(1) of Public Law 102–234 added a provision in section 1923(f)(1)(C) of the Act that requires the Secretary, before the beginning of each Federal fiscal year (beginning with fiscal year 1993), to estimate and publish in the Federal Register the national DSH payment limit and each State's allotment within that DSH limit.

Section 3(c) of Public Law 102–234 amended section 1923(b) of the Act by adding a new paragraph (4) which prohibits HCFA from restricting a State's authority to designate hospitals as DSHs. In light of this restriction, section 3(e)(2) of Public Law 102–234 provided that the proposed regulations that the Department had issued on October 31, 1991 (56 FR 56141) relating to the standards for defining DSHs under the Medicaid program be withdrawn and cancelled. This proposed rule would have prohibited States from defining as DSHs any hospital whose Medicaid or low-income utilization was below the statewide arithmetic mean. In accordance with section 3(e)(2) of Public Law 102–234, the Department published in the Federal Register on December 9, 1991 (56 FR 64228) a notice withdrawing the October 31, 1991 proposed rule.

Provisions of the Interim Final Rule

To interpret the statutory provisions of Public Law 102–234 regarding DSH payment limits, we are adding a new subpart E to part 447 entitled "Payment Adjustments for Hospitals that Serve a Disproportionate Share of Low-Income Patients." Under the new subpart E, we are adding a new § 447.296, Limitation on aggregate payments for disproportionate share hospitals for the period January 1, 1992 through September 30, 1992. This section provides the applicable limits on DSH payments for the moratorium period in effect January 1, 1992 through September 30, 1992. In addition, this section describes the specific criteria that determine the availability of FFP for DSH payments during this period. Under § 447.296, FFP is available for DSH payments made during the period January 1, 1992 through September 30, 1992, only if the payments are made in accordance with sections 1902(a)(13(A) and 1923 of the Act and are based on one of the following:

- A State plan in effect by September 30, 1991.

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

March 23, 2023

MEMORANDUM FOR AGENCY GENERAL COUNSELS

FROM: Daniel F. Jacobson
General Counsel, Office of Management and Budget

SUBJECT: Addressing Severability in Agency Rulemaking

This memorandum provides guidance to Federal agencies on addressing severability during the rulemaking process.

As legal challenges to agency actions have become more prevalent, questions about what remedy is appropriate when a court rules against an agency have taken on greater importance. Courts sometimes prohibit the implementation of an entire agency rule, even when they find only one portion invalid. Such decisions can impose significant costs on agencies, which must re-promulgate any valid portions of the rule the agency wishes to take effect, and on the public, which is deprived of the positive effects of the remaining portions of the rule unless the agency re-promulgates them.

Because the legal test for severability depends on the agency's intent and on the workability of the agency's regulatory program without the invalid portion of a rule, agencies can aid a court's remedial analysis by addressing severability within a rule. This memorandum suggests measures that agencies should consider to address severability throughout the rulemaking process, informed by current severability doctrine, the Office of Management and Budget's (OMB's) experience coordinating regulatory review, and input from the Department of Justice.[1]

Background

Severability is an important remedial doctrine that arises in cases challenging the legality of statutes and agency rules. When reviewing a rule, if a court determines that a particular provision is unlawful, severability addresses whether judicial relief should extend to the entire rule or whether it can be limited to the invalid provision, leaving in effect the remainder of the rule.[2]

[1] This memorandum does not address whether and under what circumstances it is appropriate for a court to vacate a rule universally rather than limiting relief to the parties before the court. *See* Brief for the Petitioners, *United States v. Texas*, No. 22-58 (U.S.), at 40–44 (arguing that the Administrative Procedure Act generally does not authorize universal vacatur and that courts should instead grant party-specific relief). The principles in this memorandum are relevant in determining the scope of both a universal vacatur and party-specific relief such as an injunction.

[2] *See generally* Administrative Conference of the United States (ACUS), Administrative Conference Recommendation 2018-2, Severability in Agency Rulemaking (2018), https://perma.cc/SZ2C-ECM6.

Courts evaluating the severability of agency rules typically consider two factors: (1) the agency's intent and (2) the workability of the rule without the invalid provisions.[3] Under the first factor, courts decline to sever an invalid portion of the rule if "there is substantial doubt" that the agency would have adopted the valid portions without the invalid portion.[4] A rule is inseverable if the agency has "indicat[ed] that the regulation would not have been [promulgated] but for [the] inclusion" of the invalid portion.[5]

Under the second factor, courts evaluate "whether the remainder of the regulation could function sensibly without the stricken provision."[6] Applying this factor, courts examine whether the rule could "sensibly serve the goals for which it was designed,"[7] and whether other provisions were "expressly conditioned" on the invalid provision.[8]

Courts often give significant weight to an agency's statements in its rule regarding severability—though such statements are not dispositive.[9] For example, the D.C. Circuit recently severed one section of a rule that the court found invalid where the agency had stated in the rule's preamble that it intended the invalid section to be "severable from" another section that "operate[d] independently."[10] Courts likewise have treated as conclusive agency statements that they do *not* intend certain provisions of their rules to be severable.[11] Courts give less weight to statements of intent made for the first time in litigation, as opposed to in the agency's underlying action.[12]

Notably, some courts have doubted that an agency would have promulgated a rule absent the invalid portion—and on that basis held the rule inseverable—even when the agency included general severability language in the rule.[13] These decisions relied on statements elsewhere in the rule that the invalid portion was central to the rule's overall

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[3] *Belmont Mun. Light Dep't v. FERC*, 38 F.4th 173, 187–88 (D.C. Cir. 2022). Although *Belmont* involved an agency order rather than a rule, courts apply the same two factors in evaluating the severability of both types of actions. *See id.* at 187; *K-Mart Corp. v. Cartier, Inc.*, 486 U.S. 281, 294 (1988); *High Country Conservation Advocates v. U.S. Forest Serv.*, 951 F.3d 1217, 1228–29 (10th Cir. 2020).

[4] *Belmont*, 38 F.4th at 187; *see also, e.g.*, *North Carolina v. FERC*, 730 F.2d 790, 796 (D.C. Cir. 1984) ("Where there is substantial doubt that the agency would have adopted the same disposition regarding the unchallenged portion if the challenged portion were subtracted, partial affirmance is improper.").

[5] *K-Mart*, 486 U.S. at 294; *see also, e.g.*, *Davis Cnty. Solid Waste Mgmt. v. EPA*, 108 F.3d 1454, 1460 (D.C. Cir. 1997) (en banc).

[6] *Belmont*, 38 F.4th at 188 (quoting *MD/DC/DE Broad. Ass'n v. FCC*, 236 F.3d 13, 22 (D.C. Cir. 2001)).

[7] *MD/DC/DE Broad. Ass'n v. FCC*, 253 F.3d 732, 734 (D.C. Cir. 2001) (denying rehearing).

[8] *Am. Hosp. Ass'n v. Azar*, No. CV 18-2841 (RMC), 2019 WL 5328814, at *2 (D.D.C. Oct. 21, 2019).

[9] *Cmty. for Creative Non-Violence v. Turner*, 893 F.2d 1387, 1394 (D.C. Cir. 1990) ("Our inquiry does not end simply because the Regulation contains no severability clause."); *Virginia v. EPA*, 116 F.3d 499, 500–01 (D.C. Cir. 1997) (finding rule severable even absent express discussion of severability in rule).

[10] *Am. Fuel & Petrochemical Mfrs. v. EPA*, 3 F.4th 373, 384 (D.C. Cir. 2021).

[11] *Id.* (agency described determinations made under invalid portion of rule as "a single, unified program" and stated that it "d[id] not intend for any of the[] individual actions to be severable"); *North Carolina*, 730 F.2d at 796 (agency stated that it took challenged action "only in conjunction with" the order as a whole).

[12] *See, e.g.*, *MD/DC/DE Broad.*, 253 F.3d at 735.

[13] *See Mayor of Baltimore v. Azar*, 973 F.3d 258, 292 (4th Cir. 2020) (en banc); *Nasdaq Stock Mkt. LLC v. SEC*, 38 F.4th 1126, 1145 (D.C. Cir. 2022).

purpose, or that various portions of the rule were elements of a single, unified policy.[14] Courts have also found rules inseverable despite agencies' generalized statements that they intended the rules to be severable where the court independently determined that the rule would be unworkable without the invalid portions.[15]

Recommendations

A court's decision to invalidate an agency's entire rule, rather than solely the invalid portion, imposes significant burdens on the Executive Branch and the public. As the Administrative Conference of the United States (ACUS) observed in its 2018 Recommendation regarding severability, invalidating an entire agency rule "can impose unnecessary costs on the agency, if it chooses to re-promulgate the portions of the rule that the court did not hold unlawful but nonetheless set aside."[16] Invalidating an entire rule can also harm the public, which will temporarily or sometimes permanently lose out on "any benefits that would have accrued under th[e] [valid] portions of the rule."[17]

Agencies can proactively reduce these risks. Because severability doctrine focuses on the agency's intent and on the workability of an agency's regulatory scheme if portions of a rule are excised, an agency's statements in its rulemaking can significantly inform a court's severability determination. While agencies must ultimately decide how to approach severability on a rule-by-rule basis, OMB recommends that agencies adopt the following best practices for evaluating and incorporating severability principles.

1. Consider Severability Systematically and Early in the Regulatory Process

Agencies should systematically evaluate severability in developing and drafting their rules. Making severability analysis a routine part of the rulemaking process will build internal agency expertise on the topic and ensure that agencies have sufficient time to provide nuanced consideration of the interrelationships among different provisions of a rule and whether those provisions can operate independently. When agencies issue requests for information, for example, they can include severability questions where public comment could provide relevant insights and information. The importance of considering severability is greatest when a rule is likely to face a legal challenge or when different parts of a rule vary in their degree of litigation risk.

Numerous other factors may be relevant to whether an agency should include severability language in a given rule, but factors to consider include:

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[14] *See Baltimore*, 973 F.3d at 292 (rule inseverable "[d]espite the severability clause," in part because agency "label[led]" the invalid provisions as "[m]ajor [p]rovisions" and they were "its primary purpose"); *Nasdaq*, 38 F.4th at 1145 (order inseverable despite inclusion of severability clause, in part because agency had "made clear" that it viewed the portions as part of "a single, consolidated … plan").

[15] *Nasdaq*, 38 F.4th at 1144–45.

[16] ACUS, *supra* note 2, at 1; *see also* Charles W. Tyler & E. Donald Elliott, Report, *Tailoring the Scope of Judicial Remedies in Administrative Law* 9 (2018), https://perma.cc/2GH6-W35E ("total vacatur results in administrative waste," and "as administrative rulemaking becomes ever more complex, there is reason to think that these costs will increase").

[17] ACUS, *supra* note 2, at 1.

- whether the rule sets forth distinct programs or policies, or multiple methods of enforcing a particular program or policy;
- whether and how the regulatory program could operate even if some components of the rule were invalidated;
- whether the benefits of the rule would still justify the costs even if some components of the rule were invalidated;
- whether any provisions are necessary to the operation of the entire rule; and
- whether there would be harm to the agency or the public if the agency were required to re-promulgate aspects of the rule following litigation.

2. Where Appropriate, Agencies Should Consider Addressing Severability in Proposed and Final Rules, and in the Preamble and Regulatory Text

If an agency determines that a rule's provisions should be severable, the agency should address severability in the proposed and final rules. Addressing severability in the rulemaking is important because, as noted, courts have accorded less weight to statements about severability made for the first time in litigation. Agencies should not avoid proactively addressing severability out of a generalized fear that doing so will signal legal vulnerability. The threat of litigation is omnipresent in rulemakings, and irrespective of litigation risk, including severability language is a well-recognized, appropriate response to the questions courts have raised in evaluating severability. Agencies are uniquely positioned to address how their policy decisions were made and how different aspects of a rule will function if a portion is struck. The Department of Justice (DOJ) concurs with OMB that agencies should not avoid severability language based on fear of signaling legal vulnerability. If an agency is concerned that proactively discussing severability will create litigation risk in a specific situation, it should discuss that question with DOJ.

OMB recommends that agencies consider including severability language in their notices of proposed rulemaking. Discussing severability in a proposed rule's preamble provides the public with an opportunity to comment on issues related to severability, such as whether the rule in general includes provisions amenable to severability; whether specific parts of the rule could operate independently; whether the benefits would continue to justify the costs should particular provisions be severed; or whether individual provisions are essential to the entire rule's workability. In turn, the agency's responses to these public comments in the discussion of severability in the final rule will allow the agency to provide the public—and courts, in the event of litigation—with further specificity regarding which portions of the rule the agency intends to be severable and how the rule would function absent a particular portion.

OMB also recommends that agencies consider addressing severability in the regulatory text in addition to the rule's preamble. Multiple agencies have taken this approach across a host of rules.[18] While the inclusion and proper formulation of regulatory text will depend on the circumstances, codifying severability in the regulation

[18] *See, e.g.*, 8 C.F.R. § 236.24 (DHS); 12 C.F.R. § 1041.14 (CFPB); 16 C.F.R. § 437.10 (FTC); 24 C.F.R. § 100.500(g) (HUD); 28 C.F.R. § 94.101(c) (DOJ); 29 C.F.R. § 23.80 (DOL); 40 C.F.R. § 57.111 (EPA); 43 C.F.R. § 2881.9 (Interior); 45 C.F.R. § 147.212(d) (HHS).

typically carries little if any downside, and in appropriate circumstances may help dispel any doubt about the agency's intent and how the regulation would operate if severed.

3. Where Appropriate, Specificity in Describing Severability Is Helpful

To ensure that reviewing courts have the information they need, it is helpful (where appropriate) for a discussion of severability in the preamble and regulatory text to be specific to the particular portions or applications that the agency views as severable, and explain how the remainder of the rule would function absent those provisions. That is particularly true for portions of a rule likely to be challenged. If an agency focuses its severability discussion on specific portions or applications of a rule, but also views other parts of the rule as severable, it should make clear that the discussion is illustrative rather than exhaustive so a court does not view those other parts as inseverable.

A recent rule involving consumer privacy provides a helpful illustration. The rule's preamble, while noting that "the unity and comprehensiveness of the" regulatory scheme "maximize[d] its utility," explained that the rule's "constituent elements each operate independently," and that "[w]ere any element of this scheme stayed or invalidated by a reviewing court, the elements that remained in effect would continue to provide vital consumer protections."[19] The agency identified specific aspects of the rule that would continue to protect consumers even if another provision were held unlawful, and emphasized that "the benefit of the rules" governing one telecommunications service did "not hinge on the same rules applying to other telecommunications services."[20]

Providing this level of specificity is beneficial for several reasons. First, increased specificity helps ensure that courts conducting remedial analyses understand and respect any nuances in the agency's intent. As discussed above, agencies sometimes may desire one portion of a rule to be severable if held invalid, whereas other portions may genuinely be interdependent. In these more nuanced situations, a generic severability clause could prove counterproductive.

Second, specificity can help assuage a court's concern that the agency did not thoroughly consider whether it intended a particular provision to be severable or whether a rule would be workable absent a particular provision. Decisions holding rules inseverable on workability grounds have expressed concern that the agency's statements regarding its intent were too generalized and provided inadequate explanation of how exactly the rule could operate if the invalid portion were excised.[21]

4. Imprecise Statements Can Inadvertently Undermine Severability

As described above, while the inclusion of severability language in a rule is important to courts' consideration of severability, courts do not always find such language dispositive. Several courts have held that agency actions are inseverable—even

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[19] FCC, *Protecting the Privacy of Customers of Broadband and Other Telecommunications Services*, 81 Fed. Reg. 87274, 87331 (Dec. 2, 2016).

[20] *Id.* at 87331–32.

[21] *Nasdaq*, 38 F.4th at 1145 (noting that the agency had "pay[ed] little more than lip service to" the court's "concern that severing parts of the [order] would render the plan unworkable").

in the face of express severability language—based on other statements made by an agency in its rule. In particular, courts have relied on agency statements indicating that the invalid portion was central to the rule's purpose,[22] or characterizing the invalid portion as part of "a single, integrated proposal."[23] Agencies should be cautious in making such statements where the agency intends for the rule to be severable.

5. Agencies May Consider Alternatives to Severability, Such as Issuing Multiple Rules to Implement a Regulatory Program

Severability is not the sole method by which agencies can mitigate the risk of overbroad judicial remedies.[24] In situations where the harms from an injunction against uncontroversial portions of a regulatory program would be particularly great, agencies may consider promulgating the program through multiple separate rules rather than a single one.[25] Dividing a regulatory program into multiple rules reduces the likelihood that potential vulnerabilities with one component will lead to invalidation of the other, particularly when the regulatory program can logically be divided into multiple parts.[26]

There are potential drawbacks, however, to pursuing this approach. Dividing a regulatory program into multiple rules may prolong agencies' regulatory timeline. If agencies do divide a regulatory program into multiple rules, they should also consider whether the benefits of each component rule justify the costs.[27]

* * *

OMB encourages agencies to carefully evaluate severability issues early in the rulemaking process and to consider the steps recommended in this memorandum to effectuate their intent regarding severability. Carefully addressing severability should reduce the risk that a court will invalidate entire agency rules after finding only a portion invalid and, in turn, will help ensure that portions of agency regulations continue to remain effective even in the event of an unfavorable judicial ruling.

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[22] *See Baltimore*, 973 F.3d at 292 (holding rule inseverable "[d]espite the severability clause," where agency "label[led]" invalid provisions as "[m]ajor [p]rovisions," which were "its primary purpose").

[23] *Sierra Club*, 867 F.3d at 1367; *see also Nasdaq*, 38 F.4th at 1145 (agency had "made clear" that it viewed the portions as part of "a single, consolidated … plan").

[24] *See* Tyler & Elliott, *supra* note 16, at 26–29 (suggesting several alternative options).

[25] *See id.* at 26–27; Jennifer Nou & Edward H. Stiglitz, *Regulatory Bundling*, 128 YALE L.J. 1174 (2019). Although this memorandum focuses on notice-and-comment rulemaking, OMB recommends that agencies conduct a similar analysis when formulating informal guidance and other policy documents that are likely to prompt legal challenge (for example, by assessing whether distinct agency policies should be issued in separate guidance documents or be explicitly delineated as separate in the same document).

[26] A court might consolidate challenges to separate rules if the challenges involved the same parties or implicated the same, similar, or related issues. But even if a court consolidated challenges to separate rules, it would not grant relief against both rules unless it found legal infirmities in both.

[27] In determining whether an action is "significant" under Executive Order 12866, OIRA may consider the interactions of multiple rules. *See* Exec. Order No. 12866 §§ 1(b)(10), 3(f)(2), 3(f)(4), 3 C.F.R. 638 (1994).

Nicholson, Emmett (CMS/OSORA)

From: Howe, Rory (CMS/CMCS)
Sent: Wednesday, April 26, 2023 5:18 PM
To: Daniel Tsai (CMS/OA) (daniel.tsai@cms.hhs.gov)
Cc: Costello, Anne Marie (CMS/CMCS);Vitolo, Sara (CMS/CMCS);Perrie Briskin (CMS/OA) (perrie.briskin@cms.hhs.gov);Hebert, Krista (CMS/CMCS);Kochanski, Joseph (CMS/CMCS)
Subject: MO/TX Tax Timeline
Attachments: Key MO-TX-Tax Timeline, 4-26-23.docx; Attachment A - 2008 Final Tax Rule - Summary of Relevant Discussion.docx; Attachment B - Provider Reimbursement Review Board Decision 2009 D-42.pdf; Attachment C - Decision of the Administrator Review of PRRB Decision Number 2009-D42.pdf; Attachment D - LPPF Questions and Answers 10.16.docx; Attachment E - Greenberg_Texas Financing Letter12 20 18.pdf; Attachment F - LPPF Hold Harmless Evidence.pdf; Attachment G - HHSC Responses to CMS Questions 08202019.docx; Attachment H - Missouri FRA Tax Hold Harmless - OGC Note to FMG (002).pdf; Attachment I - CMS Letter MO Medicaid Managed Care 07 28 2020 final - Signed.pdf

Hi Dan,

As discussed this afternoon, please see attached the requested timeline and attachments. We focused on pre-2021 activity. Please let us know if you have questions or need anything else.

Rory

Nicholson, Emmett (CMS/OSORA)

From: Howe, Rory (CMS/CMCS)
Sent: Tuesday, November 8, 2022 4:17 PM
To: Stacie Weeks
Cc: Silanskis, Jeremy (CMS/CMCS)
Subject: RE: RE: Attestation Form
Attachments: NV Financing, 11-8-22.docx

Hi Stacie,

Please see attached some information regarding possible provider attestation approaches that we previously discussed and have shared with other states. The first option involves direct written attestations from each provider and the second option consists of an alternative approach involving meeting with your provider community. For the written attestations, the key language that we would expect to see is specified in #3 in the attached. We are open to reviewing alternate language from the state, noting that we would expect something very similar in effect. We also defer to the state regarding any additional process-related language if the state decides to take a written attestation approach.

If it would be helpful, we are open to reviewing draft attestation language, discussing the information that I attached, discussing alternative approaches, or setting up some time to talk about any other questions or concerns that you might have.

Regards,
Rory

Rory Howe
Director
Financial Management Group
CMS/CMCS

(b)(6)

From: Stacie Weeks <sweeks@dhcfp.nv.gov>
Sent: Monday, November 7, 2022 7:29 PM
To: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>
Subject: Attestation Form

Do you happen to have a template for the attestation form for the provider tax/payments that you mentioned the other day on our call?

Nevada Department of Health and Human Services
DIVISION OF HEALTH CARE FINANCING AND POLICY

Stacie Weeks, JD, MPH
Deputy Administrator
Nevada Department of Health and Human Services
Division of Health Care Financing and Policy
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Nicholson, Emmett (CMS/OSORA)

From: Mauser, Gayle (CMS/OL)
Sent: Monday, March 13, 2023 12:05 PM
To: Howe, Rory (CMS/CMCS);Silanskis, Jeremy (CMS/CMCS);Maccarroll, Amber (CMS/CMCS);Arnold, Charlie (CMS/CMCS);Boston, Beverly (CMS/CMCS)
Cc: Kirchgraber, Kate (CMS/OL);Wiley, Evelyn (CMS/CMCS)
Subject: RE: RE: E&C Majority Inquiry - Hold Harmless

Hi all, in addition to the follow-up we owe E&C majority staff, Rep. Al Green's (D-TX) office has inquired about the guidance and how it relates specifically to Texas. We would like to schedule a call between Rory and Rep. Green's office (it will be his Chief of Staff, but it is possible Rep. Green also joins). We'll provide draft Texas-specific talking points that build on the information provided below closer to the meeting.

In the interim, **Evelyn**, can you help us set up the following? If you can offer FMG availability, we will do our best to work around your schedules.

- 30 minutes to prep for the Al Green call, ideally in the couple of days prior to the actual briefing
- A few 30-minute holds that we can offer Rep. Green's office for the week of 3/27

Thanks!
Gayle

From: Mauser, Gayle (CMS/OL)
Sent: Friday, March 10, 2023 2:00 PM
To: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Cc: Kirchgraber, Kate (CMS/OL) <Kate.Kirchgraber@cms.hhs.gov>; Wiley, Evelyn (CMS/CMCS) <Evelyn.Wiley@cms.hhs.gov>
Subject: RE: E&C Majority Inquiry - Hold Harmless

Hi again FMG team,

We are following up on our prior discussion regarding the hold harmless question we received from E&C majority on what states have impermissible arrangements. Attention has been pulled away from this topic for a bit, but we expect that there will be renewed interest soon (and we've started to get some questions from a Texas member as well).

Below are draft talking points for a call with E&C majority, which include a few internal notes and a couple placeholders I am hoping you all can help fill in.

Rory, after FMG reviews these, I believe you were also going to run them by CMCS leadership. Looping Evelyn here to see if we can also hold some windows on your calendar to offer to Committee staff for this discussion – perhaps we aim for times within the next couple weeks? Committee staff haven't pinged us again yet, but we will let you know if they do.

Thanks,
Gayle

DRAFT Talking Points for E&C Majority Staff Call – Hold Harmless Guidance

- As you know, on February 17, 2023, CMS issued a Medicaid informational bulletin regarding health care-related taxes and hold harmless arrangements involving the redistribution of Medicaid payments.
- Hold harmless arrangements, as defined in the Medicaid statute, are arrangements in which the State or another 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. The statute prohibits these arrangements.
- Recently, we have been approached by several states with questions about complying with this provision of law, and we have also learned of states that may have existing arrangements or are considering establishing them, particularly with respect to states establishing or renewing Medicaid managed care state directed payments.
- The informational bulletin reiterates the federal requirements concerning hold harmless arrangements with respect to health care-related taxes. We hope that this guidance provides additional clarity to states, and we also encourage them to raise any questions or concerns they may have about the permissibility of health care-related taxes to CMS as early in the process as possible, to avoid any issues.
- Regarding your question about which states may have these types of arrangements, there are 3 states that CMS understands may have impermissible hold harmless arrangements, and 1 state we wanted to mention as an example of where we were able to intervene early in the process of establishing what may have been an impermissible hold harmless arrangement.
- Starting with the 3 states that may have these arrangements:
    - ***Texas:***
        - Texas has in place what is known as the Local Provider Payment Fund or LPPF. Based on information obtained by CMS, including limited information provided by the state and publicly available third-party materials, the LPPF arrangements used by some localities in Texas appear to include hold harmless arrangements because the localities impose a tax and the state directly or indirectly provides for payments that guarantee to hold the taxpayers harmless for all or any portion of the tax amount. If our understanding of those LPPF arrangements is correct, they constitute hold harmless arrangements that are prohibited under the Medicaid statute and CMS regulations. [this language is pulled from the publicly available November 2021 letter to the State; page 5 includes additional detail regarding our understanding of the arrangement]
        - CMS has communicated these concerns to the state and, when we recently approved Texas' state directed payments, we included in our approval letter that approval of the state directed payments does not constitute any specific Medicaid financing mechanism used to support the non-federal share of the provider payment arrangement. We also clarified that we reserve the authority to enforce requirements, including by initiating separate deferrals and/or disallowances of federal financial participation.
        - As you may be aware, the HHS OIG announced in November 2021 that it is examining states' use of LPPFs as the state share of Medicaid payments, and that it expects to issue a report in FY 2023 that indicates whether the LPPFs the state agency used were permissible. (b)(5)

(b)(5)

    - ***Fl***
        - Similarly, Florida has in place an LPPF that we also understand includes hold harmless arrangements. [the attached FMR engagement letter includes additional detail regarding our understanding of the arrangement]
        - In Florida's case, we were working with the state for some time in an effort to address the concerns, but have been unable to resolve them. Like Texas, we communicated our concerns to the state and, when we recently approved Florida's state directed payments, we provided the same information as was included in the letter to Texas—that the approval does not constitute approval of the Medicaid financing mechanism, and that we reserve the authority to enforce requirements.
        - In late February, we sent a letter to Florida initiating a Financial Management Review (FMR) to examine the state Medicaid agency's compliance with federal requirements over the next several months.

- ***Missouri:***
  - Lastly, Missouri has a longstanding arrangement called the Federal Reimbursement Allowance tax program that appears to include a hold harmless arrangement, and in 2020, CMS engaged the state about its concerns. Also in 2020, the then CMCS Director sent a letter to the state describing our concerns and memorializing a conversation with state Medicaid agency leadership who at that time committed to ending the hold harmless arrangement by X timeframe.
  - While the state has not done that, state leadership has been willing to respond to CMS' questions. In late February, we also sent a letter to Missouri—but, based on our ability to obtain more information from Missouri, we have initiated a focused review of Missouri's program expenditures reported to CMS on the Form CMS-64, rather than an FMR. [the attached CMS-64 review letter includes some additional information]
- With respect to the state I mentioned where we were successful in intervening early:
  - ***Louisiana:***
    - In X month and year, we received information that suggested Louisiana's legislature was developing what would have been a hold harmless arrangement as part of the financing mechanism for its state directed payment program. We engaged the state about those issues, worked with the state on alternatives that would comply with federal law, and ultimately the state withdrew the state directed payment proposal it had submitted and submitted a modified proposal.
- We are hopeful that the guidance we issued will further promote our efforts to work with states and get ahead of these issues as we did in Louisiana.

From: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>
Sent: Tuesday, February 21, 2023 2:37 PM
To: Mauser, Gayle (CMS/OL) <Gayle.Mauser@cms.hhs.gov>
Cc: Costello, Anne Marie (CMS/CMCS) <AnneMarie.Costello@cms.hhs.gov>; Briskin, Perrie (CMS/CMCS) <Perrie.Briskin@cms.hhs.gov>; Kirchgraber, Kate (CMS/OL) <Kate.Kirchgraber@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Subject: RE: E&C Majority Inquiry - Hold Harmless

Hi Gayle,

A call sounds right to me. Please also include Jeremy, Amber, and Charlie in the discussion. For awareness, tomorrow, FMG is planning to issue a letter to Florida and a question set to Missouri on this issue. Both states appear to have concerning arrangements in place and the letter/question set tomorrow are part of our work to address the arrangements. Let me know if you have any questions in the interim.

Thanks,
Rory

From: Mauser, Gayle (CMS/OL) <Gayle.Mauser@cms.hhs.gov>
Sent: Tuesday, February 21, 2023 1:57 PM
To: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>
Cc: Costello, Anne Marie (CMS/CMCS) <AnneMarie.Costello@cms.hhs.gov>; Briskin, Perrie (CMS/CMCS) <Perrie.Briskin@cms.hhs.gov>; Kirchgraber, Kate (CMS/OL) <Kate.Kirchgraber@cms.hhs.gov>
Subject: E&C Majority Inquiry - Hold Harmless

Hi Rory,

After Friday's hold harmless CIB went out, we received an inquiry from House E&C majority staff asking for more information—in particular, about the language from the list serv notice indicating "recently, CMS became aware that some health care-related tax programs appear to involve agreements among providers to redistribute their Medicaid payments to hold taxpayers harmless for the cost of the tax."

Specifically, the staff would like to know about the instances CMS has found, and the steps the agency is taking to address those agreements.

I imagine it will be most efficient to have a quick call to discuss actions to date, anticipated upcoming actions, and next steps for responding to the Hill—does that work for you? Are there others who should be included?

Thanks,
Gayle

Gayle Mauser
(she/her)
Low Income Programs Analysis Group
Office of Legislation
Centers for Medicare & Medicaid Services (CMS)
Cell Phone
(b)(6)

Nicholson, Emmett (CMS/OSORA)

From: Sebree, Fredrick (CMS/CMCS)
Sent: Monday, April 3, 2023 8:37 AM
To: Endelman (he/him), Jonathan (CMS/CMCS)
Subject: FW: FW: SPA MO 22-0025 NF rebase
Attachments: B1B2 - Actual SFY 2022 & Projections SFY 2023.xlsx; State Response to CMS email dated 3-29-23.docx; MPP Addendum A.pdf

Good morning Jonathan,

Responses from the state regarding the NFRA is attached. Looks like they are referencing the MPP for the distribution.

Fredrick J. Sebree
Accountant
Division of Reimbursement Review
Centers for Medicare and Medicaid Services
600 East Monroe Street, Room 215
Springfield, Illinois 62701

RightFax: 443-380-5221
Email: Fredrick.sebree@cms.hhs.gov

From: Brite, Tony <Tony.Brite@dss.mo.gov>
Sent: Friday, March 31, 2023 12:13 PM
To: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>
Cc: Crump, Marissa <Marissa.Crump@dss.mo.gov>; Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>; Percy, Nate <Nate.Percy@dss.mo.gov>
Subject: Fwd: SPA MO 22-0025 NF rebase

Fred,
Please find the responses and attachments related to the questions below.

Thanks,
Tony

From: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>
Sent: Wednesday, March 29, 2023 7:45 AM
To: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>; Crump, Marissa <Marissa.Crump@dss.mo.gov>
Cc: Brite, Tony <Tony.Brite@dss.mo.gov>
Subject: RE: SPA MO 22-0025 NF rebase

Good morning,

MO 22-0025 has been presented to leadership and the SPA is good to go but our tax team wanted to touch base on the NFRA. Below are a few questions/confirmations:

1. To confirm, the Nursing Facility Reimbursement Allowance (NFRA) does not have any redistributions. Is that correct?
2. Is the NFRA broad-based and uniform? Are any providers excluded? Are any providers taxed at different rates?
3. Using the most recent data available, how much does the state anticipate raising from the NFRA?
4. For the purposes of the 6% test, what percentage of net patient revenue for the permissible class is raised by all taxes on the services of nursing facilities, including the NFRA?

Thanks again

Fredrick J. Sebree

Accountant

Division of Reimbursement Review

Centers for Medicare and Medicaid Services

600 East Monroe Street, Room 215

Springfield, Illinois 62701

RightFax: 443-380-5221

Email: Fredrick.sebree@cms.hhs.gov

From: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>
Sent: Tuesday, March 21, 2023 12:24 PM
To: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>; Crump, Marissa <Marissa.Crump@dss.mo.gov>
Cc: Brite, Tony <Tony.Brite@dss.mo.gov>
Subject: RE: SPA MO 22-0025 NF rebase

The approval package looks good.

Thank you,

Rebecca L. Rucker, CPA

Assistant Deputy Director, IRU

Department of Social Services, MO HealthNet Division

(573) 751-3737

Rebecca.L.Rucker@dss.mo.gov

"Together we will build a best in class Medicaid program that addresses the needs of Missouri's most vulnerable in a way that is financially sustainable."

From: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>
Sent: Tuesday, March 21, 2023 9:44 AM
To: Crump, Marissa <Marissa.Crump@dss.mo.gov>
Cc: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>; Brite, Tony <Tony.Brite@dss.mo.gov>
Subject: RE: SPA MO 22-0025 NF rebase

Thanks again for the responses, attached is the unsigned approval package. I updated the 179 to reflect the new title page in block 7 since it is not getting superseded but needing to get included in the new pages. I also updated the acting director, thanks for catching that. If you can send concurrence I will move forward with the approval recommendation.

V/R

Fredrick J. Sebree

Accountant

Division of Reimbursement Review

Centers for Medicare and Medicaid Services

600 East Monroe Street, Room 215

Springfield, Illinois 62701

RightFax: 443-380-5221

Email: Fredrick.sebree@cms.hhs.gov

From: Crump, Marissa <Marissa.Crump@dss.mo.gov>
Sent: Monday, March 20, 2023 2:11 PM
To: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>
Cc: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>; Brite, Tony <Tony.Brite@dss.mo.gov>
Subject: RE: SPA MO 22-0025 NF rebase

Please see attached in response to your email below. Let us know if there is anything else you need from us.

Thank you,

Marissa Crump

Executive Assistant

Missouri Department of Social Services/MO HealthNet Division

Marissa.Crump@dss.mo.gov

(573)751-6884

From: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>
Sent: Thursday, March 16, 2023 11:10 AM
To: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>; Brite, Tony <Tony.Brite@dss.mo.gov>
Subject: RE: SPA MO 22-0025 NF rebase

Good morning,

Below are the last round of questions, I believe, I have. I attached the unsigned draft of the approval package as well as the SFQs. Please review the unsigned draft of the approval package to make sure we are capturing the new pages correctly, since the SPA is so big, so we can avoid any miscommunication or technical corrections after the approval. If we have updates to the pages or 179 we can just make the updates to this document, if that is alright.

Language

-The title page, prior to page 66, is not referenced in block 7 of the 179 and does not have any page number so it may get omitted on our side when cataloging in the system. Can we add "title" page to block 7 or assign a page number (65a) to make sure it gets included in CMS' version of the state plan (also in the correct location after 65)?

-Page 1 appears to be the beginning of the of the current (soon to be obsolete) NF methodology. It seems that the state intends to keep the old methodology and sunset it for 6/30/2022. So the beginning pages of the 4.19-D will be sunset after this SPA is approved (I am pretty sure is not the case but may be better to refernce)?. Please confirm my understanding and let me know if it would be more comprehensive to reference the new methodology and that it starts on page 66.

SFQs

-The non-federal share of the funding referenced in the SFQs for NF services includes appropriations, IGT, and CPE. I did not see taxes (NFRA) referenced in the SFQs but I see it is still in the plan language. Is the NFRA still a provider assessment for NF services? Does 13 CSR 70-10.110 still apply ($12.93 to all NFs on a per patient basis)? If so can we get the NFRA added to the SFQs for this SPA and future SPAs where the NFRA is in effect?

-The SFQs references Swope Ridge Geriatric Center as the only provider that utilizes a CPE. It seems that there is a reconciliation process so I don't see any issues with the mechanics. My question is the frequency of the CPE. I see that the 2021 NF UPL captured the provider and it looks like we will see the provider in the 2023 NF UPL (given the language in the SFQs). Why was the provider omitted from the 2022 NF UPL? From the language it seems 2021 CPE was paid in 2022 for 2021 but it was in the 2021 UPL. Why is that not the case for the 2022 CPE? It looks like there hasn't been any changes to the language since MO 18-0015 starting on page 60 BB1, please confirm.

Thanks again and feel free to send any questions you have.

Fredrick J. Sebree

Accountant

Division of Reimbursement Review

Centers for Medicare and Medicaid Services

600 East Monroe Street, Room 215

Springfield, Illinois 62701

RightFax: 443-380-5221

Email: Fredrick.sebree@cms.hhs.gov

From: Sebree, Fredrick (CMS/CMCS)
Sent: Wednesday, March 15, 2023 2:34 PM
To: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>; Brite, Tony <Tony.Brite@dss.mo.gov>
Subject: RE: SPA MO 22-0025 NF rebase

I knew I seen them somewhere, thanks.

Fredrick J. Sebree

Accountant

Division of Reimbursement Review

Centers for Medicare and Medicaid Services

600 East Monroe Street, Room 215

Springfield, Illinois 62701

RightFax: 443-380-5221

Email: Fredrick.sebree@cms.hhs.gov

From: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>
Sent: Wednesday, March 15, 2023 2:32 PM
To: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>; Brite, Tony <Tony.Brite@dss.mo.gov>
Subject: RE: SPA MO 22-0025 NF rebase

Fredrick,

The standard funding questions are included in the cover letter. I've attached a copy of the letter for your convenience.

Thank you,

Rebecca L. Rucker, CPA

Assistant Deputy Director, IRU

Department of Social Services, MO HealthNet Division

(573) 751-3737

Rebecca.L.Rucker@dss.mo.gov

"Together we will build a best in class Medicaid program that addresses the needs of Missouri's most vulnerable in a way that is financially sustainable."

From: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>
Sent: Wednesday, March 15, 2023 2:02 PM
To: Brite, Tony <Tony.Brite@dss.mo.gov>
Cc: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>
Subject: RE: SPA MO 22-0025 NF rebase

Good afternoon Tony,

Can you forward the standard funding questions for NF services? I am not seeing it in my folder. My apologies if it was sent and I am missing it.

Fredrick J. Sebree

Accountant

Division of Reimbursement Review

Centers for Medicare and Medicaid Services

600 East Monroe Street, Room 215

Springfield, Illinois 62701

RightFax: 443-380-5221

Email: Fredrick.sebree@cms.hhs.gov

From: Brite, Tony <Tony.Brite@dss.mo.gov>
Sent: Monday, March 6, 2023 2:34 PM
To: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>
Cc: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>
Subject: RE: SPA MO 22-0025 NF rebase

Fred,

The stakeholders concerns regarding the payment methodology have been remedied. Hope that helps with the review.

Thanks,

Tony

From: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>
Sent: Monday, March 6, 2023 10:42 AM
To: Brite, Tony <Tony.Brite@dss.mo.gov>
Cc: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>
Subject: RE: SPA MO 22-0025 NF rebase

Good morning Tony,

I had a chance to go through both the informal inquiry and the formal RAI last week and I think are looking good. It's a big SPA so I plan to comb through the pages another time and finish the review of the UPL soon but I don't anticipate any issues. Thanks for sending the NF reimbursement FAQs with the stakeholders comments and questions during the process. The only question I can think of at this point is if all the stakeholder concerns remedied. If you could confirm that I will keep you in the loop as the review progresses. I am hoping to wrap it up by next week if that works.

Thanks for checking in.

Fredrick J. Sebree

Accountant

Division of Reimbursement Review

Centers for Medicare and Medicaid Services

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Springfield, Illinois 62701

RightFax: 443-380-5221

Email: Fredrick.sebree@cms.hhs.gov

From: Brite, Tony <Tony.Brite@dss.mo.gov>
Sent: Monday, March 6, 2023 10:07 AM
To: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>
Cc: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>
Subject: RE: SPA MO 22-0025 NF rebase

Hello Fred,

I am checking in on the status of the NF rate review. Can you provide any information in terms of timeline? Or whether we should expect any additional questions?

Thanks for your help!

Tony

From: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>
Sent: Thursday, February 23, 2023 10:53 AM
To: Crump, Marissa <Marissa.Crump@dss.mo.gov>; Walker, Michala (CMS/CMCS) <Michala.Walker@cms.hhs.gov>
Cc: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>; Brite, Tony <Tony.Brite@dss.mo.gov>; Bromwell, Robert (CMS/CMCS) <Robert.Bromwell@cms.hhs.gov>
Subject: RE: SPA MO 22-0025 NF rebase

Thanks again Marissa, Ill keep you in the loop as I review.

Fredrick J. Sebree

Accountant

Division of Reimbursement Review

Centers for Medicare and Medicaid Services

600 East Monroe Street, Room 215

Springfield, Illinois 62701

RightFax: 443-380-5221

Email: Fredrick.sebree@cms.hhs.gov

From: Crump, Marissa <Marissa.Crump@dss.mo.gov>
Sent: Thursday, February 23, 2023 10:47 AM
To: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>; Walker, Michala (CMS/CMCS) <Michala.Walker@cms.hhs.gov>
Cc: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>; Brite, Tony <Tony.Brite@dss.mo.gov>; Bromwell, Robert (CMS/CMCS) <Robert.Bromwell@cms.hhs.gov>
Subject: RE: SPA MO 22-0025 NF rebase

Attached is our response to this IRAI.

Thank you,

Marissa Crump

Executive Assistant

Missouri Department of Social Services/MO HealthNet Division

Marissa.Crump@dss.mo.gov

(573)751-6884

From: Brite, Tony <Tony.Brite@dss.mo.gov>
Sent: Monday, October 31, 2022 10:10 AM
To: Crump, Marissa <Marissa.Crump@dss.mo.gov>
Cc: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>
Subject: Fwd: SPA MO 22-0025 NF rebase

FYI

Sent from my iPad

Begin forwarded message:

> **From:** "Sebree, Fredrick (CMS/CMCS)" <Fredrick.Sebree@cms.hhs.gov>
> **Date:** October 31, 2022 at 10:04:50 AM CDT
> **To:** "Brite, Tony" <Tony.Brite@dss.mo.gov>
> **Cc:** "Rucker, Rebecca L" <Rebecca.L.Rucker@dss.mo.gov>, "Read, Deborah (CMS/CMCS)" <Deborah.Read@cms.hhs.gov>
> **Subject: RE: SPA MO 22-0025 NF rebase**
>
> Good morning Tony,
>
> Sorry again for the delay. Below are a few informal questions I have for MO 22-0025, NF rebase:
>
> 1. Attached are the proposed pages for 66-120 that contains the new language. These pages annotate “draft” on each of the pages with the exception of the title page. Is there a final “clean” version? Does the state want to keep the first title page or is it part of the draft version?
> 2. Please provide a calculation of the budget impact annotated on the CMS 179 block 6.
> 3. Does the state have any supporting info/documentation/explanation behind how the rate methodology was developed to help support the economy and efficiency of the rates? The UPL helps support the economy and efficiency, just wanted to know if it was establish during the development of the methodology in some way. Were stakeholders involved in the rate development process? If so, how? Was the methodology modeled after another state?
> 4. Please provide any stakeholder comments/concerns, if any, during the public notice period.
> 5. Did the state model the value based language and incentives from CMS guidance? If not, how was the methodology developed?

Our quality team at CMS will be reviewing the incentive language as well as myself. We will get back to you on any specifics in the language as soon as we can.

Thanks again

Fredrick J. Sebree

Accountant

Division of Reimbursement Review

Centers for Medicare and Medicaid Services

600 East Monroe Street, Room 215

Springfield, Illinois 62701

RightFax: 443-380-5221

Email: Fredrick.sebree@cms.hhs.gov

From: Brite, Tony <Tony.Brite@dss.mo.gov>
Sent: Friday, October 28, 2022 9:22 AM
To: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>
Cc: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>
Subject: RE: SPA MO 22-0025 NF rebase

Thanks Fred, we just wanted to make sure we hadn't missed it. Have a good weekend!

From: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>
Sent: Friday, October 28, 2022 9:16 AM
To: Brite, Tony <Tony.Brite@dss.mo.gov>
Cc: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>
Subject: Re: SPA MO 22-0025 NF rebase

Hello Tony,

You are correct and I was hoping to send them this week. I'll make sure to get them out to you first thing next week. Hope that is alright.

Thanks for checking in.

Fredrick J. Sebree

Accountant

Division of Reimbursement Review

Centers for Medicare and Medicaid Services

600 East Monroe Street, Room 215

Springfield, Illinois 62701

RightFax: 443-380-5221

Email: Fredrick.sebree@cms.hhs.gov

From: Brite, Tony <Tony.Brite@dss.mo.gov>
Sent: Friday, October 28, 2022, 9:01 AM
To: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>
Cc: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>
Subject: SPA MO 22-0025 NF rebase

Hi Fred,

You had mentioned on the 15 day call a few weeks ago that you anticipated providing us with initial questions that week on 22-0025 for Nursing Facilities. Do you know if those were sent? I have not seen them come through yet.

Thanks,

Tony

Nicholson, Emmett (CMS/OSORA)

From: Clark, Jennifer (CMS/CMCS)
Sent: Wednesday, April 12, 2023 10:14 AM
To: Endelman (he/him), Jonathan (CMS/CMCS)
Cc: Goldstein, Stuart (CMS/CMCS);Arnold, Charlie (CMS/CMCS)
Subject: FW: FW: MO disallowance letter?
Attachments: Draft FRA Tax Letter - 4-11-23.docx

Hi Jonathan,

Please see below and attached. This is the same letter that is attached to the SharePoint link in Beverly's email. Rory sent this to OGC for review yesterday. This is the letter that Rory would like you to please use to update the "reactive statement."

Feel free to call me if you have any questions.

Thanks,
Jen

(b)(6)

From: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>
Sent: Wednesday, April 12, 2023 9:38 AM
To: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Curry, Celestine (CMS/CMCS) <Celestine.Curry@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>
Cc: Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>
Subject: FW: MO disallowance letter?

FYI

From: Howe, Rory (CMS/CMCS)
Sent: Tuesday, April 11, 2023 8:08 PM
To: Vogel, Jeremy (HHS/OGC) <Jeremy.Vogel@hhs.gov>
Subject: RE: MO disallowance letter?

Hi Jeremy,

We have not started drafting the disallowance letter yet. However, I have attached an additional drat letter to the state that OA and Dan asked for and mentioned to Paul. I think this might be what Susan referenced. We are planning to release it on April 21st and it would provide notice to the state that we intend to issue a disallowance no earlier than 60 days following the letter if the state has not provided information supporting the allowability of the tax or demonstrating that the state has fixed the tax. Please let me know if you have questions.

As you mentioned below, I think it would be good to discuss during the TX call tomorrow given there is clear overlap. I hope this helps.

Thanks,
Rory

From: Vogel, Jeremy (HHS/OGC) <Jeremy.Vogel@hhs.gov>
Sent: Tuesday, April 11, 2023 5:41 PM
To: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>
Subject: MO disallowance letter?

Hi Rory,

Susan Lyons (you're probably aware, our Deputy Associate General Counsel for Litigation in CMSD) is asking about the draft disallowance letter to MO. Any update? I expect you might have paused this pending some further analysis/discussion of the Texas case, but if there is any update on your drafting of that letter, please let me know so I can pass it along.

Thanks & have a great evening,

Jeremy Vogel (he/him)
Attorney, United States Department of Health and Human Services
Office of the General Counsel, Centers for Medicare & Medicaid Services Division
330 Independence Ave. S.W., Washington, D.C. 20201
(202) 205-8778 | Jeremy.Vogel@hhs.gov

Nicholson, Emmett (CMS/OSORA)

From: Mauser, Gayle (CMS/OL)
Sent: Monday, March 13, 2023 12:05 PM
To: Howe, Rory (CMS/CMCS);Silanskis, Jeremy (CMS/CMCS);Maccarroll, Amber (CMS/CMCS);Arnold, Charlie (CMS/CMCS);Boston, Beverly (CMS/CMCS)
Cc: Kirchgraber, Kate (CMS/OL);Wiley, Evelyn (CMS/CMCS)
Subject: RE: RE: E&C Majority Inquiry - Hold Harmless

Hi all, in addition to the follow-up we owe E&C majority staff, Rep. Al Green's (D-TX) office has inquired about the guidance and how it relates specifically to Texas. We would like to schedule a call between Rory and Rep. Green's office (it will be his Chief of Staff, but it is possible Rep. Green also joins). We'll provide draft Texas-specific talking points that build on the information provided below closer to the meeting.

In the interim, **Evelyn**, can you help us set up the following? If you can offer FMG availability, we will do our best to work around your schedules.

- 30 minutes to prep for the Al Green call, ideally in the couple of days prior to the actual briefing
- A few 30-minute holds that we can offer Rep. Green's office for the week of 3/27

Thanks!
Gayle

From: Mauser, Gayle (CMS/OL)
Sent: Friday, March 10, 2023 2:00 PM
To: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Cc: Kirchgraber, Kate (CMS/OL) <Kate.Kirchgraber@cms.hhs.gov>; Wiley, Evelyn (CMS/CMCS) <Evelyn.Wiley@cms.hhs.gov>
Subject: RE: E&C Majority Inquiry - Hold Harmless

Hi again FMG team,

We are following up on our prior discussion regarding the hold harmless question we received from E&C majority on what states have impermissible arrangements. Attention has been pulled away from this topic for a bit, but we expect that there will be renewed interest soon (and we've started to get some questions from a Texas member as well).

Below are draft talking points for a call with E&C majority, which include a few internal notes and a couple placeholders I am hoping you all can help fill in.

Rory, after FMG reviews these, I believe you were also going to run them by CMCS leadership. Looping Evelyn here to see if we can also hold some windows on your calendar to offer to Committee staff for this discussion – perhaps we aim for times within the next couple weeks? Committee staff haven't pinged us again yet, but we will let you know if they do.

Thanks,
Gayle

DRAFT Talking Points for E&C Majority Staff Call – Hold Harmless Guidance

- As you know, on February 17, 2023, CMS issued a Medicaid informational bulletin regarding health care-related taxes and hold harmless arrangements involving the redistribution of Medicaid payments.
- Hold harmless arrangements, as defined in the Medicaid statute, are arrangements in which the State or another 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. The statute prohibits these arrangements.
- Recently, we have been approached by several states with questions about complying with this provision of law, and we have also learned of states that may have existing arrangements or are considering establishing them, particularly with respect to states establishing or renewing Medicaid managed care state directed payments.
- The informational bulletin reiterates the federal requirements concerning hold harmless arrangements with respect to health care-related taxes. We hope that this guidance provides additional clarity to states, and we also encourage them to raise any questions or concerns they may have about the permissibility of health care-related taxes to CMS as early in the process as possible, to avoid any issues.
- Regarding your question about which states may have these types of arrangements, there are 3 states that CMS understands may have impermissible hold harmless arrangements, and 1 state we wanted to mention as an example of where we were able to intervene early in the process of establishing what may have been an impermissible hold harmless arrangement.
- Starting with the 3 states that may have these arrangements:
    - ***Texas:***
        - Texas has in place what is known as the Local Provider Payment Fund or LPPF. Based on information obtained by CMS, including limited information provided by the state and publicly available third-party materials, the LPPF arrangements used by some localities in Texas appear to include hold harmless arrangements because the localities impose a tax and the state directly or indirectly provides for payments that guarantee to hold the taxpayers harmless for all or any portion of the tax amount. If our understanding of those LPPF arrangements is correct, they constitute hold harmless arrangements that are prohibited under the Medicaid statute and CMS regulations. [this language is pulled from the publicly available November 2021 letter to the State; page 5 includes additional detail regarding our understanding of the arrangement]
        - CMS has communicated these concerns to the state and, when we recently approved Texas' state directed payments, we included in our approval letter that approval of the state directed payments does not constitute any specific Medicaid financing mechanism used to support the non-federal share of the provider payment arrangement. We also clarified that we reserve the authority to enforce requirements, including by initiating separate deferrals and/or disallowances of federal financial participation.
        - As you may be aware, the HHS OIG announced in November 2021 that it is examining states' use of LPPFs as the state share of Medicaid payments, and that it expects to issue a report in FY 2023 that indicates whether the LPPFs the state agency used were permissibl (b)(5) (b)(5)
    - ***Florida:***
        - Similarly, Florida has in place an LPPF that we also understand includes hold harmless arrangements. [the attached FMR engagement letter includes additional detail regarding our understanding of the arrangement]
        - In Florida's case, we were working with the state for some time in an effort to address the concerns, but have been unable to resolve them. Like Texas, we communicated our concerns to the state and, when we recently approved Florida's state directed payments, we provided the same information as was included in the letter to Texas—that the approval does not constitute approval of the Medicaid financing mechanism, and that we reserve the authority to enforce requirements.
        - In late February, we sent a letter to Florida initiating a Financial Management Review (FMR) to examine the state Medicaid agency's compliance with federal requirements over the next several months.

- ***Missouri:***
  - Lastly, Missouri has a longstanding arrangement called the Federal Reimbursement Allowance tax program that appears to include a hold harmless arrangement, and in 2020, CMS engaged the state about its concerns. Also in 2020, the then CMCS Director sent a letter to the state describing our concerns and memorializing a conversation with state Medicaid agency leadership who at that time committed to ending the hold harmless arrangement by X timeframe.
  - While the state has not done that, state leadership has been willing to respond to CMS' questions. In late February, we also sent a letter to Missouri—but, based on our ability to obtain more information from Missouri, we have initiated a focused review of Missouri's program expenditures reported to CMS on the Form CMS-64, rather than an FMR. [the attached CMS-64 review letter includes some additional information]
- With respect to the state I mentioned where we were successful in intervening early:
  - ***Louisiana:***
    - In X month and year, we received information that suggested Louisiana's legislature was developing what would have been a hold harmless arrangement as part of the financing mechanism for its state directed payment program. We engaged the state about those issues, worked with the state on alternatives that would comply with federal law, and ultimately the state withdrew the state directed payment proposal it had submitted and submitted a modified proposal.
- We are hopeful that the guidance we issued will further promote our efforts to work with states and get ahead of these issues as we did in Louisiana.

From: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>
Sent: Tuesday, February 21, 2023 2:37 PM
To: Mauser, Gayle (CMS/OL) <Gayle.Mauser@cms.hhs.gov>
Cc: Costello, Anne Marie (CMS/CMCS) <AnneMarie.Costello@cms.hhs.gov>; Briskin, Perrie (CMS/CMCS) <Perrie.Briskin@cms.hhs.gov>; Kirchgraber, Kate (CMS/OL) <Kate.Kirchgraber@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Subject: RE: E&C Majority Inquiry - Hold Harmless

Hi Gayle,

A call sounds right to me. Please also include Jeremy, Amber, and Charlie in the discussion. For awareness, tomorrow, FMG is planning to issue a letter to Florida and a question set to Missouri on this issue. Both states appear to have concerning arrangements in place and the letter/question set tomorrow are part of our work to address the arrangements. Let me know if you have any questions in the interim.

Thanks,
Rory

From: Mauser, Gayle (CMS/OL) <Gayle.Mauser@cms.hhs.gov>
Sent: Tuesday, February 21, 2023 1:57 PM
To: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>
Cc: Costello, Anne Marie (CMS/CMCS) <AnneMarie.Costello@cms.hhs.gov>; Briskin, Perrie (CMS/CMCS) <Perrie.Briskin@cms.hhs.gov>; Kirchgraber, Kate (CMS/OL) <Kate.Kirchgraber@cms.hhs.gov>
Subject: E&C Majority Inquiry - Hold Harmless

Hi Rory,

After Friday's hold harmless CIB went out, we received an inquiry from House E&C majority staff asking for more information—in particular, about the language from the list serv notice indicating "recently, CMS became aware that some health care-related tax programs appear to involve agreements among providers to redistribute their Medicaid payments to hold taxpayers harmless for the cost of the tax."

Specifically, the staff would like to know about the instances CMS has found, and the steps the agency is taking to address those agreements.

I imagine it will be most efficient to have a quick call to discuss actions to date, anticipated upcoming actions, and next steps for responding to the Hill—does that work for you? Are there others who should be included?

Thanks,
Gayle

Gayle Mauser
(she/her)
Low Income Programs Analysis Group
Office of Legislation
Centers for Medicare & Medicaid Services (CMS)
Cell Phone:
(b)(6)

Sent:	4/27/2023 8:40:08 PM +0000
To:	"Vogel, Jeremy (HHS/OGC)" <Jeremy.Vogel@hhs.gov>; "Campbell, Matthew (HHS/OGC)" <Matthew.Campbell@hhs.gov>
CC:	"Mannchen, Garrett (HHS/OGC)" <Garrett.Mannchen@hhs.gov>
Subject:	FW: FW: MO/TX Tax Timeline
Attachments:	Key MO-TX-Tax Timeline, 4-26-23.docx; Attachment A - 2008 Final Tax Rule - Summary of Relevant Discussion.docx; Attachment B - Provider Reimbursement Review Board Decision 2009 D-42.pdf; Attachment C - Decision of the Administrator Review of PRRB Decision Number 2009-D42.pdf; Attachment D - LPPF Questions and Answers 10.16.docx; Attachment E - Greenberg_Texas Financing Letter12 20 18.pdf; Attachment F - LPPF Hold Harmless Evidence.pdf; Attachment G - HHSC Responses to CMS Questions 08202019.docx; Attachment H - Missouri FRA Tax Hold Harmless - OGC Note to FMG (002).pdf; Attachment I - CMS Letter MO Medicaid Managed Care 07 28 2020 final - Signed.pdf

Hi Jeremy and Matt,

At Dan's request, FMG pulled together this timeline (and related attachments) outlining selected activity regarding TX and MO tax arrangements and the broader hold harmless arrangements at issue. Dan requested it in response to a binder that some external parties prepared. It addresses a few questions that Dan had on the timeline and is not close to comprehensive, but I thought I would share with you in case it contains any information that you do not already have.

Also, James Bickford attended a meeting with Dan

From: Howe, Rory (CMS/CMCS)
Sent: Wednesday, April 26, 2023 5:18 PM
To: Daniel Tsai (CMS/OA) (daniel.tsai@cms.hhs.gov) <daniel.tsai@cms.hhs.gov>
Cc: Costello, Anne Marie (CMS/CMCS) <AnneMarie.Costello@cms.hhs.gov>; Vitolo, Sara (CMS/CMCS) <Sara.Vitolo@cms.hhs.gov>; Perrie Briskin (CMS/OA) (perrie.briskin@cms.hhs.gov) <perrie.briskin@cms.hhs.gov>; Hebert, Krista (CMS/CMCS) <krista.hebert@cms.hhs.gov>; Kochanski, Joseph (CMS/CMCS) <Joseph.Kochanski@cms.hhs.gov>
Subject: MO/TX Tax Timeline

Hi Dan,

As discussed this afternoon, please see attached the requested timeline and attachments. We focused on pre-2021 activity. Please let us know if you have questions or need anything else.

Rory

From: "Snyder, Laura (CMS/CMCS)" (b)(5)
(b)(5)

(b)(5)

Sent: 1/26/2023 1:34:52 PM +0000
To: "Giles, John (CMS/CMCS)" <John.Giles1@cms.hhs.gov>
Subject: FW: FW: FL Companion letter on LPPF
Attachments: RE: WA Inquiry-hospital directed payment CMS conditions letter

FYI – we can definitely follow-up with WA per FMG's suggestions (they didn't want to share the letter….there is a CIB coming, etc.)

However, I wanted to flag – they asked for the email chain; apparently the question set of a "ripple of worry in FMG". The email thread we have so far is attached; the WA Medicaid Assistant Director cited you mentioning something a month or so ago at a meeting. Let me know how you want to handle this.

Thanks,
Laura

From: Bonelli, Anna (CMS/CMCS) <Anna.Bonelli@cms.hhs.gov>
Sent: Wednesday, January 25, 2023 10:35 AM
To: Snyder, Laura (CMS/CMCS) <Laura.Snyder1@cms.hhs.gov>
Cc: CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>
Subject: RE: FL Companion letter on LPPF

Laura,

Couple things. FMG does not want to share the letter:

- First, it is going to be out of date/old news once the CIB comes out (CIB just went through HHS clearance).
- Second, we try not to share things that put other states in a bad light.

Suggest saying to the state something like, "We generally do not like to share such information with other states, but you may reach out to Florida directly for the information. If this information is pressing (that is, you need to share it with your Legislature in order to inform legislation), we may be able to talk with you further on this. In addition, we are planning to release new guidance that clarifies CMS' policies that should help."

I have to say, this question has touched off a ripple of worry in FMG. Can you please send me the email chain so I can see how clear/unclear the tone is about the LPPF?

Thank you!

anna

From: Snyder, Laura (CMS/CMCS) <Laura.Snyder1@cms.hhs.gov>
Sent: Tuesday, January 24, 2023 11:30 AM
To: Bonelli, Anna (CMS/CMCS) <Anna.Bonelli@cms.hhs.gov>
Cc: CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>
Subject: RE: FL Companion letter on LPPF

To be honest, not clear; the email was routed through lots of hands before getting to us and there is not a lot of detail.

From: Bonelli, Anna (CMS/CMCS) <Anna.Bonelli@cms.hhs.gov>
Sent: Tuesday, January 24, 2023 11:29 AM
To: Snyder, Laura (CMS/CMCS) <Laura.Snyder1@cms.hhs.gov>
Cc: CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>
Subject: RE: FL Companion letter on LPPF

Hi Laura! I think it's fine but let me double check.

And when you say that Washington may have similar issues, do you mean they have an LPPF or something similar? [nervous emoji]

From: Snyder, Laura (CMS/CMCS) <Laura.Snyder1@cms.hhs.gov>
Sent: Tuesday, January 24, 2023 10:23 AM
To: Bonelli, Anna (CMS/CMCS) <Anna.Bonelli@cms.hhs.gov>
Cc: CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>
Subject: FL Companion letter on LPPF

Hi Anna,

We got a really random question from the Assistant Medicaid Director in WA. He heard about the companion letter issued to FL (the one that references LPPF and denotes CMS' concerns.) He is apparently having similar issues in WA or starting to and wanted a copy of the letter that FL received. We wanted to check with you all if you have any concerns with

sharing that letter with WA; we think it should be fine, but wanted to check particularly given the FL FMR that will focus on the LPPF issue.

Thanks,

Laura

Laura Snyder

(she/her/hers)

Technical Director

Division of Managed Care Policy

Centers for Medicaid and CHIP Services

Phone: 410-786-3198

Laura.Snyder1@cms.hhs.gov

From:	CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>
Sent:	1/20/2023 7:48:34 PM +0000
To:	"Kivisaari, John (CMS/CMCS)" <John.Kivisaari@cms.hhs.gov>; "Walaszek, Edwin (CMS/CMCS)" <Edwin.Walaszek1@cms.hhs.gov>
CC:	"Delvecchio, Lynn (CMS/CMCS)" <Lynn.DelVecchio@cms.hhs.gov>; CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>
Subject:	RE: RE: WA Inquiry-hospital directed payment CMS conditions letter

Hi John,

Thanks for sending this request our way. I am the lead SDP analyst for Washington – nice to meet you ☺.

The short answer is, yes, we will be able to assist Washington. The longer answer is that I will need to circle with the lead analyst for FL next week when she returns and try to decipher exactly what information WA is seeking so we can help them out.

In the meantime, Edwin, you may direct the state to send their questions to the SDP inbox at statedirectedpayment@cms.hhs.gov. This way we will be able to track the inquiry and make sure the state gets the information they need.

Thanks,

Tara

From: Kivisaari, John (CMS/CMCS) <John.Kivisaari@cms.hhs.gov>
Sent: Friday, January 20, 2023 2:40 PM
To: Walaszek, Edwin (CMS/CMCS) <Edwin.Walaszek1@cms.hhs.gov>; CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>
Cc: Delvecchio, Lynn (CMS/CMCS) <Lynn.DelVecchio@cms.hhs.gov>
Subject: RE: WA Inquiry-hospital directed payment CMS conditions letter

(Adding the DMCP SDP mailbox)

Good afternoon, Edwin:

Thanks for reaching out. This issue appears related to a recently approved state-directed payment out of Florida. **SDP team, are you able to assist regarding Washington's request for information related to the Florida SDP?** Their request is more fully-described below.

Note: I have only just begun transitioning to my role as the managed care analyst in DMCO for WA, but if there's anything DMCO can do to assist with this request please let me know.

Best regards,

John

John Kivisaari

Managed Care Analyst

Centers for Medicare & Medicaid Services (CMS)

Medicaid and Children's Health Operations Group (MCOG)

Division of Managed Care Operations (DMCO)

(312)-353-0508

john.kivisaari@cms.hhs.gov

From: Walaszek, Edwin (CMS/CMCS) <Edwin.Walaszek1@cms.hhs.gov>
Sent: Friday, January 20, 2023 1:07 PM
To: Delvecchio, Lynn (CMS/CMCS) <Lynn.DelVecchio@cms.hhs.gov>
Cc: Kivisaari, John (CMS/CMCS) <John.Kivisaari@cms.hhs.gov>
Subject: WA Inquiry-hospital directed payment CMS conditions letter

Hi Lynn and John,

Hope your Friday is going well, I'm sorry to bother you, Washington state Assistant Director Jason McGill reached out this morning on a letter that was issued in Florida related to recent hospital safety net/directed payment, their request is a little vague, do you happen to know any information on this letter issued to Florida? Washington is seeking out information as how this will relate to them?

Thank you,

Edwin Walaszek

Washington State Lead

Division of Program Operations – West | Medicaid & CHIP Operations Group

Center for Medicaid & CHIP Services | Centers for Medicare & Medicaid Services

Email:Edwin.Walaszek1@cms.hhs.gov

From: Tisdale, Ryan (CMS/CMCS) <Ryan.Tisdale@cms.hhs.gov>
Sent: Friday, January 20, 2023 1:58 PM
To: Walaszek, Edwin (CMS/CMCS) <Edwin.Walaszek1@cms.hhs.gov>; Abdullah-Mclaughlin, Annese (CMS/CMCS) <Annese.Abdullah-Mclaughlin@cms.hhs.gov>; Moreth, James (CMS/CMCS) <James.Moreth@cms.hhs.gov>; Caughey, Tom (CMS/CMCS) <Tom.Caughey@cms.hhs.gov>; Knight, Gary (CMS/CMCS) <Gary.Knight@cms.hhs.gov>
Subject: RE: WA Inquiry-hospital directed payment CMS conditions letter

Hi Edwin,

I believe directed payments are specific to managed care, so DMCP may be the best equipped to help with this inquiry?

Thanks,

Ryan

From: Walaszek, Edwin (CMS/CMCS) <Edwin.Walaszek1@cms.hhs.gov>
Sent: Friday, January 20, 2023 1:47 PM

To: Abdullah-Mclaughlin, Annese (CMS/CMCS) <Annese.Abdullah-Mclaughlin@cms.hhs.gov>; Moreth, James (CMS/CMCS) <James.Moreth@cms.hhs.gov>; Tisdale, Ryan (CMS/CMCS) <Ryan.Tisdale@cms.hhs.gov>; Caughey, Tom (CMS/CMCS) <Tom.Caughey@cms.hhs.gov>; Knight, Gary (CMS/CMCS) <Gary.Knight@cms.hhs.gov>
Subject: WA Inquiry-hospital directed payment CMS conditions letter

Good Friday all,

Washington state is inquiring about a letter that was issued in Florida related to recent hospital safety net/directed payment, their request is a little vague at least from my view, would you all happen to have any additional information on this topic or have any suggestions on who would?

Thank you in advance for any guidance,

Edwin Walaszek

Washington State Lead

Division of Program Operations – West | Medicaid & CHIP Operations Group

Center for Medicaid & CHIP Services | Centers for Medicare & Medicaid Services

Email:Edwin.Walaszek1@cms.hhs.gov

From: McGill, Jason T (HCA) <jason.mcgill@hca.wa.gov>
Sent: Friday, January 20, 2023 1:39 PM
To: Walaszek, Edwin (CMS/CMCS) <Edwin.Walaszek1@cms.hhs.gov>
Subject: Re: Florida hospital directed payment CMS conditions letter

I understood it's the entire state hospital inpatient payment (billions of dollars) for Florida through a directed payment. John reported he issued a 7 page conditions letter due to many concerns. Hope this helps. Thanks!

From: Walaszek, Edwin (CMS/CMCS) <Edwin.Walaszek1@cms.hhs.gov>
Sent: Friday, January 20, 2023 9:55:50 AM
To: McGill, Jason T (HCA) <jason.mcgill@hca.wa.gov>
Subject: Florida hospital directed payment CMS conditions letter

Hi Jason,

Thank you for reaching out, can you provide a little more context as I need to reach out to the team that specializes in this area, is this related to administrative claiming or reimbursement? Is Washington state currently working with anyone in CMS related to this issue or area so that I can reach out to them for a status on this?

Thank you,

Edwin Walaszek

Washington State Lead

Division of Program Operations – West | Medicaid & CHIP Operations Group

Center for Medicaid & CHIP Services | Centers for Medicare & Medicaid Services

Email:Edwin.Walaszek1@cms.hhs.gov

From: McGill, Jason T (HCA) <jason.mcgill@hca.wa.gov>
Sent: Friday, January 20, 2023 12:42 PM
To: Walaszek, Edwin (CMS/CMCS) <Edwin.Walaszek1@cms.hhs.gov>
Subject: Florida hospital directed payment CMS conditions letter

Hi Edwin,

I understand CMS issued a fairly detailed conditions letter to Florida upon approval of its recent hospital safety net/directed payment. John Giles mentioned that to me at a meeting a month or so ago. I was hoping to see that as we're also starting to deal with it here in Washington.

Thanks,

jason

Jason T. McGill

Assistant Director

Medicaid Programs Division

office: 360-725-1093 | cell: (b)(6)

jason.mcgill@hca.wa.gov

Washington State Health Care Authority

www.hca.wa.gov

Sent:	3/1/2023 7:17:45 PM +0000
To:	"Arnold, Charlie (CMS/CMCS)" <Charlie.Arnold@cms.hhs.gov>; "Maccarroll, Amber (CMS/CMCS)" <Amber.MacCarroll@cms.hhs.gov>; "Silanskis, Jeremy (CMS/CMCS)" <Jeremy.Silanskis@cms.hhs.gov>; "Goldstein, Stuart (CMS/CMCS)" <STUART.GOLDSTEIN@cms.hhs.gov>; "Cuno, Richard (CMS/CMCS)" <Richard.Cuno@cms.hhs.gov>; "Endelman (he/him), Jonathan (CMS/CMCS)" <Jonathan.Endelman@cms.hhs.gov>; "Clark, Jennifer (CMS/CMCS)" <Jennifer.Clark@cms.hhs.gov>
CC:	"Fan, Kristin (CMS/CMCS)" <Kristin.Fan@cms.hhs.gov>; "Schoonover, Matthew (CMS/CMCS)" <matthew.schoonover@cms.hhs.gov>; "Mosley, Elle (CMS/CMCS)" <larrica.mosley@cms.hhs.gov>
Subject:	RE: RE: Discussion of Request for CMS Technical Assistance for Nevada Private Hospital DPP
Attachments:	RE: Attestation Form

-----Original Appointment-----
From: Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>
Sent: Monday, February 27, 2023 1:14 PM
To: Arnold, Charlie (CMS/CMCS); Howe, Rory (CMS/CMCS); Maccarroll, Amber (CMS/CMCS); Silanskis, Jeremy (CMS/CMCS); Goldstein, Stuart (CMS/CMCS); Cuno, Richard (CMS/CMCS); Endelman (he/him), Jonathan (CMS/CMCS); Clark, Jennifer (CMS/CMCS)
Cc: Fan, Kristin (CMS/CMCS); Schoonover, Matthew (CMS/CMCS); Mosley, Elle (CMS/CMCS)
Subject: Discussion of Request for CMS Technical Assistance for Nevada Private Hospital DPP
When: Wednesday, March 1, 2023 2:00 PM-3:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: https://cms.zoomgov.com/j/1608906908?pwd=SzFwTFVmWk9WZkxJZkh5cEh0ZW5Qdz09

Charlie Arnold is inviting you to a scheduled ZoomGov meeting.

Join ZoomGov Meeting
https://cms.zoomgov.com/j/ (b)(5)

Meeting ID: (b)(5)
Password (b)(5)

One tap mobile
+16692545252, (b)(5) US (San Jose)
+16468287666, US (New York)

Dial by your location
+1 669 254 5252 US (San Jose)
+1 646 828 7666 US (New York)
833 568 8864 US Toll-free
Meeting ID (b)(5)
Password: (b)(5)
Find your local number: https://cms.zoomgov.com/u/abRjqaVzu

Join by SIP
Password (b)(5)

sip (b)(5) @sip.zoomgov.com

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.

From: "Howe, Rory (CMS/CMCS)" (b)(5)

(b)(5)

Sent: 11/8/2022 9:16:39 PM +0000
To: Stacie Weeks <sweeks@dhcfp.nv.gov>
CC: "Silanskis, Jeremy (CMS/CMCS)" <Jeremy.Silanskis@cms.hhs.gov>
Subject: RE: RE: Attestation Form
Attachments: NV Financing, 11-8-22.docx

Hi Stacie,

Please see attached some information regarding possible provider attestation approaches that we previously discussed and have shared with other states. The first option involves direct written attestations from each provider and the second option consists of an alternative approach involving meeting with your provider community. For the written attestations, the key language that we would expect to see is specified in #3 in the attached. We are open to reviewing alternate language from the state, noting that we would expect something very similar in effect. We also defer to the state regarding any additional process-related language if the state decides to take a written attestation approach.

If it would be helpful, we are open to reviewing draft attestation language, discussing the information that I attached, discussing alternative approaches, or setting up some time to talk about any other questions or concerns that you might have.

Regards,

Rory

Rory Howe

Director

Financial Management Group

CMS/CMCS

(b)(6)

From: Stacie Weeks <sweeks@dhcfp.nv.gov>
Sent: Monday, November 7, 2022 7:29 PM
To: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>
Subject: Attestation Form

Do you happen to have a template for the attestation form for the provider tax/payments that you mentioned the other day on our call?

Nevada Department of Health and Human Services
DIVISION OF HEALTH CARE FINANCING AND POLICY

Stacie Weeks, JD, MPH

Deputy Administrator

Nevada Department of Health and Human Services

Division of Health Care Financing and Policy

1100 East William Street, Suite 101| Carson City, NV 89701 -

Office: (775) 687-7101 |Email: sweeks@dhcfp.nv.gov

Mobile: (b)(6)

http://dhhs.nv.gov/ | http://dhcfp.nv.gov/

Helping People. It's who we are and what we do.

Find help 24/7 by dialing 2-1-1; texting 898-211; or visiting www.nevada211.org

Sent: 2/17/2023 12:46:53 PM +0000
To: "Giles, John (CMS/CMCS)" <John.Giles1@cms.hhs.gov>
Subject: FW: FW: FL Proposal D Amendment 2020-2021-just FYI
Attachments: Attachments A and B 102722 (002).docx

I don't know where to start on this one, but if you are going to be talking to Bill, maybe ask him if he can ask his analysts to STAY IN THEIR LANE!!!! Aimee decided to share her feedback with FMG running the FMR in FL on a preprint that isn't applicable to their review without getting feedback from us first. I AM LIVID. The preprint is one we requested I believe because the amount in the rate cert was higher than what was in the rate cert; review has just begun.

From: Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>
Sent: Friday, February 17, 2023 7:10 AM
To: Staton, Sidney (CMS/CMCS) <Sidney.Staton@cms.hhs.gov>; Campbell-OConnor, Aimee (CMS/CMCS) <Aimee.Campbell-OConnor1@cms.hhs.gov>; Sarah Whitehouse <Whitehouse-Sarah@norc.org>; Snyder, Laura (CMS/CMCS) <Laura.Snyder1@cms.hhs.gov>; Davis, Lovie (CMS/CMCS) <Lovie.Davis@cms.hhs.gov>; Loizias, Alex (CMS/CMCS) <Alexandra.Loizias@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Heitt, Melissa (CMS/FCHCO) <Melissa.Heitt@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>; Holligan, Ricardo (CMS/CMCS) <Ricardo.Holligan@cms.hhs.gov>
Subject: RE: FL Proposal D Amendment 2020-2021-just FYI

Also, just in case people don't have this document already, here is a document detailing the financial management review or FMR that we are doing in Florida relating to LPPFs. It's third on the list. An FMR is a kind of audit that FMG does when we have questions about something that is more in depth than the standard review as part of our regular oversight activities and reviewing the CMS-64. We did a similar FMR on Florida's SDP for the previous year as well that Laura Snyder, Lovie, Alex, and DMCP were heavily involved in throughout the process. I imagine that state directed payments will be an increasingly common topic for FMRs in the future given the large and increasing dollar amount that seems to be shifting into state directed payments. As you can see, conditionality of IGTs is one of the items we are reviewing. We write, "This is to ensure the state is not making payment into the LPPFs / IGT a contingency for receiving SDPs back from the state."

Best,

Jonathan

Jonathan Endelman, PhD
Social Science Research Analyst
Centers for Medicare & Medicaid Services (CMS)
Center for Medicaid and CHIP Services (CMCS)
Financial Management Group (FMG)
Division of Financial Policy (DFP)
410.786.4738
jonathan.endelman@cms.hhs.gov
7500 Security Blvd.
Mail Stop, S3-14-28
Baltimore, MD 21244-1850

From: Endelman (he/him), Jonathan (CMS/CMCS)
Sent: Friday, February 17, 2023 7:00 AM

To: Staton, Sidney (CMS/CMCS) <Sidney.Staton@cms.hhs.gov>; Campbell-OConnor, Aimee (CMS/CMCS) <Aimee.Campbell-OConnor1@cms.hhs.gov>; Sarah Whitehouse <Whitehouse-Sarah@norc.org>; Snyder, Laura (CMS/CMCS) <Laura.Snyder1@cms.hhs.gov>; Davis, Lovie (CMS/CMCS) <Lovie.Davis@cms.hhs.gov>; Loizias, Alex (CMS/CMCS) <Alexandra.Loizias@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Heitt, Melissa (CMS/FCHCO) <Melissa.Heitt@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>
Subject: RE: FL Proposal D Amendment 2020-2021-just FYI

Thank you Aimee for the article and for your concerns. I believe that the new managed care rule that is currently in development will help to address some of the oversight deficiencies that you have identified regarding the lack of a UPL-type mechanism on the managed care side to serve as an upper ceiling on payment amounts. I believe that ACR or average commercial rate is one of the tools that we have used in the past to serve in this capacity. Regarding your point about actuarial soundness, I agree. It's something that Anna and I have discussed in the past and others have also brought up. Regarding the article from AHCA the "Florida Medicaid Health Care Alert" from July 22, 2021, I think that is helpful. The entity mentioned in the article "Adelanto Healthcare Ventures" is a health care consultant based out of Austin that was also involved in setting up the Texas LPPF. In most instances of what we would think of as "taxes" in everyday life, no one wants to be taxed. In the world of healthcare-related taxes, everyone wants to be taxed because they anticipate receiving more than their tax cost back in increased Medicaid payments. Regarding the conditional nature of the IGT, "If your hospital is not sure whether you are included and would like to be included in the Agency's projections for the hospital directed payment program" I seem to remember something that this may be problematic, but I would defer to Andrew for that as being the SME on IGTs. These are important issues. The oversight system was built on Medicaid FFS payments. Now that 80% or more of payments have shifted to be on managed care and especially with the growing importance of state directed payments, oversight becomes more difficult because state directed payments are relatively new and don't have all of the oversight mechanisms in place as exist on the FFS side of the house. We are working on building them now and we hope that they will be operational moving forward. I definitely think the larger issues you point out are worth discussing either on the next NORC FMR call or else on a separate call. I look forward to talking with you.

Best,

Jonathan

Jonathan Endelman, PhD
Social Science Research Analyst
Centers for Medicare & Medicaid Services (CMS)
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Division of Financial Policy (DFP)
410.786.4738
jonathan.endelman@cms.hhs.gov
7500 Security Blvd.
Mail Stop, S3-14-28
Baltimore, MD 21244-1850

From: Staton, Sidney (CMS/CMCS) <Sidney.Staton@cms.hhs.gov>
Sent: Thursday, February 16, 2023 3:44 PM
To: Campbell-OConnor, Aimee (CMS/CMCS) <Aimee.Campbell-OConnor1@cms.hhs.gov>
Cc: Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>
Subject: RE: FL Proposal D Amendment 2020-2021-just FYI

Hi Aimee – Thank you for sharing. I do not participate in the SDP pre-prints review. I'm also cc Jonathan in case he has not seen this.
Sid

From: Campbell-OConnor, Aimee (CMS/CMCS) <Aimee.Campbell-OConnor1@cms.hhs.gov>
Sent: Thursday, February 16, 2023 2:58 PM
To: Staton, Sidney (CMS/CMCS) <Sidney.Staton@cms.hhs.gov>
Subject: FW: FL Proposal D Amendment 2020-2021-just FYI

Hey Sid!

Just sharing as FYI. Not sure whether you participate in review of SDP pre-prints.

Aimee

From: Campbell-OConnor, Aimee (CMS/CMCS)
Sent: Thursday, February 16, 2023 2:55 PM
To: Delvecchio, Lynn (CMS/CMCS) <Lynn.DelVecchio@cms.hhs.gov>
Subject: FW: FL Proposal D Amendment 2020-2021

Just FYI. 

From: Campbell-OConnor, Aimee (CMS/CMCS)
Sent: Thursday, February 16, 2023 2:52 PM
To: CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>
Subject: RE: FL Proposal D Amendment 2020-2021

Hi Alex!

I reviewed the SDP pre-print. I guess I don't understand how submission of a pre-print amendment for 2020-2021, 2 years after the fact is actually tied to helping with access or utilization at this point? The support provided for this SDP in the pre-print is minimal at best. I don't have any actual comments because there doesn't seem to be much justification in terms of an improvement in care for beneficiaries for these payments.

What is the purpose of this amendment? The purpose seems to be to provide extra funds to the hospitals using the SDP as a vehicle. If the rates were determined to be actuarily sound, then access should have been considered as part of that. If the rates are not sufficient at this point, where is the data to show that and why wouldn't they just address any concerns with the plans? And/or, raise rates with a rate amendment?

See- http://www.icontact-archive.com/archive?c=227375&f=11179&s=13873&m=852437&t=850d8a08f66cb5c2e1e49656573dbe0caeb447b39b9d192096e732cbe37425f5

This arrangement where the State indicates to the hospitals that we are offering you an opportunity to get higher payments if you help contribute the State match, sounds potentially problematic. There is an article from FL Taxwatch on the SDP program that provides some insight. (attached)

I know that on the FFS side of the house we have UPLs, scrutiny of taxation and CPE arrangements to make sure that funds are not "recycled." Here is an article from George Mason university on State financing strategies in Medicaid that mentions IGTs as a problematic strategy. https://www.mercatus.org/research/research-papers/medicaid-provider-taxes-gimmick-exposes-flaws-medicaids-financing

Florida may be allowed to use IGTs as State match under current regulations but I do wonder about how well their strategy aligns with the safeguards CMS has put in place on the FFS side.

I hope this is helpful. I know that Sid and FMG are looking at the Provider Participation Fund for this coming year and that CMS sent a Companion letter with one of the approvals last year. This may be an area where further guidance would be beneficial.

Aimee

Aimee.Campbell-OConnor1@cms.hhs.gov
(207) 441-2788
West Branch
Division of Managed Care Operations (DMCO)
Centers for Medicare & Medicaid Services (CMS)

From: CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>
Sent: Friday, February 10, 2023 1:11 PM
To: CMS OACT Medicaid Managed Care <OACTMedicaidManagedCare@cms.hhs.gov>; CMS SDP_QUALITY <SDP_QUALITY@cms.hhs.gov>; Campbell-OConnor, Aimee (CMS/CMCS) <Aimee.Campbell-OConnor1@cms.hhs.gov>
Cc: CMS DMCP Medicaid Managed Care Rates <DMCPrates@cms.hhs.gov>; CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>
Subject: FL Proposal D Amendment 2020-2021

Good Afternoon FRT,

Florida submitted a preprint amendment for formal CMS approval pursuant to 42 CFR 438.6(c). The files are available at the following link (b)(5)

(b)(5)

Please note the following:

- This is an amendment submission for this payment arrangement.
- The previously approved preprint is available here (b)(5)
- This proposal is eligible for an annual approval.
- The 90th day for this review is May 11, 2023

FRT feedback for the state is due by **COB, March 3, 2023**. If DMCP does not receive a response by this deadline, we will assume that the FRT member has no questions for the state for addition to the question set and concurs on approval of the preprint. Please reach out with any questions and thanks for your review.

Thank you,

Lovie

From: "Snyder, Laura (CMS/CMCS)" < (b)(5)

(b)(5)

Sent: 2/17/2023 12:58:04 PM +0000
To: "Giles, John (CMS/CMCS)" <John.Giles1@cms.hhs.gov>
Subject: FW: FW: FL Proposal D Amendment 2020-2021-just FYI
Attachments: Attachments A and B 102722 (002).docx

Question – do I respond to this or let it be? DMCO is again I feel like creating a mess without all the details…

From: Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>
Sent: Friday, February 17, 2023 7:10 AM
To: Staton, Sidney (CMS/CMCS) <Sidney.Staton@cms.hhs.gov>; Campbell-OConnor, Aimee (CMS/CMCS) <Aimee.Campbell-OConnor1@cms.hhs.gov>; Sarah Whitehouse <Whitehouse-Sarah@norc.org>; Snyder, Laura (CMS/CMCS) <Laura.Snyder1@cms.hhs.gov>; Davis, Lovie (CMS/CMCS) <Lovie.Davis@cms.hhs.gov>; Loizias, Alex (CMS/CMCS) <Alexandra.Loizias@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Heitt, Melissa (CMS/FCHCO) <Melissa.Heitt@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>; Holligan, Ricardo (CMS/CMCS) <Ricardo.Holligan@cms.hhs.gov>
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Best,

Jonathan

Jonathan Endelman, PhD

Social Science Research Analyst

Centers for Medicare & Medicaid Services (CMS)

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Baltimore, MD 21244-1850

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Best,

Jonathan

Jonathan Endelman, PhD

Social Science Research Analyst

Centers for Medicare & Medicaid Services (CMS)

Center for Medicaid and CHIP Services (CMCS)

Financial Management Group (FMG)

Division of Financial Policy (DFP)

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jonathan.endelman@cms.hhs.gov

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Baltimore, MD 21244-1850

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Cc: Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>
Subject: RE: FL Proposal D Amendment 2020-2021-just FYI

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Sid

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To: Staton, Sidney (CMS/CMCS) <Sidney.Staton@cms.hhs.gov>
Subject: FW: FL Proposal D Amendment 2020-2021-just FYI

Hey Sid!

Just sharing as FYI. Not sure whether you participate in review of SDP pre-prints.

😊

Aimee

From: Campbell-OConnor, Aimee (CMS/CMCS)
Sent: Thursday, February 16, 2023 2:55 PM
To: Delvecchio, Lynn (CMS/CMCS) <Lynn.DelVecchio@cms.hhs.gov>
Subject: FW: FL Proposal D Amendment 2020-2021

Just FYI. 😊

From: Campbell-OConnor, Aimee (CMS/CMCS)
Sent: Thursday, February 16, 2023 2:52 PM
To: CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>
Subject: RE: FL Proposal D Amendment 2020-2021

Hi Alex!

I reviewed the SDP pre-print. I guess I don't understand how submission of a pre-print amendment for 2020-2021, 2 years after the fact is actually tied to helping with access or utilization at this point? The support provided for this SDP in the pre-print is minimal at best. I don't have any actual comments because there doesn't seem to be much justification in terms of an improvement in care for beneficiaries for these payments.

What is the purpose of this amendment? The purpose seems to be to provide extra funds to the hospitals using the SDP as a vehicle. If the rates were determined to be actuarily sound, then access should have been considered as part of that. If the rates are not sufficient at this point, where is the data to show that and why wouldn't they just address any concerns with the plans? And/or, raise rates with a rate amendment?

See- http://www.icontact-archive.com/archive?c=227375&f=11179&s=13873&m=852437&t=850d8a08f66cb5c2e1e49656573dbe0caeb447b39b9d192096e732cbe37425f5

This arrangement where the State indicates to the hospitals that we are offering you an opportunity to get higher payments if you help contribute the State match, sounds potentially problematic. There is an article from FL Taxwatch on the SDP program that provides some insight. (attached)

I know that on the FFS side of the house we have UPLs, scrutiny of taxation and CPE arrangements to make sure that funds are not "recycled." Here is an article from George Mason university on State financing strategies in Medicaid that mentions IGTs as a problematic strategy. https://www.mercatus.org/research/research-papers/medicaid-provider-taxes-gimmick-exposes-flaws-medicaids-financing

Florida may be allowed to use IGTs as State match under current regulations but I do wonder about how well their strategy aligns with the safeguards CMS has put in place on the FFS side.

I hope this is helpful. I know that Sid and FMG are looking at the Provider Participation Fund for this coming year and that CMS sent a Companion letter with one of the approvals last year. This may be an area where further guidance would be beneficial.

☺

Aimee

Aimee.Campbell-OConnor1@cms.hhs.gov

(207) 441-2788

West Branch

Division of Managed Care Operations (DMCO)

Centers for Medicare & Medicaid Services (CMS)

From: CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>
Sent: Friday, February 10, 2023 1:11 PM
To: CMS OACT Medicaid Managed Care <OACTMedicaidManagedCare@cms.hhs.gov>; CMS SDP_QUALITY <SDP_QUALITY@cms.hhs.gov>; Campbell-OConnor, Aimee (CMS/CMCS) <Aimee.Campbell-OConnor1@cms.hhs.gov>
Cc: CMS DMCP Medicaid Managed Care Rates <DMCPrates@cms.hhs.gov>; CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>
Subject: FL Proposal D Amendment 2020-2021

Good Afternoon FRT,

Florida submitted a preprint amendment for formal CMS approval pursuant to 42 CFR 438.6(c). The files are available at the following link (b)(5)

(b)(5)

Please note the following:

- This is an amendment submission for this payment arrangement.

- The previously approved preprint is available here: (b)(5)
- This proposal is eligible for an annual approval.
- The 90th day for this review is May 11, 2023

FRT feedback for the state is due by **COB, March 3, 2023**. If DMCP does not receive a response by this deadline, we will assume that the FRT member has no questions for the state for addition to the question set and concurs on approval of the preprint. Please reach out with any questions and thanks for your review.

Thank you,

Lovie

From:	"Endelman (he/him), Jonathan (CMS/CMCS)" <Jonathan.Endelman@cms.hhs.gov>
Sent:	2/6/2023 1:34:12 PM +0000
To:	"Snyder, Laura (CMS/CMCS)" <Laura.Snyder1@cms.hhs.gov>; "Bonelli, Anna (CMS/CMCS)" <Anna.Bonelli@cms.hhs.gov>
CC:	"Giles, John (CMS/CMCS)" <John.Giles1@cms.hhs.gov>; "Goldstein, Stuart (CMS/CMCS)" <STUART.GOLDSTEIN@cms.hhs.gov>; "Holligan, Ricardo (CMS/CMCS)" <Ricardo.Holligan@cms.hhs.gov>; "Staton, Sidney (CMS/CMCS)" <Sidney.Staton@cms.hhs.gov>; "Arnold, Charlie (CMS/CMCS)" <Charlie.Arnold@cms.hhs.gov>; "Clark, Jennifer (CMS/CMCS)" <Jennifer.Clark@cms.hhs.gov>; "Cuno, Richard (CMS/CMCS)" <Richard.Cuno@cms.hhs.gov>; "Fan, Kristin (CMS/CMCS)" <Kristin.Fan@cms.hhs.gov>; "Heitt, Melissa (CMS/FCHCO)" <Melissa.Heitt@cms.hhs.gov>; "Mosley, Elle (CMS/CMCS)" <larrica.mosley@cms.hhs.gov>; "Schoonover, Matthew (CMS/CMCS)" <matthew.schoonover@cms.hhs.gov>
Subject:	RE: RE: FL_Fee_IPH.OPH4_Renewal_20221001-20230930
Attachments:	RE: FL FMR Materials for Dan's Book

Hello Laura,

We are in the process of conducting a financial management review for the State of Florida relating to its SDPs and the LPPF with the assistance of our contractor NORC. We had a meeting to discuss this last Thursday. We have a timeline for our review attached that we placed in Dan’s book last Friday. We also provided for Dan’s book a more in-depth presentation on the possible proposed tax rule designed to close down the loophole in the statistical test for waivers of the uniformity requirement for health care-related taxes that enable states to pass in regulation despite taxing Medicaid business much more heavily than non-Medicaid business contrary to statutory and regulatory intent. We have been working with OACT to devise a new statistical test to shut down this loophole, which we have called the M1/M2. We are awaiting Dan’s feedback on proceeding forward with proposing a rule in this direction. We look forward to talking with you this morning.

Best,

Jonathan

Jonathan Endelman, PhD

Social Science Research Analyst

Centers for Medicare & Medicaid Services (CMS)

Center for Medicaid and CHIP Services (CMCS)

Financial Management Group (FMG)

Division of Financial Policy (DFP)

410.786.4738

jonathan.endelman@cms.hhs.gov

7500 Security Blvd.

Mail Stop, S3-14-28

Baltimore, MD 21244-1850

From: Snyder, Laura (CMS/CMCS) <Laura.Snyder1@cms.hhs.gov>
Sent: Sunday, February 5, 2023 9:37 AM
To: Bonelli, Anna (CMS/CMCS) <Anna.Bonelli@cms.hhs.gov>; Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>
Cc: Giles, John (CMS/CMCS) <John.Giles1@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>
Subject: FW: FL_Fee_IPH.OPH4_Renewal_20221001-20230930

Hi Anna, Jonathan and Stuart,

We wanted to consult with you all. Florida has indicated that several pieces of this preprint submission are still incomplete (and will likely to remain so until they complete an analysis in April 2023.)

We are considering options on next steps. At a staff level, we think that it makes sense to still consider this incomplete. However, we didn't know if you all would want to engage with the state now on the financing. The final figures on the financing are dependent on the analysis in April, but I believe, though defer to you all, that the LPPF concerns from the last review, were not dependent upon the final $$. Would you all believe it would be beneficial to engage the state on any of the financing now?

Happy to talk further tomorrow at the scheduled FMG/DMCP TB or outside of that meeting too.

Thanks,

Laura

From: Wallace, Tom <Thomas.Wallace@ahca.myflorida.com>
Sent: Friday, February 3, 2023 10:00 PM
To: CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>; Giering, Cole <cole.giering@ahca.myflorida.com>
Cc: Sokoloski, Kristin <Kristin.Sokoloski@ahca.myflorida.com>; Barry, Joycee <Joycee.Barry@ahca.myflorida.com>; Cai, Jun <Jun.Cai@ahca.myflorida.com>; Lacroix, Rachel <Rachel.Lacroix@ahca.myflorida.com>; Giles, John (CMS/CMCS) <John.Giles1@cms.hhs.gov>; Snyder, Laura (CMS/CMCS) <Laura.Snyder1@cms.hhs.gov>
Subject: RE: FL_Fee_IPH.OPH4_Renewal_20221001-20230930

Hello,

The State acknowledges receipt of CMS's response to our preprint submission. The sections of the preprint highlighted below depend on an updated calculation of gross Medicaid shortfall and allocation percentages by provider class based on CY 2021 claims and encounter experience. The State is in the process of updating this analysis and anticipates providing an amended preprint that includes the requested information in April 2023.

Thank you,

Tom

Tom Wallace

Deputy Secretary

Agency for Health Care Administration

850-251-0095

From: CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>
Sent: Wednesday, February 1, 2023 1:36 PM
To: Giering, Cole <cole.giering@ahca.myflorida.com>
Cc: Wallace, Tom <Thomas.Wallace@ahca.myflorida.com>; Sokoloski, Kristin <Kristin.Sokoloski@ahca.myflorida.com>; Barry, Joycee <Joycee.Barry@ahca.myflorida.com>; Cai, Jun <Jun.Cai@ahca.myflorida.com>; Lacroix,

Rachel <Rachel.Lacroix@ahca.myflorida.com>; Giles, John (CMS/CMCS) <John.Giles1@cms.hhs.gov>; Snyder, Laura (CMS/CMCS) <Laura.Snyder1@cms.hhs.gov>; CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>
Subject: FL_Fee_IPH.OPH4_Renewal_20221001-20230930

Good morning,

Thank you for your submission. CMS has determined that we require responses to the below questions to ensure CMS has adequate documentation to begin our review.

1. Specifically, please include responses to the following incomplete sections:
    - the provider payment analysis section is incomplete (Preprint Question 23/ Table 2); and
    - the data sources and methodology are incomplete (Preprint Question 27).
2. In addition, the state noted several sections of the preprint that are incomplete and/or missing updated information including:
    - Updated gross payment amounts based on CY 2021 Medicaid shortfall calculations (impacting responses to prompts 4 and 23 - 27).
    - Updated estimated uniform percentage increase amounts (impacting response to prompt 19.b)
    - Non-federal funding sources and amounts (impacting response to prompts 35 and 36).

Please provide the state's anticipated timeline to submit the updated information to CMS for review.

We request that the state acknowledge receipt of this communication and respond within 2 working days to respond to the above questions. CMS awaits the state's response to begin review of the preprint.

The control name for this preprint will be "FL_Fee_IPH.OPH4_Renewal_20221001-20230930." This control name must be used for all communication regarding the review of this preprint. CMS also requests that the state utilize this control name for the preprint when referencing this state directed payment within the applicable rate certification(s).

Thanks,

Laura

From: CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>
Sent: Wednesday, February 1, 2023 11:48 AM
To: Giering, Cole <cole.giering@ahca.myflorida.com>
Cc: Wallace, Tom <Thomas.Wallace@ahca.myflorida.com>; Sokoloski, Kristin <Kristin.Sokoloski@ahca.myflorida.com>; Barry, Joycee <Joycee.Barry@ahca.myflorida.com>; Cai, Jun <Jun.Cai@ahca.myflorida.com>; Lacroix, Rachel <Rachel.Lacroix@ahca.myflorida.com>; Giles, John (CMS/CMCS) <John.Giles1@cms.hhs.gov>; Snyder, Laura (CMS/CMCS) <Laura.Snyder1@cms.hhs.gov>; CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>
Subject: RE: FL_Fee.IPH.OPH4 RY 22/23 Renewal

Good Morning Cole,

Thank you for your email. CMS acknowledges receipt of the preprint and corresponding documents. We would like to request status updates regarding the state's anticipated timeframe to submit the following items:

1. Preprint amendment related to Florida's revised HCBS Spending Plan,
2. FL Proposal D 2020-2021 revised preprint amendment, and
3. The five state directed payment preprints for the October 1, 2022 through September 30, 2023 rating period.

Thank you,

Lovie

From: Giering, Cole <cole.giering@ahca.myflorida.com>
Sent: Tuesday, January 31, 2023 4:22 PM
To: CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>
Cc: Wallace, Tom <Thomas.Wallace@ahca.myflorida.com>; Sokoloski, Kristin <Kristin.Sokoloski@ahca.myflorida.com>; Barry, Joycee <Joycee.Barry@ahca.myflorida.com>; Cai, Jun <Jun.Cai@ahca.myflorida.com>; Lacroix, Rachel <Rachel.Lacroix@ahca.myflorida.com>
Subject: FL_Fee.IPH.OPH4 RY 22/23 Renewal

Good afternoon,

Please find attached the State of Florida's preprint for program year 3 of the hospital uniform rate increase directed payment program (CMS Provided State Directed Payment Identifier: FL_Fee.IPH.OPH4).

Please Note: we are in the process of updating the calculation of gross Medicaid shortfall and allocation percentages by provider class based on CY 2021 claims and encounter experience. When this analysis is complete, we will amend this preprint to include final values for:

- Updated gross payment amounts based on CY 2021 Medicaid shortfall calculations (impacting responses to prompts 4 and 23 - 27).
- Updated estimated uniform percentage increase amounts (impacting response to prompt 19.b)
- Non-federal funding sources and amounts (impacting response to prompts 35 and 36).

Best,

Cole Giering, MPH

Program Administrator

Rules and State Plan Unit

cole.giering@ahca.myflorida.com

+1 850-412-4691 (Office)

BUREAU OF MEDICAID POLICY

AHCA HQ Bidg 3 Rm 2307D

From:	"Endelman (he/him), Jonathan (CMS/CMCS)" <Jonathan.Endelman@cms.hhs.gov>
Sent:	2/3/2023 8:35:50 PM +0000
To:	"Arnold, Charlie (CMS/CMCS)" <Charlie.Arnold@cms.hhs.gov>; "Bonelli, Anna (CMS/CMCS)" <Anna.Bonelli@cms.hhs.gov>; "Clark, Jennifer (CMS/CMCS)" <Jennifer.Clark@cms.hhs.gov>; "Cuno, Richard (CMS/CMCS)" <Richard.Cuno@cms.hhs.gov>; "Fan, Kristin (CMS/CMCS)" <Kristin.Fan@cms.hhs.gov>; "Goldstein, Stuart (CMS/CMCS)" <STUART.GOLDSTEIN@cms.hhs.gov>; "Heitt, Melissa (CMS/FCHCO)" <Melissa.Heitt@cms.hhs.gov>; "Mosley, Elle (CMS/CMCS)" <larrica.mosley@cms.hhs.gov>; "Schoonover, Matthew (CMS/CMCS)" <matthew.schoonover@cms.hhs.gov>
Subject:	RE: RE: FL FMR Materials for Dan's Book
Attachments:	RE: FL FMR Materials for Dan's Book; RE: Discussion of Possible Proposed Tax Rule

Dear all,

There are two sets of materials that moved forward for Dan’s book. The first is on the Florida FMR. The second is on the possible proposed tax rule.

Best,

Jonathan

Jonathan Endelman, PhD

Social Science Research Analyst

Centers for Medicare & Medicaid Services (CMS)

Center for Medicaid and CHIP Services (CMCS)

Financial Management Group (FMG)

Division of Financial Policy (DFP)

410.786.4738

jonathan.endelman@cms.hhs.gov

7500 Security Blvd.

Mail Stop, S3-14-28

Baltimore, MD 21244-1850

From: Endelman (he/him), Jonathan (CMS/CMCS)
Sent: Friday, February 3, 2023 3:13 PM
To: Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Heitt, Melissa (CMS/FCHCO) <Melissa.Heitt@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Bonelli, Anna (CMS/CMCS) <Anna.Bonelli@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>
Subject: FW: FL FMR Materials for Dan's Book

Dear all,

Please find below the materials that have been placed in Dan’s book for tonight.

Best,

Jonathan

Jonathan Endelman, PhD

Social Science Research Analyst

Centers for Medicare & Medicaid Services (CMS)

Center for Medicaid and CHIP Services (CMCS)

Financial Management Group (FMG)

Division of Financial Policy (DFP)

410.786.4738

jonathan.endelman@cms.hhs.gov

7500 Security Blvd.

Mail Stop, S3-14-28

Baltimore, MD 21244-1850

From: adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Sent: Friday, February 3, 2023 3:07 PM

To: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>
Cc: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Barraza, Leticia (CMS/CMCS) <Leticia.Barraza@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Holligan, Ricardo (CMS/CMCS) <Ricardo.Holligan@cms.hhs.gov>
Subject: RE: FL FMR Materials for Dan's Book

Thanks, Rory.

Below is what moved forward:

2/3	**FMG:** Florida Tax FMR Follow-up **Purpose:** As a follow-up to 01/18 Joint Clearance, FMG has revised the draft FMR engagement letter (incorporating OCD feedback). We are also including the documentation request and timeline of the FMR and possible compliance enforcement.	• **Engagement Letter** • **Document and Information Request** • **Timeline**	**OCD/Dan**	**N/A**

From: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>
Sent: Friday, February 3, 2023 3:00 PM
To: adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Cc: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Barraza, Leticia (CMS/CMCS) <Leticia.Barraza@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Holligan, Ricardo (CMS/CMCS) <Ricardo.Holligan@cms.hhs.gov>
Subject: FL FMR Materials for Dan's Book

Hi Lia,

Per our discussion, for Dan’s book please see attached the FL FMR timeline Dan requested and an updated draft (incorporating OCD feedback) of the FMR engagement letter and documentation request.

Thanks,

Rory

From: "adams, lia (CMS/CMCS)" <Lia.Adams@cms.hhs.gov>
Sent: 2/3/2023 8:07:08 PM +0000
To: "Howe, Rory (CMS/CMCS)" <Rory.Howe@cms.hhs.gov>
CC: "Boston, Beverly (CMS/CMCS)" <Beverly.Boston@cms.hhs.gov>; "Maccarroll, Amber (CMS/CMCS)" <Amber.MacCarroll@cms.hhs.gov>; "Arnold, Charlie (CMS/CMCS)" <Charlie.Arnold@cms.hhs.gov>; "Goldstein, Stuart (CMS/CMCS)" <STUART.GOLDSTEIN@cms.hhs.gov>; "Endelman (he/him), Jonathan (CMS/CMCS)" <Jonathan.Endelman@cms.hhs.gov>; "Lane, Robert (CMS/CMCS)" <Robert.Lane@cms.hhs.gov>; "Barraza, Leticia (CMS/CMCS)" <Leticia.Barraza@cms.hhs.gov>; "Clark, Jennifer (CMS/CMCS)" <Jennifer.Clark@cms.hhs.gov>; "Holligan, Ricardo (CMS/CMCS)" <Ricardo.Holligan@cms.hhs.gov>
Subject: RE: RE: FL FMR Materials for Dan's Book

Thanks, Rory.

Below is what moved forward:

2/3	**FMG:** Florida Tax FMR Follow-up **Purpose:** As a follow-up to 01/18 Joint Clearance, FMG has revised the draft FMR engagement letter (incorporating OCD feedback). We are also including the documentation request and timeline of the FMR and possible compliance enforcement.	• **Engagement Letter** • **Document and Information Request** • **Timeline**	**OCD/Dan**	**N/A**

From: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>
Sent: Friday, February 3, 2023 3:00 PM
To: adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Cc: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>; Lane, Robert (CMS/CMCS) <Robert.Lane@cms.hhs.gov>; Barraza, Leticia (CMS/CMCS) <Leticia.Barraza@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Holligan, Ricardo (CMS/CMCS) <Ricardo.Holligan@cms.hhs.gov>
Subject: FL FMR Materials for Dan's Book

Hi Lia,

Per our discussion, for Dan’s book please see attached the FL FMR timeline Dan requested and an updated draft (incorporating OCD feedback) of the FMR engagement letter and documentation request.

Thanks,

Rory

From:	"Maccarroll, Amber (CMS/CMCS)" <Amber.MacCarroll@cms.hhs.gov>
Sent:	2/3/2023 8:04:41 PM +0000
To:	"Endelman (he/him), Jonathan (CMS/CMCS)" <Jonathan.Endelman@cms.hhs.gov>; "adams, lia (CMS/CMCS)" <Lia.Adams@cms.hhs.gov>; "Howe, Rory (CMS/CMCS)" <Rory.Howe@cms.hhs.gov>
CC:	"Boston, Beverly (CMS/CMCS)" <Beverly.Boston@cms.hhs.gov>; "Arnold, Charlie (CMS/CMCS)" <Charlie.Arnold@cms.hhs.gov>; "Goldstein, Stuart (CMS/CMCS)" <STUART.GOLDSTEIN@cms.hhs.gov>; "Fan, Kristin (CMS/CMCS)" <Kristin.Fan@cms.hhs.gov>; "Silanskis, Jeremy (CMS/CMCS)" <Jeremy.Silanskis@cms.hhs.gov>
Subject:	RE: RE: Discussion of Possible Proposed Tax Rule

Hi Jonathan –

Good catch. The only comment we see is on slide 8 – and yes, we should delete that. Are you or Lia able to do so?

Let us know if there are other comments we missed.

Thanks, Amber

From: Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>
Sent: Friday, February 3, 2023 3:01 PM
To: adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>; Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>
Cc: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>
Subject: RE: Discussion of Possible Proposed Tax Rule

Lia and Stuart,

I went in and updated the links Lia provided with the correct information. That should take care of it. There are still comments in the PowerPoint. Let me know if you think we should delete those or leave them.

Best,

Jonathan

Jonathan Endelman, PhD

Social Science Research Analyst

Centers for Medicare & Medicaid Services (CMS)

Center for Medicaid and CHIP Services (CMCS)

Financial Management Group (FMG)

Division of Financial Policy (DFP)

410.786.4738

jonathan.endelman@cms.hhs.gov

7500 Security Blvd.

Mail Stop, S3-14-28

Baltimore, MD 21244-1850

From: adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Sent: Friday, February 3, 2023 2:51 PM
To: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>
Cc: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>
Subject: RE: Discussion of Possible Proposed Tax Rule

This is what moved forward to Dan's book. Please let me know if needs to be revised.

2/3	**FMG: Provider Taxes M1/M2 Test Deep Dive** **Purpose:** As a follow-up to 01/26 Joint Clearance, FMG	**Provider Taxes – M1/M2 Test Deep Dive**	**OCD/Dan**	**ASAP**

	has prepared slides on a deep dive of the M1/M2 Test with examples. FMG is also providing very detailed underlying supporting calculations for the three examples in the slides if Dan is interested. FMG is seeking guidance from OCD on whether we should move forward drafting the NPRM. FMG is available to meet to walk through the slide deck and/or the detailed calculations.	*** very detailed calculations that we are sharing only if you want to review them** • **Hawaii** • **Nevada** • **California**		

From: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>
Sent: Friday, February 3, 2023 2:35 PM
To: adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Cc: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>
Subject: FW: Discussion of Possible Proposed Tax Rule

Per our conversation

From: Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>
Sent: Friday, February 3, 2023 11:12 AM
To: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>
Cc: Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Bonelli, Anna (CMS/CMCS) <Anna.Bonelli@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>; Truffer, Christopher (CMS/OACT) <Christopher.Truffer@cms.hhs.gov>; Sagandykov, Makhmud (CMS/OACT) <Makhmud.Sagandykov@cms.hhs.gov>; Fan, Kristin (CMS/CMCS)

<Kristin.Fan@cms.hhs.gov>
Subject: RE: Discussion of Possible Proposed Tax Rule

Rory,

While the Arizona NF tax with an effective date of October 1, 2021 did not pass the M1/M2 the Arizona NF tax with an effective date of October 1, 2022 does just barely pass the M1/M2 test with a value of .9519. This is the case with many of the NF taxes that don't pass the M1/M2. They just barely don't pass and could pass if slightly modified. I could put AZ back as the example in the PowerPoint if desired using the October 1, 2022 tax.

Best,

Jonathan

Jonathan Endelman, PhD

Social Science Research Analyst

Centers for Medicare & Medicaid Services (CMS)

Center for Medicaid and CHIP Services (CMCS)

Financial Management Group (FMG)

Division of Financial Policy (DFP)

410.786.4738

jonathan.endelman@cms.hhs.gov

7500 Security Blvd.

Mail Stop, S3-14-28

Baltimore, MD 21244-1850

From: Endelman (he/him), Jonathan (CMS/CMCS)
Sent: Friday, February 3, 2023 10:10 AM
To: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>
Cc: Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Bonelli, Anna (CMS/CMCS) <Anna.Bonelli@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>;

Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>; Truffer, Christopher (CMS/OACT) <Christopher.Truffer@cms.hhs.gov>; Sagandykov, Makhmud (CMS/OACT) <Makhmud.Sagandykov@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>
Subject: RE: Discussion of Possible Proposed Tax Rule

Dear Rory,

Please see attached for a PowerPoint presentation that answers your questions as well as supporting spreadsheets. We have included additional details for how we calculated M1 and M2 as requested. CA's MCO tax was on "member months" and the presentation had been changed to "covered lives." I am not sure if that is synonymous. We had to take out the AZ example and replace it with Hawaii because AZ NF does not pass. It comes out to 0.93. We had inadvertently switched M1 and M2 in the original calculation. I believe the Center Director has a valid point that the M1 M2 could be disruptive to states with existing NF taxes. North Carolina, California, Arizona, and Pennsylvania would all not pass the M1/M2 with value of 0.95. However, we are not currently proposing to apply the M1/M2 to these taxes. Our options are as follows:

1. Apply M1/M2 only to MCO taxes
2. Apply M1/M2 only to Medicaid/non-Medicaid broken down taxes.
3. Give states the choice of M1/M2 or undue burden for Medicaid/non-Medicaid broken down taxes.

I think we have discarded the option of applying the M1/M2 to all B1/B2 taxes. None of the remaining options would involve us imposing the M1/M2 on any NF taxes. These documents are also attached to the meeting on Monday.

Best,

Jonathan

Jonathan Endelman, PhD

Social Science Research Analyst

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Baltimore, MD 21244-1850

From: Endelman (he/him), Jonathan (CMS/CMCS)
Sent: Thursday, February 2, 2023 1:31 PM
To: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>
Cc: Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Bonelli, Anna (CMS/CMCS) <Anna.Bonelli@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>; Truffer, Christopher (CMS/OACT) <Christopher.Truffer@cms.hhs.gov>; Sagandykov, Makhmud (CMS/OACT) <Makhmud.Sagandykov@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>
Subject: RE: Discussion of Possible Proposed Tax Rule

Thank you Rory. We will take a look at the comments and edits and respond by tomorrow in preparation for the meeting on Monday. We will also include the spreadsheets that are the basis for the PowerPoint for reference and in case the Center Director wants to take a closer look at them.

Best,

Jonathan

Jonathan Endelman, PhD

Social Science Research Analyst

Centers for Medicare & Medicaid Services (CMS)

Center for Medicaid and CHIP Services (CMCS)

Financial Management Group (FMG)

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410.786.4738

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Mail Stop, S3-14-28

Baltimore, MD 21244-1850

From: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>
Sent: Thursday, February 2, 2023 1:27 PM
To: Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>
Cc: Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Bonelli, Anna (CMS/CMCS) <Anna.Bonelli@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>; Truffer, Christopher (CMS/OACT) <Christopher.Truffer@cms.hhs.gov>; Sagandykov, Makhmud (CMS/OACT) <Makhmud.Sagandykov@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>
Subject: RE: Discussion of Possible Proposed Tax Rule

Hi Charlie,

Thanks to Jonathan for pulling this together so quickly. Per our discussion, please see attached some suggested edits and three comments requesting that we show a little bit more of the M1/M2 calculation for each example (i.e., the "standard" tax, the "loophole" tax and the "standard tax with breaks"). I think this could easily happen on the existing slide for each example. As discussed, please also share the underlying Excel spreadsheets supporting each example. I plan to share with Dan and provide the option for him to dive in separately or for us to walk through them live. Let me know if you have any questions.

Thanks again,

Rory

From: Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>
Sent: Monday, January 30, 2023 12:53 PM
To: Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Bonelli, Anna (CMS/CMCS) <Anna.Bonelli@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>; Truffer, Christopher (CMS/OACT) <Christopher.Truffer@cms.hhs.gov>; Sagandykov, Makhmud (CMS/OACT) <Makhmud.Sagandykov@cms.hhs.gov>
Cc: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>
Subject: RE: Discussion of Possible Proposed Tax Rule

Thanks Jonathan. I added some comments about whether we should distinguish the notion between "standard" and "bad". What we consider standard is where the rates within an individual provider do not vary – rather rates vary about the characteristic of the totality of the provider.

From: Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>
Sent: Friday, January 27, 2023 3:28 PM
To: Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Bonelli, Anna (CMS/CMCS) <Anna.Bonelli@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>; Truffer, Christopher (CMS/OACT) <Christopher.Truffer@cms.hhs.gov>; Sagandykov, Makhmud (CMS/OACT) <Makhmud.Sagandykov@cms.hhs.gov>
Cc: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>
Subject: RE: Discussion of Possible Proposed Tax Rule

Dear all,

Please see attached for the PowerPoint presentation for Dan. As always, please edit to improve if you see anything that can be made better. Please use the SharePoint link provided below for any edits, comments, or changes. I am quite proud of how this turned out. I hope that it is useful. We will use this as the basis for Tuesday's discussion. The PowerPoint shows how B1/B2 and M1/M2 would work in three instances:

1. "Standard" tax waivers that we have approved repeatedly that we have approved repeatedly like Nevada's NF tax. These taxes continue to pass the B1/B2 and the M1/M2
2. "Bad" tax waivers that exploit the statistical loophole and pose an undue burden of the Medicaid program. These taxes pass the B1/B2 and, by design, fail the M1/M2.
3. Taxes that give "breaks" to **some** low Medicaid utilization providers such as CCRCs or small facilities, but balance those breaks out with breaks to **other** higher Medicaid utilizing facilities. **These facilities continue to pass the M1/M2 just as they pass the B1/B2.** This will allay OCD's fear that states can never give breaks to some low Medicaid utilization facilities for policy reasons and pass the M1/M2. This is not the case.

An Illustration of the M1 M2 Test in Action with Concrete Examples

I look forward to discussing this on Tuesday

Best,

Jonathan

From: Endelman (he/him), Jonathan (CMS/CMCS)
Sent: Friday, January 27, 2023 12:40 PM
To: Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Bonelli, Anna (CMS/CMCS) <Anna.Bonelli@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>
Cc: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>
Subject: RE: Discussion of Possible Proposed Tax Rule

Hello all,

I wanted to give an update. I met today with Kristin, Jeremy, and Rory to follow up on Dan's Feedback from 1/25/2023. Rory said that we should come up with a series of examples to show Dan to illustrate how the M1/M2 works. I was thinking of three examples:

1. An illustration of how a "standard" health care-related tax we have passes the M1/M2 test. I was thinking the Nevada NF tax.
2. An illustration of how a "clearly bad" tax that exploits the statistical loophole fails the M1/M2. I was thinking of the California MCO tax because Dan is very familiar with that example.
3. An illustration of how states can still exclude or tax at a lower rate certain groups of providers, such as CCRCs, and still manage to pass the M1/M2 like they currently pass the B1/B2 by giving other taxes a "break." I was thinking Michigan's nursing facility tax since it gives a "break" to CCRC and facilities with fewer than 40 beds, which both have low Medicaid, but makes up for it by taking higher Medicaid facilities a lower tax rate than all other facilities.
4. I am thinking that the best, i.e. most effective way to do this is a PowerPoint presentation where we show:

- The structure of the tax for each of these taxes by taking a "snip" from the tax waiver approval letters. I don't think Dan wants to see actual spreadsheets and, in any case, it would be very difficult to "share" spreadsheets on Zoom anyway. You would constantly need to start and stop sharing when you move from spreadsheet to spreadsheet. We can say that if he wants to take a look at the spreadsheets, we can email them to him.
- The M1/M2 for each of these taxes by taking a "snip" of the Excel spreadsheets.
- In the case of the Michigan NF tax, a "snip" of the Goldstein-Fan test that shows the tax rates and Medicaid utilization for all taxpayer groups. It would show that this passes the M1/M2 test despite giving a "break" to CCRCs and under 40 beds (low Medicaid) by making up for it with a "break" for high Medicaid facilities.

We are thinking that it would be beneficial to have a smaller group discussion apart from joint/cross cutting clearance with more time to explain. I think it would also be beneficial to invite OACT again. We have a meeting to discuss this on Tuesday. I will have the PowerPoint ready by then. Thanks.

Best,

Jonathan

-----Original Appointment-----
From: Endelman (he/him), Jonathan (CMS/CMCS)
Sent: Friday, January 20, 2023 11:17 AM
To: Endelman (he/him), Jonathan (CMS/CMCS); Arnold, Charlie (CMS/CMCS); Bonelli, Anna (CMS/CMCS); Clark, Jennifer (CMS/CMCS); Cuno, Richard (CMS/CMCS); Fan, Kristin (CMS/CMCS); Goldstein, Stuart (CMS/CMCS); Mosley, Elle (CMS/CMCS)

Subject: Discussion of Possible Proposed Tax Rule
When: Tuesday, January 31, 2023 9:00 AM-9:30 AM (UTC-05:00) Eastern Time (US & Canada).
Where:
https://cms.zoomgov.com/j/ (b)(5)

This is a meeting to discuss the possible proposed tax rule.

Best,

Jonathan

Join ZoomGov Meeting

https://cms.zoomgov.com (b)(5)

Meeting ID: 160 108 9740

Password: 623452

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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.

From: CMS State Directed Payment (b)(5)

(b)(5)

Sent: 11/28/2022 4:18:01 PM +0000

To: "Endelman (he/him), Jonathan (CMS/CMCS)" (b)(5)

(b)(5)

(b)(5) "Fan, Kristin (CMS/CMCS)" < (b)(5)

(b)(5)

(b)(5)

(b)(5) "Teal, Lela (CMS/CMCS)" < (b)(5)

(b)(5)

(b)(5) ; "Arnold, Charlie (CMS/CMCS)" (b)(5)

(b)(5) "Bonelli, Anna (CMS/CMCS)" (b)(5)

(b)(5)

(b)(5) "Burns, James (CMS/CMCS)" (b)(5)

(b)(5)

(b)(5) "Clark, Jennifer (CMS/CMCS)" (b)(5)

(b)(5) "Cuno, Richard (CMS/CMCS)" < (b)(5)

(b)(5)

(b)(5) oldstein, Stuart (CMS/CMCS)" < (b)(5)

(b)(5)

CC: "Snyder, Laura (CMS/CMCS)" <Laura.Snyder1@cms.hhs.gov>; CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>

Subject: RE: RE: North Carolina

Attachments: RE: [External] NC_Fee_OPH_Renewal_20220701-20230630

Hi Jonathan,

Happy Monday! North Carolina is requesting a status update regarding their tax waiver submission (please see attachment). Does FMG have follow questions for the state? I'll add this topic the DMCP/FMG meeting agenda for tomorrow.

Thanks,

Lovie

From: Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>
Sent: Tuesday, November 1, 2022 1:39 PM
To: Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>; CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Bonelli, Anna (CMS/CMCS) <Anna.Bonelli@cms.hhs.gov>; Burns, James (CMS/CMCS) <James.Burns@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>
Subject: FW: North Carolina

Dear all,

I started to review North Carolina's IP hospital services and OP hospital services health care-related taxes. I can already tell this one is going to require a lot of work before it gets to something approaching a tax for which we could recommend approval. It's certainly not the most straight forward or easily understandable submission we have ever received. It's been a decade since the state has come in to us with a tax waiver submission and it shows. I don't think someone has worked on this data in a long time. In general, the more recent a tax waiver approval is, the better shape it tends to be. In an ideal world, states would go in every so often to make sure the data is correct, clean things up, etc. We had a section of MFAR that had an expiration date of three years for tax waivers that I think would have partially addressed this issue. Please see attached for questions and the submission from the State. Please also see attached for the tax waiver approval from 2011. Also, it would be good to hear more detail from Rory about what he knows specifically about the pooling and redistribution mechanism that we believe may be attached to this tax and the extant hold harmless concerns. I am copying DMCP for awareness. I will also copy when we send questions to the state.

Best,

Jonathan

Jonathan Endelman

Social Science Research Analyst

Centers for Medicare & Medicaid Services (CMS)

Center for Medicaid and CHIP Services (CMCS)

Financial Management Group (FMG)

Division of Financial Policy (DFP)

410.786.4738

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Baltimore, MD 21244-1850

From: Endelman (he/him), Jonathan (CMS/CMCS)
Sent: Friday, October 7, 2022 2:35 PM
To: cecilia.williams@dhhs.nc.gov; Betty.J.Staton@dhhs.nc.gov
Cc: Teal, Lela (CMS/CMCS) <Lela.Teal@cms.hhs.gov>; CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Bonelli, Anna (CMS/CMCS) <Anna.Bonelli@cms.hhs.gov>; Burns, James (CMS/CMCS) <James.Burns@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>
Subject: North Carolina

Good afternoon Ms. Staton,

My name is Jonathan Endelman and I am a member of the tax team located in the Financial Management Group (FMG) at CMS. We are responsible for reviewing all health care-related tax waivers of the broad-based and uniformity requirements. We are acknowledging receipt of the State's submission of 10/6/2022 requesting a waiver of the broad-based and uniformity requirements for its inpatient and outpatient hospital services taxes. We will be in touch in case we have any questions or concerns over the course of our review. In the future, please address all tax waivers to:

Mr. Rory Howe, Director

Financial Management Group

Center for Medicaid and CHIP Services

U.S. Department of Health & Human Services

7500 Security Boulevard

Baltimore, Maryland 21244-1850

Thank you.

Best,

Jonathan

From: "Staton, Betty J" <Betty.J.Staton@dhhs.nc.gov>
Sent: 11/22/2022 6:54:55 PM +0000
To: "Williams, Cecilia" <cecilia.williams@dhhs.nc.gov>; CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>
CC: "Graves, Donald (CMS/CMCS)" <Donald.Graves@cms.hhs.gov>; "Sandoe, Emma" <Emma.Sandoe@dhhs.nc.gov>; "Abbott, Sarah (CMS/CMCS)" <Sarah.Abbott@cms.hhs.gov>; "Davis, Lovie (CMS/CMCS)" <Lovie.Davis@cms.hhs.gov>
Subject: RE: RE: [External] NC_Fee_OPH_Renewal_20220701-20230630

Good afternoon,
Does CMS need additional information regarding this submission?
Thanks,

Betty J. Staton, MBA
State Plan and Amendments Manager
NC Medicaid (Benefits and Services)
Mobile

(b)(6)

Find a vaccine location, get questions answered and more at YourSpotYourShot.nc.gov.

From: Williams, Cecilia <cecilia.williams@dhhs.nc.gov>
Sent: Thursday, October 6, 2022 7:22 AM
To: Staton, Betty J <Betty.J.Staton@dhhs.nc.gov>; CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>
Cc: Graves, Donald (CMS/CMCS) <Donald.Graves@cms.hhs.gov>; Sandoe, Emma <Emma.Sandoe@dhhs.nc.gov>; Abbott, Sarah (CMS/CMCS) <Sarah.Abbott@cms.hhs.gov>; Davis, Lovie (CMS/CMCS) <Lovie.Davis@cms.hhs.gov>
Subject: RE: [External] NC_Fee_OPH_Renewal_20220701-20230630

Good morning,
Attached are two submissions, recognizing different CMS areas of responsibility.

1. Standard submission to CMS for the Hospital Tax Waiver request. This is pursuant to CMS guidance in their communication on September 13, 2022 as part of this subject preprint. This submission should include:
    a. Provider Tax Waiver Letter (pdf)
    b. NC B1 / B2 Test (Excel)
    c. NCGS 108a, Article 7B (pdf)
2. Secondly, the same three documents plus the response to the Round 4 Questions (Word) for the Preprint Team.

Thanks,

Cecilia Williams
State Plan and Amendments Coordinator
NC Medicaid
Division of Health Benefits
NC Department of Health and Human Services

Vax Up OR Mask Up

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Mobile: (b)(6)
Office: (919) 527-7105
Cecilia.Williams@dhhs.nc.gov
820 S. Boylan Ave., McBryde Building
1950 Mail Service Center
Raleigh, NC 27699-1950
Twitter | Facebook | YouTube | LinkedIn

From: Staton, Betty J <Betty.J.Staton@dhhs.nc.gov>
Sent: Thursday, September 22, 2022 3:08 PM
To: CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>; Williams, Cecilia <cecilia.williams@dhhs.nc.gov>
Cc: Graves, Donald (CMS/CMCS) <Donald.Graves@cms.hhs.gov>; Sandoe, Emma <Emma.Sandoe@dhhs.nc.gov>; Bush, Melanie E <melanie.bush@dhhs.nc.gov>; Abbott, Sarah (CMS/CMCS) <Sarah.Abbott@cms.hhs.gov>
Subject: RE: [External] NC_Fee_OPH_Renewal_20220701-20230630

Thanks Lovie, we appreciate it.

Betty J. Staton, MBA
State Plan and Amendments Manager
NC Medicaid (Benefits and Services)
Mobile (b)(6)

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From: CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>
Sent: Thursday, September 22, 2022 2:33 PM
To: Staton, Betty J <Betty.J.Staton@dhhs.nc.gov>; Williams, Cecilia <cecilia.williams@dhhs.nc.gov>
Cc: Graves, Donald (CMS/CMCS) <Donald.Graves@cms.hhs.gov>; Sandoe, Emma <Emma.Sandoe@dhhs.nc.gov>; Bush, Melanie E <melanie.bush@dhhs.nc.gov>; Abbott, Sarah (CMS/CMCS) <Sarah.Abbott@cms.hhs.gov>; CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>
Subject: RE: [External] NC_Fee_OPH_Renewal_20220701-20230630

Good Afternoon Betty,
An extension until October 3, 2022 is granted.
Thank you,
Lovie

From: Staton, Betty J <Betty.J.Staton@dhhs.nc.gov>
Sent: Thursday, September 22, 2022 12:59 PM
To: Williams, Cecilia <cecilia.williams@dhhs.nc.gov>; CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>
Cc: Graves, Donald (CMS/CMCS) <Donald.Graves@cms.hhs.gov>; Dawson, Rick (CMS/CMCS) <Rick.Dawson@cms.hhs.gov>; Sandoe, Emma <Emma.Sandoe@dhhs.nc.gov>; Bush, Melanie E <melanie.bush@dhhs.nc.gov>; Abbott, Sarah (CMS/CMCS) <Sarah.Abbott@cms.hhs.gov>
Subject: RE: [External] NC_Fee_OPH_Renewal_20220701-20230630

Hi Lovie,
We are requesting an extension until 10/3/22 to submit responses.
Thanks,
Betty J. Staton, MBA
State Plan and Amendments Manager
NC Medicaid (Benefits and Services)
Mobile (b)(6)

Find a vaccine location, get questions answered and more at YourSpotYourShot.nc.gov.

From: Williams, Cecilia <cecilia.williams@dhhs.nc.gov>
Sent: Tuesday, September 13, 2022 1:52 PM
To: CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>; Staton, Betty J <Betty.J.Staton@dhhs.nc.gov>
Cc: Graves, Donald (CMS/CMCS) <Donald.Graves@cms.hhs.gov>; Dawson, Rick (CMS/CMCS) <Rick.Dawson@cms.hhs.gov>; Sandoe, Emma <Emma.Sandoe@dhhs.nc.gov>; Bush, Melanie E <melanie.bush@dhhs.nc.gov>; Abbott, Sarah (CMS/CMCS) <Sarah.Abbott@cms.hhs.gov>
Subject: RE: [External] NC_Fee_OPH_Renewal_20220701-20230630

Hi, Lovie!
This has been received and will be shared with the NC teams.
Thanks,
Cecilia Williams
State Plan and Amendments Coordinator
NC Medicaid
Division of Health Benefits
NC Department of Health and Human Services

Find a vaccine location, get questions answered and more at YourSpotYourShot.nc.gov.
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From: CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>
Sent: Tuesday, September 13, 2022 1:49 PM
To: Williams, Cecilia <cecilia.williams@dhhs.nc.gov>; Staton, Betty J <Betty.J.Staton@dhhs.nc.gov>
Cc: Graves, Donald (CMS/CMCS) <Donald.Graves@cms.hhs.gov>; Dawson, Rick (CMS/CMCS) <Rick.Dawson@cms.hhs.gov>; Sandoe, Emma <Emma.Sandoe@dhhs.nc.gov>; Bush, Melanie E <melanie.bush@dhhs.nc.gov>; Abbott, Sarah (CMS/CMCS) <Sarah.Abbott@cms.hhs.gov>; CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>
Subject: RE: [External] NC_Fee_OPH_Renewal_20220701-20230630

Good Afternoon,
Please find attached CMSâ€™ Round 4 questions and corresponding documents regarding this preprint. Please provide responses by September 23, 2022 if possible. If you have any questions please let us know.
Thank you,
Lovie

From: CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>
Sent: Wednesday, August 31, 2022 1:13 PM
To: Williams, Cecilia <cecilia.williams@dhhs.nc.gov>; Staton, Betty J <Betty.J.Staton@dhhs.nc.gov>
Cc: Graves, Donald (CMS/CMCS) <Donald.Graves@cms.hhs.gov>; Dawson, Rick D.(CMS/CMCS) <Rick.Dawson@cms.hhs.gov>; Sandoe, Emma <Emma.Sandoe@dhhs.nc.gov>; Bush, Melanie E <melanie.bush@dhhs.nc.gov>; Kahnowitz, Michael (CMS/CMCS) <Michael.Kahnowitz@cms.hhs.gov>; CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>
Subject: RE: [External] NC_Fee_OPH_Renewal_20220701-20230630
Good Afternoon Cecelia,
CMS acknowledges receipt of the stateâ€™s responses and corresponding document.
Thank you,
Lovie
From: Williams, Cecilia <cecilia.williams@dhhs.nc.gov>
Sent: Friday, August 26, 2022 10:48 AM
To: Staton, Betty J <Betty.J.Staton@dhhs.nc.gov>; CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>; Davis, Lovie (CMS/CMCS) <Lovie.Davis@cms.hhs.gov>
Cc: Graves, Donald (CMS/CMCS) <Donald.Graves@cms.hhs.gov>; Dawson, Rick D.(CMS/CMCS) <Rick.Dawson@cms.hhs.gov>; Sandoe, Emma <Emma.Sandoe@dhhs.nc.gov>; Bush, Melanie E <melanie.bush@dhhs.nc.gov>; Kahnowitz, Michael (CMS/CMCS) <Michael.Kahnowitz@cms.hhs.gov>
Subject: RE: [External] NC_Fee_OPH_Renewal_20220701-20230630

Good morning, everyone!
Please see the attached from the state. Once again, thanks for the extension.

Cecilia Williams
State Plan and Amendments Coordinator
NC Medicaid
Division of Health Benefits
NC Department of Health and Human Services

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From: Staton, Betty J <Betty.J.Staton@dhhs.nc.gov>
Sent: Thursday, August 18, 2022 3:46 PM
To: CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>; Williams, Cecilia <cecilia.williams@dhhs.nc.gov>
Cc: Graves, Donald (CMS/CMCS) <Donald.Graves@cms.hhs.gov>; Dawson, Rick D.(CMS/CMCS) <Rick.Dawson@cms.hhs.gov>; Sandoe, Emma <Emma.Sandoe@dhhs.nc.gov>; Bush, Melanie E <melanie.bush@dhhs.nc.gov>; Kahnowitz, Michael (CMS/CMCS) <Michael.Kahnowitz@cms.hhs.gov>
Subject: RE: [External] NC_Fee_OPH_Renewal_20220701-20230630
Thanks Lovie.

Betty J. Staton, MBA
State Plan and Amendments Manager

NC Medicaid (Benefits and Services)
Mobile (b)(6)

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From: CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>
Sent: Thursday, August 18, 2022 3:41 PM
To: Williams, Cecilia <cecilia.williams@dhhs.nc.gov>; Staton, Betty J <Betty.J.Staton@dhhs.nc.gov>
Cc: Graves, Donald (CMS/CMCS) <Donald.Graves@cms.hhs.gov>; Dawson, Rick D.(CMS/CMCS) <Rick.Dawson@cms.hhs.gov>; Sandoe, Emma <Emma.Sandoe@dhhs.nc.gov>; Bush, Melanie E <melanie.bush@dhhs.nc.gov>; Kahnowitz, Michael (CMS/CMCS) <Michael.Kahnowitz@cms.hhs.gov>; CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>
Subject: RE: [External] NC_Fee_OPH_Renewal_20220701-20230630

Hi Cecilia,
Thank you for your email. An extension until 8/26 is fine.
Thank you,
Lovie

From: Williams, Cecilia <cecilia.williams@dhhs.nc.gov>
Sent: Thursday, August 18, 2022 2:33 PM
To: CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>; Staton, Betty J <Betty.J.Staton@dhhs.nc.gov>
Cc: Graves, Donald (CMS/CMCS) <Donald.Graves@cms.hhs.gov>; Dawson, Rick D.(CMS/CMCS) <Rick.Dawson@cms.hhs.gov>; Sandoe, Emma <Emma.Sandoe@dhhs.nc.gov>; Bush, Melanie E <melanie.bush@dhhs.nc.gov>; Kahnowitz, Michael (CMS/CMCS) <Michael.Kahnowitz@cms.hhs.gov>
Subject: RE: [External] NC_Fee_OPH_Renewal_20220701-20230630

Hi Lovie!
Our team need additional time to submit the questions mentioned below and would like to request an extension until 8/26.
Please advise if this is acceptable.
Thanks,

Cecilia Williams
State Plan and Amendments Coordinator
NC Medicaid
Division of Health Benefits
NC Department of Health and Human Services

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From: CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>
Sent: Friday, August 12, 2022 11:31 AM
To: Williams, Cecilia <cecilia.williams@dhhs.nc.gov>; Staton, Betty J <Betty.J.Staton@dhhs.nc.gov>
Cc: Graves, Donald (CMS/CMCS) <Donald.Graves@cms.hhs.gov>; Dawson, Rick D.(CMS/CMCS) <Rick.Dawson@cms.hhs.gov>; Sandoe, Emma <Emma.Sandoe@dhhs.nc.gov>; Bush, Melanie E <melanie.bush@dhhs.nc.gov>; Kahnowitz, Michael (CMS/CMCS) <Michael.Kahnowitz@cms.hhs.gov>; CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>
Subject: RE: [External] NC_Fee_OPH_Renewal_20220701-20230630

Hi Cecilia,
Please find attached CMSâ€™ Round 3 questions and corresponding documents regarding this preprint. Please provide responses by August 22, 2022 if possible. If you have any questions please let us know.
Thank you,
Lovie

From: Williams, Cecilia <cecilia.williams@dhhs.nc.gov>
Sent: Monday, July 18, 2022 1:41 PM
To: CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>; Staton, Betty J <Betty.J.Staton@dhhs.nc.gov>
Cc: Graves, Donald (CMS/CMCS) <Donald.Graves@cms.hhs.gov>; Dawson, Rick D.(CMS/CMCS) <Rick.Dawson@cms.hhs.gov>; Sandoe, Emma <Emma.Sandoe@dhhs.nc.gov>; Bush, Melanie E <melanie.bush@dhhs.nc.gov>; Kahnowitz, Michael (CMS/CMCS) <Michael.Kahnowitz@cms.hhs.gov>
Subject: RE: [External] RE: NC_Fee_OPH_Renewal_20220701-20230630

Hi All,
Please find the attached from the NC team.
Thanks so much!

Cecilia Williams
State Plan and Amendments Coordinator
NC Medicaid
Division of Health Benefits
NC Department of Health and Human Services

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Cecilia.Williams@dhhs.nc.gov
820 S. Boylan Ave., McBryde Building
1950 Mail Service Center
Raleigh, NC 27699-1950
Twitter | Facebook | YouTube | LinkedIn

From: Williams, Cecilia
Sent: Thursday, July 7, 2022 2:24 PM
To: CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>; Staton, Betty J <Betty.J.Staton@dhhs.nc.gov>
Cc: Graves, Donald (CMS/CMCS) <Donald.Graves@cms.hhs.gov>; Dawson, Rick D.(CMS/CMCS) <Rick.Dawson@cms.hhs.gov>; Sandoe, Emma <Emma.Sandoe@dhhs.nc.gov>; Bush, Melanie E <melanie.bush@dhhs.nc.gov>; Kahnowitz, Michael (CMS/CMCS) <Michael.Kahnowitz@cms.hhs.gov>
Subject: RE: [External] RE: NC_Fee_OPH_Renewal_20220701-20230630

Thanks, Lovie!
Received by the state..

Cecilia Williams
State Plan and Amendments Coordinator
NC Medicaid
Division of Health Benefits
NC Department of Health and Human Services

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From: CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>
Sent: Thursday, July 7, 2022 2:21 PM
To: Williams, Cecilia <cecilia.williams@dhhs.nc.gov>; Staton, Betty J <Betty.J.Staton@dhhs.nc.gov>
Cc: Graves, Donald (CMS/CMCS) <Donald.Graves@cms.hhs.gov>; Dawson, Rick D.(CMS/CMCS) <Rick.Dawson@cms.hhs.gov>; Sandoe, Emma <Emma.Sandoe@dhhs.nc.gov>; Bush, Melanie E <melanie.bush@dhhs.nc.gov>; Kahnowitz, Michael (CMS/CMCS) <Michael.Kahnowitz@cms.hhs.gov>; CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>
Subject: [External] RE: NC_Fee_OPH_Renewal_20220701-20230630

Good Afternoon,
Please find attached CMSâ€™ Round 2 questions regarding this preprint. Please provide responses by July 18, 2022 if possible. If you have any questions please let us know.
Thank you,
Lovie

From: Williams, Cecilia <cecilia.williams@dhhs.nc.gov>
Sent: Tuesday, June 7, 2022 3:45 PM
To: CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>; Staton, Betty J <Betty.J.Staton@dhhs.nc.gov>
Cc: Graves, Donald (CMS/CMCS) <Donald.Graves@cms.hhs.gov>; Dawson, Rick D.(CMS/CMCS) <Rick.Dawson@cms.hhs.gov>; Sandoe, Emma <Emma.Sandoe@dhhs.nc.gov>; Bush, Melanie E <melanie.bush@dhhs.nc.gov>; Kahnowitz, Michael (CMS/CMCS) <Michael.Kahnowitz@cms.hhs.gov>; Davis, Lovie (CMS/CMCS) <Lovie.Davis@cms.hhs.gov>
Subject: RE: [External] RE: NC_Fee_OPH_Renewal_20220701-20230630

Hi,
Please find the attached documents from the NC Team.
Thanks!

Cecilia Williams
State Plan and Amendments Coordinator
NC Medicaid
Division of Health Benefits
NC Department of Health and Human Services

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Raleigh, NC 27699-1950

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From: "Sebree, Fredrick (CMS/CMCS)" (b)(5)

(b)(5)

Sent: 4/3/2023 12:36:40 PM +0000
To: "Endelman (he/him), Jonathan (CMS/CMCS)" <Jonathan.Endelman@cms.hhs.gov>
Subject: FW: FW: SPA MO 22-0025 NF rebase
Attachments: B1B2 - Actual SFY 2022 & Projections SFY 2023.xlsx; State Response to CMS email dated 3-29-23.docx; MPP Addendum A.pdf

Good morning Jonathan,

Responses from the state regarding the NFRA is attached. Looks like they are referencing the MPP for the distribution.

Fredrick J. Sebree

Accountant

Division of Reimbursement Review

Centers for Medicare and Medicaid Services

600 East Monroe Street, Room 215

Springfield, Illinois 62701

RightFax: 443-380-5221

Email: Fredrick.sebree@cms.hhs.gov

From: Brite, Tony <Tony.Brite@dss.mo.gov>
Sent: Friday, March 31, 2023 12:13 PM
To: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>
Cc: Crump, Marissa <Marissa.Crump@dss.mo.gov>; Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>; Percy, Nate <Nate.Percy@dss.mo.gov>
Subject: Fwd: SPA MO 22-0025 NF rebase

Fred,

Please find the responses and attachments related to the questions below.

Thanks,

Tony

From: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>
Sent: Wednesday, March 29, 2023 7:45 AM
To: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>; Crump, Marissa <Marissa.Crump@dss.mo.gov>
Cc: Brite, Tony <Tony.Brite@dss.mo.gov>
Subject: RE: SPA MO 22-0025 NF rebase

Good morning,

MO 22-0025 has been presented to leadership and the SPA is good to go but our tax team wanted to touch base on the NFRA. Below are a few questions/confirmations:

1. To confirm, the Nursing Facility Reimbursement Allowance (NFRA) does not have any redistributions. Is that correct?
2. Is the NFRA broad-based and uniform? Are any providers excluded? Are any providers taxed at different rates?
3. Using the most recent data available, how much does the state anticipate raising from the NFRA?
4. For the purposes of the 6% test, what percentage of net patient revenue for the permissible class is raised by all taxes on the services of nursing facilities, including the NFRA?

Thanks again

Fredrick J. Sebree

Accountant

Division of Reimbursement Review

Centers for Medicare and Medicaid Services

600 East Monroe Street, Room 215

Springfield, Illinois 62701

RightFax: 443-380-5221

Email: Fredrick.sebree@cms.hhs.gov

From: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>
Sent: Tuesday, March 21, 2023 12:24 PM
To: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>; Crump, Marissa <Marissa.Crump@dss.mo.gov>
Cc: Brite, Tony <Tony.Brite@dss.mo.gov>
Subject: RE: SPA MO 22-0025 NF rebase

The approval package looks good.

Thank you,

Rebecca L. Rucker, CPA

Assistant Deputy Director, IRU

Department of Social Services, MO HealthNet Division

(573) 751-3737

Rebecca.L.Rucker@dss.mo.gov

â€œTogether we will build a best in class Medicaid program that addresses the needs of Missouriâ€™s most vulnerable in a way that is financially sustainable.â€□

From: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>
Sent: Tuesday, March 21, 2023 9:44 AM
To: Crump, Marissa <Marissa.Crump@dss.mo.gov>

Cc: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>; Brite, Tony <Tony.Brite@dss.mo.gov>
Subject: RE: SPA MO 22-0025 NF rebase

Thanks again for the responses, attached is the unsigned approval package. I updated the 179 to reflect the new title page in block 7 since it is not getting superseded but needing to get included in the new pages. I also updated the acting director, thanks for catching that. If you can send concurrence I will move forward with the approval recommendation.

V/R

Fredrick J. Sebree

Accountant

Division of Reimbursement Review

Centers for Medicare and Medicaid Services

600 East Monroe Street, Room 215

Springfield, Illinois 62701

RightFax: 443-380-5221

Email: Fredrick.sebree@cms.hhs.gov

From: Crump, Marissa <Marissa.Crump@dss.mo.gov>
Sent: Monday, March 20, 2023 2:11 PM
To: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>
Cc: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>; Brite, Tony <Tony.Brite@dss.mo.gov>
Subject: RE: SPA MO 22-0025 NF rebase

Please see attached in response to your email below. Let us know if there is anything else you need from us.

Thank you,

Marissa Crump

Executive Assistant

Missouri Department of Social Services/MO HealthNet Division

Marissa.Crump@dss.mo.gov

(573)751-6884

From: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>
Sent: Thursday, March 16, 2023 11:10 AM
To: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>; Brite, Tony <Tony.Brite@dss.mo.gov>
Subject: RE: SPA MO 22-0025 NF rebase

Good morning,

Below are the last round of questions, I believe, I have. I attached the unsigned draft of the approval package as well as the SFQs. Please review the unsigned draft of the approval package to make sure we are capturing the new pages correctly, since the SPA is so big, so we can avoid any miscommunication or technical corrections after the approval. If we have updates to the pages or 179 we can just make the updates to this document, if that is alright.

Language

-The title page, prior to page 66, is not referenced in block 7 of the 179 and does not have any page number so it may get omitted on our side when cataloging in the system. Can we add â€œtitleâ€□ page to block 7 or assign a page number (65a) to make sure it gets included in CMSâ€™ version of the state plan (also in the correct location after 65)?

-Page 1 appears to be the beginning of the of the current (soon to be obsolete) NF methodology. It seems that the state intends to keep the old methodology and sunset it for 6/30/2022. So the beginning pages of the 4.19-D will be sunset after this SPA is approved (I am pretty sure is not the case but may be better to refernce)?. Please confirm my understanding and let me know if it would be more comprehensive to reference the new methodology and that it starts on page 66.

SFQs

-The non-federal share of the funding referenced in the SFQs for NF services includes appropriations, IGT, and CPE. I did not see taxes (NFRA) referenced in the SFQs but I see it is still in the plan language. Is the NFRA still a provider assessment for NF services? Does 13 CSR 70-10.110 still apply ($12.93 to all NFs on a per patient basis)? If so can we get the NFRA added to the SFQs for this SPA and future SPAs where the NFRA is in effect?

-The SFQs references Swope Ridge Geriatric Center as the only provider that utilizes a CPE. It seems that there is a reconciliation process so I donâ€™t see any issues with the mechanics. My question is the frequency of the CPE. I see that the 2021 NF UPL captured the provider and it looks like we will see the provider in the 2023 NF UPL (given the language in the SFQs). Why was the provider omitted from the 2022 NF UPL? From the language it seems 2021 CPE was paid in 2022 for 2021 but it was in the 2021 UPL. Why is that not the case for the 2022 CPE? It looks like there hasnâ€™t been any changes to the language since MO 18-0015 starting on page 60 BB1, please confirm.

Thanks again and feel free to send any questions you have.

Fredrick J. Sebree

Accountant

Division of Reimbursement Review

Centers for Medicare and Medicaid Services

600 East Monroe Street, Room 215

Springfield, Illinois 62701

RightFax: 443-380-5221

Email: Fredrick.sebree@cms.hhs.gov

From: Sebree, Fredrick (CMS/CMCS)
Sent: Wednesday, March 15, 2023 2:34 PM
To: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>; Brite, Tony <Tony.Brite@dss.mo.gov>
Subject: RE: SPA MO 22-0025 NF rebase

I knew I seen them somewhere, thanks.

Fredrick J. Sebree

Accountant

Division of Reimbursement Review

Centers for Medicare and Medicaid Services

600 East Monroe Street, Room 215

Springfield, Illinois 62701

RightFax: 443-380-5221

Email: Fredrick.sebree@cms.hhs.gov

From: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>
Sent: Wednesday, March 15, 2023 2:32 PM
To: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>; Brite, Tony <Tony.Brite@dss.mo.gov>
Subject: RE: SPA MO 22-0025 NF rebase

Fredrick,

The standard funding questions are included in the cover letter. Iâ€™ve attached a copy of the letter for your convenience.

Thank you,

Rebecca L. Rucker, CPA

Assistant Deputy Director, IRU

Department of Social Services, MO HealthNet Division

(573) 751-3737

Rebecca.L.Rucker@dss.mo.gov

â€œTogether we will build a best in class Medicaid program that addresses the needs of Missouriâ€™s most vulnerable in a way that is financially sustainable.â€□

From: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>
Sent: Wednesday, March 15, 2023 2:02 PM
To: Brite, Tony <Tony.Brite@dss.mo.gov>
Cc: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>
Subject: RE: SPA MO 22-0025 NF rebase

Good afternoon Tony,

Can you forward the standard funding questions for NF services? I am not seeing it in my folder. My apologies if it was sent and I am missing it.

Fredrick J. Sebree

Accountant

Division of Reimbursement Review

Centers for Medicare and Medicaid Services

600 East Monroe Street, Room 215

Springfield, Illinois 62701

RightFax: 443-380-5221

Email: Fredrick.sebree@cms.hhs.gov

From: Brite, Tony <Tony.Brite@dss.mo.gov>
Sent: Monday, March 6, 2023 2:34 PM
To: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>
Cc: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>
Subject: RE: SPA MO 22-0025 NF rebase

Fred,

The stakeholders concerns regarding the payment methodology have been remedied. Hope that helps with the review.

Thanks,

Tony

From: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>
Sent: Monday, March 6, 2023 10:42 AM
To: Brite, Tony <Tony.Brite@dss.mo.gov>
Cc: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>
Subject: RE: SPA MO 22-0025 NF rebase

Good morning Tony,

I had a chance to go through both the informal inquiry and the formal RAI last week and I think are looking good. Itâ€™s a big SPA so I plan to comb through the pages another time and finish the review of the UPL soon but I donâ€™t anticipate any issues. Thanks for sending the NF reimbursement FAQs with the stakeholders comments and questions during the process. The only question I can think of at this point is if all the stakeholder concerns remedied. If you could confirm that I will keep you in the loop as the review progresses. I am hoping to wrap it up by next week if that works.

Thanks for checking in.

Fredrick J. Sebree

Accountant

Division of Reimbursement Review

Centers for Medicare and Medicaid Services

600 East Monroe Street, Room 215

Springfield, Illinois 62701

RightFax: 443-380-5221

Email: Fredrick.sebree@cms.hhs.gov

From: Brite, Tony <Tony.Brite@dss.mo.gov>
Sent: Monday, March 6, 2023 10:07 AM
To: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>
Cc: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>
Subject: RE: SPA MO 22-0025 NF rebase

Hello Fred,

I am checking in on the status of the NF rate review. Can you provide any information in terms of timeline? Or whether we should expect any additional questions?

Thanks for your help!

Tony

From: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>
Sent: Thursday, February 23, 2023 10:53 AM
To: Crump, Marissa <Marissa.Crump@dss.mo.gov>; Walker, Michala (CMS/CMCS) <Michala.Walker@cms.hhs.gov>
Cc: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>; Brite, Tony <Tony.Brite@dss.mo.gov>; Bromwell, Robert (CMS/CMCS) <Robert.Bromwell@cms.hhs.gov>
Subject: RE: SPA MO 22-0025 NF rebase

Thanks again Marissa, Ill keep you in the loop as I review.

Fredrick J. Sebree

Accountant

Division of Reimbursement Review

Centers for Medicare and Medicaid Services

600 East Monroe Street, Room 215

Springfield, Illinois 62701

RightFax: 443-380-5221

Email: Fredrick.sebree@cms.hhs.gov

From: Crump, Marissa <Marissa.Crump@dss.mo.gov>
Sent: Thursday, February 23, 2023 10:47 AM
To: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>; Walker, Michala (CMS/CMCS) <Michala.Walker@cms.hhs.gov>
Cc: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>; Brite, Tony <Tony.Brite@dss.mo.gov>; Bromwell, Robert (CMS/CMCS) <Robert.Bromwell@cms.hhs.gov>
Subject: RE: SPA MO 22-0025 NF rebase

Attached is our response to this IRAI.

Thank you,

Marissa Crump

Executive Assistant

Missouri Department of Social Services/MO HealthNet Division

Marissa.Crump@dss.mo.gov

(573)751-6884

From: Brite, Tony <Tony.Brite@dss.mo.gov>
Sent: Monday, October 31, 2022 10:10 AM
To: Crump, Marissa <Marissa.Crump@dss.mo.gov>
Cc: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>
Subject: Fwd: SPA MO 22-0025 NF rebase

FYI

Sent from my iPad

Begin forwarded message:

From: "Sebree, Fredrick (CMS/CMCS)" <Fredrick.Sebree@cms.hhs.gov>
Date: October 31, 2022 at 10:04:50 AM CDT
To: "Brite, Tony" <Tony.Brite@dss.mo.gov>
Cc: "Rucker, Rebecca L" <Rebecca.L.Rucker@dss.mo.gov>, "Read, Deborah (CMS/CMCS)" <Deborah.Read@cms.hhs.gov>
Subject: RE: SPA MO 22-0025 NF rebase

ï»¿

Good morning Tony,

Sorry again for the delay. Below are a few informal questions I have for MO 22-0025, NF rebase:

1. Attached are the proposed pages for 66-120 that contains the new language. These pages annotate â€œdraftâ€□ on each of the pages with the exception of the title page. Is there a final â€œcleanâ€□ version? Does the state want to keep the first title page or is it part of the draft version?
2. Please provide a calculation of the budget impact annotated on the CMS 179 block 6.
3. Does the state have any supporting info/documentation/explanation behind how the rate methodology was developed to help support the economy and efficiency of the rates? The UPL helps support the economy and efficiency, just wanted to know if it was establish during the development of the methodology in some way. Were stakeholders involved in the rate development process? If so, how? Was the methodology modeled after another state?
4. Please provide any stakeholder comments/concerns, if any, during the public notice period.
5. Did the state model the value based language and incentives from CMS guidance? If not, how was the methodology developed?

Our quality team at CMS will be reviewing the incentive language as well as myself. We will get back to you on any specifics in the language as soon as we can.

Thanks again

Fredrick J. Sebree

Accountant

Division of Reimbursement Review

Centers for Medicare and Medicaid Services

600 East Monroe Street, Room 215

Springfield, Illinois 62701

RightFax: 443-380-5221

Email: Fredrick.sebree@cms.hhs.gov

From: Brite, Tony <Tony.Brite@dss.mo.gov>
Sent: Friday, October 28, 2022 9:22 AM
To: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>
Cc: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>
Subject: RE: SPA MO 22-0025 NF rebase

Thanks Fred, we just wanted to make sure we hadnâ€™t missed it. Have a good weekend!

From: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>
Sent: Friday, October 28, 2022 9:16 AM
To: Brite, Tony <Tony.Brite@dss.mo.gov>
Cc: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>
Subject: Re: SPA MO 22-0025 NF rebase

Hello Tony,

You are correct and I was hoping to send them this week. I'll make sure to get them out to you first thing next week. Hope that is alright.

Thanks for checking in.

Fredrick J. Sebree

Accountant

Division of Reimbursement Review

Centers for Medicare and Medicaid Services

600 East Monroe Street, Room 215

Springfield, Illinois 62701

RightFax: 443-380-5221

Email: Fredrick.sebree@cms.hhs.gov

From: Brite, Tony <Tony.Brite@dss.mo.gov>
Sent: Friday, October 28, 2022, 9:01 AM
To: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>
Cc: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>
Subject: SPA MO 22-0025 NF rebase

Hi Fred,

You had mentioned on the 15 day call a few weeks ago that you anticipated providing us with initial questions that week on 22-0025 for Nursing Facilities. Do you know if those were sent? I have not seen them come through yet.

Thanks,

Tony

From:	"Mauser, Gayle (CMS/OL)" (b)(5) (b)(5)
Sent:	3/10/2023 6:59:38 PM +0000
To:	"Howe, Rory (CMS/CMCS)" <Rory.Howe@cms.hhs.gov>; "Silanskis, Jeremy (CMS/CMCS)" <Jeremy.Silanskis@cms.hhs.gov>; "Maccarroll, Amber (CMS/CMCS)" <Amber.MacCarroll@cms.hhs.gov>; "Arnold, Charlie (CMS/CMCS)" <Charlie.Arnold@cms.hhs.gov>; "Boston, Beverly (CMS/CMCS)" <Beverly.Boston@cms.hhs.gov>
CC:	"Kirchgraber, Kate (CMS/OL)" <Kate.Kirchgraber@cms.hhs.gov>; "Wiley, Evelyn (CMS/CMCS)" <Evelyn.Wiley@cms.hhs.gov>
Subject:	RE: RE: E&C Majority Inquiry - Hold Harmless
Attachments:	Hold Harmless_Florida Initial Document Request.pdf; Hold Harmless_Florida FMR Engagement Letter.pdf; Hold Harmless_Missouri CMS-64 Review.docx

Hi again FMG team,

We are following up on our prior discussion regarding the hold harmless question we received from E&C majority on what states have impermissible arrangements. Attention has been pulled away from this topic for a bit, but we expect that there will be renewed interest soon (and we've started to get some questions from a Texas member as well).

Below are draft talking points for a call with E&C majority, which include a few internal notes and a couple placeholders I am hoping you all can help fill in.

Rory, after FMG reviews these, I believe you were also going to run them by CMCS leadership. Looping Evelyn here to see if we can also hold some windows on your calendar to offer to Committee staff for this discussion – perhaps we aim for times within the next couple weeks? Committee staff haven't pinged us again yet, but we will let you know if they do.

Thanks,

Gayle

DRAFT Talking Points for E&C Majority Staff Call – Hold Harmless Guidance

- As you know, on February 17, 2023, CMS issued a Medicaid informational bulletin regarding health care-related taxes and hold harmless arrangements involving the redistribution of Medicaid payments.
- Hold harmless arrangements, as defined in the Medicaid statute, are arrangements in which the State or another 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. The statute prohibits these arrangements.

- Recently, we have been approached by several states with questions about complying with this provision of law, and we have also learned of states that may have existing arrangements or are considering establishing them, particularly with respect to states establishing or renewing Medicaid managed care state directed payments.
- The informational bulletin reiterates the federal requirements concerning hold harmless arrangements with respect to health care-related taxes. We hope that this guidance provides additional clarity to states, and we also encourage them to raise any questions or concerns they may have about the permissibility of health care-related taxes to CMS as early in the process as possible, to avoid any issues.
- Regarding your question about which states may have these types of arrangements, there are 3 states that CMS understands may have impermissible hold harmless arrangements, and 1 state we wanted to mention as an example of where we were able to intervene early in the process of establishing what may have been an impermissible hold harmless arrangement.
- Starting with the 3 states that may have these arrangements:
    - ***Texas:***
        - Texas has in place what is known as the Local Provider Payment Fund or LPPF. Based on information obtained by CMS, including limited information provided by the state and publicly available third-party materials, the LPPF arrangements used by some localities in Texas appear to include hold harmless arrangements because the localities impose a tax and the state directly or indirectly provides for payments that guarantee to hold the taxpayers harmless for all or any portion of the tax amount. If our understanding of those LPPF arrangements is correct, they constitute hold harmless arrangements that are prohibited under the Medicaid statute and CMS regulations. [this language is pulled from the publicly available November 2021 letter to the State; page 5 includes additional detail regarding our understanding of the arrangement]
        - CMS has communicated these concerns to the state and, when we recently approved Texas' state directed payments, we included in our approval letter that approval of the state directed payments does not constitute any specific Medicaid financing mechanism used to support the non-federal share of the provider payment arrangement. We also clarified that we reserve the authority to enforce requirements, including by initiating separate deferrals and/or disallowances of federal financial participation.
        - As you may be aware, the HHS OIG announced in November 2021 that it is examining states' use of LPPFs as the state share of Medicaid payments, and that it expects to issue a report in FY 2023 that indicates whether the LPPFs the state agency used were permissible.

(b)(5)

    - ***Fl***
        - Similarly, Florida has in place an LPPF that we also understand includes hold harmless arrangements. [the attached FMR engagement letter includes additional detail regarding our understanding of the arrangement]

        - In Florida's case, we were working with the state for some time in an effort to address the concerns, but have been unable to resolve them. Like Texas, we communicated our concerns to the state and, when we recently approved Florida's state directed payments, we provided the same information as was included in the letter to Texas—that the approval does not constitute approval of the Medicaid financing mechanism, and that we reserve the authority to enforce requirements.
        - In late February, we sent a letter to Florida initiating a Financial Management Review (FMR) to examine the state Medicaid agency's compliance with federal requirements over the next several months.
    - ***Missouri:***
        - Lastly, Missouri has a longstanding arrangement called the Federal Reimbursement Allowance tax program that appears to include a hold harmless arrangement, and in 2020, CMS engaged the state about its concerns. Also in 2020, the then CMCS Director sent a letter to the state describing our concerns and memorializing a conversation with state Medicaid agency leadership who at that time committed to ending the hold harmless arrangement by X timeframe.
        - While the state has not done that, state leadership has been willing to respond to CMS' questions. In late February, we also sent a letter to Missouri—but, based on our ability to obtain more information from Missouri, we have initiated a focused review of Missouri's program expenditures reported to CMS on the Form CMS-64, rather than an FMR. [the attached CMS-64 review letter includes some additional information]
- With respect to the state I mentioned where we were successful in intervening early:
    - ***Louisiana:***
        - In X month and year, we received information that suggested Louisiana's legislature was developing what would have been a hold harmless arrangement as part of the financing mechanism for its state directed payment program. We engaged the state about those issues, worked with the state on alternatives that would comply with federal law, and ultimately the state withdrew the state directed payment proposal it had submitted and submitted a modified proposal.
- We are hopeful that the guidance we issued will further promote our efforts to work with states and get ahead of these issues as we did in Louisiana.

From: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>
Sent: Tuesday, February 21, 2023 2:37 PM
To: Mauser, Gayle (CMS/OL) <Gayle.Mauser@cms.hhs.gov>
Cc: Costello, Anne Marie (CMS/CMCS) <AnneMarie.Costello@cms.hhs.gov>; Briskin, Perrie (CMS/CMCS) <Perrie.Briskin@cms.hhs.gov>; Kirchgraber, Kate (CMS/OL) <Kate.Kirchgraber@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Boston, Beverly (CMS/CMCS)

<Beverly.Boston@cms.hhs.gov>
Subject: RE: E&C Majority Inquiry - Hold Harmless

Hi Gayle,

A call sounds right to me. Please also include Jeremy, Amber, and Charlie in the discussion. For awareness, tomorrow, FMG is planning to issue a letter to Florida and a question set to Missouri on this issue. Both states appear to have concerning arrangements in place and the letter/question set tomorrow are part of our work to address the arrangements. Let me know if you have any questions in the interim.

Thanks,

Rory

From: Mauser, Gayle (CMS/OL) <Gayle.Mauser@cms.hhs.gov>
Sent: Tuesday, February 21, 2023 1:57 PM
To: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>
Cc: Costello, Anne Marie (CMS/CMCS) <AnneMarie.Costello@cms.hhs.gov>; Briskin, Perrie (CMS/CMCS) <Perrie.Briskin@cms.hhs.gov>; Kirchgraber, Kate (CMS/OL) <Kate.Kirchgraber@cms.hhs.gov>
Subject: E&C Majority Inquiry - Hold Harmless

Hi Rory,

After Friday's hold harmless CIB went out, we received an inquiry from House E&C majority staff asking for more information—in particular, about the language from the list serv notice indicating "recently, CMS became aware that some health care-related tax programs appear to involve agreements among providers to redistribute their Medicaid payments to hold taxpayers harmless for the cost of the tax."

Specifically, the staff would like to know about the instances CMS has found, and the steps the agency is taking to address those agreements.

I imagine it will be most efficient to have a quick call to discuss actions to date, anticipated upcoming actions, and next steps for responding to the Hill—does that work for you? Are there others who should be included?

Thanks,

Gayle

Gayle Mauser
(she/her)

Low Income Programs Analysis Group

Office of Legislation

Centers for Medicare & Medicaid Services (CMS)

Cell Phone (b)(6)

From:	"Endelman (he/him), Jonathan (CMS/CMCS)" (b)(5) ADMINISTRATIVE GROUP
	(b)(5)
Sent:	4/27/2023 7:44:24 PM +0000
To:	CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>; "Cuno, Richard (CMS/CMCS)" <Richard.Cuno@cms.hhs.gov>; "Goldstein, Stuart (CMS/CMCS)" <STUART.GOLDSTEIN@cms.hhs.gov>; "McClure, Deb (CMS/CMCS)" <Deborah.McClure@cms.hhs.gov>
CC:	"Snyder, Laura (CMS/CMCS)" <Laura.Snyder1@cms.hhs.gov>; "Arnold, Charlie (CMS/CMCS)" <Charlie.Arnold@cms.hhs.gov>; "Clark, Jennifer (CMS/CMCS)" <Jennifer.Clark@cms.hhs.gov>; "Fan, Kristin (CMS/CMCS)" <Kristin.Fan@cms.hhs.gov>; "Mosley, Elle (CMS/CMCS)" <larrica.mosley@cms.hhs.gov>; "Schoonover, Matthew (CMS/CMCS)" <matthew.schoonover@cms.hhs.gov>
Subject:	RE: RE: FMG Consult Requested: MO_Fee_IPH_Renewal_20230701-20240630 and MO_Fee_OPH_Renewal_20230701-20240630

Drew,

As you may be aware, we have many questions about the Federal Reimbursement Allowance. I am raising this to my group leadership to see how they would like to handle the issue.

Best,

Jonathan

Jonathan Endelman, PhD

Acting Technical Director

Centers for Medicare & Medicaid Services (CMS)

Center for Medicaid and CHIP Services (CMCS)

Financial Management Group (FMG)

Division of Financial Policy (DFP)

410.786.4738

jonathan.endelman@cms.hhs.gov

7500 Security Blvd.

Mail Stop, S3-14-28

Baltimore, MD 21244-1850

From: CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>
Sent: Thursday, April 27, 2023 3:02 PM
To: Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; McClure, Deb (CMS/CMCS) <Deborah.McClure@cms.hhs.gov>
Cc: Snyder, Laura (CMS/CMCS) <Laura.Snyder1@cms.hhs.gov>; CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>
Subject: FMG Consult Requested: MO_Fee_IPH_Renewal_20230701-20240630 and MO_Fee_OPH_Renewal_20230701-20240630

Good Afternoon,

The Division of Managed Care Policy (DMCP) is currently reviewing two 438.6(c) preprint submissions from Missouri – one preprint for inpatient hospital services and one for outpatient hospital services.

For both proposals, the state indicates that the non-federal share is funded by state general revenue, Health Care-Related Provider tax(es) / assessment(s), as well as "Healthy Families Trust Fund & Life Sciences Research Trust Fund (Tobacco Settlement Funds), Health Initiative Funds, Premium Funds, Uncompensated Care Funds".

Table 5: Health Care-Related Provider Tax/Assessment(s)

Name of the Health Care-Related Provider Tax / Assessment (enter each on a separate line)	Identify the permissible class for this tax / assessment	Is the tax / assessment broad-based?	Is the tax / assessment uniform?	Is the tax / assessment under the 6% indirect hold harmless limit?	If not under the 6% indirect hold harmless limit, does it pass the "75/75" test?	Does it contain a hold harmless arrangement that guarantees to return all or any portion of the tax payment to the tax payer?
i. Federal Reimbursement Allowance	Hospital	Yes	Yes	Yes		No

Table six is blank:

Table 6: Health Care-Related Provider Tax/Assessment Waivers

Name of the Health Care-Related Provider Tax/Assessment Waiver (enter each on a separate line)	Submission Date	Current Status (Under Review, Approved)	Approval Date
i.			

Could you please let us know if FMG has any concerns with these funding sources and/or has follow up questions that you'd like us to send the state **by COB May 18th**?

I've attached both preprint submissions for your reference. Please feel free to loop in additional FMG staff as needed.

Many thanks,

Drew

From:	"Endelman (he/him), Jonathan (CMS/CMCS)" (b)(5) ADMINISTRATIVE GROUP (b)(5)
Sent:	2/3/2023 7:46:41 PM +0000
To:	"Howe, Rory (CMS/CMCS)" <Rory.Howe@cms.hhs.gov>; "adams, lia (CMS/CMCS)" <Lia.Adams@cms.hhs.gov>
CC:	"Boston, Beverly (CMS/CMCS)" <Beverly.Boston@cms.hhs.gov>; "Maccarroll, Amber (CMS/CMCS)" <Amber.MacCarroll@cms.hhs.gov>; "Arnold, Charlie (CMS/CMCS)" <Charlie.Arnold@cms.hhs.gov>; "Goldstein, Stuart (CMS/CMCS)" <STUART.GOLDSTEIN@cms.hhs.gov>; "Fan, Kristin (CMS/CMCS)" <Kristin.Fan@cms.hhs.gov>; "Silanskis, Jeremy (CMS/CMCS)" <Jeremy.Silanskis@cms.hhs.gov>
Subject:	RE: RE: Discussion of Possible Proposed Tax Rule
Attachments:	Copy of Nevada M1 M2 for PowerPoint Revised.xlsx

Rory,

I just noticed that the Nevada spreadsheet had a number missing. M1 was blank. Here it is.

Best,

Jonathan

Jonathan Endelman, PhD

Social Science Research Analyst

Centers for Medicare & Medicaid Services (CMS)

Center for Medicaid and CHIP Services (CMCS)

Financial Management Group (FMG)

Division of Financial Policy (DFP)

410.786.4738

jonathan.endelman@cms.hhs.gov

7500 Security Blvd.

Mail Stop, S3-14-28

Baltimore, MD 21244-1850

From: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>
Sent: Friday, February 3, 2023 2:35 PM
To: adams, lia (CMS/CMCS) <Lia.Adams@cms.hhs.gov>
Cc: Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>
Subject: FW: Discussion of Possible Proposed Tax Rule

Per our conversation

From: Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>
Sent: Friday, February 3, 2023 11:12 AM
To: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>
Cc: Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Bonelli, Anna (CMS/CMCS) <Anna.Bonelli@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>; Truffer, Christopher (CMS/OACT) <Christopher.Truffer@cms.hhs.gov>; Sagandykov, Makhmud (CMS/OACT) <Makhmud.Sagandykov@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>
Subject: RE: Discussion of Possible Proposed Tax Rule

Rory,

While the Arizona NF tax with an effective date of October 1, 2021 did not pass the M1/M2 the Arizona NF tax with an effective date of October 1, 2022 does just barely pass the M1/M2 test with a value of .9519. This is the case with many of the NF taxes that don't pass the M1/M2. They just barely don't pass and could pass if slightly modified. I could put AZ back as the example in the PowerPoint if desired using the October 1, 2022 tax.

Best,

Jonathan

Jonathan Endelman, PhD

Social Science Research Analyst

Centers for Medicare & Medicaid Services (CMS)

Center for Medicaid and CHIP Services (CMCS)

Financial Management Group (FMG)

Division of Financial Policy (DFP)

410.786.4738

jonathan.endelman@cms.hhs.gov

7500 Security Blvd.

Mail Stop, S3-14-28

Baltimore, MD 21244-1850

From: Endelman (he/him), Jonathan (CMS/CMCS)
Sent: Friday, February 3, 2023 10:10 AM
To: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>
Cc: Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Bonelli, Anna (CMS/CMCS) <Anna.Bonelli@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>; Truffer, Christopher (CMS/OACT) <Christopher.Truffer@cms.hhs.gov>; Sagandykov, Makhmud (CMS/OACT) <Makhmud.Sagandykov@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>
Subject: RE: Discussion of Possible Proposed Tax Rule

Dear Rory,

Please see attached for a PowerPoint presentation that answers your questions as well as supporting spreadsheets. We have included additional details for how we calculated M1 and M2 as requested. CA's MCO tax was on "member months" and the presentation had been changed to "covered lives." I am not sure if that is synonymous. We had to take out the AZ example and replace it with Hawaii because AZ NF does not pass. It comes out to 0.93. We

had inadvertently switched M1 and M2 in the original calculation. I believe the Center Director has a valid point that the M1 M2 could be disruptive to states with existing NF taxes. North Carolina, California, Arizona, and Pennsylvania would all not pass the M1/M2 with value of 0.95. However, we are not currently proposing to apply the M1/M2 to these taxes. Our options are as follows:

1. Apply M1/M2 only to MCO taxes
2. Apply M1/M2 only to Medicaid/non-Medicaid broken down taxes.
3. Give states the choice of M1/M2 or undue burden for Medicaid/non-Medicaid broken down taxes.

I think we have discarded the option of applying the M1/M2 to all B1/B2 taxes. None of the remaining options would involve us imposing the M1/M2 on any NF taxes. These documents are also attached to the meeting on Monday.

Best,

Jonathan

Jonathan Endelman, PhD

Social Science Research Analyst

Centers for Medicare & Medicaid Services (CMS)

Center for Medicaid and CHIP Services (CMCS)

Financial Management Group (FMG)

Division of Financial Policy (DFP)

410.786.4738

jonathan.endelman@cms.hhs.gov

7500 Security Blvd.

Mail Stop, S3-14-28

Baltimore, MD 21244-1850

From: Endelman (he/him), Jonathan (CMS/CMCS)
Sent: Thursday, February 2, 2023 1:31 PM
To: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>
Cc: Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Maccarroll, Amber

(CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Bonelli, Anna (CMS/CMCS) <Anna.Bonelli@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>; Truffer, Christopher (CMS/OACT) <Christopher.Truffer@cms.hhs.gov>; Sagandykov, Makhmud (CMS/OACT) <Makhmud.Sagandykov@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>
Subject: RE: Discussion of Possible Proposed Tax Rule

Thank you Rory. We will take a look at the comments and edits and respond by tomorrow in preparation for the meeting on Monday. We will also include the spreadsheets that are the basis for the PowerPoint for reference and in case the Center Director wants to take a closer look at them.

Best,

Jonathan

Jonathan Endelman, PhD

Social Science Research Analyst

Centers for Medicare & Medicaid Services (CMS)

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410.786.4738

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Mail Stop, S3-14-28

Baltimore, MD 21244-1850

From: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>
Sent: Thursday, February 2, 2023 1:27 PM
To: Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>

Cc: Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Bonelli, Anna (CMS/CMCS) <Anna.Bonelli@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>; Truffer, Christopher (CMS/OACT) <Christopher.Truffer@cms.hhs.gov>; Sagandykov, Makhmud (CMS/OACT) <Makhmud.Sagandykov@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>
Subject: RE: Discussion of Possible Proposed Tax Rule

Hi Charlie,

Thanks to Jonathan for pulling this together so quickly. Per our discussion, please see attached some suggested edits and three comments requesting that we show a little bit more of the M1/M2 calculation for each example (i.e., the "standard" tax, the "loophole" tax and the "standard tax with breaks"). I think this could easily happen on the existing slide for each example. As discussed, please also share the underlying Excel spreadsheets supporting each example. I plan to share with Dan and provide the option for him to dive in separately or for us to walk through them live. Let me know if you have any questions.

Thanks again,

Rory

From: Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>
Sent: Monday, January 30, 2023 12:53 PM
To: Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Bonelli, Anna (CMS/CMCS) <Anna.Bonelli@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>; Truffer, Christopher (CMS/OACT) <Christopher.Truffer@cms.hhs.gov>; Sagandykov, Makhmud (CMS/OACT) <Makhmud.Sagandykov@cms.hhs.gov>
Cc: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>
Subject: RE: Discussion of Possible Proposed Tax Rule

Thanks Jonathan. I added some comments about whether we should distinguish the notion between "standard" and "bad". What we consider standard is where the rates within an individual provider do not vary – rather rates vary about the characteristic of the totality of the provider.

From: Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>
Sent: Friday, January 27, 2023 3:28 PM
To: Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Bonelli, Anna (CMS/CMCS) <Anna.Bonelli@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>; Truffer, Christopher (CMS/OACT) <Christopher.Truffer@cms.hhs.gov>; Sagandykov, Makhmud (CMS/OACT) <Makhmud.Sagandykov@cms.hhs.gov>
Cc: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>
Subject: RE: Discussion of Possible Proposed Tax Rule

Dear all,

Please see attached for the PowerPoint presentation for Dan. As always, please edit to improve if you see anything that can be made better. Please use the SharePoint link provided below for any edits, comments, or changes. I am quite proud of how this turned out. I hope that it is useful. We will use this as the basis for Tuesday's discussion. The PowerPoint shows how B1/B2 and M1/M2 would work in three instances:

1. "Standard" tax waivers that we have approved repeatedly that we have approved repeatedly like Nevada's NF tax. These taxes continue to pass the B1/B2 and the M1/M2
2. "Bad" tax waivers that exploit the statistical loophole and pose an undue burden of the Medicaid program. These taxes pass the B1/B2 and, by design, fail the M1/M2.
3. Taxes that give "breaks" to **some** low Medicaid utilization providers such as CCRCs or small facilities, but balance those breaks out with breaks to **other** higher Medicaid utilizing facilities. **These facilities continue to pass the M1/M2 just as they pass the B1/B2.** This will allay OCD's fear that states can never give breaks to some low Medicaid utilization facilities for policy reasons and pass the M1/M2. This is not the case.

An Illustration of the M1 M2 Test in Action with Concrete Examples

I look forward to discussing this on Tuesday

Best,

Jonathan

From: Endelman (he/him), Jonathan (CMS/CMCS)
Sent: Friday, January 27, 2023 12:40 PM
To: Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Bonelli, Anna (CMS/CMCS) <Anna.Bonelli@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>
Cc: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>
Subject: RE: Discussion of Possible Proposed Tax Rule

Hello all,

I wanted to give an update. I met today with Kristin, Jeremy, and Rory to follow up on Dan's Feedback from 1/25/2023. Rory said that we should come up with a series of examples to show Dan to illustrate how the M1/M2 works. I was thinking of three examples:

1. An illustration of how a "standard" health care-related tax we have passes the M1/M2 test. I was thinking the Nevada NF tax.
2. An illustration of how a "clearly bad" tax that exploits the statistical loophole fails the M1/M2. I was thinking of the California MCO tax because Dan is very familiar with that example.
3. An illustration of how states can still exclude or tax at a lower rate certain groups of providers, such as CCRCs, and still manage to pass the M1/M2 like they currently pass the B1/B2 by giving other taxes a "break." I was thinking Michigan's nursing facility tax since it gives a "break" to CCRC and facilities with fewer than 40 beds,

which both have low Medicaid, but makes up for it by taking higher Medicaid facilities a lower tax rate than all other facilities.

4. I am thinking that the best, i.e. most effective way to do this is a PowerPoint presentation where we show:

- The structure of the tax for each of these taxes by taking a "snip" from the tax waiver approval letters. I don't think Dan wants to see actual spreadsheets and, in any case, it would be very difficult to "share" spreadsheets on Zoom anyway. You would constantly need to start and stop sharing when you move from spreadsheet to spreadsheet. We can say that if he wants to take a look at the spreadsheets, we can email them to him.
- The M1/M2 for each of these taxes by taking a "snip" of the Excel spreadsheets.
- In the case of the Michigan NF tax, a "snip" of the Goldstein-Fan test that shows the tax rates and Medicaid utilization for all taxpayer groups. It would show that this passes the M1/M2 test despite giving a "break" to CCRCs and under 40 beds (low Medicaid) by making up for it with a "break" for high Medicaid facilities.

We are thinking that it would be beneficial to have a smaller group discussion apart from joint/cross cutting clearance with more time to explain. I think it would also be beneficial to invite OACT again. We have a meeting to discuss this on Tuesday. I will have the PowerPoint ready by then. Thanks.

Best,

Jonathan

-----Original Appointment-----
From: Endelman (he/him), Jonathan (CMS/CMCS)
Sent: Friday, January 20, 2023 11:17 AM
To: Endelman (he/him), Jonathan (CMS/CMCS); Arnold, Charlie (CMS/CMCS); Bonelli, Anna (CMS/CMCS); Clark, Jennifer (CMS/CMCS); Cuno, Richard (CMS/CMCS); Fan, Kristin (CMS/CMCS); Goldstein, Stuart (CMS/CMCS); Mosley, Elle (CMS/CMCS)
Subject: Discussion of Possible Proposed Tax Rule
When: Tuesday, January 31, 2023 9:00 AM-9:30 AM (UTC-05:00) Eastern Time (US & Canada).
Where:
https://cms.zoomgov.com/j (b)(5)

This is a meeting to discuss the possible proposed tax rule.

Best,

Jonathan

Join ZoomGov Meeting

https://cms.zoomgov.com/j (b)(5)

Meeting ID: (b)(5)

Password (b)(5)

One tap mobile

+16692545252 (b)(5) S (San Jose)

+16468287666 S (New York)

Dial by your location

+1 669 254 5252 US (San Jose)

+1 646 828 7666 US (New York)

833 568 8864 US Toll-free

Meeting ID: (b)(5)

Find your local number: https://cms.zoomgov.com/u/aeeNCLsqpo

Join by SIP

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sip: (b)(5) sip.zoomgov.com

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

From: "Endelman (he/him), Jonathan (CMS/CMCS)" (b)(5)
ADMINISTRATIVE GROUP

(b)(5)

Sent: 2/17/2023 12:09:54 PM +0000
To: "Staton, Sidney (CMS/CMCS)" <Sidney.Staton@cms.hhs.gov>; "Campbell-OConnor, Aimee (CMS/CMCS)" <Aimee.Campbell-OConnor1@cms.hhs.gov>; Sarah Whitehouse <Whitehouse-Sarah@norc.org>; "Snyder, Laura (CMS/CMCS)" <Laura.Snyder1@cms.hhs.gov>; "Davis, Lovie (CMS/CMCS)" <Lovie.Davis@cms.hhs.gov>; "Loizias, Alex (CMS/CMCS)" <Alexandra.Loizias@cms.hhs.gov>; "Arnold, Charlie (CMS/CMCS)" <Charlie.Arnold@cms.hhs.gov>; "Clark, Jennifer (CMS/CMCS)" <Jennifer.Clark@cms.hhs.gov>; "Cuno, Richard (CMS/CMCS)" <Richard.Cuno@cms.hhs.gov>; "Fan, Kristin (CMS/CMCS)" <Kristin.Fan@cms.hhs.gov>; "Goldstein, Stuart (CMS/CMCS)" <STUART.GOLDSTEIN@cms.hhs.gov>; "Heitt, Melissa (CMS/FCHCO)" <Melissa.Heitt@cms.hhs.gov>; "Mosley, Elle (CMS/CMCS)" <larrica.mosley@cms.hhs.gov>; "Schoonover, Matthew (CMS/CMCS)" <matthew.schoonover@cms.hhs.gov>; "Holligan, Ricardo (CMS/CMCS)" <Ricardo.Holligan@cms.hhs.gov>
Subject: RE: RE: FL Proposal D Amendment 2020-2021-just FYI
Attachments: Attachments A and B 102722 (002).docx

Also, just in case people donâ€™t have this document already, here is a document detailing the financial management review or FMR that we are doing in Florida relating to LPPFs. Itâ€™s third on the list. Â An FMR is a kind of audit that FMG does when we have questions about something that is more in depth than the standard review as part of our regular oversight activities and reviewing the CMS-64. We did a similar FMR on Floridaâ€™s SDP for the previous year as well that Laura Snyder, Lovie, Alex, and DMCP were heavily involved in throughout the process. I imagine that state directed payments will be an increasingly common topic for FMRs in the future given the large and increasing dollar amount that seems to be shifting into state directed payments. As you can see, conditionality of IGTs is one of the items we are reviewing. We write, â€œThis is to ensure the state is not making payment into the LPPFs / IGT a contingency for receiving SDPs back from the state.â€□

Best,

Jonathan

Jonathan Endelman, PhD

Social Science Research Analyst

Centers for Medicare & Medicaid Services (CMS)

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410.786.4738

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Baltimore, MD 21244-1850

From: Endelman (he/him), Jonathan (CMS/CMCS)
Sent: Friday, February 17, 2023 7:00 AM
To: Staton, Sidney (CMS/CMCS) <Sidney.Staton@cms.hhs.gov>; Campbell-OConnor, Aimee (CMS/CMCS) <Aimee.Campbell-OConnor1@cms.hhs.gov>; Sarah Whitehouse <Whitehouse-Sarah@norc.org>; Snyder, Laura (CMS/CMCS) <Laura.Snyder1@cms.hhs.gov>; Davis, Lovie (CMS/CMCS) <Lovie.Davis@cms.hhs.gov>; Loizias, Alex (CMS/CMCS) <Alexandra.Loizias@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Clark, Jennifer (CMS/CMCS) <Jennifer.Clark@cms.hhs.gov>; Cuno, Richard (CMS/CMCS) <Richard.Cuno@cms.hhs.gov>; Fan, Kristin (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>; Goldstein, Stuart (CMS/CMCS) <STUART.GOLDSTEIN@cms.hhs.gov>; Heitt, Melissa (CMS/FCHCO) <Melissa.Heitt@cms.hhs.gov>; Mosley, Elle (CMS/CMCS) <larrica.mosley@cms.hhs.gov>; Schoonover, Matthew (CMS/CMCS) <matthew.schoonover@cms.hhs.gov>
Subject: RE: FL Proposal D Amendment 2020-2021-just FYI

Thank you Aimee for the article and for your concerns. I believe that the new managed care rule that is currently in development will help to address some of the oversight deficiencies that you have identified regarding the lack of a UPL-type mechanism on the managed care side to serve as an upper ceiling on payment amounts. I believe that ACR or average commercial rate is one of the tools that we have used in the past to serve in this capacity. Regarding your point about actuarial soundness, I agree. Itâ€™s something that Anna and I have discussed in the past and others have also brought up. Regarding the article from AHCA the â€œFlorida Medicaid Health Care Alertâ€□ from July 22, 2021, I think that is helpful. The entity mentioned in the article â€œAdelanto Healthcare Venturesâ€□ is a health care consultant based out of Austin that was also involved in setting up the Texas LPPF. In most instances of what we would think of as â€œtaxesâ€□ in everyday life, no one wants to be taxed. In the world of healthcare-related taxes, everyone wants to be taxed because they anticipate receiving more than their tax cost back in increased Medicaid payments. Regarding the conditional nature of the IGT, â€œIf your hospital is not sure whether you are included and would like to be included in the Agencyâ€™s projections for the hospital directed payment programâ€□ I seem to remember something that this may be problematic, but I would defer to Andrew for that as being the SME on IGTs. These are important issues. The oversight system was built on Medicaid FFS payments. Now that 80% or more of payments have shifted to be on managed care and especially with the growing importance of state directed payments, oversight becomes more difficult because state directed payments are relatively new and donâ€™t have all of the oversight mechanisms in place as exist on the FFS side of the house. We are working on building them now and we hope that they will be operational moving forward. I definitely think the larger issues you point out are worth discussing either on the next NORC FMR call or else on a separate call. I look forward to talking with you.

Best,

Jonathan

Jonathan Endelman, PhD

Social Science Research Analyst

Centers for Medicare & Medicaid Services (CMS)

Center for Medicaid and CHIP Services (CMCS)

Financial Management Group (FMG)

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Baltimore, MD 21244-1850

From: Staton, Sidney (CMS/CMCS) <Sidney.Staton@cms.hhs.gov>
Sent: Thursday, February 16, 2023 3:44 PM
To: Campbell-OConnor, Aimee (CMS/CMCS) <Aimee.Campbell-OConnor1@cms.hhs.gov>
Cc: Endelman (he/him), Jonathan (CMS/CMCS) <Jonathan.Endelman@cms.hhs.gov>
Subject: RE: FL Proposal D Amendment 2020-2021-just FYI

Hi Aimee â€“ Thank you for sharing. I do not participate in the SDP pre-prints review. Iâ€™m also cc Jonathan in case he has not seen this.

Sid

From: Campbell-OConnor, Aimee (CMS/CMCS) <Aimee.Campbell-OConnor1@cms.hhs.gov>
Sent: Thursday, February 16, 2023 2:58 PM
To: Staton, Sidney (CMS/CMCS) <Sidney.Staton@cms.hhs.gov>
Subject: FW: FL Proposal D Amendment 2020-2021-just FYI

Hey Sid!

Just sharing as FYI. Not sure whether you participate in review of SDP pre-prints.

☺

Aimee

From: Campbell-OConnor, Aimee (CMS/CMCS)
Sent: Thursday, February 16, 2023 2:55 PM
To: Delvecchio, Lynn (CMS/CMCS) <Lynn.DelVecchio@cms.hhs.gov>
Subject: FW: FL Proposal D Amendment 2020-2021

Just FYI. 😊

From: Campbell-OConnor, Aimee (CMS/CMCS)
Sent: Thursday, February 16, 2023 2:52 PM
To: CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>
Subject: RE: FL Proposal D Amendment 2020-2021

Hi Alex!

I reviewed the SDP pre-print. I guess I donâ€™t understand how submission of a pre-print amendment for 2020-2021, 2 years after the fact is actually tied to helping with access or utilization at this point? The support provided for this SDP in the pre-print is minimal at best. I donâ€™t have any actual comments because there doesnâ€™t seem to be much justification in terms of an improvement in care for beneficiaries for these payments.

What is the purpose of this amendment? The purpose seems to be to provide extra funds to the hospitals using the SDP as a vehicle. If the rates were determined to be actuarily sound, then access should have been considered as part of that. If the rates are not sufficient at this point, where is the data to show that and why wouldnâ€™t they just address any concerns with the plans? And/or, raise rates with a rate amendment?

See- http://www.icontact-archive.com/archive?c=227375&f=11179&s=13873&m=852437&t=850d8a08f66cb5c2e1e49656573dbe0caeb447b39b9d192096e732cbe37425f5

This arrangement where the State indicates to the hospitals that we are offering you an opportunity to get higher payments if you help contribute the State match, sounds potentially problematic. There is an article from FL Taxwatch on the SDP program that provides some insight. (attached)

I know that on the FFS side of the house we have UPLs, scrutiny of taxation and CPE arrangements to make sure that funds are not â€œrecycled.â€□ Here is an article from George Mason university on State financing strategies in Medicaid that mentions IGTs as a problematic strategy. https://www.mercatus.org/research/research-papers/medicaid-provider-taxes-gimmick-exposes-flaws-medicaids-financing

Florida may be allowed to use IGTs as State match under current regulations but I do wonder about how well their strategy aligns with the safeguards CMS has put in place on the FFS side.

I hope this is helpful. I know that Sid and FMG are looking at the Provider Participation Fund for this coming year and that CMS sent a Companion letter with one of the approvals last year. This may be an area where further guidance would be beneficial.

☺

Aimee

Aimee.Campbell-OConnor1@cms.hhs.gov

(207) 441-2788

West Branch

Division of Managed Care Operations (DMCO)

Centers for Medicare & Medicaid Services (CMS)

From: CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>
Sent: Friday, February 10, 2023 1:11 PM
To: CMS OACT Medicaid Managed Care <OACTMedicaidManagedCare@cms.hhs.gov>; CMS SDP_QUALITY <SDP_QUALITY@cms.hhs.gov>; Campbell-OConnor, Aimee (CMS/CMCS) <Aimee.Campbell-OConnor1@cms.hhs.gov>
Cc: CMS DMCP Medicaid Managed Care Rates <DMCPrates@cms.hhs.gov>; CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>
Subject: FL Proposal D Amendment 2020-2021

Good Afternoon FRT,

Florida submitted a preprint amendment for formal CMS approval pursuant to 42 CFR 438.6(c). The files are available at the following link (b)(5)

(b)(5)

Please note the following:

- This is an amendment submission for this payment arrangement.
- The previously approved preprint is available here: (b)(5)

- This proposal is eligible for an annual approval.
- The 90th day for this review is May 11, 2023

FRT feedback for the state is due by **COB, March 3, 2023**. If DMCP does not receive a response by this deadline, we will assume that the FRT member has no questions for the state for addition to the question set and concurs on approval of the preprint. Please reach out with any questions and thanks for your review.

Thank you,

Lovie

From:	"Sebree, Fredrick (CMS/CMCS)" <Fredrick.Sebree@cms.hhs.gov>
Sent:	4/3/2023 12:36:40 PM +0000
To:	"Endelman (he/him), Jonathan (CMS/CMCS)" <Jonathan.Endelman@cms.hhs.gov>
Subject:	FW: FW: SPA MO 22-0025 NF rebase
Attachments:	B1B2 - Actual SFY 2022 & Projections SFY 2023.xlsx; State Response to CMS email dated 3-29-23.docx; MPP Addendum A.pdf

Good morning Jonathan,

Responses from the state regarding the NFRA is attached. Looks like they are referencing the MPP for the distribution.

Fredrick J. Sebree

Accountant

Division of Reimbursement Review

Centers for Medicare and Medicaid Services

600 East Monroe Street, Room 215

Springfield, Illinois 62701

RightFax: 443-380-5221

Email: Fredrick.sebree@cms.hhs.gov

From: Brite, Tony <Tony.Brite@dss.mo.gov>
Sent: Friday, March 31, 2023 12:13 PM
To: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>
Cc: Crump, Marissa <Marissa.Crump@dss.mo.gov>; Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>; Percy, Nate <Nate.Percy@dss.mo.gov>
Subject: Fwd: SPA MO 22-0025 NF rebase

Fred,

Please find the responses and attachments related to the questions below.

Thanks,

Tony

From: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>
Sent: Wednesday, March 29, 2023 7:45 AM
To: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>; Crump, Marissa <Marissa.Crump@dss.mo.gov>
Cc: Brite, Tony <Tony.Brite@dss.mo.gov>
Subject: RE: SPA MO 22-0025 NF rebase

Good morning,

MO 22-0025 has been presented to leadership and the SPA is good to go but our tax team wanted to touch base on the NFRA. Below are a few questions/confirmations:

1. To confirm, the Nursing Facility Reimbursement Allowance (NFRA) does not have any redistributions. Is that correct?
2. Is the NFRA broad-based and uniform? Are any providers excluded? Are any providers taxed at different rates?
3. Using the most recent data available, how much does the state anticipate raising from the NFRA?
4. For the purposes of the 6% test, what percentage of net patient revenue for the permissible class is raised by all taxes on the services of nursing facilities, including the NFRA?

Thanks again

Fredrick J. Sebree

Accountant

Division of Reimbursement Review

Centers for Medicare and Medicaid Services

600 East Monroe Street, Room 215

Springfield, Illinois 62701

RightFax: 443-380-5221

Email: Fredrick.sebree@cms.hhs.gov

From: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>
Sent: Tuesday, March 21, 2023 12:24 PM
To: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>; Crump, Marissa <Marissa.Crump@dss.mo.gov>
Cc: Brite, Tony <Tony.Brite@dss.mo.gov>
Subject: RE: SPA MO 22-0025 NF rebase

The approval package looks good.

Thank you,

Rebecca L. Rucker, CPA

Assistant Deputy Director, IRU

Department of Social Services, MO HealthNet Division

(573) 751-3737

Rebecca.L.Rucker@dss.mo.gov

â€œTogether we will build a best in class Medicaid program that addresses the needs of Missouriâ€™s most vulnerable in a way that is financially sustainable.â€□

From: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>
Sent: Tuesday, March 21, 2023 9:44 AM
To: Crump, Marissa <Marissa.Crump@dss.mo.gov>
Cc: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>; Brite, Tony <Tony.Brite@dss.mo.gov>
Subject: RE: SPA MO 22-0025 NF rebase

Thanks again for the responses, attached is the unsigned approval package. I updated the 179 to reflect the new title page in block 7 since it is not getting superseded but needing to get included in the new pages. I also updated the acting director, thanks for catching that. If you can send concurrence I will move forward with the approval recommendation.

V/R

Fredrick J. Sebree

Accountant

Division of Reimbursement Review

Centers for Medicare and Medicaid Services

600 East Monroe Street, Room 215

Springfield, Illinois 62701

RightFax: 443-380-5221

Email: Fredrick.sebree@cms.hhs.gov

From: Crump, Marissa <Marissa.Crump@dss.mo.gov>
Sent: Monday, March 20, 2023 2:11 PM
To: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>
Cc: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>; Brite, Tony <Tony.Brite@dss.mo.gov>
Subject: RE: SPA MO 22-0025 NF rebase

Please see attached in response to your email below. Let us know if there is anything else you need from us.

Thank you,

Marissa Crump

Executive Assistant

Missouri Department of Social Services/MO HealthNet Division

Marissa.Crump@dss.mo.gov

(573)751-6884

From: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>
Sent: Thursday, March 16, 2023 11:10 AM
To: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>; Brite, Tony <Tony.Brite@dss.mo.gov>
Subject: RE: SPA MO 22-0025 NF rebase

Good morning,

Below are the last round of questions, I believe, I have. I attached the unsigned draft of the approval package as well as the SFQs. Please review the unsigned draft of the approval package to make sure we are capturing the new pages correctly, since the SPA is so big, so we can avoid any miscommunication or technical corrections after the approval. If we have updates to the pages or 179 we can just make the updates to this document, if that is alright.

Language

-The title page, prior to page 66, is not referenced in block 7 of the 179 and does not have any page number so it may get omitted on our side when cataloging in the system. Can we add â€œtitleâ€□ page to block 7 or assign a page number (65a) to make sure it gets included in CMSâ€™ version of the state plan (also in the correct location after 65)?

-Page 1 appears to be the beginning of the of the current (soon to be obsolete) NF methodology. It seems that the state intends to keep the old methodology and sunset it for 6/30/2022. So the beginning pages of the 4.19-D will be sunset after this SPA is approved (I am pretty sure is not the case but may be better to refernce)?. Please confirm my understanding and let me know if it would be more comprehensive to reference the new methodology and that it starts on page 66.

SFQs

-The non-federal share of the funding referenced in the SFQs for NF services includes appropriations, IGT, and CPE. I did not see taxes (NFRA) referenced in the SFQs but I see it is still in the plan language. Is the NFRA still a provider assessment for NF services? Does 13 CSR 70-10.110 still apply

($12.93 to all NFs on a per patient basis)? If so can we get the NFRA added to the SFQs for this SPA and future SPAs where the NFRA is in effect?

-The SFQs references Swope Ridge Geriatric Center as the only provider that utilizes a CPE. It seems that there is a reconciliation process so I donâ€™t see any issues with the mechanics. My question is the frequency of the CPE. I see that the 2021 NF UPL captured the provider and it looks like we will see the provider in the 2023 NF UPL (given the language in the SFQs). Why was the provider omitted from the 2022 NF UPL? From the language it seems 2021 CPE was paid in 2022 for 2021 but it was in the 2021 UPL. Why is that not the case for the 2022 CPE? It looks like there hasnâ€™t been any changes to the language since MO 18-0015 starting on page 60 BB1, please confirm.

Thanks again and feel free to send any questions you have.

Fredrick J. Sebree

Accountant

Division of Reimbursement Review

Centers for Medicare and Medicaid Services

600 East Monroe Street, Room 215

Springfield, Illinois 62701

RightFax: 443-380-5221

Email: Fredrick.sebree@cms.hhs.gov

From: Sebree, Fredrick (CMS/CMCS)
Sent: Wednesday, March 15, 2023 2:34 PM
To: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>; Brite, Tony <Tony.Brite@dss.mo.gov>
Subject: RE: SPA MO 22-0025 NF rebase

I knew I seen them somewhere, thanks.

Fredrick J. Sebree

Accountant

Division of Reimbursement Review

Centers for Medicare and Medicaid Services

600 East Monroe Street, Room 215

Springfield, Illinois 62701

RightFax: 443-380-5221

Email: Fredrick.sebree@cms.hhs.gov

From: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>
Sent: Wednesday, March 15, 2023 2:32 PM
To: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>; Brite, Tony <Tony.Brite@dss.mo.gov>
Subject: RE: SPA MO 22-0025 NF rebase

Fredrick,

The standard funding questions are included in the cover letter. Iâ€™ve attached a copy of the letter for your convenience.

Thank you,

Rebecca L. Rucker, CPA

Assistant Deputy Director, IRU

Department of Social Services, MO HealthNet Division

(573) 751-3737

Rebecca.L.Rucker@dss.mo.gov

â€œTogether we will build a best in class Medicaid program that addresses the needs of Missouriâ€™s most vulnerable in a way that is financially sustainable.â€□

prohibited. If you have received this in error, please notify the sender and destroy the material received.

From: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>
Sent: Wednesday, March 15, 2023 2:02 PM
To: Brite, Tony <Tony.Brite@dss.mo.gov>
Cc: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>
Subject: RE: SPA MO 22-0025 NF rebase

Good afternoon Tony,

Can you forward the standard funding questions for NF services? I am not seeing it in my folder. My apologies if it was sent and I am missing it.

Fredrick J. Sebree

Accountant

Division of Reimbursement Review

Centers for Medicare and Medicaid Services

600 East Monroe Street, Room 215

Springfield, Illinois 62701

RightFax: 443-380-5221

Email: Fredrick.sebree@cms.hhs.gov

From: Brite, Tony <Tony.Brite@dss.mo.gov>
Sent: Monday, March 6, 2023 2:34 PM
To: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>
Cc: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>
Subject: RE: SPA MO 22-0025 NF rebase

Fred,

The stakeholders concerns regarding the payment methodology have been remedied. Hope that helps with the review.

Thanks,

Tony

From: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>
Sent: Monday, March 6, 2023 10:42 AM
To: Brite, Tony <Tony.Brite@dss.mo.gov>
Cc: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>
Subject: RE: SPA MO 22-0025 NF rebase

Good morning Tony,

I had a chance to go through both the informal inquiry and the formal RAI last week and I think are looking good. Itâ€™s a big SPA so I plan to comb through the pages another time and finish the review of the UPL soon but I donâ€™t anticipate any issues. Thanks for sending the NF reimbursement FAQs with the stakeholders comments and questions during the process. The only question I can think of at this point is if all the stakeholder concerns remedied. If you could confirm that I will keep you in the loop as the review progresses. I am hoping to wrap it up by next week if that works.

Thanks for checking in.

Fredrick J. Sebree

Accountant

Division of Reimbursement Review

Centers for Medicare and Medicaid Services

600 East Monroe Street, Room 215

Springfield, Illinois 62701

RightFax: 443-380-5221

Email: Fredrick.sebree@cms.hhs.gov

From: Brite, Tony <Tony.Brite@dss.mo.gov>
Sent: Monday, March 6, 2023 10:07 AM

To: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>
Cc: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>
Subject: RE: SPA MO 22-0025 NF rebase

Hello Fred,

I am checking in on the status of the NF rate review. Can you provide any information in terms of timeline? Or whether we should expect any additional questions?

Thanks for your help!

Tony

From: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>
Sent: Thursday, February 23, 2023 10:53 AM
To: Crump, Marissa <Marissa.Crump@dss.mo.gov>; Walker, Michala (CMS/CMCS) <Michala.Walker@cms.hhs.gov>
Cc: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>; Brite, Tony <Tony.Brite@dss.mo.gov>; Bromwell, Robert (CMS/CMCS) <Robert.Bromwell@cms.hhs.gov>
Subject: RE: SPA MO 22-0025 NF rebase

Thanks again Marissa, Ill keep you in the loop as I review.

Fredrick J. Sebree

Accountant

Division of Reimbursement Review

Centers for Medicare and Medicaid Services

600 East Monroe Street, Room 215

Springfield, Illinois 62701

RightFax: 443-380-5221

Email: Fredrick.sebree@cms.hhs.gov

From: Crump, Marissa <Marissa.Crump@dss.mo.gov>
Sent: Thursday, February 23, 2023 10:47 AM
To: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>; Walker, Michala (CMS/CMCS) <Michala.Walker@cms.hhs.gov>
Cc: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>; Brite, Tony <Tony.Brite@dss.mo.gov>; Bromwell, Robert (CMS/CMCS) <Robert.Bromwell@cms.hhs.gov>
Subject: RE: SPA MO 22-0025 NF rebase

Attached is our response to this IRAI.

Thank you,

Marissa Crump

Executive Assistant

Missouri Department of Social Services/MO HealthNet Division

Marissa.Crump@dss.mo.gov

(573)751-6884

From: Brite, Tony <Tony.Brite@dss.mo.gov>
Sent: Monday, October 31, 2022 10:10 AM
To: Crump, Marissa <Marissa.Crump@dss.mo.gov>
Cc: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>
Subject: Fwd: SPA MO 22-0025 NF rebase

FYI

Sent from my iPad

Begin forwarded message:

From: "Sebree, Fredrick (CMS/CMCS)" <Fredrick.Sebree@cms.hhs.gov>
Date: October 31, 2022 at 10:04:50 AM CDT
To: "Brite, Tony" <Tony.Brite@dss.mo.gov>
Cc: "Rucker, Rebecca L" <Rebecca.L.Rucker@dss.mo.gov>, "Read, Deborah (CMS/CMCS)" <Deborah.Read@cms.hhs.gov>
Subject: RE: SPA MO 22-0025 NF rebase

ï»¿

Good morning Tony,

Sorry again for the delay. Below are a few informal questions I have for MO 22-0025, NF rebase:

1. Attached are the proposed pages for 66-120 that contains the new language. These pages annotate â€œdraftâ€□ on each of the pages with the exception of the title page. Is there a final â€œcleanâ€□ version? Does the state want to keep the first title page or is it part of the draft version?
2. Please provide a calculation of the budget impact annotated on the CMS 179 block 6.
3. Does the state have any supporting info/documentation/explanation behind how the rate methodology was developed to help support the economy and efficiency of the rates? The UPL helps support the economy and efficiency, just wanted to know if it was establish during the development of the methodology in some way. Were stakeholders involved in the rate development process? If so, how? Was the methodology modeled after another state?
4. Please provide any stakeholder comments/concerns, if any, during the public notice period.
5. Did the state model the value based language and incentives from CMS guidance? If not, how was the methodology developed?

Our quality team at CMS will be reviewing the incentive language as well as myself. We will get back to you on any specifics in the language as soon as we can.

Thanks again

Fredrick J. Sebree

Accountant

Division of Reimbursement Review

Centers for Medicare and Medicaid Services

600 East Monroe Street, Room 215

Springfield, Illinois 62701

RightFax: 443-380-5221

Email: Fredrick.sebree@cms.hhs.gov

From: Brite, Tony <Tony.Brite@dss.mo.gov>
Sent: Friday, October 28, 2022 9:22 AM
To: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>
Cc: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>
Subject: RE: SPA MO 22-0025 NF rebase

Thanks Fred, we just wanted to make sure we hadnâ€™t missed it. Have a good weekend!

From: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>
Sent: Friday, October 28, 2022 9:16 AM
To: Brite, Tony <Tony.Brite@dss.mo.gov>
Cc: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>
Subject: Re: SPA MO 22-0025 NF rebase

Hello Tony,

You are correct and I was hoping to send them this week. I'll make sure to get them out to you first thing next week. Hope that is alright.

Thanks for checking in.

Fredrick J. Sebree

Accountant

Division of Reimbursement Review

Centers for Medicare and Medicaid Services

600 East Monroe Street, Room 215

Springfield, Illinois 62701

RightFax: 443-380-5221

Email: Fredrick.sebree@cms.hhs.gov

From: Brite, Tony <Tony.Brite@dss.mo.gov>
Sent: Friday, October 28, 2022, 9:01 AM
To: Sebree, Fredrick (CMS/CMCS) <Fredrick.Sebree@cms.hhs.gov>
Cc: Rucker, Rebecca L <Rebecca.L.Rucker@dss.mo.gov>
Subject: SPA MO 22-0025 NF rebase

Hi Fred,

You had mentioned on the 15 day call a few weeks ago that you anticipated providing us with initial questions that week on 22-0025 for Nursing Facilities. Do you know if those were sent? I have not seen them come through yet.

Thanks,

Tony

330 Independence Ave. S.W., Washington, D.C. 20201

(202) 205-8778 | Jeremy.Vogel@hhs.gov

From:	"Howe, Rory (CMS/CMCS)" (b)(5) (b)(5)
Sent:	4/26/2023 9:17:34 PM +0000
To:	Daniel Tsai (CMS/OA) (daniel.tsai@cms.hhs.gov)
CC:	"Costello, Anne Marie (CMS/CMCS)" <AnneMarie.Costello@cms.hhs.gov>; "Vitolo, Sara (CMS/CMCS)" <Sara.Vitolo@cms.hhs.gov>; Perrie Briskin (CMS/OA) (perrie.briskin@cms.hhs.gov); "Hebert, Krista (CMS/CMCS)" <krista.hebert@cms.hhs.gov>; "Kochanski, Joseph (CMS/CMCS)" <Joseph.Kochanski@cms.hhs.gov>
Subject:	MO/TX Tax Timeline
Attachments:	Key MO-TX-Tax Timeline, 4-26-23.docx; Attachment A - 2008 Final Tax Rule - Summary of Relevant Discussion.docx; Attachment B - Provider Reimbursement Review Board Decision 2009 D-42.pdf; Attachment C - Decision of the Administrator Review of PRRB Decision Number 2009-D42.pdf; Attachment D - LPPF Questions and Answers 10.16.docx; Attachment E - Greenberg_Texas Financing Letter12 20 18.pdf; Attachment F - LPPF Hold Harmless Evidence.pdf; Attachment G - HHSC Responses to CMS Questions 08202019.docx; Attachment H - Missouri FRA Tax Hold Harmless - OGC Note to FMG (002).pdf; Attachment I - CMS Letter MO Medicaid Managed Care 07 28 2020 final - Signed.pdf

Hi Dan,

As discussed this afternoon, please see attached the requested timeline and attachments. We focused on pre-2021 activity. Please let us know if you have questions or need anything else.

Rory

From: "Howe, Rory (CMS/CMCS)" (b)(5)

(b)(5)

Sent: 1/3/2023 8:56:41 PM +0000
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: FW: FOR CLEARANCE: Internal Q&As for CIB Health Care Related Taxes and Hold Harmless Arrangements
Attachments: Healthcare Related Taxes CIB-Final (CMSDOGCmarkup) FMG.docx

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

202.690.6277

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

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From: "Howe, Rory (CMS/CMCS)" (b)(5)

(b)(5)

Sent: 11/8/2022 9:16:39 PM +0000
To: Stacie Weeks <sweeks@dhcfp.nv.gov>
CC: "Silanskis, Jeremy (CMS/CMCS)" <Jeremy.Silanskis@cms.hhs.gov>
Subject: RE: RE: Attestation Form
Attachments: NV Financing, 11-8-22.docx

Hi Stacie,

Please see attached some information regarding possible provider attestation approaches that we previously discussed and have shared with other states. The first option involves direct written attestations from each provider and the second option consists of an alternative approach involving meeting with your provider community. For the written attestations, the key language that we would expect to see is specified in #3 in the attached. We are open to reviewing alternate language from the state, noting that we would expect something very similar in effect. We also defer to the state regarding any additional process-related language if the state decides to take a written attestation approach.

If it would be helpful, we are open to reviewing draft attestation language, discussing the information that I attached, discussing alternative approaches, or setting up some time to talk about any other questions or concerns that you might have.

Regards,

Rory

Rory Howe

Director

Financial Management Group

CMS/CMCS

(b)(6)

From: Stacie Weeks <sweeks@dhcfp.nv.gov>
Sent: Monday, November 7, 2022 7:29 PM
To: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>
Subject: Attestation Form

Do you happen to have a template for the attestation form for the provider tax/payments that you mentioned the other day on our call?

Stacie Weeks, JD, MPH

Deputy Administrator

Nevada Department of Health and Human Services

Division of Health Care Financing and Policy

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From:	"Mauser, Gayle (CMS/OL)" <Gayle.Mauser@cms.hhs.gov>
Sent:	3/10/2023 6:59:38 PM +0000
To:	"Howe, Rory (CMS/CMCS)" <Rory.Howe@cms.hhs.gov>; "Silanskis, Jeremy (CMS/CMCS)" <Jeremy.Silanskis@cms.hhs.gov>; "Maccarroll, Amber (CMS/CMCS)" <Amber.MacCarroll@cms.hhs.gov>; "Arnold, Charlie (CMS/CMCS)" <Charlie.Arnold@cms.hhs.gov>; "Boston, Beverly (CMS/CMCS)" <Beverly.Boston@cms.hhs.gov>
CC:	"Kirchgraber, Kate (CMS/OL)" <Kate.Kirchgraber@cms.hhs.gov>; "Wiley, Evelyn (CMS/CMCS)" <Evelyn.Wiley@cms.hhs.gov>
Subject:	RE: RE: E&C Majority Inquiry - Hold Harmless
Attachments:	Hold Harmless_Florida Initial Document Request.pdf; Hold Harmless_Florida FMR Engagement Letter.pdf; Hold Harmless_Missouri CMS-64 Review.docx

Hi again FMG team,

We are following up on our prior discussion regarding the hold harmless question we received from E&C majority on what states have impermissible arrangements. Attention has been pulled away from this topic for a bit, but we expect that there will be renewed interest soon (and weâ€™ve started to get some questions from a Texas member as well).

Below are draft talking points for a call with E&C majority, which include a few internal notes and a couple placeholders I am hoping you all can help fill in.

Rory, after FMG reviews these, I believe you were also going to run them by CMCS leadership. Looping Evelyn here to see if we can also hold some windows on your calendar to offer to Committee staff for this discussion â€“ perhaps we aim for times within the next couple weeks? Committee staff havenâ€™t pinged us again yet, but we will let you know if they do.

Thanks,

Gayle

DRAFT Talking Points for E&C Majority Staff Call â€“ Hold Harmless Guidance

- As you know, on February 17, 2023, CMS issued a Medicaid informational bulletin regarding health care-related taxes and hold harmless arrangements involving the redistribution of Medicaid payments.
- Hold harmless arrangements, as defined in the Medicaid statute, are arrangements in which the State or another 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. The statute prohibits these arrangements.

- Recently, we have been approached by several states with questions about complying with this provision of law, and we have also learned of states that may have existing arrangements or are considering establishing them, particularly with respect to states establishing or renewing Medicaid managed care state directed payments.
- The informational bulletin reiterates the federal requirements concerning hold harmless arrangements with respect to health care-related taxes. We hope that this guidance provides additional clarity to states, and we also encourage them to raise any questions or concerns they may have about the permissibility of health care-related taxes to CMS as early in the process as possible, to avoid any issues.
- Regarding your question about which states may have these types of arrangements, there are 3 states that CMS understands may have impermissible hold harmless arrangements, and 1 state we wanted to mention as an example of where we were able to intervene early in the process of establishing what may have been an impermissible hold harmless arrangement.
- Starting with the 3 states that may have these arrangements:
    - ***Texas:***
        - Texas has in place what is known as the Local Provider Payment Fund or LPPF. Based on information obtained by CMS, including limited information provided by the state and publicly available third-party materials, the LPPF arrangements used by some localities in Texas appear to include hold harmless arrangements because the localities impose a tax and the state directly or indirectly provides for payments that guarantee to hold the taxpayers harmless for all or any portion of the tax amount. If our understanding of those LPPF arrangements is correct, they constitute hold harmless arrangements that are prohibited under the Medicaid statute and CMS regulations. [this language is pulled from the publicly available November 2021 letter to the State; page 5 includes additional detail regarding our understanding of the arrangement]
        - CMS has communicated these concerns to the state and, when we recently approved Texasâ€™ state directed payments, we included in our approval letter that approval of the state directed payments does not constitute any specific Medicaid financing mechanism used to support the non-federal share of the provider payment arrangement. We also clarified that we reserve the authority to enforce requirements, including by initiating separate deferrals and/or disallowances of federal financial participation.
        - As you may be aware, the HHS OIG announced in November 2021 that it is examining statesâ€™ use of LPPFs as the state share of Medicaid payments, and that it expects to issue a report in FY 2023 that indicates whether the LPPFs the state agency used were permissible.
    - ***Flori*** (b)(5) (b)(5)
        - Similarly, Florida has in place an LPPF that we also understand includes hold harmless arrangements. [the attached FMR engagement letter includes additional detail regarding our understanding of the arrangement]
        - In Floridaâ€™s case, we were working with the state for some time in an effort to address the concerns, but have been unable to resolve

them. Like Texas, we communicated our concerns to the state and, when we recently approved Floridaâ€™s state directed payments, we provided the same information as was included in the letter to Texasâ€”that the approval does not constitute approval of the Medicaid financing mechanism, and that we reserve the authority to enforce requirements.
        - In late February, we sent a letter to Florida initiating a Financial Management Review (FMR) to examine the state Medicaid agencyâ€™s compliance with federal requirements over the next several months.
    - ***Missouri:***
        - Lastly, Missouri has a longstanding arrangement called the Federal Reimbursement Allowance tax program that appears to include a hold harmless arrangement, and in 2020, CMS engaged the state about its concerns. Also in 2020, the then CMCS Director sent a letter to the state describing our concerns and memorializing a conversation with state Medicaid agency leadership who at that time committed to ending the hold harmless arrangement by X timeframe.
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- With respect to the state I mentioned where we were successful in intervening early:
    - ***Louisiana:***
        - In X month and year, we received information that suggested Louisianaâ€™s legislature was developing what would have been a hold harmless arrangement as part of the financing mechanism for its state directed payment program. We engaged the state about those issues, worked with the state on alternatives that would comply with federal law, and ultimately the state withdrew the state directed payment proposal it had submitted and submitted a modified proposal.
- We are hopeful that the guidance we issued will further promote our efforts to work with states and get ahead of these issues as we did in Louisiana.

From: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>
Sent: Tuesday, February 21, 2023 2:37 PM
To: Mauser, Gayle (CMS/OL) <Gayle.Mauser@cms.hhs.gov>
Cc: Costello, Anne Marie (CMS/CMCS) <AnneMarie.Costello@cms.hhs.gov>; Briskin, Perrie (CMS/CMCS) <Perrie.Briskin@cms.hhs.gov>; Kirchgraber, Kate (CMS/OL) <Kate.Kirchgraber@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Boston, Beverly (CMS/CMCS)

<Beverly.Boston@cms.hhs.gov>
Subject: RE: E&C Majority Inquiry - Hold Harmless

Hi Gayle,

A call sounds right to me. Please also include Jeremy, Amber, and Charlie in the discussion. For awareness, tomorrow, FMG is planning to issue a letter to Florida and a question set to Missouri on this issue. Both states appear to have concerning arrangements in place and the letter/question set tomorrow are part of our work to address the arrangements. Let me know if you have any questions in the interim.

Thanks,

Rory

From: Mauser, Gayle (CMS/OL) <Gayle.Mauser@cms.hhs.gov>
Sent: Tuesday, February 21, 2023 1:57 PM
To: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>
Cc: Costello, Anne Marie (CMS/CMCS) <AnneMarie.Costello@cms.hhs.gov>; Briskin, Perrie (CMS/CMCS) <Perrie.Briskin@cms.hhs.gov>; Kirchgraber, Kate (CMS/OL) <Kate.Kirchgraber@cms.hhs.gov>
Subject: E&C Majority Inquiry - Hold Harmless

Hi Rory,

After Fridayâ€™s hold harmless CIB went out, we received an inquiry from House E&C majority staff asking for more informationâ€”in particular, about the language from the list serv notice indicating â€œrecently, CMS became aware that some health care-related tax programs appear to involve agreements among providers to redistribute their Medicaid payments to hold taxpayers harmless for the cost of the tax.â€□

Specifically, the staff would like to know about the instances CMS has found, and the steps the agency is taking to address those agreements.

I imagine it will be most efficient to have a quick call to discuss actions to date, anticipated upcoming actions, and next steps for responding to the Hillâ€”does that work for you? Are there others who should be included?

Thanks,

Gayle

Gayle Mauser
(she/her)

Low Income Programs Analysis Group

Office of Legislation

Centers for Medicare & Medicaid Services (CMS)

Cell Phon
(b)(6)

From:	"Mauser, Gayle (CMS/OL)" <Gayle.Mauser@cms.hhs.gov>
Sent:	3/13/2023 4:04:35 PM +0000
To:	"Howe, Rory (CMS/CMCS)" <Rory.Howe@cms.hhs.gov>; "Silanskis, Jeremy (CMS/CMCS)" <Jeremy.Silanskis@cms.hhs.gov>; "Maccarroll, Amber (CMS/CMCS)" <Amber.MacCarroll@cms.hhs.gov>; "Arnold, Charlie (CMS/CMCS)" <Charlie.Arnold@cms.hhs.gov>; "Boston, Beverly (CMS/CMCS)" <Beverly.Boston@cms.hhs.gov>
CC:	"Kirchgraber, Kate (CMS/OL)" <Kate.Kirchgraber@cms.hhs.gov>; "Wiley, Evelyn (CMS/CMCS)" <Evelyn.Wiley@cms.hhs.gov>
Subject:	RE: RE: E&C Majority Inquiry - Hold Harmless

Hi all, in addition to the follow-up we owe E&C majority staff, Rep. Al Green's (D-TX) office has inquired about the guidance and how it relates specifically to Texas. We would like to schedule a call between Rory and Rep. Green's office (it will be his Chief of Staff, but it is possible Rep. Green also joins). We'll provide draft Texas-specific talking points that build on the information provided below closer to the meeting.

In the interim, **Evelyn**, can you help us set up the following? If you can offer FMG availability, we will do our best to work around your schedules.

- 30 minutes to prep for the Al Green call, ideally in the couple of days prior to the actual briefing
- A few 30-minute holds that we can offer Rep. Green's office for the week of 3/27

Thanks!

Gayle

From: Mauser, Gayle (CMS/OL)
Sent: Friday, March 10, 2023 2:00 PM
To: Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Silanskis, Jeremy (CMS/CMCS) <Jeremy.Silanskis@cms.hhs.gov>; Maccarroll, Amber (CMS/CMCS) <Amber.MacCarroll@cms.hhs.gov>; Arnold, Charlie (CMS/CMCS) <Charlie.Arnold@cms.hhs.gov>; Boston, Beverly (CMS/CMCS) <Beverly.Boston@cms.hhs.gov>
Cc: Kirchgraber, Kate (CMS/OL) <Kate.Kirchgraber@cms.hhs.gov>; Wiley, Evelyn (CMS/CMCS) <Evelyn.Wiley@cms.hhs.gov>
Subject: RE: E&C Majority Inquiry - Hold Harmless

Hi again FMG team,

We are following up on our prior discussion regarding the hold harmless question we received from E&C majority on what states have impermissible arrangements. Attention has been pulled away from this topic for a bit, but we expect that there will be renewed interest soon (and we've started to get some questions from a Texas member as well).

Below are draft talking points for a call with E&C majority, which include a few internal notes and a couple placeholders I am hoping you all can help fill in.

Rory, after FMG reviews these, I believe you were also going to run them by CMCS leadership. Looping Evelyn here to see if we can also hold some windows on your calendar to offer to Committee staff for this discussion – perhaps we aim for times within the next couple weeks? Committee staff haven't pinged us again yet, but we will let you know if they do.

Thanks,

Gayle

DRAFT Talking Points for E&C Majority Staff Call – Hold Harmless Guidance

- As you know, on February 17, 2023, CMS issued a Medicaid informational bulletin regarding health care-related taxes and hold harmless arrangements involving the redistribution of Medicaid payments.
- Hold harmless arrangements, as defined in the Medicaid statute, are arrangements in which the State or another 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. The statute prohibits these arrangements.
- Recently, we have been approached by several states with questions about complying with this provision of law, and we have also learned of states that may have existing arrangements or are considering establishing them, particularly with respect to states establishing or renewing Medicaid managed care state directed payments.
- The informational bulletin reiterates the federal requirements concerning hold harmless arrangements with respect to health care-related taxes. We hope that this guidance provides additional clarity to states, and we also encourage them to raise any questions or concerns they may have about the permissibility of health care-related taxes to CMS as early in the process as possible, to avoid any issues.
- Regarding your question about which states may have these types of arrangements, there are 3 states that CMS understands may have impermissible hold harmless arrangements, and 1 state we wanted to mention as an example of where we were able to intervene early in the process of establishing what may have been an impermissible hold harmless arrangement.
- Starting with the 3 states that may have these arrangements:
    - ***Texas:***
        - Texas has in place what is known as the Local Provider Payment Fund or LPPF. Based on information obtained by CMS, including limited information provided by the state and publicly available third-party materials, the LPPF arrangements used by some localities in Texas

appear to include hold harmless arrangements because the localities impose a tax and the state directly or indirectly provides for payments that guarantee to hold the taxpayers harmless for all or any portion of the tax amount. If our understanding of those LPPF arrangements is correct, they constitute hold harmless arrangements that are prohibited under the Medicaid statute and CMS regulations. [this language is pulled from the publicly available November 2021 letter to the State; page 5 includes additional detail regarding our understanding of the arrangement]

- CMS has communicated these concerns to the state and, when we recently approved Texas' state directed payments, we included in our approval letter that approval of the state directed payments does not constitute any specific Medicaid financing mechanism used to support the non-federal share of the provider payment arrangement. We also clarified that we reserve the authority to enforce requirements, including by initiating separate deferrals and/or disallowances of federal financial participation.
- As you may be aware, the HHS OIG announced in November 2021 that it is examining states' use of LPPFs as the state share of Medicaid payments, and that it expects to issue a report in FY 2023 that indicates whether the LPPFs the state agency used were permissible.

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- ***Flo***
  - Similarly, Florida has in place an LPPF that we also understand includes hold harmless arrangements. [the attached FMR engagement letter includes additional detail regarding our understanding of the arrangement]
  - In Florida's case, we were working with the state for some time in an effort to address the concerns, but have been unable to resolve them. Like Texas, we communicated our concerns to the state and, when we recently approved Florida's state directed payments, we provided the same information as was included in the letter to Texas—that the approval does not constitute approval of the Medicaid financing mechanism, and that we reserve the authority to enforce requirements.
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John Giles, MPA

Director, Division of Managed Care Policy

Disabled and Elderly Health Programs Group

Center for Medicaid and CHIP Services

Centers for Medicare and Medicaid Services

Department of Health and Human Services

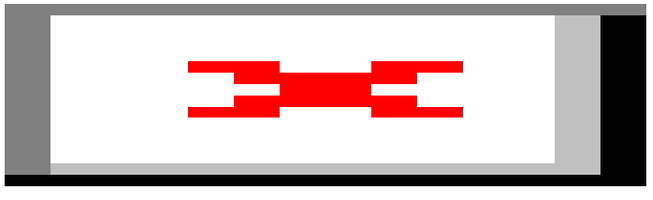
Phone: 410-786-5545

E-mail: John.Giles1@cms.hhs.gov

From: Burke, Sherry Lynn (HHS/OGC) <SherryLynn.Burke@hhs.gov>
Sent: Thursday, April 27, 2023 4:55 PM
To: Giles, John (CMS/CMCS) <John.Giles1@cms.hhs.gov>; Burns, Amanda Paige (CMS/CMCS) <AmandaPaige.Burns@cms.hhs.gov>; Gentile, Amy (CMS/CMCS) <Amy.Gentile@cms.hhs.gov>; Snyder, Laura (CMS/CMCS) <Laura.Snyder1@cms.hhs.gov>
Cc: Kosin, Donald (HHS/OGC) <Donald.Kosin@HHS.GOV>
Subject: FW: [FR] Public Inspection Documents from Centers for Medicare & Medicaid Services

Congrats on the NPRM going out.

From: Federal Register Subscriptions <subscriptions@mail.federalregister.gov>
Sent: Thursday, April 27, 2023 4:17 PM
To: Burke, Sherry Lynn (HHS/OGC) <SherryLynn.Burke@hhs.gov>
Subject: [FR] Public Inspection Documents from Centers for Medicare & Medicaid Services



subscription results for Thursday, April 27th, 2023 2 matching public inspection documents

Public Inspection Documents from Centers for Medicare & Medicaid Services

MATCHING SPECIAL FILINGS

Special Filing updated at 4:15 PM on Thursday, April 27, 2023

Centers for Medicare & Medicaid Services

Proposed Rules

Medicaid Program:

Ensuring Access to Medicaid Services

Filed on: 04/27/2023 at 4:15 pm
Scheduled Pub. Date: 05/03/2023
FR Document: 2023-08959

PDF 410 Pages *(1.02 MB)*
Permalink

Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality

Filed on: 04/27/2023 at 4:15 pm
Scheduled Pub. Date: 05/03/2023
FR Document: 2023-08961

PDF 501 Pages *(1.17 MB)*
Permalink

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