May 22, 2007

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

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

Dear Ms. Norwalk:

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

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

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

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

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

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

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

The three major areas of concern identified by states include:

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

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

<u>Provisions of the Proposed Rule</u>

§433.68(f) Tests to Determine Hold Harmless Arrangements

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

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

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

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

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

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

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

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

§433.68(f)(2) Medicaid Payment Test

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

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

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

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

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

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

§433.68(f)(3) Guarantee Test
Under the third test for a hold harmless arrangement, the guarantee test determines if there is a direct or indirect guarantee that holds taxpayers harmless for any portion of their tax cost. States recognize that Congress sought to provide clarity through the Tax Relief and Health Care Act of 2006, by incorporating the indirect guarantee "safe harbor" test provision into Section 1093(w)(4)(C) of the statute.

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

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

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

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

Conclusion

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

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

Sincerely,

Jerry Friedman
Executive Director
American Public Human Services Association

David Parrella
Chair
NASMD Executive Committee