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May 29, 2009

Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

***Re: (CMS-2275-P2) Medicaid Program; Health Care-Related Taxes Proposed Rule
Delay Implementation (Vo. 74, No.86), May 6, 2009***

Dear Ms. Frizzera:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 40,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule to delay implementation of changes in Medicaid policy on health care-related taxes used by the states to support their share of Medicaid expenditures. The AHA applauds CMS' decision to delay the implementation of the policy changes until July 1, 2010 to allow for additional time to determine if these changes are necessary.

In previous correspondence to CMS, the AHA raised serious concerns regarding the agency's changes to the standards for determining whether an impermissible hold harmless arrangement exists within a health care-related tax. In February 2009, Congress expressed its concerns by enacting a moratorium of the February 22, 2008 final rule in the *American Recovery and Reinvestment Act*. CMS' policy changes in the final rule represent a substantial departure from long-standing Medicaid policy by imposing subjective, overly broad standards for determining the existence of hold harmless arrangements. These policy changes could create great uncertainty for state governments and hospitals, making it difficult for them to adopt or implement Medicaid health care-related tax programs with reasonable assurance that they are compliant. As a result, states and hospitals will be left open to after-the-fact challenges. In addition, the vaguer and broader standards CMS imposes in the final rule could limit states from implementing legitimate provider tax programs that are consistent with the Medicaid statute and congressional intent. **The AHA recommends that CMS permanently withdraw the policy changes below regarding the standards for determining an impermissible hold harmless arrangement.**



STANDARDS FOR DETERMINING A HOLD HARMLESS ARRANGEMENT

The current standards for determining the existence of impermissible hold harmless arrangements within health care-related taxes are: the positive correlation test; the Medicaid payment test; and the guarantee test. Through the *Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991* (P.L. 102-234), Congress provided guidance on how to frame the standards for determining when a tax-paying provider is being held harmless for the payment of a tax. The implementing regulations further clarified the standards for the hold harmless test and were developed jointly with state governments and other key stakeholders. The agency sought to apply clear and specific rules for identifying a hold harmless arrangement because, as it noted in the 1993 final rule, a more subjective analysis would be administratively burdensome and virtually impossible to apply fairly (HCFA Final Rule, Health Care-Related Taxes, 58 Federal Register 43,156, 43166, 43167 (August 13, 1993)).

However, CMS clearly states in the preamble to the 2007 proposed rule and in the response to comments in the final rule, that some degree of subjectivity would be part of its analysis of hold harmless arrangements, and in doing so, the agency implied it is willing to accept the uncertainty and potential unfairness of a subjective standard (FR Vol. 72, No. 56 13729). Furthermore, under the policy in the final rule, states and hospitals would no longer be able to rely on explicit standards contained in CMS regulations when considering provider tax programs, but would have to live with the uncertainty that subjective analysis undoubtedly would bring.

POSITIVE CORRELATION TEST

The 1993 rule defined the term “positively correlated” to require a statistical analysis. However, in the proposed rule and final rule, CMS argues that establishing a positive correlation should not be limited to a quantitative analysis but be broadened to include a more subjective analysis, such as finding linkages between a tax rate and other payments to providers. CMS claims that a positive correlation can be found simply by the fact that a provider payment, grant or credit program and a provider tax are enacted in the same legislative session. In this case, CMS appears to be reserving as much leeway as possible to determine what is and is not an appropriate tax. In doing so, we continue to argue that the agency has made its guidance so broad as to be meaningless, using as a rationale that it is impossible to anticipate all the hold harmless arrangements that could be created.

MEDICAID PAYMENT TEST

Current federal law governing health care-related taxes states that the prohibition of hold harmless arrangements “...shall not prevent the 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” (U.S.C. Section 1936b(w)(4)). The law and current regulation recognize that a provider’s expenses for the Medicaid portion of a provider tax are an allowable Medicaid expenditure. CMS, through the final rule, would reverse policy and statute by asserting that a hold harmless arrangement is present when the state makes Medicaid payments to providers in a supplemental form or

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otherwise, and the payment would be measured by the Medicaid portion of the provider's tax liability.

GUARANTEE TEST

The third test the agency used in the final rule to determine if an impermissible hold harmless arrangement exists was whether the taxpayers are directly or indirectly held harmless for any portion of tax costs. CMS stated in the preamble to the proposed rule and in comments to the final rule that a direct guarantee does not need to be an explicit promise or assurance of payment. The agency suggested that merely having a state statute, regulation or policy that provides for a payment to the provider would be enough to trigger the suspicion of a hold harmless arrangement. In this policy CMS reversed its own long-standing policy established in the 1993 regulation and acted contrary to the language of the statute when it stated that a direct guarantee could be triggered even in the absence of an explicit assurance. Once more, CMS would be relying on subjective analysis to determine the existence of a hold harmless arrangement when looking at the direct guarantee test.

Through the final rule, CMS gives itself broad sweeping authority to determine when an impermissible hold harmless arrangement exists. CMS admitted that it would be using subjective analyses when making these determinations. The effect of the final rule could be to eliminate provider tax programs that are authorized by the statute and that Congress intended states to be able to maintain. And the final rule could reduce the ability of state government and hospitals to understand whether a provider tax program under development could meet CMS' approval. This degree of subjective analysis and uncertainty is unacceptable. The AHA urges CMS to permanently withdraw the policy changes contained in the final rule regarding the standards identified above for determining an impermissible hold harmless arrangement.

If you have any questions regarding our comments, please contact me or Molly Collins Offner, senior associate director for policy, at (202) 626-2326 or mcollins@aha.org.

Sincerely,

Rick Pollack
Executive Vice President