CMS Is Aware of At Least 14 States That Contest Authority Over Private Agreements

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At least 14 states specifically objected to Centers for Medicare and Medicaid Services' (CMS) last attempt to expand the hold harmless definition to include private agreements, the Medicaid Fiscal Accountability Rule (MFAR). That rule would have established the same "reasonable expectation of reimbursement" test CMS now proposes in the February 2023 Informational Bulletin. Notably, CMS withdrew MFAR, acknowledging comments from many states and stakeholders criticizing the rule as agency overreach. Nevertheless, CMS is resurrecting its abandoned position and now imposing a new duty on states, telling them that they must (1) make clear to providers that any such redistribution arrangements are not permissible, (2) learn the details of how health care-related taxes are collected, and (3) take steps to curtail redistribution practices if they exist.

Alabama Medicaid Agency	In short, the statute does not give CMS the authority to hold States responsible for private transactions among taxpayers to which they are not a party, and such an interpretation threatens enormous liability on the States for activity over which they have no control. Further, the proposed rule would strongly discourage provider participation in the Alabama Medicaid program if participation means being subjected to burdensome scrutiny of the provider's financials by state Medicaid agencies. Finally, lack of provider participation would result in a decrease to access for care for those dependent on Alabama Medicaid.
North Carolina Department of Health and Human Services	[P]roviders enter into myriad arrangements with each other for various legitimate business reasons; NC DHHS is concerned that any agreement between two providers could be subject to scrutiny and jeopardize the State's entire provider tax. It is also unclear what role, if any, the Medicaid Agency plays in making such a determination. If finalized, the lack of clarity could lead to considerable confusion for states and providers as they attempt to comply with the regulations.
Oregon Health Authority	Oregon is concerned the "net effect" test could impact current hospital taxes and IGT agreements, which provide the state's share of qualified directed payments to Oregon hospitals tied to utilization of CCO-enrolled Medicaid and CHIP Oregon Health Plan members. While Oregon can attest the state is not aware of any written or legally enforceable agreements that would guarantee any specific hospital(s) would be held harmless for health-care related taxes, Oregon is unsure how it could comply with the "net effect" test, which gives CMS the authority to consider the "totality of the circumstances" and unwritten or non-legally enforceable agreements.
Commonwealth of Pennsylvania Department of Human Services	For example, the term "net effect" is very broadly defined and includes any transfers of value or financial transactions of participating entities. This definition is so broad it appears that CMS may investigate any and all transactions that CMS deems relevant. CMS also has not provided any information or discussion on how such a review would be conducted or what documents will be required from entities, including private-related entities. In addition, CMS states in this definition that a net effect could include unwritten and legally unenforceable arrangements. These terms inject a subjective review and it is unclear what parameters and authority CMS has to request information or to determine arrangements that are not documented or enforceable and may be otherwise unrelated to the review and oversight of a Medicaid program.
Tennessee Department of Finance and Administration, Division of TennCare	In our view, CMS has previously tolerated these situations precisely because it does not have the authority to regulate or take into account transactions to which the state is not a party in determining whether there is a hold harmless in place. There is no statutory basis for considering a private arrangement between private parties, without state involvement, to be a guarantee on the part of the state to hold taxpayers harmless. We disagree that Section 1903(w)(4) gives CMS the authority to regulate (or to require states to regulate) transactions between private providers in which the state is not involved, and it is unreasonable to hold states responsible for the effects of such arrangements if the state itself is not involved in the pooling or redistribution arrangement.
Texas Health & Human Services Commission	CMS lacks statutory authority to hold the states responsible for the actions of private entities. The statutory language is clear that CMS's authority extends only as far as an arrangement that involves "the State or other unit of government imposing the tax provid[ing]...for any payment, offset, or waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax." CMS simply does not have the statutory authority to require states to police arrangements between private parties. . . While the States must assure that payments are consistent with efficiency, economy, and quality of care as required in section 1902(a)(30)(A) of the Social Security Act, the states are not required to regulate private arrangements between third parties.
Joint Letter from Medicaid Directors in Colorado, Illinois, Louisiana, Michigan*, Missouri, Oregon, New York, Pennsylvania, South Carolina, Tennessee*, and Washington	There is no reasonable interpretation of the statute under which a private arrangement between private parties, without state involvement, can be interpreted to be "the State" "provid[ing]" for a payment that "guarantees" to hold the taxpayer harmless. The Commenting States are aware of numerous situations in which CMS has known about, and not moved to prevent, hospitals redistributing Medicaid payments among themselves (without involvement from the State) in the manner CMS now seeks to prohibit.

* These states have active directed payment programs financed by provider taxes.