CMS is Resurrecting the Withdrawn Medicaid Fiscal Accountability Proposed Rule

In 2019, the Centers for Medicare & Medicaid Services (CMS) proposed the Medicaid Fiscal Accountability Rule (MFAR), which would have made sweeping changes to long-standing policies and required states to make substantial changes to existing Medicaid financing practices resulting in undue burdens to our nation's health care safety net. Even though CMS withdrew MFAR from the Federal Register in January 2021 following overwhelming bipartisan opposition, CMS continues to pursue MFAR policies, through both the Centers for Medicaid and CHIP Services (CMCS) Informational Bulletin entitled "Health Care-Related Taxes and Hold Harmless Arrangements Involving the Redistribution of Medicaid Payments" released on February 17, 2023, and through a CMS proposed rule entitled "Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality" released on May 3, 2023.

As evidenced below, the Informational Bulletin and the proposed rule specifically revive, at times verbatim, the agency's unlawful attempts to assert its jurisdiction over wholly private, voluntary arrangements between hospitals, lacking any state involvement. Notably, at least 14 states objected to CMS' last attempt to expand the hold harmless definition to include private agreements. Further, when CMS raised this issue last year in federal court, a federal judge in Texas reasoned that CMS's legal position was not at all in line with the Medicaid statute. In short, the Bulletin and the proposed rule – like MFAR – is a significant and inappropriate shift in policy by CMS that is inconsistent with current law.

Medicaid Financing Policy/Issue	Medicaid Fiscal Accountability Regulation (MFAR)	Informational Bulletin	Managed Care Proposed Rule
MFAR, the CMCS Bulletin, and the Managed Care Proposed Rule characterize the provider arrangements using almost identical terms.	"[CMS has] become aware of impermissible arrangements that exist where **a state or other unit of government imposes a health-care related tax, then uses the tax revenue to fund the non-federal share of Medicaid payments back to the taxpayers.**"[1]	"CMS is increasingly encountering health care-related tax programs that appear to contain hold harmless arrangements involving the redistribution of Medicaid payments. In these arrangements, **a state or other unit of government imposes a health-care related tax, then uses the tax revenue to support the non-federal share of Medicaid payments back to the class of providers subject to the tax.**"[2]	"In the arrangements, **a state or other unit of government imposes a health-care related tax, then uses the tax revenue to fund the non-Federal share of SDPs that require Medicaid managed care plans to pay the provider taxpayers**."[3]

[1] Medicaid Fiscal Accountability Regulation, 84 Fed. Reg. 63722, 63734 (Nov. 18, 2019), hereinafter "MFAR."
[2] Daniel Tsai, *Health Care-Related Taxes and Hold Harmless Arrangements Involving the Redistribution of Medicaid Payments*, CMCS Info. Bulletin at 2 (Feb. 17, 2023), https://www.medicaid.gov/federal-policy-guidance/downloads/cib021723.pdf, hereinafter "CMCS Bulletin."
[3] Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality, 88 Fed. Reg. 28092, 28130 (May 3, 2023), hereinafter "Managed Care Proposed Rule."

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MFAR, the CMCS Bulletin, and the Managed Care Proposed Rule focus on voluntary redistribution agreements between taxpayers that do not involve states or other units of government.	"The **taxpayers enter into an agreement**, which may or may not be written, **to redistribute** these **Medicaid payments to ensure that taxpayers**, when accounting for both the original Medicaid payment (from the state, unit of local government, or MCO) and any redistribution payment from another taxpayer or taxpayers, **receive all or any portion of their tax amount back.**"[4]	"The **taxpayers** appear to have **entered into** oral or written **agreements** . . . **to** redirect or **redistribute** the **Medicaid payments to ensure that all taxpayers receive all or a portion of their tax back**, when considering each provider's retained portion of any original Medicaid payment (either directly from the state or from the state through a managed care plan) and any redistribution payment received by the provider from another taxpayer or taxpayers."[5]	"The **taxpayers** appear to **enter a pre-arranged agreement** to **redistribute the Medicaid payments to ensure that all taxpayers**, when accounting for both their original Medicaid payment (from the State through a managed care plan) and any redistribution payment received from another taxpayer(s) or other entity, **receive back** (and are thereby held harmless for) **all or at least a portion of their tax amount.**"[6]
In MFAR and the CMCS Bulletin, CMS addresses that the agreements at issue may be written or oral. CMS goes even further in the Managed Care Proposed Rule to include *any* arrangement that *might* involve Medicaid payments by providers who pay a health care-related tax.	The taxpayers enter into an agreement, **which may or may not be written**, to redistribute these Medicaid payments to ensure that taxpayers, when accounting for both the original Medicaid payment (from the state, unit of local government, or MCO) and any redistribution payment from another taxpayer or taxpayers, **receive all or any portion of their tax amount back**.[7]	The taxpayers appear to have entered into **oral or written agreements** (meaning explicit or implicit meeting of the minds, regardless of the formality or informality of any such agreement) to redirect or redistribute the Medicaid payments **to ensure that all taxpayers receive all or a portion of their tax back** ….[8]	"Regardless of whether the taxpayers participate voluntarily, whether the taxpayers receive the Medicaid payments from a Medicaid managed care plan, or whether taxpayers themselves or another entity make redistribution payments using the very dollars received as Medicaid payments or with other provider funds that are replenished by the Medicaid payments, the taxpayers participating in these redistribution agreements have a

[4] MFAR at 63734.
[5] CMCS Bulletin at 3.
[6] Managed Care Proposed Rule at 28130.
[7] MFAR at 63734.
[8] CMCS Bulletin at 3.

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			reasonable expectation that they will be held harmless for all or a portion of their tax amount."[9]
In MFAR, the CMCS Bulletin, and the Managed Care Proposed Rule, CMS relies heavily on a February 2008 final rule[10] that, in part, addresses 42 C.F.R. § 433.68(f), which describes the hold harmless provision at issue here.	"[T]he February 2008 final rule clarified the **direct guarantee test** found at § 433.68(f) by specifying that a direct guarantee to hold the taxpayer harmless for the cost of the tax **through a direct or indirect payment will be found when, 'a payment is made available to a taxpayer or party related to a taxpayer' so that a reasonable expectation exists that the taxpayer will be held harmless** for all or part of the cost of the tax as a result of the payment.'"[11]	"In the preamble to the 2008 final rule amending [42 C.F.R. § 433.68(f)(3)], 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**).'"[12]	"The February 2008 final rule on health care-related taxes specified that hold harmless arrangements prohibited by § 433.68(f)(3) exist '[w]hen a State payment is made available to a taxpayer or a party related to the 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.**"[13]
In MFAR, the CMCS Bulletin, and the Managed Care Proposed Rule, CMS contorts the "reasonable expectation" verbiage and attempts to apply the hold harmless provision to purely private arrangements, despite the statutory and regulatory requirement that a "State or other unit of government" "provides (directly or indirectly) for any	"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	"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."	"We further explained in the same preamble that **we used the term 'reasonable expectation' because 'State laws were rarely overt in requiring that State payments be used to hold taxpayers harmless**. Hold harmless arrangements **need not be overtly established through State law or contracts**, but **can be based upon a reasonable expectation that certain actions**

[9] Managed Care Proposed Rule at 28131.
[10] 73 Fed. Reg. 9685, 9694 (Feb. 22, 2008)
[11] MFAR at 63730-31.
[12] CMCS Bulletin at 4.
[13] Managed Care Proposed Rule at 28130-31 (internal quotations omitted).

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payment, offset, or waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax."[14] Despite CMS' interpretation and extrapolation in MFAR, the CMCS bulletin, and the Managed Care Proposed Rule, the 2008 rule's clarification of the scope of the "direct or indirect guarantee" test concerns the actions of a governmental entity providing a direct or indirect benefit to providers. In the same preamble, CMS specified that "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."	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.**"[15] "The fact that a private entity makes the redistribution payment does not change the essential nature of the payment, **which constitutes an indirect payment from the state or unit of government** to the entity being taxed that holds it harmless for the cost of the tax."[16]	"It is **possible for a state to indirectly provide a payment** within the meaning of section 1903(w)(4)(C)(i) of the [Social Security 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**.	**will take place among participating entities** to return to taxpaying providers all or any portion of their tax amounts. The redistribution arrangements detailed earlier constitute a hold harmless arrangement described in section 1903(w)(4) of the Act and implementing regulations in part 433."[17]
MFAR, the CMCS Bulletin, and the Managed Care Proposed Rule conclude in nearly identical terms.	"Such arrangements **undermine the fiscal integrity of the Medicaid program** and are **inconsistent with existing statutory and regulatory**	"Such arrangements **are inconsistent with statutory and regulatory requirements** and **undermine the fiscal integrity of the Medicaid program**."[19]	"Redistribution arrangements **undermine the fiscal integrity of the Medicaid program and are inconsistent with existing statutory and regulatory**

[14] 1903(w)(4)(C).
[15] MFAR at 63778.
[16] MFAR at 63735.
[17] Managed Care Proposed Rule at 28131.
[19] CMCS Bulletin at 2.

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	requirements prohibiting hold harmless arrangements."[18]		**requirements prohibiting hold harmless arrangements . . .** Such arrangements require a reduction of the State's medical assistance expenditures . . . ."[20]
In MFAR, CMS suggested additional regulatory language to bolster CMS authority. CMS also proposes additional regulatory language to bolster its authority in the obtaining information about the arrangements in the Managed Care Proposed Rule. The fact that CMS recognized in MFAR the need for additional regulatory authority weakens the agency's apparent current position that it may proceed with the same position without implementing any regulatory change, which again shifted with the introduction of the proposed rule.	"the proposed rule **would add clarifying language to the hold harmless definition in § 433.68(f)(3) to specify that CMS considers a 'net effect' standard in determining whether or not a hold harmless arrangement exists**" in order to "**aid in preventing and ending such complex financing arrangements**."[21]	CMS moved forward without any regulatory change whatsoever, claiming that the Informational Bulletin is a "reiteration" of the agency's "longstanding position."[22]	"**We believe additional measures are necessary** to ensure compliance with applicable Federal requirements for the source(s) of non-Federal share . . . We propose to revise § 438.6(c)(2)(ii) that would explicitly require that an SDP comply with all Federal legal requirements for the financing of the non-Federal share, including but not limited to, 42 CFR part 433, subpart B, as part of the CMS review process."[23] CMS separately proposes to require States "to ensure that each participating provider in an SDP arrangement attests that it does not participate in any hold harmless arrangement with respect to any health care-related tax . . . **Such hold harmless arrangements include those that produce a reasonable expectation**

[18] MFAR at 63734.
[20] Managed Care Proposed Rule at 28130-31.
[21] MFAR at 63735.
[22] CMCS Bulletin at 1.
[23] Managed Care Proposed Rule at 28132.

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			that taxpaying providers would be held harmless for all or a portion of their cost of a health care-related tax."[24] CMS then gives itself the authority to "**deny written prior approval of an SDP** if it does not comply with any of the standards in § 438.6(c)(2), including the financing of the non-Federal share is not fully compliant with all Federal legal requirements for the financing of the non-Federal share and/or the State does not require an attestation from each provider receiving a payment based on the SDP that it does not participate in any hold harmless arrangement."[25]

[24] *Id.*
[25] *Id.*