**IN THE UNITED STATES DISTRICT COURT**
**FOR THE EASTERN DISTRICT OF TEXAS**
**TYLER DIVISION**

| | |
|---|---|
| STATE OF TEXAS; TEXAS HEALTH AND HUMAN SERVICES COMMISSION,<br>*Plaintiffs*,<br><br>v.<br><br>CHIQUITA BROOKS-LASURE, in her official capacity as Administrator for the Centers for Medicare and Medicaid Services; THE CENTERS FOR MEDICARE AND MEDICAID SERVICES; XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; and the UNITED STATES OF AMERICA,<br>*Defendants*. | Civ. Action No. _____ |

## ORIGINAL COMPLAINT

1. Every day, Texas's Medicaid program ensures access to high-quality medical care for nearly 5 million Texans. For decades, the program has been a bedrock part of the State's social safety net, and its enduring vitality depends on the joint collaborative efforts of the State and the federal government.

2. Unfortunately, for the second time in three years, the Centers for Medicare and Medicaid Services (CMS), which administers Medicaid at the federal level, has wielded its oversight role as a cudgel to force Texas to adopt its policy

preferences. In the process, it has shaken the structural foundation of Medicaid's operations in Texas.

3. This case implicates how Medicaid gets funded, which is always an important issue and recently has become a contentious one. As a general matter, Medicaid is jointly paid for by the federal and state governments. Texas finances a large share of its contributions to Medicaid through the collection of healthcare provider taxes. Such taxes are expressly permissible under the Social Security Act, but the Act imposes several notable conditions on those taxes. The most relevant to this suit is that States may not hold taxpaying providers harmless for the cost of such taxes. *See* 42 U.S.C. § 1396b(w); *see also* 42 C.F.R. § 433.68. If CMS concludes that such a hold harmless provision exists, the financial consequences for the State are severe: the amount of the State's requested reimbursement from the federal government must be "reduced by the sum of any revenues received by the State" through a "broad-based health care related tax" that operates as "a hold harmless provision." *Id.* § 1396b(w)(1)(A)(iii).

4. The Act provides three separate definitions of a hold harmless provision. *Id.* § 1396b(w)(4)(A)-(C). Only one is relevant to this case: a hold harmless provision exists if "[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." *Id.* § 1396b(w)(4)(C)(i).

5. This definition is straightforward: when *the State or other government unit* provides a payment, offset, or waiver that (directly or indirectly) guarantees to

hold a taxpayer harmless, that arrangement constitutes a prohibited hold harmless provision. Rather than apply that plain text, CMS has adopted the view that an agreement between two *private* providers to protect against financial loss constitutes "a hold harmless arrangement involving Medicaid payment redistribution" if there is a "reasonable expectation" that the taxpaying provider will receive a portion of its provider tax costs returned as part of a private agreement. Ex. A at 3-4. And CMS has done so not through notice-and-comment rulemaking but by issuing an informational bulletin purporting to give immediate force and effect to this extra-textual reading of the Social Security Act. The bulletin follows years of failed rulemakings and unsuccessful threats to compel Texas's compliance with the agency's preferred interpretation of the Act. And, perhaps most disturbingly, this expanded definition applies not just prospectively but also retroactively to payments that were made years ago, requiring Texas to monitor private-party arrangements on pain of the loss of billions of dollars in federal funding.

6. The bulletin is unlawful under the Administrative Procedure Act (APA) and should be set aside. It is inconsistent with the plain language of the Social Security Act and CMS's own regulations. It was not issued with an opportunity for notice and comment. And it is arbitrary and capricious because it contradicts CMS's prior position—that private arrangements do *not* fall within the ambit of a prohibited hold harmless provision—without even attempting to explain why that position was incorrect. In the interim, the bulletin is already causing the State irreparable harm.

CMS and the other federal defendants should not be permitted to enforce or rely on the bulletin pending a final resolution of its legality.

**PARTIES**

7. Plaintiff Texas is a sovereign State. *See* Tex. Const. art. I, § 1. Texas brings this suit on its own behalf and on behalf of its citizens *parens patriae* to ensure that federal officials comply with the statutory and regulatory limits on their power when making decisions that will affect millions of Texans. Texas has the authority and responsibility to protect the health, safety, and welfare of its citizens.

8. Plaintiff Texas Health and Human Services Commission (HHSC) is an executive branch agency organized under the laws of Texas. It is the state agency designated under 42 C.F.R. § 431.10 to administer Texas's Medicaid program. For ease of reference, HHSC will be referred to collectively with the State as "Texas."

9. Defendant CMS is a federal agency organized under the laws of the United States. It is responsible for federally administering Medicaid. Although HHSC has been informed that certain actions relating to this suit are being coordinated out of CMS's office in Baltimore, CMS maintains a regional office located in Texas for administering its operations in Arkansas, Louisiana, New Mexico, Oklahoma, and Texas.

10. Defendant United States Department of Health and Human Services (HHS) is a cabinet-level federal executive branch agency organized under the laws of the United States. It is responsible for administering federal healthcare policy and is the cabinet-level Department of which CMS is a part.

11. Defendant Xavier Becerra is the Secretary of HHS. He is sued in his official capacity.

12. Defendant Chiquita Brooks-LaSure is the Administrator for CMS. She is sued in her official capacity.

13. Defendant United States of America is the federal sovereign.

**JURISDICTION AND VENUE**

14. This Court has subject-matter jurisdiction under 28 U.S.C. § 1331 because this suit concerns the legality of actions taken by federal agencies and federal officers in their official capacities.

15. The Court is authorized to award the requested declaratory and injunctive relief under 5 U.S.C. §§ 702 and 706, 28 U.S.C. § 1361, 28 U.S.C. §§ 2201-2202, Federal Rules of Civil Procedure 57 and 65, and by the Court's general legal and equitable powers.

16. Venue lies in this district pursuant to 28 U.S.C. § 1391(e)(1)(B) because the United States, two of its agencies, and two of its officers in their official capacities are defendants. Plaintiff Texas resides in this judicial district, and a substantial part of the events or omissions giving rise to Texas's claims occurred in this district. Texas previously sued these same defendants in this Court to prevent CMS from arbitrarily revoking its approval of Texas's request to extend and amend the State's managed-care system, *see Texas v. Brooks-LaSure*, No. 6:21-cv-00191, 2021 WL 5154219, at *1 (E.D. Tex. Aug. 20, 2021), and the defendants did not challenge venue in that case. Moreover, the first federal audit, initiated by the HHS Office of the Inspector General

to ensure that a Texas jurisdiction is in compliance with the bulletin, is of Smith County. That action began roughly contemporaneously with CMS approving Texas's state directed payment programs (SDPs) to avoid sanctions in the last suit. The audit has occurred and will continue to occur in this judicial district and division.

## BACKGROUND

### I. Overview of Medicaid and Hold Harmless Provisions

#### A. Medicaid's cooperative federalism framework

17. Medicaid is designed as a cooperative federal-state program that has provided medically necessary healthcare to low-income families and individuals with disabilities since 1965. *See* 42 U.S.C. § 1396 *et seq*.; *Ark. Dep't of Health & Hum. Servs. v. Ahlborn*, 547 U.S. 268, 275 (2006). At the federal level, Medicaid is administered by the Secretary of Health and Human Services, who in turn exercises his authority through CMS. *Ahlborn*, 547 U.S. at 275. At the state level, participating States are required to designate a single agency to administer their Medicaid programs. *See* 42 U.S.C. § 1396a(a)(5). HHSC fills that role for the State of Texas.

18. A State that chooses to participate in the Medicaid program—as all States, including Texas have—must submit a state Medicaid plan to CMS for federal approval. 42 U.S.C. § 1396a. After CMS approves the state plan, "the state administers Medicaid with little to no federal oversight," *Texas v. Brooks-LaSure*, No. 6:21-cv-00191, 2022 WL 741065, at *2 (E.D. Tex. Mar. 11, 2022), and the participating State is entitled to receive reimbursement from the federal government for the federal share of specified covered services. 42 U.S.C. § 1396b; 42 C.F.R. § 430.30(a)(1).

19. The federal share of a participating State's Medicaid expenditures is primarily based on the federal medical assistance percentage (FMAP). *See* 42 U.S.C. § 1396d(b), 42 U.S.C. § 1396b(a). In Texas, that percentage is presently approximately 60%. The compensation to which a State is entitled can also include supplemental Medicaid payments such as payments for incentive arrangements, pass-through payments, and directed payment programs. 42 C.F.R. § 438.6. "Although the federal contribution to a State's Medicaid program is referred to as a 'reimbursement,' the stream of revenue is actually a series of huge quarterly advance payments that are based on the State's estimate . . . of future expenditures." *Bowen v. Massachusetts*, 487 U.S. 879, 883-84 (1988) (citing 42 U.S.C. § 1396b(d)).

**B. The Social Security Act's prohibition on hold harmless provisions**

20. To receive reimbursements from the federal government, States must provide assurances that they have adequate methods to pay the state share of Medicaid. *See* 42 U.S.C. § 1396b; 42 C.F.R. § 430.30.

21. Congress passed the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments in 1991, which addresses CMS's authority to restrict or reduce federal matching funds for Medicaid. Pub. L. No. 102-234, § 2, 105 Stat. 1793 (1991) (adding subsection 1903(w), codified at 42 U.S.C. § 1396b(w), to the Social Security Act).

22. The 1991 amendments require a reduction in the amount of patient-care costs for which the States may seek reimbursement—and which are used to calculate

the federal financial participation payment—when the State obtains revenues from certain sources. *See* 42 U.S.C. § 1396b(w)(1)(A).

23. Relevant here, the amendments require the amount of the State's requested reimbursement to be "reduced by the sum of any revenues received by the State" through a "broad-based health-care-related tax" that operates as "a hold harmless provision." *Id.* § 1396b(w)(1)(A)(iii). The amendments include three definitions of a "hold harmless provision." The first is when the State or local government entity "provides (directly or indirectly) for a payment . . . to taxpayers" that is "positively correlated either to the amount of such tax or to the difference between the amount of the tax and the amount of payment under the State plan." *Id.* § 1396b(w)(4)(A). The second is when "[a]ll or any portion of the payment made under this subchapter to the taxpayer varies based only upon the amount of the total tax paid." *Id.* § 1396b(w)(4)(B). And the third, and the subject of the February 17 bulletin, is when the State or local government entity "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." *Id.* § 1396b(w)(4)(C)(i).

**C. CMS's regulations implementing the 1991 amendments**

24. In 1993, HHS promulgated a rule to implement these amendments. *See* Medicaid Program; Limitations on Provider-Related Donations and Health Care-Related Taxes; Limitations on Payments to Disproportionate Share Hospitals, 58 Fed. Reg. 43,156 (Aug. 13, 1993) (codified at 42 C.F.R. §§ 433, 447).

25. The regulations incorporate the Social Security Act's definition of a hold harmless provision into subsection (f) of 42 C.F.R. § 433.68 by "set[ting] out the three

ways of finding a 'hold harmless provision' for a state tax program." *Brooks-LaSure*, 2022 WL 741065, at *5 (setting out this history).

26. The regulation also "added detail on the third hold harmless definition" by adopting a two-part test—later formally adopted by Congress—for determining when the government entity's levy of an excessive amount of taxes on a healthcare provider rises to the level of a hold harmless "guarantee." *Id.* at *5-6; *see also* Medicaid Program; Limitations on Provider-Related Donations and Health Care-Related Taxes; Limitations on Payments to Disproportionate Share Hospitals 57 Fed. Reg. 55,129-30 (Nov. 24, 1992) (interim final rule).

27. Under that test, "[i]f the tax on the providers' revenue was at or below 6% (selected as the national average sales tax), the tax would be assumed permissible," but if "the tax was above 6%," "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." *Brooks-LaSure*, 2022 WL 741065, at *5 (citing 57 Fed. Reg. at 55,142-55,143).

28. Twelve years elapsed until a new development, spurred by CMS's own internal adjudicative body, prompted CMS to again take regulatory action. In 2005, after years of litigation, HHS's Departmental Appeals Board rejected CMS's effort to retroactively disallow years of federal funding to five States based on an overbroad interpretation of what constitutes a hold harmless provision. Specifically, without basis in statute, CMS had determined that certain state programs providing grants to nursing homes or tax credits to patients constituted impermissible hold harmless

provisions under CMS's regulations. *See Brooks-LaSure*, 2022 WL 741065, at *6-7 (citing *In re: Hawaii Dep't of Human Servs.*, Docket No. A-01-40, 2005 WL 1540188 (Dep't Appeals Bd., Appellate Div. June 24, 2005)).

29. The Board held, however, that the programs at issue did not meet either the first or third definitions of a hold harmless provision. *Id.* As to the third definition, the Board explained that no language in the States' grant or credit programs offered an explicit or direct assurance of any payment to a taxpayer-provider, and it rejected CMS's argument that the third definition was merely a "broad catch-all provision." *Id.* at *6. Ultimately, the Board found that for a state taxing authority to guarantee a payment, offset, or waiver the Board expected to see a "legally enforceable promise" in "these States' laws." *Id.* at *7.

30. Following the Board's ruling, CMS's enforcement arm sought to alleviate the purported "confusion" that the ruling caused and "clarify" the tests for finding an impermissible hold harmless arrangement. *See, e.g.*, Medicaid Program; Health Care-Related Taxes, 73 Fed. Reg. 9,685, 9,686, 9,690 (Feb. 22, 2008) (final rule). CMS amended the regulatory definition of the third hold harmless provision to "cover[] the situation where a government provides for a certain financial measure 'such that' the measure guarantees" the taxpayer will be held harmless. *Brooks-LaSure*, 2022 WL 741065, at *8. This was a departure from the statutory definition in which Congress defined a hold harmless provision to include "certain financial measure[s] 'that guarantees' indemnification." *Id.* at *7. This change "deliberate[ly]"

"remove[d] the statute's tight grammatical link between *the government*, as the actor providing for something, and *a guarantee*, as the thing provided for." *Id.*

31. As a result of the agency's "loosen[ing]" of the required link between the state taxing authority and the guarantee itself, CMS has contended that the third definition "focus[es] on the 'reasonable expectation' [of the taxpayer] about the 'result' of a state payment, as opposed to what the state provided when making a payment." *Id.* (citing 73 Fed. Reg. 9,694-95).

**D. CMS's failed 2019 amendment efforts**

32. In 2019, CMS tried to stretch the definition of a hold harmless provision in section 1396b(w)(4)(C)(i) even farther to cover private, non-governmental arrangements. *See* Medicaid Program; Medicaid Fiscal Accountability Regulation, 84 Fed. Reg. 63,722, 63,742 (Nov. 18, 2019).

33. CMS's proposed rule conflicted with the agency's prior representations to providers across the country. In early 2019, Kristin Fan, then Director of CMS's Financial Management Group, told counsel for concerned providers that though CMS is "aware that there may be arrangements" between providers that CMS may "not particularly like," CMS "do[es] not have statutory authority to address" those arrangements. Fan also agreed that States should not be expected "to seek information about these agreements or providers to disclose these agreements to the state/local government in connection with CMS' questions." This exchange was widely circulated across the country.

34. In the proposed rule, issued only nine months later, CMS took a different approach entirely. The proposal said that the agency had "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." 84 Fed. Reg. at 63,734. Critically, CMS clarified that it considered such arrangements to violate the law even if "a private entity makes the redistribution" to another private entity. *Id.* at 63,735. It reasoned that a purely private arrangement still "constitutes an indirect payment from the [S]tate or unit of government to the entity being taxed that holds it harmless for the cost of the tax." *Id.* That is because "[t]he taxpayers have a reasonable expectation to be held harmless for all or a portion of their tax amount." *Id.* at 63,734.

35. As a result, CMS proposed to amend 42 C.F.R. § 433.68(f)(3) to specify that CMS would consider the "net effect" of a particular arrangement—*i.e.*, whether the "net effect" is a "reasonable expectation" by the taxpayer that it will recoup all or a portion of its tax payment through Medicaid payments—to determine whether a hold harmless arrangement exists. *Id.* at 63,735.

36. CMS received more than 10,000 comments on the proposal, many of which faulted CMS for "lack[ing] statutory authority" and "creating regulatory provisions that were ambiguous or unclear and subject to excessive Agency discretion." This ultimately led CMS to "withdraw the proposed provisions." Medicaid Program; Medicaid Fiscal Accountability Regulation, 86 Fed. Reg. 5,105, 5,105 (Jan. 19, 2021).

37. One such commenter was Daniel Tsai—the author of the February 17 bulletin and CMS's current Deputy Administrator and Director for the Center for

Medicaid and CHIP Services—who was then serving as the Medicaid Director for the State of Massachusetts. Tsai explained that the proposed rule—including its "'net effect[]' test"—"introduce[d] new state obligations" and "significant administrative and operational burdens" that "represent[ed] an unprecedented federal overreach," "exceed[ed] CMS' statutory authority," contain[ed] "provisions [that] are highly susceptible to arbitrary and capricious application," "[was] not supported by the underlying statute," and "includ[ed] reporting on business dealings of private entities that are not available to the state." HHSC submitted a similar comment letter along those lines, as did many others.

## II. Overview of Texas Medicaid[1] and the State's Funding Mechanisms

38. To allow flexibility from the default requirements of the Social Security Act, CMS may issue a waiver that exempts a State from those otherwise mandatory requirements. One common waiver is authorized by section 1115 of the Act, codified at 42 U.S.C. § 1315. Such a waiver allows a State to implement an "experimental, pilot, or demonstration project" that diverges from federal requirements so long as

[1] A more fulsome background of the Texas Medicaid system, including its section 1115 waiver, is available in Texas's First Amended Complaint from its earlier-filed lawsuit, which is expressly incorporated herein by reference. *See Texas v. Brooks-LaSure*, No. 6:21-cv-00191 (E.D. Tex. Aug. 31, 2021), ECF No. 54. To avoid burdening the Court, this complaint discusses only those aspects of Texas Medicaid necessary for resolving the parties' current dispute, which was first litigated in the context of Texas's motion to enforce the Court's preliminary injunction. *See id.*, Mot. to Enforce J., (Nov. 2, 2021), ECF No. 75; *id.*, Reply in Supp. of Mot. to Enforce J., (Nov. 22, 2021), ECF No. 84.

the project "is likely to assist in promoting the objectives" of Medicaid. 42 U.S.C. § 1315(a).

39. In 2011, Texas applied for and received a section 1115 waiver for a demonstration project called the Texas Healthcare Transformation and Quality Improvement Program. The waiver allowed Texas to transition its Medicaid program from a fee-for-service model to a managed-care model. Through that updated model, Texas contracts with health-insurance companies to deliver healthcare services through Medicaid. The State pays a monthly capitation payment to a managed care organization for each Medicaid recipient, which reduces the overall state and federal government Medicaid expenditures by encouraging recipients to take advantage of preventative care.

40. The Texas Legislature authorized another important change to Medicaid in 2013. In addition to furthering the transition to a managed-care model, as was discussed in the prior lawsuit, Texas law was amended to allow designated hospital districts, counties, and municipalities to "administer a healthcare provider participation program to provide additional compensation to certain hospitals located in the hospital district, county, or municipality by collecting mandatory payments from each of those hospitals to be used to provide the nonfederal share of a Medicaid supplemental payment program[.]" Tex. Health & Safety Code § 300.0001; *see* Act of May 24, 2013, 83d Leg., R.S., ch. 1369, 2013 Tex. Gen. Laws 3630 (codified at Tex. Health & Safety Code ch. 288); Tex. Health & Safety Code ch. 288–300A.

41. These mandatory payments are deposited into a Local Provider Participation Fund (LPPF), which is a dedicated-purpose account that local governments may use for certain statutorily authorized purposes, including intergovernmental transfers to HHSC to support specified Medicaid programs. HHSC uses these statutorily permitted local funds as the non-federal share of Medicaid funds that are then matched with federal funds.

42. The LPPFs are managed by local government entities and are subject to a host of relevant restrictions. If the government entity authorizes a healthcare provider participation program, it must require an annual mandatory payment to be assessed based upon the net patient revenue of each institutional healthcare provider located in the applicable local unit of government.[2] Tex. Health & Safety Code § 300.0151. Money deposited into the local provider participation fund is authorized for limited purposes, including the intergovernmental transfers from the local government to the State to provide the state share of Medicaid payments for statutorily specified Medicaid programs. *See* Tex. Health & Safety Code § 300.0103(b)(1). The levies imposed by the local unit of government must be broad-based and uniform, as required under federal law. *See id.* § 300.0151(b). All local governments authorized to collect mandatory payments in LPPFs are prohibited from assessing mandatory payments that exceed six percent of net patient revenue. *Id.*

[2] The Texas statutes which authorize hospital districts to collect and deposit mandatory payments into LPPFs explicitly state that such mandatory payments are not taxes for the purposes of Article IX of Texas Constitution. However, these payments are considered healthcare-related taxes for purposes of federal law. *See, e.g.*, 42 U.S.C. § 1396b(w)(3)(A); 42 C.F.R. § 433.55.

§ 300.0151(c). And consistent with the Social Security Act, Texas law specifically prohibits these programs from holding harmless any institutional healthcare provider. *Id.* § 300.0151(b).

43. CMS encouraged Texas to implement these funds, which have grown more important to the State over time. Collectively, the funds comprised about 17.7% of Texas's state share of Medicaid funding in the last fiscal year. HHSC expects this trend: when the funding mechanism was first piloted, it required express permission from the Legislature on a jurisdiction-by-jurisdiction basis. *E.g.*, 2013 Tex. Gen. Laws 3630. With the encouragement of CMS, the Texas Legislature has since made the authorization more general. Tex. Health & Safety Code §§ 300.0001, .0003.

44. As the statewide administrator of Texas Medicaid, HHSC ensures that the authority that administers each LPPF does not provide for any payment, offset, or waiver that directly or indirectly guarantees to hold the taxpaying providers harmless for any portion of their tax costs. But HHSC does not have statutorily conferred taxing or regulatory authority over the local government entities that manage those funds, nor does HHSC have authority to examine or consider any contractual arrangements that might exist between private businesses whose taxes contribute to those funds.

45. The taxes that flow into those funds are unrelated to the methodology for calculating the Medicaid reimbursements that HHSC disburses to healthcare providers. The State does not make any such reimbursements based on the amount that a provider is taxed by a local government. Instead, Medicaid payments to

providers are based exclusively on programmatic methodologies that consider, among other factors, what an estimated Medicare or average commercial payer would have paid for those same services.

46. CMS has approved SDPs that use LPPF to fund as the non-federal share. Those programs include:

- The Comprehensive Hospital Increase Reimbursement Program (CHIRP), which began on September 1, 2021, (but not approved by CMS until March 25, 2022) and replaced a prior directed payment program no longer in effect. CHIRP provides increased Medicaid payments to hospitals for inpatient and outpatient services to eligible recipients. On August 1, 2022, CMS renewed approval for CHIRP for the program period covering September 1, 2022, to August 31, 2023.

- The Quality Incentive Payment Program (QIPP), which is a performance-based payment program designed to incentivize eligible nursing facilities to improve the quality and innovation of their services. CMS has approved this program for six straight years (but delayed approval for the program period that began on September 1, 2021, until November 15, 2021). On August 1, 2022, CMS approved QIPP for the program period covering September 1, 2022, to August 31, 2023.

- The Texas Incentives for Physicians and Professional Services (TIPPS) program, which began on September 1, 2021 (but not approved by CMS until March 25, 2022), provides increased Medicaid payments to certain physician groups providing healthcare services to eligible Medicaid recipients. On August 1, 2022, CMS renewed approval for TIPPS for the program period covering September 1, 2022, to August 31, 2023.

- The Rural Access to Primary and Preventive Services (RAPPS) program, which began on September 1, 2021 (but not approved by CMS until March 25, 2022), is designed to incentivize rural health clinics that provide primary and preventive care services to eligible Medicaid recipients in rural areas of Texas. On August 1, 2022, CMS renewed approval for RAPPS for the program period covering September 1, 2022, to August 31, 2023.

- The Directed Payment Program for Behavioral Health Services (DPP BHS), which began on September 1, 2021 (but not approved by CMS until November 15, 2021), is designed to promote and improve access to

> behavioral health services, coordination of care, and successful care transitions for eligible Medicaid recipients. On August 1, 2022, CMS renewed approval for DPP BHS for the program period covering September 1, 2022, to August 31, 2023.

47. The directed payment programs are complex, and Texas must have its directed-payment-program proposals, called "preprints," approved annually by August to process the payments the following September. Texas typically submits the preprints to CMS for approval in March. In total, CMS has approved pre-prints that contemplate the use of LPPFs at least nine times since the funds were first introduced in 28 local jurisdictions. CMS has also issued federal financial participation for the Delivery System Reform Incentive Payment (DSRIP) program and the Uncompensated Care (UC) program, which have used LPPF funds at least four times per year since 2016.

## III. CMS's Initial Encouragement of LPPFs and Sudden About-Face

48. CMS has been involved in the development of LPPFs in Texas from the outset of their existence. It was at CMS's encouragement that the Texas Legislature began authorizing LPPFs for certain jurisdictions. Later, in 2018 and 2019, CMS and Texas had lengthy discussions about the structure of LPPFs. At the time, Texas and CMS were working to resolve a disallowance that had been issued by CMS related to funds transferred from government entities in Dallas and Tarrant Counties. (Texas challenged the disallowance, and litigation is ongoing.) CMS reviewed the structure of the proposed LPPFs in Dallas and Tarrant Counties and allowed Texas to substitute funds derived from the LPPFs operated by the hospital districts in those counties for the disallowed funds.

49. Texas has long understood that its LPPFs do not run afoul of the Social Security Act's hold harmless prohibition and structured its regulatory regime accordingly. That understanding was gained in part based on CMS's assurances. In early 2019, HHSC first became aware of the possibility that business agreements might exist between private entities. HHSC officials promptly contacted CMS for guidance. CMS assured HHSC that, so long as neither the State nor a unit of local government was providing a guarantee, there was no prohibition on private business arrangements. This assurance was consistent with the email discussed above from Kristin Fan that was circulated to providers across the country around that same time.

50. Texas continued to rely upon that assurance in setting up its team that monitors local funds used as the non-federal share in the Medicaid program, including funds that are transferred to HHSC from a LPPF. Unfortunately, since the withdrawal of the 2019 proposed rule, CMS has reneged on its word and twice unsuccessfully sought to force HHSC to police private agreements.

51. During negotiations over the extension of the State's demonstration project (which was set to expire in September 2022), CMS attempted to insert special terms and conditions imposing many of the same requirements from the withdrawn proposed rule. Because those terms would have been inconsistent with the Social Security Act, Texas refused to agree to the requested terms and conditions.

52. On January 15, 2021, CMS informed Texas that its extension application was approved for a ten-year period ending on September 30, 2030. Just

three months later, on April 16, 2021, CMS reversed course and rescinded that approval. Texas challenged CMS's decision, and this Court issued a preliminary injunction obligating "defendants to treat Texas's demonstration project (Waiver Number 11-W-00278/6) as currently remaining in effect as it existed on April 15, 2021." *Brooks-LaSure*, 2021 WL 5154219, at *15.

53. As a result of that preliminary injunction, defendants were prohibited from implementing the rescission letter. The Court's orders made clear that CMS was required to treat the demonstration project as remaining in effect and to cooperate with Texas in negotiating various terms, including negotiating the approval of Texas's SDPs. *Brooks-LaSure*, 2022 WL 741065, at *10; *see also, e.g.*, *Texas v. Brooks-LaSure*, No. 6:21-cv-00191, 2021 WL 5154086, at *1-2 (E.D. Tex. Aug. 12, 2021).

54. Despite the Court's instructions, CMS attempted to impose the rejected LPPF-related terms by holding approval of five SDPs hostage until Texas would agree to CMS's terms to police private arrangements. That effort failed, too, but only after Texas returned to this Court to compel CMS to promptly issue a final decision on those SDPs. *Brooks-LaSure*, 2022 WL 741065, at *10. Even then, CMS would not withdraw its demand until this Court threatened to impose sanctions. *See id.*; Notice of Compliance with Order, *Texas v. Brooks-LaSure*, No. 6:21-cv-00191, (E.D. Tex. Mar. 25, 2022), ECF No. 100 (confirming that CMS approved the SDPs).

55. Ultimately, under threat of sanction by this Court, CMS approved the state directed payment programs, which was the only remaining issue in the prior lawsuit, and the case was dismissed.

## IV. OIG Audits and the February 17 Bulletin

56. On November 29, 2021, the HHS Office of the Inspector General (OIG) announced an audit workplan of "States' Use of Local Provider Participation Funds as the State Share of Medicaid Payments." The choice of wording was unusual: OIG did not announce a review of provider taxes categorically, or even provider taxes operated by units of local government. Instead, OIG specifically identified a review of "Local Provider Participation Funds," which is the term that Texas (and a limited number of other States) uses in state statutes authorizing this method of finance for units of local government.

57. On March 25, 2022, at approximately the same time that CMS finally agreed to the state directed payment programs contemplated by the 2021 waiver extension, OIG notified Texas that the State was selected for OIG's audit of LPPFs and held an entrance conference with Texas on April 14, 2022. After collecting information from Texas about the operation of LPPFs in this State, OIG selected Smith County, the home county for this Court, for a detailed review. OIG officials contacted Smith County and asked for information regarding private business agreements to which Smith County is not a party. The officials informed Texas that the audit would take approximately 12 months to complete, and that OIG would issue its report, including any findings, in the summer of 2023.

58. On February 17, 2023, the Deputy Administrator and Director of the Center for Medicaid and CHIP Services at CMS issued a bulletin announcing a retroactive change in CMS's definition of a hold harmless arrangement. *See* Ex. A. Without the notice and comment that CMS acknowledged was necessary when it

issued the 2019 proposed rule change, the bulletin pronounced that an agreement between private providers to redistribute Medicaid payments constitutes "a hold harmless arrangement involving Medicaid payment redistribution" if there is a "reasonable expectation" that the taxpaying providers will receive a portion of their provider tax costs returned as part of a private agreement. *Id.* at 3.

59. CMS described how, in its view, "taxpayers appear to have entered into oral or written agreements" to redirect or redistribute their Medicaid payments "to ensure that all taxpayers receive all or a portion of their tax back." *Id.* at 3. Notwithstanding the acknowledged absence of state participation in such agreements, CMS concluded they were impermissible because "[t]he redistributions occur so that taxpaying providers are held harmless for all or a portion of the health care-related tax." *Id.*

60. Without pointing to any statutory authority, the bulletin further stated CMS "intends to inquire about potential redistribution arrangements and may conduct detailed financial management reviews of healthcare-related tax programs that appear to include redistribution arrangements or that CMS has information may include redistribution arrangements." Ex. A at 5. Henceforth, States are expected "to make available *all requested documentation* regarding arrangements involving possible hold harmless arrangements and the redistribution of Medicaid payments" as part of CMS's "oversight activities and review of state payment proposals[.]" *Id.* (emphasis added).

61. CMS threatened to "take enforcement action as necessary" if an audit uncovers "impermissible financing practices." *Id.* And without regard to whether the requested documentation exists, CMS ominously warned that a State's failure to supply requested documentation regarding redistribution arrangements "may result in a deferral or disallowance of federal financial participation." *Id.*

62. After the bulletin was issued, OIG moved up the expected timeframe for completion of its report on Smith County to May 2023. On March 1, 2023, OIG sent a letter to HHSC indicating its intent to conduct new audits of local provider participation funds in Amarillo, Tarrant, and Webb counties. The "objective" of the second audit "is to determine whether the State agency adhered to the hold-harmless provisions in Federal regulations."

63. On March 9, 2023, OIG notified Texas that it had changed the original audit objective of the Smith County LPPF audit (referenced in paragraph 57) from the broad examination of whether LPPF funds were permissible and in accordance with state and federal law to the much narrower objective utilized in the new audit of the three additional local government entities.

## V. Immediate and Long-Term Effects of the Bulletin on Texas

64. This bulletin, if allowed to be implemented, will have an immediate impact on not just HHSC's ability to provide vitally needed healthcare services to Texans but also on Texas's sovereign interest in enforcing its laws.

65. Relying on the text of both the Social Security Act and CMS's existing regulations, the Texas Legislature has never deemed it necessary to create a

regulatory body with authority to examine contractual agreements that might exist between two private businesses. Nor has the Legislature ever seen fit to provide HHSC with such authority. As a result, to comply with the bulletin, HHSC will have to arrogate power to itself that it lacks under state law.

66. Beyond that injury to its sovereignty, Texas faces significant monetary costs to comply with the bulletin: it would be required to establish and operate a regulatory entity with sufficient resources to examine the contractual arrangements and financial management of every private hospital that exists in a jurisdiction with a LPPF. Ex. A at 5 (States are expected "to make available all requested documentation regarding arrangements involving possible hold harmless arrangements and the redistribution of Medicaid payments."). That is the only way Texas could accurately determine what private contractual relationships exist and whether those contracts are related to their provider tax payments. Texas would then need to take decisive action to halt private contractual agreements that fall within the scope of the bulletin's definition of a hold harmless arrangement. Ex. A at 5 (States must "take steps to curtail these practices if they exist.").

67. HHSC estimates that to achieve compliance, it will need to expend tens of millions of dollars and hire many new staff. There are 304 privately-owned hospitals located in jurisdictions that currently have a LPPF, 27% of which are not-for-profit organizations. Texas hospitals are extremely complex organizations, which have innumerable private contracts with various types of entities that Texas would

be required to examine to determine whether each contract constituted hold harmless arrangements under the bulletin's vague definitions.

68. Because current law only requires HHSC to monitor agreements involving local government entities, HHSC currently employs only about a dozen compliance staff aimed at ensuring no impermissible hold harmless provisions exist. HHSC would need to hire hundreds of additional staff to "curtail" any actions that might be inconsistent with the bulletin: those staff would include professionals like auditors, financial examiners, financial analysts, and attorneys who could competently interpret the thousands (potentially millions) of contracts or other business arrangements at each hospital and the billions of dollars of revenues and expenditures that are associated with the running of those hospitals.

69. HHSC would also need to investigate private associations or individual citizens who may have financial or other contractual relationships with any Medicaid provider that is assessed a mandatory payment as part of a LPPF. And at that juncture, HHSC would risk transgressing the First Amendment, which protects the free-association rights of individuals and nonprofit organizations—including nonprofit hospital associations.

70. The last several years have been challenging for Texas Medicaid: the pandemic, combined with CMS's past conduct that precipitated Texas's earlier lawsuit, have put providers and patients on edge. CMS's latest salvo threatens to undermine the work that HHSC has done to restore confidence in the Texas Medicaid Program and is destabilizing to the safety net that Texans enrolled in the Medicaid

program rely on to provide them life-saving care. LPPFs fund nearly a fifth of Texas's state share of Medicaid expenditures. Moreover, LPPFs are typically operated by hospital districts and other local government entities—meaning that CMS's current effort to shut off Medicaid funding is aimed at the very local government entities that are charged with creating an aspect of the entire social-safety net that serves emergent or acute medical needs. In Texas, most hospital associations are non-profits and, to comply with the bulletin, HHSC would be compelled to examine them to evaluate any financial relationship they might have with hospitals located in jurisdictions that operate LPPFs. Texas hospitals cannot afford, and the Texans they serve cannot afford, the type of uncertainty in future funding that has resulted from the bulletin.

## CLAIMS

### *Count I*

### The February 17 Bulletin Exceeds CMS's Statutory Authority and is Not in Accordance with Law (5 U.S.C. § 706)

71. Plaintiffs incorporate by reference all preceding paragraphs.

72. Under the APA, a court must "hold unlawful and set aside agency action" that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law" or "in excess of statutory . . . authority, or limitations, or short of statutory right." *See* 5 U.S.C. § 706(2)(A), (C).

73. The February 17 bulletin defines a hold harmless arrangement to reach agreements solely between private healthcare providers. Defendants lack statutory and regulatory authority to issue a definition of a hold harmless arrangement that

contradicts the plain language of the Social Security Act and CMS's own agency rules. *See* 42 U.S.C. § 1396b(w)(4); *see also* 42 C.F.R. § 433.68(f)(3).

74. The Social Security Act's definition of a prohibited hold harmless provision does not encompass private agreements exclusively between private providers. Instead, the Act requires that a) *the State or other unit of government* imposing the tax provide the payment, offset, or waiver, and b) the payment, offset, or waiver guarantees to hold taxpayers harmless for any portion of the tax. 42 U.S.C. § 1396b(w)(4)(C)(i). The redistribution agreements between private providers that CMS described in the February 17 bulletin are not hold harmless arrangements because they do not involve "[t]he State or other unit of government imposing the tax" acting to hold taxpayers harmless. *Id.* § 1396b(w)(4)(C)(i).

75. The bulletin also elevates a legally unenforceable "expectation" to the level of a guarantee, which is contrary to the plain meaning of the term "expectation." There is no indication that Congress intended for "guarantee" to have any definition other than its plain meaning.

76. Defendants did not act in accordance with the law and exceeded their statutory and regulatory authority when promulgating and relying upon the February 17 bulletin. Accordingly, the bulletin should be set aside.

### *Count II*

### The February 17 Bulletin Did Not Comport with the Requirements of Notice-and-Comment Rulemaking (5 U.S.C. § 553)

77. Plaintiffs incorporate by reference all preceding paragraphs.

78. The February 17 bulletin is a substantive or legislative rule that required notice-and-comment rulemaking under the APA. *See* 5 U.S.C. § 553. The bulletin is not exempt from the APA's notice-and-comment requirements as the bulletin is not an interpretive rule, general statement of policy, or the rule of agency organization, procedure, or practice. *See id.* § 553(b)(A).

79. "Agencies have never been able to avoid notice and comment simply by mislabeling their substantive pronouncements." *Azar v. Allina Health Servs.*, 139 S. Ct. 1804, 1812 (2019). "On the contrary, courts have long looked to the *contents* of the agency's action, not the agency's self-serving *label*, when deciding whether statutory notice and comment demands apply." *Id.*

80. CMS acknowledged that defining hold harmless arrangements to include agreements to which neither the State nor local government entities were a party is a substantive rule requiring notice-and-comment rulemaking when it initiated such a process in 2019. That conclusion was proven correct by the thousands of comments submitted to CMS discussing not only its lack of statutory authority but also the real-world obligations that the proposed rule would impose on both private parties and the States.

81. Moreover, the bulletin easily meets the definition of a legislative rule requiring notice and comment. Specifically, courts "evaluate two criteria to distinguish policy statements from substantive rules: whether the rule (1) impose[s] any rights and obligation and (2) genuinely leaves the agency and its decision-makers

free to exercise discretion." *Texas v. United States*, 809 F.3d 134, 171 (5th Cir. 2015) ("*DAPA*") (quotation marks omitted).

82. Here, the bulletin imposes rights and obligations and does not leave CMS and its decisionmakers free to exercise discretion regarding the scope of the Social Security Act's hold harmless prohibition: because of the bulletin, "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" the Social Security Act. Ex. A at 5.

83. CMS is *required* to "reduce a state's medical assistance expenditures by the amount of healthcare-related tax collections that include hold harmless arrangements, prior to calculating federal financial participation." *Id.* The bulletin is therefore substantive because it imposes more than "derivative, incidental, or mechanical burdens" and it "change[s] the substantive standards by which" CMS determines how to enforce the Social Security Act and its implementing regulations. *DAPA*, 809 F.3d at 176; *Texas v. EEOC*, 933 F.3d 433, 443-46 (5th Cir. 2019).

84. The February 17 bulletin is invalid because CMS failed to use the proper notice-and-comment procedures required by the APA. *See* 5 U.S.C. §§ 553, 706.

***Count III***

**The February 17 Bulletin Is Arbitrary and Capricious (5 U.S.C. § 706)**

85. Plaintiffs incorporate by reference all preceding paragraphs.

86. Federal administrative agencies are required to engage in reasoned decision-making. "Not only must an agency's decreed result be within the scope of its lawful authority, but the process by which it reaches that result must be logical and rational." *Allentown Mack Sales & Serv., Inc. v. NLRB*, 522 U.S. 359, 374 (1998). And when an agency reverses "prior policy," it must provide a "detailed justification" for doing so. *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515-16 (2009) (plurality op.).

87. The February 17 bulletin is arbitrary and capricious because it fails to acknowledge CMS's change in position. In 2019, CMS acknowledged the absence of statutory or regulatory authority to police, or require States to police, private provider agreements under the Social Security Act. The bulletin reaches the exact opposite conclusion, with no explanation (or even acknowledgement) of that change in position. The bulletin therefore cannot survive arbitrary-and-capricious review.

88. "[A]gencies must typically provide a 'detailed explanation' for contradicting a prior policy, particularly when the prior policy has engendered serious reliance interests." *BST Holdings, L.L.C. v. OSHA*, 17 F.4th 604, 614 (5th Cir. 2021) (quoting *Fox*, 556 U.S. at 515); *see DHS v. Regents of the Univ. of Cal.*, 140 S. Ct. 1891, 1913 (2020) (applying this principle even when there were serious questions as to the legality of the rule to be rescinded). The February 17 bulletin fails to discuss the reliance interests of States like Texas that have never needed to police redistribution agreements between private providers, and which now lack the structural and financial systems necessary to comply with CMS's edict.

89. The bulletin also fails to discuss Medicaid recipients' need for access to care that is funded by LPPFs. CMS well knows that Texas relies on $3 billion from LPPFs as part of the non-federal share of Medicaid payments. Withholding federal matching funds for this large amount of funding based on the State's inability to immediately comply with the bulletin, as CMS has threatened, Ex. A at 5-6, would devastate Texas's Medicaid finances, significantly destabilize the State's Medicaid provider network, and jeopardize the availability of options for quality healthcare for all Texans, including Medicaid recipients.

90. Moreover, agency action may be set aside as arbitrary and capricious if the agency fails to "comply with its own regulations." *See Environmental, LLC v. FCC*, 661 F.3d 80, 85 (D.C. Cir. 2011). The bulletin is inconsistent with CMS's implementing regulations, that specify that a hold harmless provision 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." *See* 42 C.F.R. § 433.68(f)(3). CMS's bulletin therefore conflicts not just with the text of the Social Security Act but with the agency's own regulations, and should be set aside on this basis, too.

91. Based on these and other flaws, the bulletin should be set aside as arbitrary and capricious.

***Count IV***

**Alternatively, the 2008 Rule Is Not in Accordance with Law (5 U.S.C. § 706)**

92. Plaintiffs incorporate by reference all preceding paragraphs.

93. CMS has taken the position that the February 17 bulletin was supported by the preamble to the 2008 rule. This is legally incorrect as a rule's preamble cannot impose obligations that are inconsistent with the rule's text. *See Entergy Servs., Inc. v. FERC*, 375 F.3d 1204, 1209 (D.C. Cir. 2004). It also misreads the preamble.

94. If the Court disagrees, however, then the 2008 rule is contrary to CMS's statutory authority and should be set aside for the reasons discussed above.

95. Although any claim challenging the process by which the 2008 rule was adopted is time-barred, 28 U.S.C. § 2401(a); *Wind River Mining Corp. v. United States*, 946 F.2d 710, 715 (9th Cir. 1991); *Texas v. United States*, 749 F.2d 1144, 1146 (5th Cir. 1985), Texas may still challenge the legality of the rule if it has been applied to Texas within the last six years, *Dunn-McCampbell Royalty Int., Inc. v. Nat'l Park Serv.*, 112 F.3d 1283, 1287 (5th Cir. 1997).

96. CMS has applied or attempted to apply its (incorrect) interpretation of the 2008 Rule multiple times since 2021: when CMS demanded the interpretation be applied as a condition of the extension of Texas's section 1115 waiver in 2021, when CMS refused to approve Texas's directed payment programs until Texas agreed to the interpretation in 2022, and now when CMS demands documents based on the interpretation of the rule in 2023.

## DEMAND FOR JUDGMENT

Plaintiffs request that the Court:

a. Declare unlawful and set aside the February 17 bulletin;

b. Issue preliminary and permanent injunctive relief enjoining defendants from enforcing or implementing the February 17 bulletin against Texas;

c. Compel defendants to conduct any Medicaid audit and oversight activities against Texas in accordance with the Social Security Act and its implementing regulations and without reliance on the February 17 bulletin;

d. Award Texas the costs of this action and reasonable attorney's fees; and

e. Award such other and further relief as the Court deems equitable and just.

Dated: April 5, 2023.

Respectfully submitted.

KEN PAXTON
Attorney General of Texas

BRENT WEBSTER
First Assistant Attorney General

CHRISTOPHER H. HILTON
Chief, General Litigation Division
Texas Bar No. 24087727
Christopher.Hilton@oag.texas.gov

LEIF A. OLSON
Chief, Special Litigation Division
Texas Bar No. 24032801
Leif.Olson@oag.texas.gov

MUNERA AL-FUHAID
Special Counsel
Texas Bar No. 24094501
Munera.Al-Fuhaid@oag.texas.gov

OFFICE OF THE ATTORNEY GENERAL
P.O. Box 12548 (MC-059)
Austin, Texas 78711-2548
(512) 936-1700

JUDD E. STONE II
Solicitor General

/s/ Lanora C. Pettit
LANORA C. PETTIT
Principal Deputy Solicitor General
*Lead Counsel*
Texas Bar No. 24115221
Lanora.Pettit@oag.texas.gov

MICHAEL R. ABRAMS
Assistant Solicitor General
Texas Bar No. 24087072
Michael.Abrams@oag.texas.gov

WILLIAM F. COLE*
Assistant Solicitor General
Texas Bar No. 24124187
William.Cole@oag.texas.gov

*Application for admission forthcoming

*Counsel for Plaintiffs*

JS 44 (Rev 04/21)

# CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)*

**I. (a) PLAINTIFFS**

State of Texas; Texas Health and Human Services Commission

**(b)** County of Residence of First Listed Plaintiff Smith County, Texas
*(EXCEPT IN U.S. PLAINTIFF CASES)*

**(c)** Attorneys *(Firm Name, Address, and Telephone Number)*
Lanora C. Pettit, Principal Deputy Solicitor General
P.O. Box 12548 MC-059, Austin, TX 78711-2548
Tel: (512) 936-1700 *see attch

**DEFENDANTS**

Chiquita Brooks-LaSure, in her official capacity as Admin. for the Ctrs for Medicare & Medicaid Services, et al. *see

County of Residence of First Listed Defendant
*(IN U.S. PLAINTIFF CASES ONLY)*

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED

Attorneys *(If Known)*

**II. BASIS OF JURISDICTION** *(Place an "X" in One Box Only)*

- ☐ 1 U S Government Plaintiff
- ☐ 3 Federal Question *(U.S. Government Not a Party)*
- ☒ 2 U S Government Defendant
- ☐ 4 Diversity *(Indicate Citizenship of Parties in Item III)*

**III. CITIZENSHIP OF PRINCIPAL PARTIES** *(Place an "X" in One Box for Plaintiff and One Box for Defendant)*
*(For Diversity Cases Only)*

| | PTF | DEF | | PTF | DEF |
|---|---|---|---|---|---|
| Citizen of This State | ☐ 1 | ☐ 1 | Incorporated *or* Principal Place of Business In This State | ☐ 4 | ☐ 4 |
| Citizen of Another State | ☐ 2 | ☐ 2 | Incorporated *and* Principal Place of Business In Another State | ☐ 5 | ☐ 5 |
| Citizen or Subject of a Foreign Country | ☐ 3 | ☐ 3 | Foreign Nation | ☐ 6 | ☐ 6 |

**IV. NATURE OF SUIT** *(Place an "X" in One Box Only)*

Click here for: Nature of Suit Code Descriptions.

**CONTRACT**
- ☐ 110 Insurance
- ☐ 120 Marine
- ☐ 130 Miller Act
- ☐ 140 Negotiable Instrument
- ☐ 150 Recovery of Overpayment & Enforcement of Judgment
- ☐ 151 Medicare Act
- ☐ 152 Recovery of Defaulted Student Loans (Excludes Veterans)
- ☐ 153 Recovery of Overpayment of Veteran's Benefits
- ☐ 160 Stockholders' Suits
- ☐ 190 Other Contract
- ☐ 195 Contract Product Liability
- ☐ 196 Franchise

**REAL PROPERTY**
- ☐ 210 Land Condemnation
- ☐ 220 Foreclosure
- ☐ 230 Rent Lease & Ejectment
- ☐ 240 Torts to Land
- ☐ 245 Tort Product Liability
- ☐ 290 All Other Real Property

**TORTS**

PERSONAL INJURY
- ☐ 310 Airplane
- ☐ 315 Airplane Product Liability
- ☐ 320 Assault, Libel & Slander
- ☐ 330 Federal Employers' Liability
- ☐ 340 Marine
- ☐ 345 Marine Product Liability
- ☐ 350 Motor Vehicle
- ☐ 355 Motor Vehicle Product Liability
- ☐ 360 Other Personal Injury
- ☐ 362 Personal Injury - Medical Malpractice

PERSONAL INJURY
- ☐ 365 Personal Injury - Product Liability
- ☐ 367 Health Care/ Pharmaceutical Personal Injury Product Liability
- ☐ 368 Asbestos Personal Injury Product Liability

PERSONAL PROPERTY
- ☐ 370 Other Fraud
- ☐ 371 Truth in Lending
- ☐ 380 Other Personal Property Damage
- ☐ 385 Property Damage Product Liability

**CIVIL RIGHTS**
- ☐ 440 Other Civil Rights
- ☐ 441 Voting
- ☐ 442 Employment
- ☐ 443 Housing/ Accommodations
- ☐ 445 Amer w/Disabilities - Employment
- ☐ 446 Amer w/Disabilities - Other
- ☐ 448 Education

**PRISONER PETITIONS**

Habeas Corpus:
- ☐ 463 Alien Detainee
- ☐ 510 Motions to Vacate Sentence
- ☐ 530 General
- ☐ 535 Death Penalty

Other:
- ☐ 540 Mandamus & Other
- ☐ 550 Civil Rights
- ☐ 555 Prison Condition
- ☐ 560 Civil Detainee - Conditions of Confinement

**FORFEITURE/PENALTY**
- ☐ 625 Drug Related Seizure of Property 21 USC 881
- ☐ 690 Other

**LABOR**
- ☐ 710 Fair Labor Standards Act
- ☐ 720 Labor/Management Relations
- ☐ 740 Railway Labor Act
- ☐ 751 Family and Medical Leave Act
- ☐ 790 Other Labor Litigation
- ☐ 791 Employee Retirement Income Security Act

**IMMIGRATION**
- ☐ 462 Naturalization Application
- ☐ 465 Other Immigration Actions

**BANKRUPTCY**
- ☐ 422 Appeal 28 USC 158
- ☐ 423 Withdrawal 28 USC 157

**INTELLECTUAL PROPERTY RIGHTS**
- ☐ 820 Copyrights
- ☐ 830 Patent
- ☐ 835 Patent - Abbreviated New Drug Application
- ☐ 840 Trademark
- ☐ 880 Defend Trade Secrets Act of 2016

**SOCIAL SECURITY**
- ☐ 861 HIA (1395ff)
- ☐ 862 Black Lung (923)
- ☐ 863 DIWC/DIWW (405(g))
- ☐ 864 SSID Title XVI
- ☐ 865 RSI (405(g))

**FEDERAL TAX SUITS**
- ☐ 870 Taxes (U S Plaintiff or Defendant)
- ☐ 871 IRS—Third Party 26 USC 7609

**OTHER STATUTES**
- ☐ 375 False Claims Act
- ☐ 376 Qui Tam (31 USC 3729(a))
- ☐ 400 State Reapportionment
- ☐ 410 Antitrust
- ☐ 430 Banks and Banking
- ☐ 450 Commerce
- ☐ 460 Deportation
- ☐ 470 Racketeer Influenced and Corrupt Organizations
- ☐ 480 Consumer Credit (15 USC 1681 or 1692)
- ☐ 485 Telephone Consumer Protection Act
- ☐ 490 Cable/Sat TV
- ☐ 850 Securities/Commodities/ Exchange
- ☐ 890 Other Statutory Actions
- ☐ 891 Agricultural Acts
- ☐ 893 Environmental Matters
- ☐ 895 Freedom of Information Act
- ☐ 896 Arbitration
- ☒ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
- ☐ 950 Constitutionality of State Statutes

**V. ORIGIN** *(Place an "X" in One Box Only)*

☒ 1 Original Proceeding ☐ 2 Removed from State Court ☐ 3 Remanded from Appellate Court ☐ 4 Reinstated or Reopened ☐ 5 Transferred from Another District *(specify)* ☐ 6 Multidistrict Litigation - Transfer ☐ 8 Multidistrict Litigation - Direct File

**VI. CAUSE OF ACTION**

Cite the U.S. Civil Statute under which you are filing *(Do not cite jurisdictional statutes unless diversity)*:
5 U.S.C. § 706

Brief description of cause:
Action challenging legality of bulletin promulgated by federal agency

**VII. REQUESTED IN COMPLAINT:**

☐ CHECK IF THIS IS A CLASS ACTION UNDER RULE 23, F.R.Cv.P.

**DEMAND $**

CHECK YES only if demanded in complaint:
**JURY DEMAND:** ☐ Yes ☒ No

**VIII. RELATED CASE(S) IF ANY**

*** see attached note**
*(See instructions):*

JUDGE Hon. J. Campbell Barker DOCKET NUMBER 6:21-cv-00191-JCB

DATE
Apr 5, 2023

SIGNATURE OF ATTORNEY OF RECORD
/s/ Lanora C. Pet it

**FOR OFFICE USE ONLY**

RECEIPT # AMOUNT APPLYING IFP JUDGE MAG JUDGE

# INSTRUCTIONS FOR ATTORNEYS COMPLETING CIVIL COVER SHEET FORM JS 44

Authority For Civil Cover Sheet

The JS 44 civil cover sheet and the information contained herein neither replaces nor supplements the filings and service of pleading or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. Consequently, a civil cover sheet is submitted to the Clerk of Court for each civil complaint filed. The attorney filing a case should complete the form as follows:

**I.(a) Plaintiffs-Defendants.** Enter names (last, first, middle initial) of plaintiff and defendant. If the plaintiff or defendant is a government agency, use only the full name or standard abbreviations. If the plaintiff or defendant is an official within a government agency, identify first the agency and then the official, giving both name and title.

**(b) County of Residence.** For each civil case filed, except U.S. plaintiff cases, enter the name of the county where the first listed plaintiff resides at the time of filing. In U.S. plaintiff cases, enter the name of the county in which the first listed defendant resides at the time of filing. (NOTE: In land condemnation cases, the county of residence of the "defendant" is the location of the tract of land involved.)

**(c) Attorneys.** Enter the firm name, address, telephone number, and attorney of record. If there are several attorneys, list them on an attachment, noting in this section "(see attachment)".

**II. Jurisdiction.** The basis of jurisdiction is set forth under Rule 8(a), F.R.Cv.P., which requires that jurisdictions be shown in pleadings. Place an "X" in one of the boxes. If there is more than one basis of jurisdiction, precedence is given in the order shown below.
United States plaintiff. (1) Jurisdiction based on 28 U.S.C. 1345 and 1348. Suits by agencies and officers of the United States are included here.
United States defendant. (2) When the plaintiff is suing the United States, its officers or agencies, place an "X" in this box.
Federal question. (3) This refers to suits under 28 U.S.C. 1331, where jurisdiction arises under the Constitution of the United States, an amendment to the Constitution, an act of Congress or a treaty of the United States. In cases where the U.S. is a party, the U.S. plaintiff or defendant code takes precedence, and box 1 or 2 should be marked.
Diversity of citizenship. (4) This refers to suits under 28 U.S.C. 1332, where parties are citizens of different states. When Box 4 is checked, the citizenship of the different parties must be checked. (See Section III below**; NOTE: federal question actions take precedence over diversity cases.**)

**III. Residence (citizenship) of Principal Parties.** This section of the JS 44 is to be completed if diversity of citizenship was indicated above. Mark this section for each principal party.

**IV. Nature of Suit.** Place an "X" in the appropriate box. If there are multiple nature of suit codes associated with the case, pick the nature of suit code that is most applicable. Click here for: Nature of Suit Code Descriptions.

**V. Origin.** Place an "X" in one of the seven boxes.
Original Proceedings. (1) Cases which originate in the United States district courts.
Removed from State Court. (2) Proceedings initiated in state courts may be removed to the district courts under Title 28 U.S.C., Section 1441.
Remanded from Appellate Court. (3) Check this box for cases remanded to the district court for further action. Use the date of remand as the filing date.
Reinstated or Reopened. (4) Check this box for cases reinstated or reopened in the district court. Use the reopening date as the filing date.
Transferred from Another District. (5) For cases transferred under Title 28 U.S.C. Section 1404(a). Do not use this for within district transfers or multidistrict litigation transfers.
Multidistrict Litigation – Transfer. (6) Check this box when a multidistrict case is transferred into the district under authority of Title 28 U.S.C. Section 1407.
Multidistrict Litigation – Direct File. (8) Check this box when a multidistrict case is filed in the same district as the Master MDL docket.
**PLEASE NOTE THAT THERE IS NOT AN ORIGIN CODE 7.** Origin Code 7 was used for historical records and is no longer relevant due to changes in statute.

**VI. Cause of Action.** Report the civil statute directly related to the cause of action and give a brief description of the cause. **Do not cite jurisdictional statutes unless diversity.** Example: U.S. Civil Statute: 47 USC 553 Brief Description: Unauthorized reception of cable service.

**VII. Requested in Complaint.** Class Action. Place an "X" in this box if you are filing a class action under Rule 23, F.R.Cv.P.
Demand. In this space enter the actual dollar amount being demanded or indicate other demand, such as a preliminary injunction.
Jury Demand. Check the appropriate box to indicate whether or not a jury is being demanded.

**VIII. Related Cases.** This section of the JS 44 is used to reference related pending cases, if any. If there are related pending cases, insert the docket numbers and the corresponding judge names for such cases.

**Date and Attorney Signature.** Date and sign the civil cover sheet.

*State of Texas, Texas Health and Human Services Commission. v. Chiquita Brooks-LaSure, in her official capacity as Administrator for the Centers for Medicare & Medicaid Services, et al.*; No. 6:23-cv-_____; United States District Court for the Eastern District of Texas, Tyler Division

## VII. RELATED CASE(S) IF ANY

*State of Texas, et al. v. Brooks-LaSure, et al.*; No. 6:21-cv-00191-JCB; E.D. Tex. Hon. J. Campbell Barker

*** Note re Related Case**

It is unclear whether this case, which was voluntarily dismissed upon specific representations by the Defendants, meets the Court's definition of "related cases." However, this case raises a legal issue that was raised in the prior litigation but not resolved as a result of the voluntary dismissal.

*State of Texas, Texas Health and Human Services Commission. v. Chiquita Brooks-LaSure, in her official capacity as Administrator for the Centers for Medicare & Medicaid Services, et al.*; No. 6:23-cv-_____; United States District Court for the Eastern District of Texas, Tyler Division

**Civil Cover Sheet**

**Exhibit A**

**Parties**

| **PLAINTIFFS** | **DEFENDANTS** |
|---|---|
| State of Texas | Chiquita Brooks-LaSure, in her official capacity as Administrator for the Centers for Medicare & Medicaid Services |
| Texas Health and Human Services Commission | Centers for Medicare and Medicaid Services |
| | Xavier Becerra, in his official capacity as Secretary of the Department of Health and Human Services |
| | United States Department of Health and Human Services |
| | United States of America |

*State of Texas, Texas Health and Human Services Commission. v. Chiquita Brooks-LaSure, in her official capacity as Administrator for the Centers for Medicare & Medicaid Services, et al.*; No. 6:23-cv-_____; United States District Court for the Eastern District of Texas, Tyler Division

**Civil Cover Sheet**

**Exhibit B**

**Counsel for Plaintiffs**

KEN PAXTON
Attorney General of Texas

BRENT WEBSTER
First Assistant Attorney General

CHRISTOPHER H. HILTON
Chief, General Litigation Division
Tex. State Bar No. 24087727
Christopher.Hilton@oag.texas.gov

LEIF A. OLSON
Chief, Special Litigation Division
Tex. State Bar No. 24032801
Leif.Olson@oag.texas.gov

MUNERA AL-FUHAID
Special Counsel
Tex. State Bar No. 24094501
Munera.Al-Fuhaid@oag.texas.gov

Office of the Attorney General
P.O. Box 12548 (MC-059)
Austin, Texas 78711-2548
(512) 936-1700

JUDD E. STONE II
Solicitor General

LANORA C. PETTIT
Principal Deputy Solicitor General
Lead Counsel
Texas Bar No. 24115221
Lanora.Pettit@oag.texas.gov

MICHAEL R. ABRAMS
Assistant Solicitor General
Texas Bar No. 24087072
Michael.Abrams@oag.texas.gov

WILLIAM F. COLE
Assistant Solicitor General
Texas Bar No. 24124187
William.Cole@oag.texas.gov

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE EASTERN DISTRICT OF TEXAS**
**TYLER DIVISION**

| | |
|---|---|
| STATE OF TEXAS; TEXAS HEALTH AND HUMAN SERVICES COMMISSION,<br>*Plaintiffs*,<br><br>v.<br><br>CHIQUITA BROOKS-LASURE, in her official capacity as Administrator for the Centers for Medicare and Medicaid Services; THE CENTERS FOR MEDICARE AND MEDICAID SERVICES; XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; and the UNITED STATES OF AMERICA,<br>*Defendants*. | Civ. Action No. _____ |

# Original Complaint

# Exhibit A

# Centers for Medicare and Medicaid Services Bulletin Feb. 17, 2023

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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

***CMCS Informational Bulletin***

**DATE:** February 17, 2023

**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) under 42 C.F.R. § 438.6(c). 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—that is, arrangements in which 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"—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 critical 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 Medicaid payment methodologies that assure payments are consistent with federal requirements.

Medicaid 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 priorities for their Medicaid programs. 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. 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. [1] CMS regularly works with states to approve such waivers in furtherance of state goals while 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 contravene 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 statutory and regulatory requirements and undermine the fiscal integrity of the Medicaid program. Recently, CMS has become aware of some health care-related tax programs 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 reiterating the federal requirements concerning hold harmless arrangements with respect to health care-related taxes. Further, states and providers should be transparent regarding any explicit or implicit 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 otherwise eligible for federal financial participation. CMS recommends that states that have questions or concerns about the permissibility of a health care-related tax 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. CMS also intends to work with states that may have existing questionable arrangements to ensure compliance with federal statutory and regulatory requirements.

**Health Care-Related Taxes and Hold Harmless Arrangements**

During standard oversight activities and the review of state payment proposals, particularly managed care SDPs and fee-for-service payment state plan amendments (SPAs), 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

[1] For non-broad based and/or non-uniform health care related taxes, these conditions are: that the tax be imposed on a permissible class or class, that the tax be generally redistributive, that the tax be not directly correlated with Medicaid payments, and that the tax lack a hold harmless arrangement. See section 1903 (w)(3)(E)(ii) for the requirement that the tax demonstrate that it is 'generally redistributive" and "not directly correlated with Medicaid payments." For the statistical test demonstrating that the tax is "generally redistributive" see 42 CFR § 433.68 (e)(1) for waivers of the broad based requirement only and 42 C.F.R. § 433.68 (e)(2) for waivers of the uniformity requirement whether or not the tax is broad-based. See section 1903 (w)(4) and implementing regulations at 42 C.F.R. § 433.68 (f) for the hold harmless requirements. See section 1903 (w)(7) and 42 C.F.R. § 433.56 for a list of permissible classes upon which states may impose health care-related taxes.

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 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[2]) 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 (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. The redistributions occur so that taxpaying providers are held harmless for all or a portion of the health care-related tax. This may include the redistribution of Medicaid payments to providers that serve no Medicaid beneficiaries.

These tax programs appear to contain impermissible hold harmless arrangements as defined in section 1903(w)(4)(C)(i) of the Act and 42 C.F.R. § 433.68(f)(3) that require 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 of a hold harmless arrangement involving Medicaid payment redistribution:

- 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.
- 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 managed care plans.
- Nine 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 eight of the nine Medicaid-participating hospitals receive. Under this arrangement, five of the six hospitals that furnish a high percentage of Medicaid-covered services receive Medicaid payments from the managed care plans, 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 the nine participating 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

[2] The term managed care plan is used here and throughout this guidance to include managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs) as defined in 42 C.F.R. § 438.2.

availability of the redistributed payments received from five of the six high Medicaid service volume hospitals (regardless of whether the funds were first pooled and then redistributed), are held harmless for at least part of their health care-related tax costs.

- 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 the tax program.

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)."[3]

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."[4] In the preamble, we 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.[5] 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.

---

[3] 73 Federal Register 9685, 9694-95 (Feb. 22, 2008).
[4] 73 Federal Register 9694
[5] *Id.*

Accordingly, 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.

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. States have an obligation to ensure that the sources of non-federal share of Medicaid expenditures comport with federal statute and regulations. As a result, states should make clear to their providers that these arrangements are not permissible under federal requirements, learn the details of how health care-related taxes are collected, and take steps to curtail these practices if they exist.

As part of the agency's normal oversight activities and review of state payment proposals, 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. As part of their obligation to ensure state sources of non-federal share meet federal requirements, we expect states to have detailed information available regarding their health care-related taxes. Consistent with federal requirements, CMS expects states to make available all requested documentation regarding arrangements involving possible hold harmless arrangements and the redistribution of Medicaid payments. States should work with their providers to ensure necessary information is available. Where appropriate, states should examine their provider participation agreements and managed care plan 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 C.F.R. § 75.364, 42 C.F.R. § 433.74, and 42 C.F.R. part 438 for any 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. If CMS or an outside oversight agency, such as the state auditing agency or the HHS Office of Inspector General discovers the existence of impermissible financing practices related to health care-related taxes CMS will take enforcement action as necessary. 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, including by reviewing proposals or existing arrangements and providing feedback to develop or modify health care-related taxes to align with state policy goals and 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 (explicit or implicit in nature) to 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 tax programs 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.

**UNITED STATES DISTRICT COURT**
**EASTERN DISTRICT OF TEXAS**
**TYLER DIVISION**

| | |
|---|---|
| STATE OF TEXAS; TEXAS HEALTH AND HUMAN SERVICES COMMISSION,<br>*Plaintiffs*,<br>v.<br>CHIQUITA BROOKS-LASURE, in her official capacity as Administrator of the Centers for Medicare and Medicaid Services; THE CENTERS FOR MEDICARE AND MEDICAID SERVICES; XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; and the UNITED STATES OF AMERICA,<br>*Defendants*. | No. 6:23-cv-00191-JDK |

**PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION**

## TABLE OF CONTENTS

## TABLE OF AUTHORITIES

**Page(s)**

**Cases:**

**Constitutional Provisions, Statutes, and Rules:**

**Other Authorities:**

## INTRODUCTION

Medicaid is designed as a cooperative endeavor between the federal and state governments to fulfill a vital need: the delivery of healthcare services to low-income Americans. But for the second time in three years, the Centers for Medicare and Medicaid Services (CMS) has disregarded Congress's cooperative-federalism design, reversed its prior position regarding what States must do to fund their share of Medicaid, ignored the Administrative Procedure Act's requirements, and attempted to force Texas to adopt a cumbersome regulatory regime entirely foreign to the Social Security Act.

"Turmoil in the State's Medicaid program resulted" the last time that CMS tried to arbitrarily revoke its approval of Texas's request to extend and amend the State's long-running, managed-care system for the delivery of most Medicaid services. *See Texas v. Brooks-LaSure*, No. 6:21-cv-00191, 2021 WL 5154219, at *1 (E.D. Tex. Aug. 20, 2021). That turmoil only relented when this Court threatened to sanction CMS for the litany of pretexts it offered to justify its actions. *Texas v. Brooks-LaSure*, No. 6:21-cv-00191, 2022 WL 741065, at *1, *10 (E.D. Tex. Mar. 11, 2022). That turmoil has returned because CMS now threatens to retroactively disallow funds based on one of those same pretexts: Texas's refusal to police private contracts that are entirely legal under the text of the Social Security Act and CMS's existing regulations. *See id.* at *8-10.

This dispute turns on a statutory provision that the parties raised, but the Court did not need to definitively interpret, in the prior litigation: the Social Security Act's prohibition on government guarantees that healthcare providers will be held harmless for certain taxes they pay to fund Medicaid. 42 U.S.C. § 1396b(w)(1)(A)(iii). Because Medicaid depends on the federal government matching state spending, Congress has prohibited States from artificially inflating the amount of federal funds

they claim by purporting to tax health-care providers for Medicaid services while guaranteeing—directly or indirectly—that a taxpaying healthcare provider will receive its total tax payment back through Medicaid payments. *Id.* These "hold harmless" agreements are prohibited when a State or local government provides the guarantee. Consistent with federal law, Texas law bars such arrangements. *See, e.g.*, Tex. Health & Safety Code § 300.0151(b). And as Texas's Medicaid agency, the Texas Health and Human Services Commission (HHSC) has promulgated rules and established processes to ensure that no such arrangements occur.

With CMS's encouragement, Texas has authorized local governments to tax healthcare providers[1] to provide one source of the state contribution to financing Medicaid. Those funds are placed in a local government's dedicated account known as a Local Provider Payment Fund (LPPF). The State has always understood that because Texas does not guarantee that it will directly or indirectly hold taxpaying providers harmless for such a healthcare tax, the State may use those LPPF funds to finance a substantial portion of the 40% of Medicaid costs for which it is responsible. Just four years ago, CMS reassured state officials that those understandings were correct. Texas has made substantial investments and structured its compliance regime based on that assurance.

This case arises because CMS has, through sub-regulatory guidance, attempted to require Texas to put an end to any purely private agreements that may exist by which Medicaid providers whose taxes are paid into LPPFs may have financial-risk-mitigation agreements amongst themselves. CMS tried to impose such

[1] The Texas statutes which authorize hospital districts to collect and deposit mandatory payments into LPPFs explicitly state that such mandatory payments are not taxes for the purposes of Article IX of the Texas Constitution. However, these payments are considered healthcare-related taxes for purposes of federal law. *See, e.g.*, 42 U.S.C. § 1396b(w)(3)(A); 42 C.F.R. § 433.55.

a requirement by rule in 2019. That failed. CMS tried to impose such a requirement as a special term and condition (STC) of renewing Texas's section 1115 waiver program in 2021. That was rejected—and properly identified by this Court as a pretext as well. *Brooks-Lasure*, 2022 WL 741065, at *10 (denying a request for sanctions "without prejudice to its reassertion in the future"). In 2022, CMS tried to demand it as a condition of approving the State's directed payments during litigation before this Court. Again, to no avail.

Apparently hoping that the fourth time will be the charm, on February 17, 2023, CMS published an "informational bulletin" with neither prior notice nor opportunity for comment. Ex. A, Dep't of Health & Hum. Servs., *CMCS Informational Bulletin* (Feb. 17, 2023). In that bulletin, CMS declared that it intends to include—and has supposedly always included—private arrangements among providers within the scope of prohibited hold harmless arrangements even though such arrangements do not involve the government. And the bulletin announced that CMS is requiring state governments to seek out and eliminate those arrangements on pain of the loss of billions of dollars in federal funding. Because CMS insists that this has been its longstanding position, it has made clear that it intends to apply this guidance retroactively to payments already made. To that end, the Health and Human Services Office of the Inspector General (OIG) has begun auditing four Texas jurisdictions for compliance with the bulletin's pronouncements—starting with the county in which this Court is located.

CMS's departures from the text of the Social Security Act, its regulations, and its prior dealings with Texas are unlawful. HHSC lacks the authority to investigate business arrangements between private providers of healthcare services—much less to prohibit them. HHSC has thus been put to an impossible choice: either (a) arrogate power found nowhere in state (or even federal) law and immediately invest millions of dollars (that have never been appropriated) in a comprehensive auditing and

enforcement program or (b) decline to comply with the bulletin and risk a level of sudden financial loss that would undoubtedly result in significant negative impacts to Medicaid providers and the Medicaid safety net in Texas. Neither option is tenable. Because of this irreparable and ongoing injury, Texas requests that the Court preliminarily enjoin the federal defendants from enforcing or relying on the bulletin pending resolution of its legality.

## BACKGROUND

### I. Overview of Medicaid and Hold Harmless Arrangements

#### A. The Medicaid program

"The Medicaid program, which provides joint federal and state funding of medical care for individuals who cannot afford to pay their own medical costs, was launched in 1965 with the enactment of Title XIX of the Social Security Act." *Ark. Dep't of Health & Hum. Servs. v. Ahlborn*, 547 U.S. 268, 275 (2006). At the federal level, the Medicaid program is administered by the "Secretary of Health and Human Services (HHS), who in turn exercises his authority through the Centers for Medicare and Medicaid Services." *Id.* Although "States are not required to participate in Medicaid . . . all of them do," *id.*, Texas among them. At present, Texas serves roughly 4.9 million Texans through its Medicaid program.[2]

---

[2] Tex. Health & Human Servs. Comm'n., *Texas Medicaid and CHIP Reference Guide*, at 4 (14th ed. 2022), http://hhs.texas.gov/sites/default/files/documents/texas-medicaid-chip-reference-guide-14th-edition.pdf. A more fulsome background of the Texas Medicaid system is also available in Texas's First Amended Complaint from its earlier-filed lawsuit. *See* Amended Complaint, *Texas v. Brooks-LaSure*, No. 6:21-cv-00191, (E.D. Tex. Aug. 31, 2021), ECF No. 54. This motion covers only those aspects of Texas Medicaid necessary for resolving the parties' current dispute. To avoid burdening the Court, Texas is not attaching voluminous, publicly available documents or copies of the filings in its previous lawsuit as exhibits to this Motion. It would be happy to provide them on request.

The administration of Medicaid is designed to be "cooperative": the federal government pays a certain percentage of the "costs that States incur for patient care, and, in return, the State pays its portion of the costs and complies with certain statutory requirements for making eligibility determinations, collecting and maintaining information, and administering the program." *Id.*

"To qualify for federal funds, States must submit" to CMS for approval "a state Medicaid plan that details the nature and scope of the State's Medicaid program." *Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, 565 U.S. 606, 610 (2012). And if a State's plan satisfies the requirements of the Social Security Act, "the Federal Government shares in the cost [of administering the program] by reimbursing[3] a participating State for patient care costs on the basis of a federal medical assistance percentage (FMAP)." *Abraham Lincoln Mem. Hosp. v. Sebelius*, 698 F.3d 536, 543 (7th Cir. 2012) (citing 42 U.S.C. § 1396b(a)(1) and 42 C.F.R. § 433.10(b)) (footnote added); *see also Harris v. McRae*, 448 U.S. 297, 308-09 (1980). "The FMAPs are used in determining the amount of federal matching funds, known as the federal financial participation . . . , participating States receive." *Sebelius*, 698 F.3d at 543. The FMAP can fluctuate based on a range of circumstances. *Id.* (citing 42 C.F.R. § 433.10(b)). For Texas, it is currently set at approximately 60%. Ex. B, Declaration of Victoria Grady, Director of Provider Finance and Government Relations Specialist for Finance, Texas Health and Human Services Commission ("Grady Declaration") ¶ 6.

[3] "Although the federal contribution to a State's Medicaid program is referred to as a 'reimbursement,' the stream of revenue is actually a series of huge quarterly advance payments that are based on the State's estimate of its anticipated future expenditures." *Bowen v. Massachusetts*, 487 U.S. 879, 883-84 & n.2 (1988) (citing 42 U.S.C. § 1396b(d)).

### B. Statutory prohibitions barring hold harmless arrangements

This case concerns the Social Security Act's requirements for calculating the FMAP and provisions that reduce the federal contribution to the States. "In the late 1980s and early 1990s, [S]tates began to take advantage of a 'loophole' in the Medicaid program that allowed [S]tates to gain extra federal matching funds without spending more state money." *Protestant Mem. Med. Ctr., Inc. v. Maram*, 471 F.3d 724, 726 (7th Cir. 2006). In that scheme, a State would "make payments to hospitals and collect the federal matching funds;" the State "would then recoup a portion of the state funding from the hospital, often in the form of a 'tax.'" *Id.*; *see also* Medicaid Program; Medicaid Fiscal Accountability Regulation (MFAR), 84 Fed. Reg. 63,722, 63,730 (Nov. 18, 2019) (proposed rule) (recounting this history).

Congress responded to this problem in 1991 through the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments. Pub. L. No. 102-234, § 2, 105 Stat. 1793 (1991) (adding subsection 1903(w), codified at 42 U.S.C. § 1396b(w), to the Social Security Act). The 1991 amendments require a reduction in the amount of patient-care costs for which the States may seek reimbursement—and which are used to calculate the federal financial participation payment—when the State obtains revenues from certain sources. *See* 42 U.S.C. § 1396b(w)(1)(A). Relevant here, the amendments require the amount of the State's requested reimbursement to be "reduced by the sum of any revenues received by the State" through a "broad-based health care related tax" that operates as "a hold-harmless provision." *Id.* § 1396b(w)(1)(A)(iii).

The statute, in turn, articulates three definitions of a "hold harmless" provision. *Id.* § 1396b(w). The first is when the taxing authority "provides (directly or indirectly) for a payment . . . to taxpayers" that is "positively correlated either to the amount of such tax or to the difference between the amount of the tax and the amount of payment under the State plan." *Id.* § 1396b(w)(4)(A). The second is when "[a]ll or

any portion of the payment made under this subchapter to the taxpayer varies based *only* upon the amount of the total tax paid." *Id.* § 1396b(w)(4)(B) (emphasis added). And the third is when 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." *Id.* § 1396b(w)(4)(C). Written in terms of actions by a taxing authority—and against the backdrop of *state* action to inflate Medicaid reimbursements—none of these provisions textually includes agreements to which no governmental actor is a party.

### C. Subsequent regulatory developments

Since the passage of the 1991 amendments, CMS has taken several regulatory actions to implement these restrictions on hold harmless arrangements.

**1.** CMS first promulgated implementing regulations in 1993. *See* Medicaid Program; Limitations on Provider-Related Donations and Health Care-Related Taxes; Limitations on Payments to Disproportionate Share Hospitals, 58 Fed. Reg. 43,156 (Aug. 13, 1993) (final rule); *see also* Medicaid Program; Limitations on Provider-Related Donations and Health Care-Related Taxes; Limitations on Payments to Disproportionate Share Hospitals, 57 Fed. Reg. 55,118 (Nov. 24, 1992) (interim final rule).

This regulation incorporated the statute's definition of a hold harmless provision into subsection (f) of 42 C.F.R. § 433.68 by "set[ting] out the three ways of finding a 'hold harmless provision' for a state tax program." *Brooks-LaSure*, 2022 WL 741065, at *5 (setting out this history). Relevant here, this regulation "added detail on the third hold-harmless definition" by adopting a two-part test—later formally adopted by Congress—for determining when the taxing authority's levy of an excessive amount of taxes on a healthcare provider rises to the level of a hold harmless "guarantee." *Id.* at *5-6; *see also* 57 Fed. Reg. at 55,129-30. Under that test,

"[i]f the tax on the providers' revenue was at or below 6% (selected as the national average sales tax), the tax would be assumed permissible," but if "the tax was above 6%," "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." *Brooks-LaSure*, 2022 WL 741065, at *5 (citing 57 Fed. Reg. at 55,142-43).

**2.** The second regulatory action took place in 2008, after HHS's Departmental Appeals Board *rejected* CMS's effort to retroactively disallow years of federal funding to five States based on an overbroad interpretation of what constitutes a hold harmless arrangement. There, CMS determined that certain state programs providing grants to nursing homes or tax credits to patients impermissibly held taxpayers harmless under CMS's regulations. *See id.* at *6-7 (citing *In re: Hawaii Dept. of Human Servs.*, Docket No. A-01-40 (lead), Decision No. 1981, 2005 WL 1540188 (Dep't Appeals Bd., Appellate Div. June 24, 2005), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2005/dab1981.htm). But the Board held that the programs at issue did *not* meet either the first or third definitions of a hold harmless provision. *Id.* As to the third definition, the Board explained that no language in the States' grant or credit programs offered an explicit or direct assurance of any payment to a taxpayer-provider, and it rejected CMS's argument that the third definition was merely a "broad catch-all provision." *Id.* at *6. Ultimately, the Board explained that for a state taxing authority to guarantee a payment, offset, or waiver, the Board expected to see a "legally enforceable" promise in "these States' laws." *Id.* at *7.

Following this interpretation of its own rules by its own internal adjudicative system, CMS's enforcement arm proposed amendments to 42 C.F.R. § 433.68 to "clarify" the agency's tests for finding the existence of an impermissible hold harmless arrangement. *See, e.g.*, Medicaid Program; Health Care-Related Taxes, 73 Fed. Reg.

9,685, 9,689-90 (Feb. 22, 2008) (final rule).[4] In turn, CMS amended the regulatory definition of the third kind of hold harmless arrangement to "cover the situation where a government provides for a certain measure '*such that*' the measure guarantees" the taxpayer will be held harmless. *Brooks-LaSure*, 2022 WL 741065, at *8 (emphasis added). This was a departure from the statutory definition in which Congress defined a hold harmless provision to include "certain financial measure[s] '*that* guarantees' indemnification." *Id.* at *7 (emphasis added). This change "deliberate[ly]" "removes the statute's tight grammatical link between *the government*, as the actor providing for something, and *a guarantee*, as the thing provided for." *Id.* at *8. As a result of the agency's "loosen[ing]" of the required link between the state taxing authority and the guarantee itself, CMS has contended that the third definition "focus[es] on the 'reasonable expectation' [of the taxpayer] about the 'result' of a state payment, as opposed to merely what *the [S]tate provided* when making a payment." *Id.* (citing 73 Fed. Reg.at 9,694-95) (emphasis in original).

**3.** Eleven years passed before, in 2019, CMS tried—and failed—again to stretch the third definition of hold harmless agreements even farther to cover private arrangements. *See* 84 Fed. Reg. at 63,722. In the intervening years, States—and especially Texas—built their compliance regimes around CMS's existing rules and interpretations. For example, in early 2019, Kristin Fan, the Director of CMS's Financial Management Group, told counsel for concerned providers that although

[4] Specifically, in explaining what would constitute a hold harmless arrangement under the newly amended regulation, CMS invoked the example of a state law providing grants to a nursing-home residents who incur increased rates as a result of bed taxes on nursing homes. 73 Fed. Reg. 9,694. This comment makes clear that CMS was seeking to address not private agreements between independent third parties, but a circumstance where one of two related parties receives a grant from the State but, because of the nature of the parties' relationship, is compelled to pass that grant funding to a related party, creating a state guarantee. *Id.*

CMS is "aware that there may be arrangements" between providers that CMS may "not particularly like," CMS "do[es] not have statutory authority to address" those arrangements. Ex. C at 1, Email Exchange Between Kristin Fan and Barbara Eyman (Apr. 10, 2019). Director Fan also agreed that States should not be expected "to seek information about these agreements or providers to disclose these agreements to the state/local government in connection with CMS' questions." *Id.* CMS similarly assured HHSC officials—in direct response to a specific question—that, so long as neither the State nor a unit of local government was providing a guarantee, there was no prohibition on private business arrangements. Grady Decl. ¶ 24. Texas relied upon that assurance in setting up its compliance regime—a significant financial investment that would eventually include more than a dozen full-time employees and a custom information-technology system. *Id.* ¶ 42.

But in the proposed rule released later that year, the agency said something else entirely. The proposal explained that CMS had "become aware of impermissible arrangements that exist where a [S]tate or other unit of government imposes a health-care related tax, then uses the tax revenue to fund the non-federal share of the Medicaid payments back to the taxpayers." 84 Fed. Reg. at 63,734. Critically, CMS clarified that it considered such arrangements to violate the law even if "a private entity makes the redistribution" to another private entity. *Id.* at 63,735. It reasoned that a purely private arrangement still "constitutes an indirect payment from the [S]tate or unit of government to the entity being taxed that holds it harmless for the cost of the tax." *Id.* That is because "[t]he taxpayers have a reasonable expectation to be held harmless for all or a portion of their tax amount." *Id.* at 63,734. As a result, CMS proposed to amend 42 C.F.R. § 433.68(f)(3) to specify that CMS would consider the "net effect" of a particular arrangement—*i.e.*, whether the "net effect" is a "reasonable expectation" by the taxpayer that it will recoup all or a portion

of its tax payment through Medicaid payments—to determine whether a hold harmless arrangement exists. *Id.* at 63,735.

The proposed rule met swift backlash. After a torrent of more than 10,000 comments—many of which faulted CMS for "lack[ing] statutory authority for its proposals" and "creating regulatory provisions that were ambiguous or unclear and subject to excessive Agency discretion"—CMS ultimately opted to "withdraw the proposed provisions." Medicaid Program; Medicaid Fiscal Accountability Regulation, 86 Fed. Reg. 5,105, 5,105 (Jan. 19, 2021). One such commenter was Daniel Tsai—CMS's current Deputy Administrator and its Director of Center for Medicaid and CHIP Services—who was then serving as the Medicaid Director for the State of Massachusetts. Ex. D, Dan Tsai Comment (Jan. 27, 2020). Tsai explained that the proposed rule—including its "'net effect[]' tests"—"introduce[d] significant new state obligations," that "[i]f implemented, . . . would represent an unprecedented federal overreach," "exceed[ed] CMS' statutory authority," contained "provisions [that] are highly susceptible to arbitrary and capricious application," was "not supported by the underlying statute," and "includ[ed] reporting on business dealings of private entities that are not available to the [S]tate." *Id.* HHSC submitted a comment letter along similar lines, as did others. Grady Decl. ¶ 17; Ex. E.

## II. Texas Medicaid and Local Provider Participation Funds

Over the last decade, Texas has modified its Medicaid program to better serve the needs of program's enrollees as well as to comply with Congress's statutory requirements and CMS's lawful regulatory directives. Two developments are particularly relevant here. *First*, in 2011, Texas transitioned from a fee-for-service to a managed-care delivery model.[5] *Brooks-LaSure*, 2021 WL 5154219, at *1. *Second*, in

[5] Texas accomplished this through a demonstration project submitted pursuant to 42 U.S.C. § 1315, which CMS then approved. CMS's sudden refusal to extend the

2013, the Texas Legislature authorized designated hospital districts, counties, and municipalities to "administer a health care provider participation program to provide additional compensation to certain hospitals located in the hospital district, county, or municipality by collecting mandatory payments from each of those hospitals to be used to provide the nonfederal share of a Medicaid supplemental payment program." Tex. Health & Safety Code § 300.0001; *see* Act of May 24, 2013, 83d Leg., R.S., ch. 1369, 2013 Tex. Gen. Laws 3630 (codified at Tex. Health & Safety Code Ch. 288); Tex. Health & Safety Code chs. 288-300A. In contrast to its position now, CMS *encouraged* Texas to implement these funds, which collectively comprised approximately 17.7% of Texas's state share of Medicaid funding in the last fiscal year. Grady Decl. ¶¶ 10, 22; *see also* Compl., ECF No. 1 ¶¶ 42-46.

The funds are managed by local governments, Grady Decl. ¶¶ 7-13, and subject to a host of relevant restrictions. If the taxing authority authorizes a healthcare provider participation program, it must require an annual mandatory payment to be assessed based upon the net patient revenue of each institutional healthcare provider located in the applicable local unit of government. Tex. Health & Safety Code § 300.0151. Money deposited into a taxing authority's LPPF is authorized to be used for limited purposes, including intergovernmental transfers from the local government to the State to provide the state share of Medicaid payments for statutorily specified Medicaid programs. *See id.* § 300.0103(b)(1). The taxes imposed by the local unit of government must be broad-based and uniform, as required under federal law. *See id.* § 300.0151(b). And Texas law specifically prohibits these programs from holding harmless any institutional healthcare provider. *Id.*

---

demonstration project in 2021 precipitated Texas's 2021 lawsuit before this Court. *See Brooks-LaSure*, 2021 WL 5154219, at *2-3.

As the statewide administrator of Texas Medicaid, HHSC ensures that the authority that administers each LPPF does not provide for any payment, offset, or waiver that directly or indirectly guarantees to hold the taxpaying providers harmless for any portion of their tax costs. Grady Decl. ¶¶ 13-16. But HHSC does *not* have taxing or regulatory authority over the governmental entities that manage those funds, nor does HHSC have authority to examine or consider any contractual arrangements that might exist between private businesses whose taxes contribute to those funds. Grady Decl. ¶ 12.

The taxes that flow into those funds are unrelated to the methodology for calculating the Medicaid reimbursements that HHSC disburses to healthcare providers. Grady Decl. ¶ 16. The State does not make any such reimbursements based on the amount that a provider is taxed by a local government. *Id.* Instead, Medicaid payments to providers are based exclusively on programmatic methodologies that consider, among other factors, what an estimated Medicare or average commercial payer would have paid for those same services. *Id.* These provisions together ensure that Texas's "complex" hospital systems, Grady Decl. ¶ 21, comport with the Social Security Act and avoid the problems that motivated Congress's 1991 amendments, *see Maram*, 471 F.3d at 726.

Nonetheless, since the withdrawal of the MFAR, Grady Dec. ¶ 27-28, CMS has at least twice sought to force HHSC to police private agreements: *first*, during negotiations over the State's demonstration project, CMS attempted to insert special terms and conditions imposing many of the same requirements from the withdrawn proposed rule (which CMS now attempts to impose by bulletin). Grady Decl. ¶¶ 30-31. *Second*, in the middle of the prior litigation, CMS held approval of five state-directed payment programs (which used LPPF funds) hostage until Texas agreed to CMS's terms. *Id.* ¶¶ 34-37. Neither gambit worked.

## III. CMS's February 17 Bulletin and Immediate Threats of Enforcement

On February 17, 2023, the Deputy Administrator and Director of CMS issued a bulletin announcing a retroactive change in CMS's definition of a hold harmless arrangement. *See* Ex. A. Without the notice-and-comment procedures that CMS acknowledged were necessary when it proposed the MFAR, the bulletin deemed any agreement between private providers to redistribute Medicaid payments to constitute "a hold harmless arrangement involving Medicaid payment redistribution" when there is a "reasonable expectation" that the taxpaying provider will receive a portion of their provider-tax costs returned as part of a private agreement. *Id.* at 3-4. CMS described how, in its view, "taxpayers appear to have entered into oral or written agreements" to redirect or redistribute their Medicaid payments "to ensure that all taxpayers receive all or a portion of their tax back." *Id.* at 3. Notwithstanding the acknowledged absence of state participation in such agreements, CMS concluded they were impermissible because "[t]he redistributions occur so that taxpaying providers are held harmless for all or a portion of the health care-related tax." *Id.* But, as this Court has recognized, this is circular: CMS has "noted a specific result that it thought should obtain on a certain fact pattern and justified the new approach because it would allow that result." *Brooks-LaSure*, 2022 WL 741065, at *8.

Without pointing to any statutory authority, the bulletin further states CMS "intends to inquire about potential redistribution arrangements and may conduct detailed financial management reviews of healthcare-related tax programs that appear to include redistribution arrangements or that CMS has information may include redistribution arrangements." Ex. A at 5. Henceforth, States are expected "to make available *all requested documentation* regarding arrangements involving possible hold harmless arrangements and the redistribution of Medicaid payments" as part of CMS's "oversight activities and review of state payment proposals[.]" *Id.* (emphasis added). CMS threatened to "take enforcement action as necessary" if an

audit uncovers "impermissible financing practices." *Id.* And without regard to whether the requested documentation exists, CMS ominously warned that a State's failure to supply requested documentation regarding redistribution arrangements "may result in a deferral or disallowance of federal financial participation." *Id.*

CMS has made clear that it intends to enforce this bulletin retrospectively. At virtually the same time that CMS sought to avoid sanctions from this Court by agreeing to Texas's directed payment programs, OIG announced that it would conduct an audit of the LPPF in the very county in which this Court is located. Grady Decl. ¶ 40. That audit process was ongoing when the bulletin issued. OIG initially told HHSC that it would issue its report and findings during the summer of 2023, but it moved up the date to May 2023 after the bulletin was announced. *Id.* Shortly thereafter, OIG sent a new letter to HHSC, indicating its intent to conduct new audits of LPPFs in the City of Amarillo as well as Tarrant and Webb Counties.[6] *See* Ex. E, Letter to Cecile Erwin Young (Mar. 3, 2023). The "objective" of the audits "is to determine whether the State agency adhered to the hold-harmless provisions in Federal regulations." *Id.* at 1.

When CMS issued similar sub-regulatory guidance in 2014, the resulting litigation before the Department Appeals Board (DAB) left the challenged funding in limbo for approximately 9 *years*. Grady Decl. ¶ 22. Such an outcome would be devastating to the social safety net in Texas: LPPFs are used to fund nearly a fifth of Texas's state share of Medicaid expenditures. *Id.* ¶ 10. Moreover, LPPFs are frequently run by *hospital* districts—meaning that CMS's current effort to shut off Medicaid funding is aimed at the aspect of the social-safety net that serves emergent

[6] OIG's letter incorrectly identified the LPPFs as operated by Amarillo County (which does not exist) and Tarrant County (which does not operate an LPPF). OIG appears to be referring to LPPFs operated by the City of Amarillo and the Tarrant County Hospital District. Grady Decl. ¶ 50 n.5.

or acute medical needs. *Id.* ¶¶ 10, 50 n.5. Of the hospitals in the jurisdictions that currently operate LPPFs, more than 1 in 4 is a non-profit, and all are part of the safety net that Texans rely on for care. In Texas, most hospital associations—which are presumably the entities most likely to be a third-party intermediary for private hospitals of the sort contemplated by the bulletin—are non-profits. *Id.* ¶ 44. They simply cannot afford the type of uncertainty that will result if the bulletin were to be implemented, and the results litigated before the DAB.

To avoid the impact that removing as much as $6 billion in annual funding would visit upon its hospital system, the State of Texas and HHSC have sued CMS, CMS Administrator Chiquita Brooks-LaSure, the U.S. Department of Health and Human Services, HHS Secretary Xavier Becerra, and the United States, asserting that the bulletin is unlawful under the APA. Compl., ECF No. 1, ¶¶ 9-13. Plaintiffs now seek a preliminary injunction to halt defendants' ongoing reliance on and enforcement of the bulletin while its legality is being determined.

## ARGUMENT

The issuance of a preliminary injunction is appropriate when the movant shows (1) a likelihood of success on the merits, (2) that he is likely to suffer irreparable harm in the absence of preliminary relief, (3) that the balance of equities tips in his favor, and (4) that an injunction is in the public interest. *Valley v. Rapides Par. Sch. Bd.*, 118 F.3d 1047, 1051 (5th Cir. 1997) (citing *Roho, Inc. v. Marquis*, 902 F.2d 356, 358 (5th Cir. 1990)). Texas satisfies each of those requirements.

### I. Texas Is Likely to Succeed on the Merits.

For at least three reasons, Texas is likely to succeed on its claims for relief under the APA. *First,* the bulletin's redefinition of a hold harmless provision to encompass purely private agreements exceeds CMS's statutory authority—as well as its own regulatory framework—because the Social Security Act defines a hold harmless

provision as a guarantee *by the government*, rather than a private party, to a taxpayer. *Second*, because the CMS bulletin is a substantive rule, the agency was required to go through the notice-and-comment process. The bulletin, which represents an about-face from not just the text but CMS's subjective understanding of the relevant law as recently as 2019, it is *not* an interpretive statement exempt from the APA's notice-and-comment procedures. *Third*, even if the agency could promulgate such a significant regulatory change by policy bulletin, CMS acted arbitrarily and capriciously by promulgating the bulletin because (a) it is an unexplained reversal of prior policy; and (b) the agency failed to consider the States' longstanding reliance interests in the understanding, which CMS endorsed, that private arrangements were not a violation of the Social Security Act or within the purview of state oversight. Any one of these reasons is sufficient to hold that the bulletin is unlawful—let alone all three.

### A. The February 17 bulletin exceeds CMS's statutory and regulatory authority.

The APA requires courts to "hold unlawful and set aside agency action" that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law" or "in excess of statutory . . . authority, or limitations, or short of statutory right." 5 U.S.C. § 706(2)(A), (C). Here, neither the Social Security Act nor its implementing regulations provides a basis for CMS to define a prohibited hold harmless arrangement the way that the bulletin does. *See* 42 U.S.C. § 1396b(w)(4); *see also* 42 C.F.R. § 433.68(f)(3). The bulletin therefore conflicts with the Act and its implementing regulations, and it is substantively unlawful under the APA. *See* 5 U.S.C. § 706(2)(A), (C).

**1. The February 17 bulletin's definition of hold harmless arrangements conflicts with the Social Security Act.**

CMS's sub-regulatory guidance is flatly incompatible with the Act's text. Section 1903(w)(4) of the Act provides that "there is in effect a hold harmless provision with respect to a broad-based health care related tax imposed with respect to a class of items or services if the Secretary determines" that any of the following circumstances exist:

> (A) The State or other unit of government imposing the tax provides (directly or indirectly) for a payment (other than under this title) to taxpayers and the amount of such payment is positively correlated either to the amount of such tax or to the difference between the amount of the tax and the amount of payment under the State plan.
>
> (B) All or any portion of the payment made under this title to the taxpayer varies based only upon the amount of the total tax paid.
>
> (C)(i) 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;
>
> (ii) For purposes of clause (i), a determination of the existence of an indirect guarantee shall be made under paragraph (3)(i) of section 433.68(f) of title 42, Code of Federal Regulations, as in effect on November 1, 2006….

42 U.S.C. § 1396b(w)(4).[7]

**a.** Nothing in the plain language of these three statutory definitions, prohibits an arrangement between private parties as a hold harmless provision. Instead, the defining feature of a hold harmless provision is a guarantee by *the government*—not a private party—to the taxpayer. This is most apparent in 42 U.S.C. § 1396b(w)(4)(A) and 42 U.S.C. § 1396b(w)(4)(C), which expressly make the "State or other unit of government" the subject of the sentence. Congress is presumed to

[7] There is an "exception" to this provision which adjusts the percentages discussed in the cited provision of the Code of Federal Regulations based on the year. 42 U.S.C. § 1396b(w)(4)(C)(ii). That exception is not relevant here.

understand the ordinary rules of English grammar and usage. Antonin Scalia & Bryan A. Garner, Reading Law: The Interpretation of Legal Texts 140 (2012). And the subject of the sentence is the person or thing doing the action. *See* Sidney Greenbaum, The Oxford English Grammar § 3.14-15 (1996). Here, Congress chose to consider only the activity of the "State or other unit of government" when prohibiting hold harmless arrangements. The choice to omit private parties from the statute's ambit is presumed intentional. *See Easom v. US Well Servs., Inc.*, 37 F.4th 238, 244 (5th Cir. 2022) (discussing the expressio unius canon of construction).

That presumption is further buttressed by the provision's context—both statutory and historical. After all, without involvement by the State in those agreements, the payment of Medicaid reimbursements alone cannot constitute a "guarantee[] to hold taxpayers harmless." *See* 42 U.S.C. § 1396b(w)(4)(C)(i). A guarantee denotes an obligation by the guarantor. *See Guarantee*, Black's Law Dictionary (10th ed. 2014). But as a non-party to any agreement that may or may not exist, Texas assumes no obligation regarding any reimbursements by private providers. And the statutory history of section 1396b(w)(4)(A) underscores that it was aimed at obligations assumed by Texas or one of its political subdivisions—not obligations assumed by private parties that Texas cannot control and of which the State may be entirely unaware. *See Thomas v. Reeves*, 961 F.3d 800, 817 n.45 (5th Cir. 2020) (en banc) (Willett, J., concurring) (explaining that while legislative history is disfavored as an interpretive aid, statutory history may give important context). After all, the "'loophole' in the Medicaid program" that Congress was trying to address, *Maram*, 471 F.3d at 726, was not that a private party might take steps to insure against losses incurred from the Medicaid program or governmental taxes, including indemnifying themselves in a way that CMS does "not particularly like." Ex. C at 1.

Given this statutory text and history, it is unsurprising that HHS's own adjudicative system (correctly) found nearly two decades ago that reading the regulations as allowing the agency "to examine the use of a payment without regard to the two-prong test where there is no explicit guarantee is unreasonable." *In re: Hawaii*, 2005 WL 1540188, at *23. Since 1991, Congress has not changed those three definitions of a disqualifying hold harmless provision. *Brooks-LaSure*, 2022 WL 741065, at *4. The Board's analysis is thus as sound today as it was when the decision issued.

**b.** In its bulletin, CMS nevertheless tries to justify this "unreasonable" position, *id.*, by pointing to subsection 1936b(w)(4)(C)(i). *See* Ex. A at 3. But that subsection creates two clear conditions: (1) the State or other unit of government imposing the tax must provide the payment, offset, or waiver; and (2) that payment, offset, or waiver must guarantee to hold taxpayers harmless. *See* 42 U.S.C. § 1396b(w)(4)(C)(i). The private-provider agreements that CMS believes may exist satisfy neither of those. The statute requires an act by "[t]he State or other unit of government imposing the tax," *see id.*, and private agreements are not an act of the government. To the extent CMS implies that merely reimbursing private providers for qualified Medicaid expenditures satisfies the statute's requirement of state involvement in a hold harmless provision, that is wrong for the reasons discussed above.

CMS also notes that subsection (C)(i) contains the phrase "(directly or indirectly)." Ex. A at 4. But the word "indirectly" cannot salvage CMS's construction of section 1396b for at least three reasons.[8]

[8] The bulletin does not suggest any "direct" action by the State, nor would that make any sense. As HHSC has explained, state law *forbids* local governments from entering into hold harmless agreements. *See, e.g.*, Tex. Health & Safety Code § 300.0151(b).

*First*, Congress specifically stated that "a determination of the existence of an *indirect* guarantee shall be made under paragraph (3)(i) of section 433.68(f) of Title 42, Code of Federal Regulations, as in effect on November 1, 2006." 42 U.S.C. § 1936b(w)(4)(C)(ii) (emphasis added). This bulletin obviously was not in the Code of Federal Regulations on November 1, 2006.

*Second*, "the words of a statute must be read in their context and with a view to their place in the overall statutory scheme." *West Virginia v. EPA*, 142 S. Ct. 2587, 2607 (2022). Properly framed, the word "indirectly" should not be read to modify "provides"—which seems to be CMS's position (although that is unclear)—because there would have been no need to set it off by parentheses. Ordinary rules of construction would have taken care of it. Scalia & Garner, *supra*, at 152 ("When the syntax involves something other than a parallel series of nouns or verbs, a prepositive or postpositive modifier normally applies only to the nearest reasonable referent."). This is confirmed by the text of the regulations in which CMS has interpreted the "guarantee" term to mean a state program that "results, directly or indirectly," in an impermissible tax outcome. 42 C.F.R. § 433.68(d)(2)(i).

*Third*, Congress's use of the word "indirectly" cannot eliminate the two requirements subsection (C)(i) spells out: a governmental payment and governmental guarantee. 42 U.S.C. § 1396b(w)(4)(C)(i). After all, "[o]ne of the most basic interpretive canons [is] that '[a] statute should be construed so that effect is given to all its provisions, so that no part will be inoperative or superfluous, void or insignificant.'" *Corley v. United States*, 556 U.S. 303, 314 (2009) (quoting *Hibbs v. Winn*, 542 U.S. 88, 101 (2004)).

In sum, as the Board recognized long ago, the "guarantee" test in subsection (C) is not "a broad catch-all provision," *see In re: Hawaii*, 2005 WL 1540188, at *3, and a private agreement that the State is not aware of, let alone responsible for, is

not a "direct or indirect" provision *by the State* that guarantees to hold a private party harmless.

**2. CMS's agency regulations do not encompass the bulletin's definition of a prohibited hold harmless arrangement.**

Because the bulletin is inconsistent with the Social Security Act, it is unlawful under the APA, and the Court can grant relief on that basis alone. 5 U.S.C. § 706(2)(A). But the bulletin is also inconsistent with CMS's own regulations, and an agency action may be set aside as arbitrary and capricious if the agency fails to "comply with its own regulations." *Environmental, LLC v. FCC*, 661 F.3d 80, 85 (D.C. Cir. 2011).

CMS insists that "[i]mplementing 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.'" Ex. A at 4. But CMS effectively conceded that was *not* true when it sought—unsuccessfully—to amend section 433.68(f)(3) through formal notice-and-comment rulemaking. 84 Fed. Reg. at 63,722. Moreover, the subject of the regulation still identifies "the State (or other unit of government)"—not private parties—as the one "provid[ing]" the hold harmless guarantee. In any case, this portion of the regulation merely restates the relevant provisions of the Act itself, meaning that the same two conditions regarding state action apply under the regulations, too. *Supra* 20-21.

The preamble to the 2008 final rule amending 42 C.F.R. § 433.68(f)(3)—upon which CMS previously relied—is also unhelpful. A rule's preamble cannot impose obligations that are inconsistent with the rule's text. *See Entergy Servs., Inc. v. FERC*, 375 F.3d 1204, 1209 (D.C. Cir. 2004). Regardless, a full reading of the preamble demonstrates that it is focused on *governmental*—not private-party—guarantees. For

example, the preamble notes that a "direct guarantee will be found when a [s]tate 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)." Ex. A at 4 (citing 73 Fed. Reg. at 9,694-95). But the immediately preceding sentence confirms that "[t]he clarification of the guarantee test is meant to specify that *a State*"—not the taxpayer—"can provide a direct or indirect guarantee through a direct or indirect payment." 73 Fed. Reg. at 9,694 (emphasis added). And in that preamble, CMS found that "the element necessary to constitute a direct guarantee is the provision for payment by [s]tate statute, regulation, or policy"—not a private contract to which the State is not a party and of which the State may not be aware *Id*. The language of its own regulation refutes CMS's attempt to expand the definition of a hold harmless arrangement. And in any case, the term "reasonable expectation" does not appear in section 1396b(w)(4) and cannot supplant the requirements that Congress expressly set out.

* * *

CMS has no authority to override Congress's legislative judgment that hold harmless agreements must involve state action just because private parties may enter into agreements that CMS does "not particularly like." Ex. C at 1. The bulletin's attempt to do so conflicts with the Social Security Act and CMS's own regulations. Texas is therefore likely to succeed on its claim that the bulletin is unlawful and should be set aside under the APA.

### B. The February 17 bulletin is procedurally invalid because it did not go through notice-and-comment rulemaking.

Even if CMS *could* direct Texas to ban private contracts because CMS finds them uncongenial, CMS was required go through notice-and-comment rulemaking to issue the challenged bulletin. *See* 5 U.S.C. § 553(b), (c). It did not, and the bulletin

should therefore be "held unlawful and set aside" as issued "without observance of procedure required by law[.]" *Id.* § 706(2)(D).

The APA establishes a three-step "notice-and-comment" procedure that governs administrative-agency rulemaking. *Perez v. Mortg. Bankers Ass'n*, 575 U.S. 92, 95-96 (2015). The "rules" that are subject to this procedure "include 'statement[s] of general or particular applicability and future effect' that are designed to 'implement, interpret, or prescribe law or policy.'" *Id.* (quoting 5 U.S.C. § 551(4)). But "[n]ot all 'rules' must be issued through the notice-and-comment process": the APA exempts "'interpretative rules, general statements of policy, or rules of agency organization, procedure, or practice'" from notice-and-comment procedures. *Id.* at 96 (quoting 5 U.S.C. § 553(b)(A)). These exceptions, however, "must be narrowly construed." *Texas v. United States*, 809 F.3d 134, 171 (5th Cir. 2015) (*DAPA*).

Moreover, a rule adopted through notice-and-comment rulemaking may be amended or abandoned only through the same notice-and-comment procedures; agencies must "use the same procedures when they amend or repeal a rule as they used to issue the rule in the first instance." *Perez*, 575 U.S. at 101. These rules of construction "protect[] the vital interests notice and comment is intended to protect," such as "ensur[ing] those affected by a proposed rule have a voice in the rule-making process and assist[ing] the agency in crafting rules that better account for the costs and benefits of agency action." *Texas v. United States*, 524 F. Supp. 3d 598, 657 (S.D. Tex. 2021); *see also U.S. Dep't of Lab. v. Kast Metals Corp.*, 744 F.2d 1145, 1153 n.17 (5th Cir. 1984) (same).

"Agencies have never been able to avoid notice and comment simply by mislabeling their substantive pronouncements." *Azar v. Allina Health Servs.*, 139 S. Ct. 1804, 1812 (2019). "On the contrary, courts have long looked to the *contents* of the agency's action, not the agency's self-serving *label*, when deciding whether statutory notice and comment demands apply." *Id.* Courts must be "mindful but

suspicious of the agency's own characterization." *DAPA*, 809 F.3d at 171. Accordingly, courts "evaluate two criteria to distinguish policy statements from substantive rules: whether the rule (1) impose[s] any rights and obligations and (2) genuinely leaves the agency and its decision-makers free to exercise discretion." *Id.* (quotations omitted). A court should "focus[] primarily on whether the rule had binding effect on agency discretion or severely restricts it." *Id.* (quotations omitted). And "an agency's pronouncement will be considered binding as a practical matter if it either appears on its face to be binding, or is applied by the agency in a way that indicates it is binding." *Id.* (cleaned up).

In this case, the bulletin is subject to notice-and-comment rulemaking because it is a substantive rule:[9] it purports to change a rule adopted by notice-and-comment rulemaking after that construction was definitely rejected by the DAB. 58 Fed. Reg. at 43,156. Moreover, it imposes rights and obligations and does not leave CMS and its decisionmakers free to exercise discretion regarding the scope of the Social Security Act's hold harmless prohibition: because of the bulletin, "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" the Social Security Act. Ex. A at 5. CMS is *required* to "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." *Id.* The bulletin is substantive because it

[9] Some cases describe "substantive rules" as "legislative rules" in contrast to "non-legislative" or "interpretive" rules. *E.g.*, *Lincoln v. Vigil*, 508 U.S. 182, 196 (1993). Texas is unaware of any distinction between the concepts—let alone one that is relevant here. *Cf. Shell Offshore Inc. v. Babbitt*, 238 F.3d 622, 628 (5th Cir. 2001) (equating "legislative" and "substantive rules").

imposes more than "derivative, incidental, or mechanical burdens" on Texas. *DAPA*, 809 F.3d at 176-77. Indeed, it directly affects billions of dollars in funding, Grady Decl. ¶ 19, and it threatens the stability of a program that is consistently the largest expenditure in Texas's budget, *compare id.* ¶ 19, *with, e.g.*, *see also* Tex. House Bill 1, tit. 2, 88th Leg. (2023). Moreover, it "change[s] the *substantive standards* by which" CMS determines how to enforce the Social Security Act and its implementing regulations, *DAPA*, 809 F.3d at 176-77—standards that arguably can only be set by Congress, *see West Virginia*, 142 S. Ct. at 2607-08.

Perhaps the best evidence that the bulletin introduces a substantive rule is CMS's own attempt to amend its regulations in 2019. That proposal would have amended 42 C.F.R. § 433.68(f)(3) such that CMS would consider the "net effect" of a particular arrangement to determine the existence of a hold harmless arrangement. 84 Fed. Reg. at 63,735. That CMS brought its 2019 proposal through the formal rulemaking process is more than ample evidence that it was required to do so here. Texas is therefore likely to show that the bulletin is invalid for failure to follow proper procedure under the APA.

### C. The bulletin is arbitrary and capricious because it departed from past practice and did not consider the States' substantial reliance interests.

Finally, even if CMS could amend the Code of Federal Regulations by interpretive bulletin, it could not do so here because it neither adequately explained its departure from past practice nor considered States' substantial reliance interests of which it had actual notice—not just through comment letters in prior rulemakings but through actual communications between the parties both before and during the prior lawsuit. "The APA's arbitrary-and-capricious standard requires that agency action be reasonable and reasonably explained." *FCC v. Prometheus Radio Project*, 141 S. Ct. 1150, 1158 (2021). Agency action qualifies as arbitrary and capricious "'if

the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise.'" *Tex. Oil & Gas Ass'n v. EPA*, 161 F.3d 923, 933 (5th Cir. 1998) (quoting *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983)). "Put simply, [the Court] must set aside any action premised on reasoning that fails to account for 'relevant factors' or evinces a 'clear error of judgment.'" *Univ. of Tex. M.D. Anderson Cancer Ctr. v. HHS*, 985 F.3d 472, 475 (5th Cir. 2021) (quoting *Marsh v. Or. Nat. Res. Council*, 490 U.S. 360, 378 (1989)). This review has never been "toothless," and "after [*Department of Homeland Security v. Regents of the University of California*, 140 S. Ct. 1891 (2020)], it has serious bite." *Wages & White Lion Invs., LLC v. FDA*, 16 F.4th 1130, 1136 (5th Cir. 2021).

**1.** "It is axiomatic that the APA requires an agency to explain its basis for a decision." *Physicians for Soc. Resp. v. Wheeler*, 956 F.3d 634, 644 (D.C. Cir. 2020). "This foundational precept of administrative law is especially important where, as here, an agency changes course." *Id.* Consequently, "[r]easoned decision-making requires that when departing from precedents or practices, an agency must 'offer a reason to distinguish them or explain its apparent rejection of their approach.'" *Id.* (quoting *Sw. Airlines Co. v. FERC*, 926 F.3d 851, 856 (D.C. Cir. 2019)). In other words, when an agency reverses "prior policy," it must provide a "detailed justification" for doing so. *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515-16 (2009) (plurality op.).

The bulletin fails to acknowledge CMS's change in position—let alone explain it—and thus cannot survive arbitrary-and-capricious review. CMS previously (both repeatedly and appropriately) acknowledged that it lacked the statutory or regulatory authority either to police or to require States to police private-provider agreements

under the Act. Grady Decl. ¶ 24; Ex. C at 1; *accord In re: Hawaii*, 2005 WL 1540188, at *23. Without even hinting at those prior representations, CMS now claims that it is merely "reiterating the federal requirements concerning hold harmless arrangements with respect to health care-related taxes." Ex. A at 2.

Not so. This position is consistent only with the *failed* regulations that CMS withdrew in 2019 after a fulsome notice-and-comment process in which CMS's own current deputy administrator then decried as "unprecedented federal overreach" which "introduce significant new state obligations" that "exceed[] CMS' statutory authority. Ex. D at 1, 2. Section 1396b(w)(4) has not been amended since this rule was withdrawn. And CMS provides no reasons for changing its view that this rule needs to go through notice-and-comment rulemaking—let alone a "detailed justification" for this substantive shift from past practice. *Fox*, 556 U.S. at 515-16 (plurality op.).

**2.** Even if CMS could overcome that deficiency (and it cannot), the bulletin also ignores the States' tremendous reliance interests in the enforcement regime that existed for decades until the bulletin upended it—interests of which the agency had *actual notice*. "[A]gencies must typically provide a 'detailed explanation' for contradicting a prior policy, particularly when the prior policy has engendered serious reliance interests." *BST Holdings, L.L.C. v. OSHA*, 17 F.4th 604, 614 (5th Cir. 2021). For three decades, States complied with the plain language of the Act and its regulations. But States have never been subject to a mandate that purports to compel them to police redistribution agreements between private providers. States have adjusted their own regulatory framework accordingly. In Texas, for example, HHSC has no statutory authority, and thus, no administrative apparatus, to demand that private parties turn over contractual arrangements that do not involve a governmental unit. Grady Decl. ¶ 12. The State cannot instantaneously build up the

kind of monitoring regime that CMS has unreasonably insisted upon. *Id.* ¶¶ 46-47.[10] Unlike some APA claims, the agency cannot even claim ignorance of these reliance interests: HHSC raised them in a comment letter in response to the MFAR in 2020, Ex. E; during the negotiations that led to the extension of the section 1115 waiver beginning in 2021, *id.* ¶ 30; and again during court-ordered negotiations regarding the state directed payments beginning in late 2021 and into 2022, *id.* ¶¶ 36, 39,

The bulletin also fails to identify, let alone to justify, its potential effects on the States' healthcare markets. CMS well knows that Texas relies on $3 billion local provider participation funds as part of the non-federal share of Medicaid payments. *Id.* ¶ 19. Withholding federal matching funds for this large amount of funding based on the State's inability to immediately comply with the bulletin, as CMS has threatened, Ex. A at 5-6, would undoubtedly result in significant negative impacts to Medicaid providers individually and the Medicaid safety net. Grady Decl. ¶ 19.

CMS was required to engage in a far more searching inquiry before it disregarded the States' settled interests in how hold harmless arrangements are monitored. Texas is therefore likely to succeed on its claim that the bulletin should be set aside under the APA because it is arbitrary and capricious.

## II. Texas Will Suffer Irreparable Harm Absent a Preliminary Injunction.

Texas faces at least two separate, but related, irreparable injuries absent a preliminary injunction. *See Nken v. Holder*, 556 U.S. 418, 434 (2009). *First*, the bulletin imposes substantial compliance costs—both monetary and sovereignty-based—that the State will never be able to recover even if it eventually prevails in

[10] This too is confirmed by Mr. Tsai's letter on behalf of Massachusetts, which described the MFAR as "operational[ly] impracticable" because it "creates the potential for substantial new ad hoc demands for information by CMS as each potential program, arrangement, fee, assessment, or donation is considered under . . . vague and broad standards of review." Ex. D at 4.

this suit. And *second*, the bulletin will require HHSC to inquire about the donors of private entities, thereby violating those entities' First Amendment rights and subjecting the State to liability from those entities.

### A. The bulletin imposes compliance burdens that Texas will never be able to recover.

The Fifth Circuit recently held that "complying with a regulation later held invalid almost always produces the irreparable harm of nonrecoverable compliance costs." *BST Holdings, LLC*, 17 F.4th at 618; *see Thunder Basin Coal Co. v. Reich*, 510 U.S. 200, 220-21 (1994) (Scalia, J., concurring in part); *Commonwealth v. Biden*, 57 F.4th 545, 556 (6th Cir. 2023); *see also NFIB v. OSHA*, 142 S. Ct. 661, 666 (2022) (factoring "billions of dollars in unrecoverable compliance costs" into assessment of the equities). This is particularly problematic where the party whose compliance is compelled is a sovereign with a sovereign's rights to set its own policies and enforce its own laws. Both harms are present here.

**1.** To start with the latter, Texas is a sovereign. "Paramount among the States' retained sovereign powers is the power to enact and enforce any laws that do not conflict with federal law." *Cameron v. EMW Women's Surgical Ctr., P.S.C.*, 142 S. Ct. 1002, 1011 (2022). The loss of that prerogative is, by definition, an irreparable harm because it cannot compensated through monetary damages. *Cf. id.*; *DFW Metro Line Servs. v. Sw. Bell Tel. Co.*, 901 F.2d 1267, 1269 (5th Cir. 1990) (defining "irreparable harm" for the purposes of a preliminary injunction). Here, there is no Texas statute that creates or permits HHSC to act in the manner demanded by the bulletin: neither CMS nor Texas has statutorily conferred authority to examine or consider any contractual agreements or arrangements that might exist between two private businesses. Grady Decl. ¶¶ 12, 26, 27, 46. As a result, to comply with the bulletin, HHSC will have to arrogate power to itself in a way that is irreconcilable with bedrock principles of Texas administrative law. *See, e.g., City of Sherman v. Pub. Util.*

*Comm'n of Tex.*, 643 S.W.2d 681, 686 (Tex. 1983) ("Agencies may only exercise those powers granted by statute, together with those necessarily implied from the statutory authority conferred or duties imposed.").

**2.** Apart from its status as a sovereign, Texas faces significant irrecoverable monetary costs to comply with CMS's whims: it would be required to create and operate a regulatory entity with sufficient resources to examine the contractual arrangements and financial management of every private hospital that exists in a jurisdiction with a LPPF. Ex. A at 5 (States are expected "to make available *all requested documentation* regarding arrangements involving possible hold harmless arrangements and the redistribution of Medicaid payments." (emphasis added)). That is the only way HHSC could accurately determine what private contractual relationships exist and whether those contracts are related to their provider tax payments. Grady Decl. ¶¶ 44-45. HHSC would then need to take decisive action to halt private contractual agreements that fell within the scope of the bulletin's definition of a hold harmless arrangement. Ex. A at 5 (States must "take steps to curtail these practices if they exist.").

The financial and labor costs of compliance would be massive. Texas hospitals are complex and sophisticated business entities with potentially thousands of contractual agreements. Grady Decl. ¶ 21. It is not uncommon for a hospital to have a contractual agreement with other healthcare providers or entities—in fact it is this interwoven fabric of cooperation amongst the more than 600 hospitals on which Texas relies to create a safety net for Medicaid patients. *Id.*

Conservatively, HHSC estimates expenditures of upwards of $50 million annually to achieve compliance. *Id.* ¶ 27. There are 304 privately-owned hospitals located in jurisdictions that currently have a LPPF, 27% of which are not-for-profit organizations. *Id.* HHSC would need hundreds of additional staff to "curtail" any actions that might be inconsistent with the bulletin; those staff would include

professionals like auditors, financial examiners, financial analysts, and attorneys who could competently interpret the thousands (potentially millions) of contracts or other business documents at each hospital and the billions of dollars of revenues and expenditures that are associated with the running of those hospitals. *Id.*

### B. The bulletin also appears to require HHSC to violate the rights of private parties.

HHSC would also need to investigate private associations or individual citizens who may have financial or other contractual relationships with any Medicaid provider. *Id.* ¶ 24. And at that juncture, HHSC would risk transgressing the First Amendment, which protects the free-association rights of individuals and nonprofit organizations—including nonprofit hospital associations. *Ams. for Prosperity Found. v. Bonta*, 141 S. Ct. 2373, 2382 (2021). Indeed, HHSC would likely violate the First Amendment by demanding that nonprofit organizations disclose the identities of their donors. *See id.* at 2385-89. A governmental mandate that "creates an unnecessary risk of chilling" that could deter free association violates the First Amendment and would subject the State to liability. *Sec'y of State of Md. v. Joseph H. Munson Co.*, 467 U.S. 947, 968 (1984). If Texas demanded this information from these entities and individuals, the State could be liable to them; those entities might bring suits that could subject the State to injunctive relief, subject individual defendants to personal liability, and subject multiple parties to attorney's fees awards. *See* 42 U.S.C. §§ 1983, 1988. As with the State's compliance costs, the State would never be able to recover those costs because of the federal government's sovereign immunity. *Commonwealth*, 57 F.4th at 556. All these harms are irreparable and warrant immediate injunctive relief.

## III. The Balance of the Equities and the Public Interest Favor Temporary and Preliminary Injunctive Relief.

The two final elements of the inquiry for entry of preliminary-injunctive relief also tilt in Texas's favor. CMS has no legitimate interest in the implementation or enforcement of an unlawful agency action. *See League of Women Voters of U.S. v. Newby*, 838 F.3d 1, 12 (D.C. Cir. 2016). Federal courts regularly enjoin federal agencies from implementing and enforcing challenged new regulations pending litigation to preserve the relative positions of the parties until a trial on the merits. *See, e.g.*, *Texas v. United States*, 787 F.3d 733, 769 (5th Cir. 2015).

An injunction also protects and promotes the public interest. Texas has a strong interest in the continued stability of its Medicaid program. The last several years have been challenging for Texas Medicaid: the pandemic, combined with CMS's past conduct that precipitated Texas's earlier lawsuit, have put providers and patients on edge. Grady Decl. ¶ 51. CMS's latest salvo threatens to undermine the work that HHSC has done to restore confidence in the Texas Medicaid Program and is "destabilizing to the safety net that Texans enrolled in the Medicaid program rely on to provide them life-saving care." *Id.* On the other side of the ledger, CMS has not demonstrated any harm arising from LPPFs or private agreements that might tangentially have something to do with those funds. The balance of the equities and the public interest strongly favor preservation of the status quo.

## CONCLUSION

Texas respectfully requests that the Court preliminarily enjoin defendants from enforcing the February 17 bulletin or taking other any actions in reliance on the bulletin.

Dated: April 14, 2023.

Respectfully submitted.

KEN PAXTON
Attorney General of Texas

BRENT WEBSTER
First Assistant Attorney General

CHRISTOPHER D. HILTON
Chief, General Litigation Division
Tex. State Bar No. 24087727
Christopher.Hilton@oag.texas.gov

LEIF A. OLSON
Chief, Special Litigation Division
Tex. State Bar No. 24032801
Leif.Olson@oag.texas.gov

MUNERA AL-FUHAID
Special Counsel
Tex. State Bar No. 24094501
Munera.Al-Fuhaid@oag.texas.gov

OFFICE OF THE ATTORNEY GENERAL
P.O. Box 12548 (MC-009)
Austin, Texas 78711-2548
(512) 463-2100

JUDD E. STONE II
Solicitor General

/s/ Lanora C. Pettit
LANORA C. PETTIT
Principal Deputy Solicitor General
*Lead Counsel*
Texas Bar No. 24115221
Lanora.Pettit@oag.texas.gov

MICHAEL R. ABRAMS
Assistant Solicitor General
Texas Bar No. 24087072
Michael.Abrams@oag.texas.gov

WILLIAM F. COLE
Assistant Solicitor General
Texas Bar No. 24124187
William.Cole@oag.texas.gov

*Counsel for Plaintiffs*

## CERTIFICATE OF CONFERENCE

On April 14, 2023, counsel for plaintiffs, Lanora Pettit and Michael Abrams, conferred by telephone with James Bickford, counsel for defendants, regarding plaintiffs' intention to file this motion. No agreement could be reached by the parties because defendants disagree with plaintiffs' contention that a preliminary injunction is warranted. The discussions conclusively ended in an impasse, leaving the issue of whether a preliminary injunction should be issued in this case for the Court to resolve.

*/s/ Lanora C. Pettit*
Lanora C. Pettit
Principal Deputy Solicitor General

## CERTIFICATE OF SERVICE

I certify that a true and accurate copy of the foregoing document was filed electronically (via CM/ECF) on April 14, 2023, and served by United States first class mail, return receipt requested, and by email on the following individual:

James Bickford
Trial Attorney, Federal Programs Branch
Civil Division, U.S. Department of Justice
1100 L Street, NW
Washington, DC 20530
James.Bickford@usdoj.gov

*/s/ Lanora C. Pettit*
Lanora C. Pettit
Principal Deputy Solicitor General

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE EASTERN DISTRICT OF TEXAS**
**TYLER DIVISION**

| | |
|---|---|
| STATE OF TEXAS; TEXAS HEALTH AND HUMAN SERVICES COMMISSION,<br>*Plaintiffs*,<br><br>v.<br><br>CHIQUITA BROOKS-LASURE, in her official capacity as Administrator for the Centers for Medicare and Medicaid Services; THE CENTERS FOR MEDICARE AND MEDICAID SERVICES; XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; and the UNITED STATES OF AMERICA,<br>*Defendants*. | Civ. Action No. 6:23-cv-00161-JDK |

**PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION**

## Exhibit A

## Centers for Medicare and Medicaid Services Bulletin (Feb. 17, 2023)

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

***CMCS Informational Bulletin***

**DATE:** February 17, 2023

**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) under 42 C.F.R. § 438.6(c). 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—that is, arrangements in which 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"—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 critical 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 Medicaid payment methodologies that assure payments are consistent with federal requirements.

Medicaid 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 priorities for their Medicaid programs. 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. 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. [1] CMS regularly works with states to approve such waivers in furtherance of state goals while 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 contravene 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 statutory and regulatory requirements and undermine the fiscal integrity of the Medicaid program. Recently, CMS has become aware of some health care-related tax programs 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 reiterating the federal requirements concerning hold harmless arrangements with respect to health care-related taxes. Further, states and providers should be transparent regarding any explicit or implicit 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 otherwise eligible for federal financial participation. CMS recommends that states that have questions or concerns about the permissibility of a health care-related tax 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. CMS also intends to work with states that may have existing questionable arrangements to ensure compliance with federal statutory and regulatory requirements.

**Health Care-Related Taxes and Hold Harmless Arrangements**

During standard oversight activities and the review of state payment proposals, particularly managed care SDPs and fee-for-service payment state plan amendments (SPAs), 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

[1] For non-broad based and/or non-uniform health care related taxes, these conditions are: that the tax be imposed on a permissible class or class, that the tax be generally redistributive, that the tax be not directly correlated with Medicaid payments, and that the tax lack a hold harmless arrangement. See section 1903 (w)(3)(E)(ii) for the requirement that the tax demonstrate that it is 'generally redistributive" and "not directly correlated with Medicaid payments." For the statistical test demonstrating that the tax is "generally redistributive" see 42 CFR § 433.68 (e)(1) for waivers of the broad based requirement only and 42 C.F.R. § 433.68 (e)(2) for waivers of the uniformity requirement whether or not the tax is broad-based. See section 1903 (w)(4) and implementing regulations at 42 C.F.R. § 433.68 (f) for the hold harmless requirements. See section 1903 (w)(7) and 42 C.F.R. § 433.56 for a list of permissible classes upon which states may impose health care-related taxes.

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 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[2]) 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 (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. The redistributions occur so that taxpaying providers are held harmless for all or a portion of the health care-related tax. This may include the redistribution of Medicaid payments to providers that serve no Medicaid beneficiaries.

These tax programs appear to contain impermissible hold harmless arrangements as defined in section 1903(w)(4)(C)(i) of the Act and 42 C.F.R. § 433.68(f)(3) that require 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 of a hold harmless arrangement involving Medicaid payment redistribution:

- 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.
- 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 managed care plans.
- Nine 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 eight of the nine Medicaid-participating hospitals receive. Under this arrangement, five of the six hospitals that furnish a high percentage of Medicaid-covered services receive Medicaid payments from the managed care plans, 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 the nine participating 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

[2] The term managed care plan is used here and throughout this guidance to include managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs) as defined in 42 C.F.R. § 438.2.

availability of the redistributed payments received from five of the six high Medicaid service volume hospitals (regardless of whether the funds were first pooled and then redistributed), are held harmless for at least part of their health care-related tax costs.

- 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 the tax program.

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)."[3]

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."[4] In the preamble, we 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.[5] 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.

---

[3] 73 Federal Register 9685, 9694-95 (Feb. 22, 2008).
[4] 73 Federal Register 9694
[5] *Id.*

Accordingly, 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.

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. States have an obligation to ensure that the sources of non-federal share of Medicaid expenditures comport with federal statute and regulations. As a result, states should make clear to their providers that these arrangements are not permissible under federal requirements, learn the details of how health care-related taxes are collected, and take steps to curtail these practices if they exist.

As part of the agency's normal oversight activities and review of state payment proposals, 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. As part of their obligation to ensure state sources of non-federal share meet federal requirements, we expect states to have detailed information available regarding their health care-related taxes. Consistent with federal requirements, CMS expects states to make available all requested documentation regarding arrangements involving possible hold harmless arrangements and the redistribution of Medicaid payments. States should work with their providers to ensure necessary information is available. Where appropriate, states should examine their provider participation agreements and managed care plan 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 C.F.R. § 75.364, 42 C.F.R. § 433.74, and 42 C.F.R. part 438 for any 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. If CMS or an outside oversight agency, such as the state auditing agency or the HHS Office of Inspector General discovers the existence of impermissible financing practices related to health care-related taxes CMS will take enforcement action as necessary. 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, including by reviewing proposals or existing arrangements and providing feedback to develop or modify health care-related taxes to align with state policy goals and 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 (explicit or implicit in nature) to 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 tax programs 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.

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE EASTERN DISTRICT OF TEXAS**
**TYLER DIVISION**

| | |
|---|---|
| STATE OF TEXAS; TEXAS HEALTH AND HUMAN SERVICES COMMISSION,<br>*Plaintiffs*,<br><br>v.<br><br>CHIQUITA BROOKS-LASURE, in her official capacity as Administrator for the Centers for Medicare and Medicaid Services; THE CENTERS FOR MEDICARE AND MEDICAID SERVICES; XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; and the UNITED STATES OF AMERICA,<br>*Defendants*. | Civ. Action No. 6:23-cv-00161-JDK |

**PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION**

## Exhibit B

## Declaration of Victoria Grady
## Texas Health and Human Services Commission

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF TEXAS
TYLER DIVISION

| | |
|---|---|
| STATE OF TEXAS; TEXAS HEALTH AND HUMAN SERVICES COMMISSION,<br>*Plaintiffs*,<br>v.<br>CHIQUITA BROOKS-LASURE, in her official capacity as Administrator of the Centers for Medicare and Medicaid Services; THE CENTERS FOR MEDICARE AND MEDICAID SERVICES; XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; and the UNITED STATES OF AMERICA,<br>*Defendants*. | No. 6:23-cv-00161-JDK |

## DECLARATION OF VICTORIA GRADY

STATE OF TEXAS §
COUNTY OF TRAVIS §

I, Victoria Grady, do hereby swear, affirm, and attest as follows, based upon my personal knowledge of the matters contained herein:

1. My name is Victoria Grady, I am over the age of 18 years of age, of sound mind, and capable of making this declaration. I have personal knowledge of the facts stated herein, and the facts are true and correct. I would testify to the facts stated in this declaration in open court if called upon to do so.

2. I currently work as the Director of Provider Finance for the Texas Health and Human Services Commission (HHSC). I have held this position since September 24, 2018. Before that, I was the Deputy Director of Provider Finance, Senior

Advisor to the Director of Provider Finance, and Government Relations Specialist for Finance. I have worked at HHSC since 2014.

3. The Provider Finance Department has 214 full time employees that work across six major areas: (1) hospital finance, (2) long-term services and supports finance, (3) acute care finance, (4) cost reporting and time studies, (5) local funds monitoring, and (6) business operations (including payment collection and administration). At any given time, Provider Finance is reviewing as many as 10,000 unique reimbursement rates for medical services that run the gamut from vaccines to organ transplants, administering hundreds of millions of dollars in payments, developing and amending 20 or more administrative rules, reviewing 5000+ cost reports,[1] and working in coordination with more than 12 other major business divisions within HHSC.

4. The Provider Finance Department at HHSC is responsible for establishing reimbursement rates for fee-for-service Medicaid and administering various supplemental and directed-payment programs, which are mainly authorized under the State's federally approved 1115 waiver. For more than 95 percent of Medicaid clients, services are administered through Medicaid managed care under the authority of an 1115 Waiver (which must be federally approved). I am well-versed in the historical implementation decisions from 2011-2014 and have personal knowledge of the Waiver related events from December 2014 to present.

5. I have previously detailed much of the information that follows in declarations filed in *Texas v. Brooks-LaSure*, No. 6:21-cv-00191 (E.D. Tex.). Those declarations explain how CMS has used multiple pretexts to try to deny outright the funds that they now threaten to recoup. For example, the declarations describe how during negotiations—that CMS insisted were in good faith—CMS claimed (among other things) that Texas's proposed programs were not actuarially sound—even though CMS admitted that no actuarial soundness analysis had been performed. CMS next claimed that the programs were too big—even though the programs varied greatly in size, were calculated on a per-beneficiary basis, and CMS could point to no statutory or regulation violated by the overall size. Indeed, CMS even offered to approve certain programs even though they shared features with programs that CMS insisted were not in compliance with statutory requirements. The facts contained in those declarations are directly connected to the timeline, pattern, and actions of the Centers for Medicare and Medicaid Services (CMS) and the ability of Texas to

[1] Cost reports are annual reports by Medicaid providers that contain hundreds of pieces of data including (among other things) utilization data, cost and charges, and facility characteristics. This information is used in Medicaid's complicated reimbursement formula.

use certain local funds as the source of non-federal share in the Medicaid program.

6. To receive federal "matching" Medicaid funds, States must provide Medicaid funds in a percentage determined by the federal medical assistance percentage (FMAP). The FMAP varies each year and for each State but is typically approximately a 60:40 split of federal to state funds in Texas. States are explicitly allowed to use a combination of public funds from state and local sources as the State's funding for Medicaid expenditures.[2] Most funding for Texas' share of supplemental and directed-payment programs is provided by units of local government, who transfer public funds to the State through an intergovernmental transfer to be used in the Medicaid program and draw down matching federal funds.

7. Local governmental entities in Texas frequently have different types of taxing authority conferred on them by state statute, such as the ability to collect ad valorem taxes on real property, certain types of hotel or occupancy taxes, user fees, etc. Since 2013, the Texas Legislature has authorized certain local governments to assess and collect mandatory payments from private hospitals. These mandatory payments are deposited in a Local Provider Participation Fund (LPPF), a dedicated-purpose account the local governments may use for certain statutorily authorized purposes, including intergovernmental transfers to HHSC to support specified Medicaid programs. HHSC uses these statutorily permitted local funds as the non-federal share of Medicaid funds that are then matched with federal funds. The mandatory payments assessed and collected by local governments are referred to at the federal level as provider taxes.

8. Under the relevant statutes, local governmental entities operating LPPFs are limited in how much tax they can impose: the aggregate amount of the mandatory payments required of all paying hospitals in the unit of government's jurisdiction may not exceed six percent of the aggregate net patient revenue from hospital services provided by all paying hospitals in the jurisdiction.[3]

9. The Texas statutes that authorize LPPFs also limit the permissible uses of the revenues collected – similar to other special purpose taxes that are then dedicated for a specific public benefit. As relevant here, a unit of government that has authority to assess hospitals within its jurisdiction can use the revenues in the LPPF to make an intergovernmental transfer to HHSC for use as the non-federal share for designated Medicaid program payments.

---

[2] §1902(a)(2) of the Social Security Act.

[3] In five jurisdictions, the relevant statutes provide that the amount of the mandatory payment required of each paying hospital may not exceed six percent of the paying hospital's net patient revenue. Although the language describing the calculation is slightly different, the effect is the same.

10. The units of government in Texas that have the authority to require a mandatory payment into an LPPF include certain counties, hospital districts, or municipalities. The governing body of the unit of government establishes the percentage taxing rate each year or on a schedule in accordance with their enabling statute. Hospitals are then invoiced by the unit of government, and the hospitals pay the taxes to the unit of government where they are held in a separate dedicated-purpose account. This account is the "fund" described by the term LPPF. The governing body of the unit of government may submit an intergovernmental transfer of funds from the LPPF account to HHSC in support of designated Medicaid programs or to use for other statutorily authorized purposes. In Texas, all statutes that authorize a unit of government to implement an LPPF require the assessment to be levied using a uniform rate (*i.e.*, the taxing percentage cannot vary from one provider to another) and to be broad-based (*i.e.*, the tax must be applied to all eligible private providers in the jurisdiction). Collectively, in fiscal year 2022, funds transferred by local governments from an LPPF constituted approximately 17.7 percent of Texas' state share of the Medicaid program.

11. The use of provider tax funds in Medicaid is authorized by and must comply with Section 1903(w)(4) of the Social Security Act, which prohibits a "hold harmless" provision described in the statute as follows:

    - The State or other unit of government imposing the tax provides (directly or indirectly) for a payment (other than under this title) to taxpayers and the amount of such payment is positively correlated either to the amount of such tax or to the difference between the amount of the tax and the amount of payment under the State plan.

    - All or any portion of the payment made under this title to the taxpayer varies based only upon the amount of the total tax paid.

    - 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.

    Federal regulations also limit the use of provider tax-derived funds (at a state or local level) as a source of the non-federal share.

12. None of the parameters in the statute or regulations require HHSC to have taxing authority or to have regulatory authority over the governmental entities that operate LPPFs. In reliance on the clear language of Section 1903(w)(4) of the Social Security Act—as well as state policy generally preferring local rule over centralized control—the Texas Legislature has never conferred upon HHSC taxing authority or regulatory authority over the governmental entities that operate LPPFs.

13. Consistent with federal law, neither the State of Texas, nor any unit of local government imposing a mandatory assessment, 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. Further, Texas' Medicaid payment methodologies are not correlated in any way to the amount paid by a taxpayer to a local government that has authority to operate an LPPF. Texas' Medicaid payment methodologies do not vary any payments based upon the amount of the tax paid. And importantly, neither Texas nor any 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.

14. All LPPFs in Texas are operated by local governments, and HHSC is the sole Medicaid agency for Texas. Local governments are, therefore, not in a position to direct Medicaid payments or Medicaid payment methodologies used in state-directed payment programs. As a result, the state can confirm that no direct guarantee exists as the state's payment methodologies are not related to the source of funds.

15. In Texas, all local governments authorized to operate an LPPF, by state law, are prohibited from assessing mandatory payments that exceed six percent of net patient revenue.

16. In Texas, neither the State nor local government is making payments to any individuals or entities based on what a hospital is assessed by a local government. Medicaid payments made to hospitals are based exclusively upon programmatic methodologies that consider the amount of the base Medicaid payments and what an estimated Medicare or Average Commercial payer would have paid for those same services.

17. CMS has stated that they nonetheless have an objection to Texas' use in the Medicaid program of funds transferred from an LPPF because CMS thinks private providers may have business agreements (to which no governmental entity is a party) to protect against a financial loss as a result of paying their mandatory payment to the unit of local government. In support of their assertion that a private business may not take steps to manage their financial risk through a private business arrangement with another privately owned and operated corporation, CMS has relied on language in the preamble to its 2008 rule that discusses a provider's "reasonable expectation." However, neither 1903(w) of the Social Security Act nor 42 C.F.R 433.68 contain the term "reasonable expectation" to define or refine the evaluation of whether a direct guarantee exists. Notably, CMS' guidance in the same 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).

18. CMS states the "reasonable expectation" is satisfied when a state payment is made to a party who is related to the entity paying the tax and is therefore subject to a requirement that could be imposed by the taxpaying entity for repayment of the tax amount. However, two hospitals that happen to be in the same geographic area and both subject to an assessment by a local government are not related parties, and there is no ability for one taxpayer to mandate repayment of tax amounts from another taxpayer. Even if "reasonable expectation" was a valid test (which it is not), in Texas, there is no payment from the State or any taxing entity to anyone that considers the amount an entity has paid as a taxpayer.

19. On February 17, 2023, CMS issued an Informational Bulletin (the Bulletin) relating to Health Care-Related Taxes and Hold Harmless Arrangements Involving the Redistribution of Medicaid Payments. The Bulletin states in part:

> 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. States have an obligation to ensure that the sources of non-federal share of Medicaid expenditures comport with federal statute and regulations. As a result, states should make clear to their providers that these arrangements are not permissible under federal requirements, learn the details of how health care-related taxes are collected, and take steps to curtail these practices if they exist.

The Bulletin—which is contrary to statutory law, how hospitals function, and CMS's own past practice—threatens the more than $6 billion per year in federal funding that is received as the federal match to the more than $3 billion in LPPF-derived funds used for Medicaid payments. This level of sudden financial loss cannot be sustained by any economic sector, including the healthcare market, and would undoubtedly result in significant negative impacts to Medicaid providers individually and the Medicaid Safety net collectively.

20. The Bulletin is irreconcilable with current law. Neither CMS nor Texas have statutorily conferred authority to examine or consider any contractual agreements or arrangements that might exist between two private businesses. As discussed above, though CMS has raised its current position before, CMS has never been able to produce a Texas state statute, regulation, or policy that would implicate a guarantee in violation of 42 C.F.R. 433.68(f)(3) because none exist.

21. The Bulletin is incompatible with how hospitals function in Texas—and, I suspect, across the country. Texas hospitals are complex and sophisticated business entities who have potentially thousands of contractual agreements. It is not uncommon for a hospital to have a contractual agreement with other healthcare providers (which includes not just hospitals but doctors and other medical professionals) or entities. In fact, Texas relies on the interwoven fabric of cooperation amongst the more than 600 hospitals to create the safety net for Medicaid patients.

22. CMS's current position is inconsistent with its past practice of encouraging the development of LPPFs in Texas. However, issuing sub-regulatory guidance that it relies on to disallow funds is becoming a disturbing new normal. In 2014, CMS issued a State Medicaid Director Letter (SMDL) that purported to clarify federal statutes and regulations regarding certain public-private partnerships and the permissibility (or impermissibility) of funds for use in the Medicaid program from public entities in these partnerships that CMS did not consider bona-fide donations by private providers to governmental entities. CMS relied on the SMDL and issued a disallowance of funding in Dallas County and Tarrant County. HHSC appealed the disallowance to the Departmental Appeals Board (DAB) through the required administrative process and ultimately judicial review. The matter remains pending.

23. Despite the ongoing appeals over the SMDL, Texas attempted to work cooperatively with CMS and find a pathway forward to ensure the financial stability of the Medicaid program. In 2018 and 2019, CMS and Texas discussed at length the structure of LPPFs as Texas and CMS worked to resolve a disallowance that had been issued by CMS related to funds transferred from governmental entities in Dallas and Tarrant Counties that CMS asserted constituted improper donations.[4] Unless Texas was able to replace the allegedly improper non-federal share, Texas stood to lose $4 billion in federal matching funds. Texas's proposed solution was to statutorily authorize LPPFs—then a new financing mechanism for Texas—in Dallas and Tarrant Counties. CMS reviewed the structure of these proposed LPPFs and allowed the substitution of funds.

[4] Texas challenged the disallowance and litigation is ongoing.

24. In early 2019, HHSC first became aware of the possibility that private business agreements might exist between private entities, and Texas contacted CMS to seek guidance. Consistent with the plain text of the Social Security Act, CMS advised at that time that so long as neither the State nor unit of local government was providing the guarantee, there is not a prohibition on such private business arrangements. This response was consistent with the 2003 U.S. HHS OIG audit in Missouri ("Review of Medicaid Disproportionate Share Funds Flow in the State of Missouri," (A-07-02-02097)).

25. CMS has subsequently changed its position on LPPF funds and asserted that use of these funds violates 1903(w)(4) of the Social Security Act. CMS sent Texas a series of questions on May 21, 2019, that implied that the existence of private business arrangements may not be permissible. At the time, HHSC believed that CMS was gathering information about LPPFs rather than asserting its authority to demand production of the agreements. The basis of this belief was an email exchange dated April 10, 2019, that was widely circulated, between the then-Director of CMS' Financial Management Group, Kristin Fan, and an attorney that represents industry stakeholders. The email exchange summarizes a March 26, 2019, phone call wherein CMS agreed that:

> CMS is aware that there may be arrangements out there among providers that you do not particularly like, but that [CMS does] not have statutory authority to address, which would include these types of mitigation agreements. Therefore, [CMS does] not expect states to seek information about these agreements or providers to disclose these agreements to the state/local government in connection with CMS' question.

26. When the State responded on August 20, 2019, that the State could not provide information about those arrangements because these agreements would be outside of the scope of federal law and HHSC did not have authority to seek that type of information, CMS then took action to promulgate rules that sought to expand their reach into private business arrangements.

27. The Medicaid Fiscal Accountability Rule (MFAR) was published on November 18, 2019 and sought to expand and modify CMS' regulatory authority with respect to the use of local funds as the non-federal share in the Medicaid program. The publication of this proposed rule came shortly after CMS sent the above-described request to Texas, and Texas responded that it was beyond our authority to answer and CMS' authority to ask. Texas, as well as many others, commented at the time of the proposal that we believed that federal law does not allow CMS to examine business arrangements to which a governmental entity is not a party for purposes of determining whether a health care-related tax on those providers is in compliance with the Medicaid program requirements and the proposal exceeded CMS' statutory authority under 1903(w) of the Social

Security Act. A true and correct copy of the comments submitted by Texas is attached hereto to the motion for a preliminary injunction as Exhibit E.

28. After acknowledging receipt of more than 10,000 public comments, the MFAR rule was withdrawn on September 14, 2020, by the then-CMS Administrator who stated, "we've listened closely to concerns that have been raised by our state and provider partners about potential unintended consequences of the proposed rule, which require further study." To my knowledge, no further study of the matter has ever been conducted. CMS has never provided an answer as to why their position changed from 2019, when the former Director of Financial Management at CMS acknowledged in writing that CMS had no legal authority to prohibit private agreements.

29. The global pandemic caused by the novel coronavirus, COVID-19, began in January 2020 and created an unprecedented instability in healthcare. The situation caused unusual patterns in client behavior, provider finances, and the broad economy as supply chains were disrupted and outbreaks caused surges that were unforeseen. The impact to the world, including Texas, was grave and disastrous.

30. Texas applied for a renewal of the state's 1115 Waiver in November 2020 as the state grappled with the Public Health Emergency caused by COVID-19 and the destabilizing and detrimental impact to our healthcare industry caused by the lack of certainty around the future of Texas' waiver. During the negotiations of the waiver—which was sought to stabilize a Medicaid program that was on the verge of a major market contraction—CMS tried to insert Special Terms and Conditions that would have imposed many MFAR-like requirements and prohibitions. Texas reiterated to CMS during the negotiation of the Waiver extension STCs that we do not believe either CMS or Texas has statutory authority to seek this type of information or prohibit these arrangements. We, therefore, requested that the STCs related to arrangements amongst providers be excluded from our Waiver extension but agreed to other STCs that we believed were lawful. The waiver, without the STCs that were objectionable, was approved on January 15, 2021.

31. As a result, on January 8, 2021, CMS published a new pre-print template for directed payment programs. A pre-print template is a form that States use to seek approval from CMS before implementing certain kinds of directed payment programs, as required by 42 C.F.R. § 438.6. The new pre-print template, again, inserted requests for information similar to MFAR and the objectionable STCs. It further escalated the pressure of CMS' overreaching efforts because the pre-print had to be approved for Texas to receive federal funding for a program design. We attempted to answer their questions within the confines of the authority that HHSC has; but answered in a way that clearly indicated that some of what CMS was requesting was beyond the authority of CMS or HHSC

to obtain or consider. HHSC submitted the pre-prints for 5 programs—the Comprehensive Hospital Increased Reimbursement Program (CHIRP), the Quality Incentive Payment Program (QIPP), the Texas Incentives for Physician and Professional Services (TIPPS), the Directed Payment Program for Behavioral Health Services (DPP BHS), and the Rural Access to Primary and Preventive Services (RAPPS). These programs were all contemplated in the January 15, 2021, 1115 Waiver that was approved by CMS.

32. On April 16, 2021, CMS notified Texas that our Waiver approval was being rescinded. The Waiver withdrawal threw the Texas healthcare system into a state of unprecedented instability. Additionally, CMS virtually stopped working with Texas to evaluate the pre-prints that Texas submitted for review when Texas was unable to provide CMS with the information CMS was seeking on the source of the non-federal share.

33. Texas filed suit on May 14, 2021, and received relief from a preliminary injunction related to the Waiver rescission, compelling CMS to restart discussions with the state on our pre-prints. During these discussions, CMS continued to insist that Texas give them information related to private business arrangements, or in lieu of providing them the information directly, provide written attestations from every private hospital about their private business arrangements. We asked CMS to specify under what statutory or regulatory authority we could require this type of attestation, but no response was provided.

34. Nevertheless, CMS remained insistent that they could not approve our programs due to concerns about the non-federal share. CMS then withheld approval of more than $7 million per day in provider payments in an effort to renegotiate settled aspects of Waiver and exceed the limitations of their statutory authority. The State was required to seek further court intervention to enforce the terms of the Preliminary Injunction and prevent CMS' attempts to pursue a regulatory agenda that is unsupported by the law.

35. As part of the directed payment program negotiations, CMS sent questions to Texas on November 10, 2021, including threats of deferrals. During this negotiation, CMS' threat also implicated Uncompensated Care payments and payments for other programs that use LPPF funding.

36. With respect to the non-federal share, Texas has provided CMS affirmations, reports, and documentation demonstrating an increased monitoring of local funds used in the Medicaid program at a cost of millions of dollars per year to the state. Texas has reiterated its compliance with 1903(w) of the Act and 42 C.F.R. § 433.68, which prohibit the state or other units of government imposing a provider tax from providing 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.

37. CMS has never provided an answer as to why its position changed from 2019, when the former Director of Financial Management at CMS acknowledged in writing that CMS had no legal authority to prohibit private agreements. On November 2, 2021, left with no other option but to exceed its statutory authority or lose billions in funding, HHSC filed motion to enforce the preliminary injunction in the litigation that was ongoing over the 1115 Waiver and sought immediate relief.

38. On November 29, 2021, the HHS OIG announced that they were adding to their audit workplan "States' Use of Local Provider Participation Funds as the State Share of Medicaid Payments." Importantly, HHS OIG did not announce that they were reviewing provider taxes categorically, or even provider taxes operated by units of local government, but specifically identified that they would review "Local Provider Participation Funds," which is the term that Texas and a limited number of other States have chosen to use in the state statutes authorizing this method of finance for units of local government.

39. After this Court indicated that further pretextual delay would lead to sanctions, CMS notified HHSC on March 25, 2022, that CMS was no longer going to withhold the approval of our programs, but notably only after CMS was threatened with judicial sanctions if CMS failed to act. The approval reserved its authority to disallow federal funding if it determined the funding mechanisms were impermissible. As the approvals resolved the legal questions in the pending litigation, HHSC accepted the approvals and proceeded with all haste to implement the programs in good faith. At that point, both sides mutually agreed to conclude the lawsuit.

40. On March 25, 2022, HHS OIG notified Texas that we were a selected State for their audit of LPPFs. On April 14, 2022, HHS OIG held an entrance conference with Texas to begin an audit of our Local Provider Participation Funds. After collecting information from the State about payments related to 2019, HHS OIG determined that it would select Smith County, Texas for a detailed review. HHS OIG contacted officials in Smith County and asked for information on private business agreements to which Smith County is not a party. HHS OIG had initially told Texas it believed its audit would take approximately 12 months and that it would issue their report, including any findings, in the summer of 2023. However, shortly after the issuance of the Bulletin by CMS, HHS OIG stated its intent to conclude the Smith County audit and issue its findings by May 2023.

41. As referenced above, the Bulletin explicitly and directly asserts that CMS expects States to investigate private business arrangements. The Bulletin states: "Some states have cited challenges with identifying and providing details on redistribution arrangements because they may not be parties to the redistribution agreements...States have an obligation to ensure that the sources

of non-federal share of Medicaid expenditures comport with federal statute and regulations. As a result, States should make clear to their providers that these arrangements are not permissible under federal requirements, learn the details of how health care-related taxes are collected, and take steps to curtail these practices if they exist."

42. Texas has invested significant resources into the monitoring of local governments that submit intergovernmental transfer funds for use in the Medicaid program (a fact that CMS is aware of because Texas submitted information to CMS regarding our Local Funds Monitoring plan in August 2021). The current monitoring efforts are focused exclusively on monitoring local governmental entities, the collection of documents and agreements between the local government and providers, and other financial information necessary for HHSC to determine that the sources comport with federal statute and regulations. The Local Funds Monitoring program that HHSC has put into place has 14 full-time staff and a custom information technology system, the Local Funds Tracking System (LoFTS), for the collection of information annually. The initial creation of the team and the building of LoFTS had a cost of more than $4 million and the ongoing annual cost is approximately $2 million annually. Because all documents being collected are governmental records, HHSC has authority to request these documents as they are public records. Because I have overseen the creation of this team, I can use this to estimate what would be required to be expended by Texas to comply with the Bulletin.

43. For HHSC to comply with the Bulletin, Texas would be required to go far beyond monitoring and record review. Rather, HHSC would need to act as a regulatory agent of private business relationships. The Bulletin states that the arrangements they are concerned with can be "entered into oral or written agreements (meaning explicit or implicit meeting of the minds, regardless of the formality or informality of any such agreement)." It further contemplates that the arrangements "may be made directly from one taxpaying provider to another, or the funds may be contributed first to an in intermediary..." Thus, HHSC's scope of review would need to extend beyond reviewing explicit documents and contracts, but to a full examination of the financial expenditures (both incoming and outgoing) to determine whether a relationship might exist between a payment, contract, donation, or other financial transaction and Medicaid payments. The Bulletin is not specific that the intermediary or agreement is restricted to business organizations, but could potentially include individuals, charitable foundations or organizations, and political or advocacy organizations. To ensure that there is no implicit agreement being facilitated by a third-party intermediary, HHSC would be obligated to examine the records of any entity or individual who engaged in a financial transaction (either payment or expenditure) to determine whether that entity or individual has a relationship with another hospital.

44. In view of the example highlighted in the Missouri audit (referenced above), I assume that we would be required to investigate the financial records of any hospital association to which a hospital might have a membership and/or make financial contributions. To my knowledge, all the major hospital associations in Texas are not-for-profit organizations with either a 501(c)(4) or 501(c)(6) designation. Such private organizations can and sometimes do choose to keep their membership lists and affiliations confidential to the extent permitted under federal law. To comply with the Bulletin, it would seem like HHSC would have to force disclosure of potentially confidential information.

45. But the Bulletin is not specific enough to limit the search for third-party intermediaries to hospital associations or other businesses. It is so vague that a state would have to consider the possibility that any person could be the third-party intermediary of an oral agreement especially given the likely circumstance that an employee or contractor would have a relationship with more than one hospital in a limited geographic area. This would mean that the review of records would need to extend to any individual who receives remuneration from a hospital—including employees or contractors of the hospital—to determine if the individual then used those funds at a second hospital.

46. And, further, once HHSC has determined that the third-party entity or individual has a financial relationship with the second hospital, HHSC would have to evaluate whether the relationship exists to facilitate a "meeting of the minds." If HHSC, after all the examination of the records and financial transactions of the hospitals and any individual or entity with which the hospital has an oral or written agreement, determines that the arrangement may be similar to one described by CMS in the Bulletin, HHSC would be obligated to take actions to try to prohibit the hospital from continuing the business agreement. Depending on the nature of the agreement that is being prohibited, HHSC would be forced to try to require a hospital or an entity or individual that HHSC believes has acted an "intermediary" to cancel a contract and recover/return expended funds, refund or rescind a donation made from or to a charitable or advocacy organization, or to take other corrective actions. This enforcement effort would likely require creation of an informal and formal appeal process through the State Office of Administrative Hearings and/or a judicial review process for which HHSC would need attorneys and legal personnel to handle hearings and other legal work.

47. There are 304 privately-owned hospitals located in jurisdictions that currently have an LPPF. 27 percent of those hospitals are not-for-profit and 72% are for-profit organizations. I conservatively estimate that HHSC would need an additional 352 full-time staff, a major expansion of LoFTS, and the creation of an enforcement effort to "curtail" any actions that might be inconsistent with the Bulletin. The hospitals that would be subject to review range in complexity and size, so HHSC would need to hire Auditors, Financial Examiners, Financial

Analysts, Hearing Officers, Attorneys, and support personnel to evaluate the thousands (potentially millions) of contracts or other business documents at each hospital and the billions of dollars of revenues and expenditures that are associated with the running of these hospitals. I estimate the annual cost to Texas to comply with the Bulletin at approximately $55 million.

48. Given that the number of individuals or entities that would be subject to the seizure and review of their financial records is unknown, it is not possible for me to estimate the cost of the review of those records or the enforcement efforts that would be required to truly comply with the standards of the Bulletin. As I am not a lawyer, I am also unable to estimate the litigation costs that HHSC would incur if any of the private hospital associations, some of which are associated with religious groups, were to assert a First Amendment right not to disclose the entities with which they are affiliated.

49. The Bulletin goes further by threatening that "If CMS or an outside oversight agency, such as the state auditing agency or the HHS Office of Inspector General discovers the existence of impermissible financing practices related to health care-related taxes CMS will take enforcement action as necessary." Through this language in this sub-regulatory guidance, CMS is signaling the HHS OIG has authority to demand production of and review private business arrangements and that the State will be subject to enforcement actions if we cannot produce information about the business arrangements. Those enforcement actions can include not just disallowance of FMAP for any funds for which HHSC cannot produce the demanded documentation but complete exclusion from the Medicaid program.

50. On March 1, 2023, HHS OIG notified Texas that they would be starting a new, *additional* audit on LPPFs and would be selecting three additional local governmental entities to review.[5] They scheduled an entrance conference with the state on March 6, 2023. At the entrance conference, HHS OIG said that the decision to open this new audit of additional local governmental entities in Texas is at the direction of their division leadership in Baltimore, Maryland. HHS OIG stated the objective of the new audit is to determine solely whether Texas adhered to the hold-harmless provisions in federal regulations. Thereafter, on March 9, 2023, HHS OIG notified Texas that it had changed the original audit objective of the Smith County LPPF audit (referenced in paragraph 40) from the broad examination of whether LPPF funds were permissible and in accordance with state and federal law to the much narrower objective utilized in the new audit of the three additional local governmental entities (*i.e.*, whether the state

[5] The letter specified that the Audits were of Amarillo, Tarrant, and Webb Counties. However, neither Amarillo nor Tarrant County operates a LPPF. The audits appear to refer to the City of Amarillo and Tarrant County Hospital Districts, which do operate LPPFs.

agency adhered to the hold-harmless provision in federal regulations). The narrowed objective seems to reflect HHS OIG's reliance on the Bulletin that CMS issued just weeks before. Specifically, the objective changed from the broad examination of whether LPPF funds were permissible and in accordance with state and federal law to the much narrower objective of whether the state agency adhered to the hold-harmless provision in federal regulations. The narrowed objective is consistent with that announced in the new audit of the three additional jurisdiction, but it seems to reflect HHS OIG's reliance on the Bulletin that CMS issued just weeks before.

51. Since the Bulletin was issued on February 17, 2023, I have received numerous requests from providers and advocacy organizations for information on how HHSC will comply with the CMS requirements. The provider community is extremely concerned because the Bulletin states that "failure to comply with reporting requirements may result in a deferral or disallowance of federal financial participation." Texas hospitals experienced the severe disruption that a deferral of federal funding can cause when CMS withheld approvals of programs valued at more than $7 million per day for a period of seven months in 2021-2022. The instability caused havoc in the healthcare system and threatened the operations of many small and rural hospitals in Texas. Recovering from the damage that delayed payments caused is a slow process, and the inability of a provider to be certain that Medicaid payments for services will be forthcoming at the level they anticipate increases the fragility of a healthcare system that continues to be impacted by the impact of the pandemic and its ripple effects into the broader economy. To find ourselves a year later facing a threat that we must incur millions of dollars in costs to taxpayer funds for the search through an untold number of financial records of potentially unlimited intermediary individuals or entities is destabilizing to the very same safety net that Texans enrolled in the Medicaid program rely on to provide them life-saving care and that we fought to protect by obtaining the 1115 Waiver in January 2021.

I declare under penalty of perjury that the foregoing is true and correct.

Executed in Travis County, State of Texas, on the 13th of April 2023.

VICTORIA GRADY

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE EASTERN DISTRICT OF TEXAS**
**TYLER DIVISION**

| | |
|---|---|
| STATE OF TEXAS; TEXAS HEALTH AND HUMAN SERVICES COMMISSION,<br>*Plaintiffs*,<br><br>v.<br><br>CHIQUITA BROOKS-LASURE, in her official capacity as Administrator for the Centers for Medicare and Medicaid Services; THE CENTERS FOR MEDICARE AND MEDICAID SERVICES; XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; and the UNITED STATES OF AMERICA,<br>*Defendants*. | Civ. Action No. 6:23-cv-00161-JDK |

**PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION**

## Exhibit C

## Email from Kristin Fan to Barbara Eyman (Apr. 10, 2019)

## Barbara Eyman

**From:** Fan, Kristin A. (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>
**Sent:** Wednesday, April 10, 2019 5:24 PM
**To:** Barbara Eyman
**Subject:** RE: Provider tax question

This is accurate. I would just add that CMS reserves the right to ask these types of questions that may help inform further policy.

---

**From:** Barbara Eyman [mailto:beyman@eymanlaw.com]
**Sent:** Wednesday, April 10, 2019 3:39 PM
**To:** Fan, Kristin A. (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>
**Subject:** FW: Provider tax question

Hi Kristin: Resending this per your request. Thanks again for your help.

Barbara

---

**From:** Barbara Eyman
**Sent:** Tuesday, March 26, 2019 3:45 PM
**To:** 'Kristin Fan (Kristin.Fan@cms.hhs.gov)' <Kristin.Fan@cms.hhs.gov>
**Subject:** Provider tax question

Hi Kristin:

This email contains my understanding of our phone conversation just now. Can you confirm that I accurately captured our discussion? Thank you as always.

I noted that CMS is increasingly asking states about agreements *among* providers (not just between states/local governments and providers) in connection with your review of various non-federal share funding arrangements. I also noted that in several states or local jurisdictions where there is a provider tax, providers have entered into agreements through which they have voluntarily agreed to buffer some of the financial disruption that might occur because of a provider tax. These agreements typically do not involve the state/local government and have not been shared with the state/local government. So I asked whether these are the types of agreements CMS is looking for when asking the question about agreements among providers, or whether you are more interested in other types of provider agreements. I also asked about CMS' view of these agreements.

You indicated that those questions are intended to obtain information that CMS believes might be indicative of provider donations, such as "burden alleviation" agreements or exchanges of ownership. They are not intended to address the kind of provider tax mitigation arrangements I asked about. You also indicated that CMS is aware that there may be arrangements out there among providers that you do not particularly like, but that you do not have statutory authority to address, which would include these types of mitigation agreements. Therefore, you do not expect states to seek information about these agreements or providers to disclose these agreements to the state/local government in connection with CMS' questions.

Did I summarize this accurately?

Thanks Kristin,
Barbara

Barbara Eyman
Eyman Associates, P.C.
1120 G Street NW
Suite 770
Washington, DC 20005
(202) 567-6203 phone
(202) 290-3941 fax
beyman@eymanlaw.com
https://protect2.fireeye.com/url?k=017f008e-5d2b19f2-017f31b1-0cc47adc5fa2-53c110538f4c04a5&u=http://www.eymanlaw.com/

**From:** Fan, Kristin A. (CMS/CMCS)
**To:** Barbara Eyman
**Subject:** RE: My voice mail
**Date:** Friday, April 19, 2019 11:57:00 AM

Sorry – I didn't get a chance to return the call.

[redacted]

On another note – I want to clarify some points regarding your previous email looking for clarification regarding agreements and tax programs. Yes – CMS has become increasingly concerned about donation arrangements, but that does not mean that we do not evaluate health care related taxes and look at underlying information.

**From:** Barbara Eyman [mailto:beyman@eymanlaw.com]
**Sent:** Thursday, April 18, 2019 11:18 PM
**To:** Fan, Kristin A. (CMS/CMCS) <Kristin.Fan@cms.hhs.gov>
**Subject:** My voice mail

Hi Kristin:
I left you a voice mail yesterday, but thought I'd follow up via email to let you know why I was calling, in case it's easier to respond by email. I am working with providers in the city of Orlando Florida, and they are working with the City of Orlando on a local provider assessment. The assessment would require a waiver of the broad based requirement, and the state (the FL Agency for Health Care Administration) just submitted a waiver request earlier this week. The hospitals are concerned, however, because the assessment is intended to fund Low Income Pool payments and those payments must be made by the end of the SFY, which is June 30. The City Council is waiting for confirmation that the waiver has been granted before it can act on the assessment resolution, but the timing is really tight. The Council meets twice per month, and the resolution must go through two readings at separate meetings. And they need to have materials assembled two weeks ahead of time. So given all of that, they are thinking that they really need to be ready to go with their resolution by May 21 (ideally May 7, but they can make May 21 work). I know that's a pretty quick turnaround for you, but I was wondering whether it is at all realistic that you would be able to complete your review in that time frame? They pass the P1/P2 test with a comfortable margin (the excluded hospital is a children's hospital with high Medicaid volume).

Feel free to call me if this is easier to discuss by phone. And FYI for the record, these clients are not the clients for whom I was reaching out to you recently with my other question regarding provider tax related agreements).

I will be on my cell tomorrow (301-9961-1626) or will be in the office next week (202-567-6203). Thanks as always.

Barbara Eyman
Eyman Associates, P.C.

1120 G Street NW
Suite 770
Washington, DC 20005

(202) 567-6203 phone
(202) 290-3941 fax
beyman@eymanlaw.com
https://protect2.fireeye.com/url?k=cc9b5475-90ce5da5-cc9b654a-0cc47a6a52de-46a5ac1abaec6a90&u=http://www.eymanlaw.com/

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE EASTERN DISTRICT OF TEXAS**
**TYLER DIVISION**

| | |
|---|---|
| STATE OF TEXAS; TEXAS HEALTH AND HUMAN SERVICES COMMISSION,<br>*Plaintiffs*,<br><br>v.<br><br>CHIQUITA BROOKS-LASURE, in her official capacity as Administrator for the Centers for Medicare and Medicaid Services; THE CENTERS FOR MEDICARE AND MEDICAID SERVICES; XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; and the UNITED STATES OF AMERICA,<br>*Defendants*. | Civ. Action No. 6:23-cv-00161-JDK |

**PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION**

## Exhibit D

## Daniel Tsai, Comments on Medicaid Program; Medicaid Fiscal Accountability Regulation [CMS–2393–P] (Jan. 27, 2020)

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
One Ashburton Place, Room 1109
Boston, Massachusetts 02108

CHARLES D. BAKER
Governor

KARYN E. POLITO
Lieutenant Governor

MARYLOU SUDDERS
Secretary

DANIEL TSAI
Assistant Secretary for
MassHealth

Tel: (617) 573-1600
Fax: (617) 573-1891
www.mass.gov/eohhs

January 27, 2020

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–2393–P
P.O. Box 8016
Baltimore, MD 21244–8016

**Re: Comments on Medicaid Program; Medicaid Fiscal Accountability Regulation [CMS–2393–P]**

Dear Administrator Verma,

On behalf of the Massachusetts Medicaid and CHIP program, known as MassHealth, I am writing to provide comments on the Proposed Rule on Medicaid Fiscal Accountability (the rule).[1] MassHealth provides comprehensive, affordable health care coverage for over 1.8 million low-income Massachusetts residents, including 40% of all Massachusetts children and 60% of all residents with disabilities. MassHealth's mission is to improve health outcomes among our diverse members and families across the Commonwealth by providing access to integrated health care services that sustainably and equitably promote health, well-being, independence, and quality of life.

Massachusetts supports CMS' stated goals of transparency, accountability and good governance; specifically, we support the fact that CMS has made program integrity and provider accountability among its priorities for the Medicaid program as part of its focus on both fiscal sustainability and delivery system reform through accountable care models. Massachusetts has worked closely and collaboratively with CMS to restructure many of its historical supplemental payments, a key subject of the proposed rule.

However, in an attempt to address a wide range of issues in the rule, CMS proposes far-reaching and consequential changes to Medicaid financing and introduces significant new state obligations. If implemented, the rule would represent an unprecedented federal overreach. It would create unnecessary barriers and limitations for states to manage their programs, and undermine states' efforts to reach delivery system and policy goals. In addition, the rule would create significant administrative and

[1] https://www.govinfo.gov/content/pkg/FR-2019-11-18/pdf/2019-24763.pdf

operational burdens. Cutting across all of these issues is the fact that the rule is ambiguous and inconsistent.

The restrictions, requirements, risks and uncertainty that this rule creates for state Medicaid programs will ultimately have a negative impact on Medicaid beneficiaries, including children, seniors and individuals with disabilities, who depend on Medicaid for their health care.

Given the expansive scope and negative impacts of the rule on state Medicaid programs, Massachusetts strongly urges CMS to withdraw the rule as proposed and work collaboratively with the states to further its goals of program integrity and provider accountability.

***The rule represents an unprecedented federal overreach***

The rule aims to comprehensively update CMS's oversight of virtually all state arrangements to finance Medicaid state share, including health care related taxes and provider donations, intergovernmental transfers (IGTs), certified public expenditures (CPEs), and supplemental payments. This proposed rule exceeds CMS' statutory authority.

The rule proposes the use of a number of overly broad and indefinite standards of review to be used by CMS in analyzing aspects of payment and financing arrangements, including "totality of circumstances" and "net effect" tests. These tests can be used, among other things, to determine whether any exchange in value is a provider-related donation, whether any fee or assessment is a health care-related tax, and whether any newly identified or existing financial arrangement meeting either definition is permissible.

The poorly defined scope of these standards of review grants CMS nearly unlimited discretion to scrutinize the financial transactions of the Medicaid agency, providers, certifying entities, and other parties. This gives CMS significant leeway to make subjective decisions on what is a permissible state financing mechanism, creating significant uncertainty for states, both in terms of what current programs will remain allowable and what future programs might be approved by CMS. These provisions are highly susceptible to arbitrary and capricious application, particularly across administrations, and Massachusetts requests that they be removed if the rule is finalized.

The rule also imposes arbitrary limits on common financing arrangements. For example, the rule limits permissible certified public expenditures (CPEs) only to "payments" made to State government or non-State government "providers", such as a municipality. The rule also sets forth a prescriptive payment methodology for CPEs, requires that all claims related to CPEs be processed through a state's Medicaid management information system (MMIS), and requires that the certifying entity "receive and retain" the full amount of federal financial participation (FFP) associated with the CPE. Even for the types of CPEs for which this methodology could be appropriate, CMS has not provided justification for why that is the *only* permissible process and methodology. States currently use, and CMS has historically approved, other processes and methodologies that accomplish the same goals of tying expenditures to specific services and enrollees, and ensuring that certified expenditures do not exceed costs. Massachusetts requests that CMS continue to allow states the flexibility to utilize alternative methodologies where appropriate to meet policymaking and delivery system reform goals.

In addition, the rule's new requirements for intergovernmental transfers (IGTs) are problematic and more restrictive than the statute allows. These new requirements are also a significant departure from longstanding policy and practice. Specifically, the rule's requirement that IGTs must be derived from state or local taxes (or funds appropriated to state university teaching hospitals) is unjustified and is not supported by the underlying statute. By restricting the source of the non-federal share as proposed, CMS

is overlooking and prohibiting the use of other legitimate sources of state or local funds, such as bond issues, lottery funds, public college tuition, revenues from health care services provided by public providers, and other non-tax revenues. This proposed requirement is especially concerning in its interference of state autonomy to fund their share of Medicaid.

***Imposes unnecessary limitations on policymaking and delivery system reform***

The rule poses significant challenges for states and interferes with the legitimate and appropriate role of the state in the Medicaid program's federal-state partnership. The ambiguous and inconsistent nature of the rule creates significant uncertainty for states and would impose severe limitations on states' flexibility to channel funding toward new policy and delivery system reforms.

The rule would redefine "public funds" as "state and local funds" for purposes of specifying the permissible state share of Medicaid payments, and would impose an additional requirement that appropriations of these funds can only be considered state share if they are appropriated directly to the Medicaid agency from the state's general fund and do not include federal funds. It is simply not practical for earned federal revenue deposited in a state's general fund (and mixed with other revenue generated by the state through tax revenue, non-tax revenue, or some other source) to be segregated out for purposes of an appropriation, and CMS should not assert or maintain control over such revenue once it has been paid to a state and deposited in its general fund.

These proposed new restrictions on standard general fund appropriations would also hinder the role of state sister agencies in helping to accomplish the goals of the Medicaid program. Many state Medicaid agencies partner with sister agencies, such as agencies serving the elderly, individuals with intellectual and developmental disabilities, or individuals with substance use disorders, to provide covered Medicaid services directly or through contracted providers to some of their most vulnerable populations. These new restrictions on the use of standard general fund appropriations would substantially impact state operations that rely on sister agencies to best serve the Medicaid population.

In addition, the rule's handling of managed care organization (MCO) provider payments marks a departure from current practice. It appears that the rule will now require states to include payments to providers from MCOs for services rendered to Medicaid beneficiaries enrolled with those plans when calculating the state's upper payment limit (UPL). CMS recently implemented a wide-ranging managed care rule that created comprehensive processes and governance for directed and pass-through payments made through managed care vehicles. The managed care rule explicitly prohibits states from directing the expenditures of its MCOs, expect in certain limited circumstances that require special CMS authorization. Requiring a state to include MCO provider payments in its UPL demonstration could lead to unreasonable limitations on the state for actions outside of the state's control: namely, the rate-setting and benefit coverage decisions of its managed care contractors. Additionally, MCOs are permitted to cover services beyond those included under the state plan, and in an amount, duration, and scope that exceeds those covered under the state plan. Requiring these payments to be included in the UPL could unfairly impact the state based on the decisions of its managed care contractors to cover additional services. Massachusetts therefore requests that CMS clarify that states are not required to include MCO provider payments in their UPL calculations and continue to allow the current managed care rule to govern these payments.

Finally, the rule does not provide adequate guidance as to how its provisions will apply to supplemental payments for which states have existing approvals from CMS through section 1115 demonstrations, creating instability for states and providers. For instance, some approved section 1115 demonstrations already include detailed limits and requirements governing the supplemental payments authorized through those vehicles. Similarly, the rule includes a three-year approval cycle for supplemental

payments, while most supplemental payments approved through section 1115 demonstrations align with the five-year authorization period for such waivers. The rule does not describe how it would interact with those requirements or limits and creates confusion for states that are planning efforts to advance value-based care and delivery system reforms through those demonstrations. At minimum, Massachusetts requests that CMS clarify that any requirements or limits on a supplemental payment set forth in an existing section 1115 demonstration will govern the payment for at least the term of the demonstration.

***The rule creates significant administrative burden and is operationally impractical***

The rule introduces substantial new requirements for detailed quarterly and annual reporting on supplemental payments, including reporting on the business dealings of private entities that are not available to the state. Increasing mandatory reporting represents an enormous burden for states and providers. Massachusetts is also concerned that the reporting requirements attached to the periodic renewal of state plan authority of supplemental payments will result in a high volume of renewal requests that could result in substantial delays in processing state plan amendments.

The rule also creates the potential for substantial new ad hoc demands for information by CMS, as each potential program, arrangement, fee, assessment, or donation is considered under the vague and broad standards of review discussed above. This could exacerbate the administrative burden on states and providers, and result in potential delays by CMS as it attempts to digest and process this information. Such proposed requirements introduce potential new costs to state reporting systems as well as stress on state budgets and staff. Delays in approvals of necessary payments can also negatively impact providers and members' access to services. At minimum, Massachusetts requests that CMS delay implementation of these reporting requirements and associated potential FFP withholds, eliminate the quarterly reporting requirements entirely, and scale back the information required in the annual reports.

**Conclusion**

For the reasons described above, Massachusetts strongly urges CMS to withdraw the proposed rule. If re-proposed, we urge it be submitted if and when substantial revisions are made that address the unprecedented federal overreach it represents, the unnecessary limitations for policymaking and delivery system reforms it imposes, and the burden it will place on states. Massachusetts welcomes the opportunity to engage with CMS about these specific concerns with the proposed rule and how we might partner to more reasonably and effectively achieve the aims of transparency, accountability, and integrity.

Sincerely,

Daniel Tsai
Assistant Secretary for MassHealth and Medicaid Director

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE EASTERN DISTRICT OF TEXAS**
**TYLER DIVISION**

| | |
|---|---|
| STATE OF TEXAS; TEXAS HEALTH AND HUMAN SERVICES COMMISSION,<br>*Plaintiffs*,<br><br>v.<br><br>CHIQUITA BROOKS-LASURE, in her official capacity as Administrator for the Centers for Medicare and Medicaid Services; THE CENTERS FOR MEDICARE AND MEDICAID SERVICES; XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; and the UNITED STATES OF AMERICA,<br>*Defendants*. | Civ. Action No. 6:23-cv-00161-JDK |

**PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION**

**Exhibit E**

**Texas Health and Human Services Commission Comments: File Code CMS— 2393-P**

To Whom It May Concern:

The Texas Health and Human Services Commission (HHSC) appreciates the opportunity to provide comments on the proposed rule regarding Medicaid Program; Medicaid Fiscal Accountability Regulation, as requested in the *Federal Register* Vol. 84, No 222, issued on November 18, 2019 [File Code CMS–2393-P].

HHSC's comments follow.

***General Comment***

HHSC appreciates the desire on the part of the Centers for Medicare and Medicaid Services (CMS) to increase accountability related to public funds. The State of Texas strongly believes that the use and derivation of Medicaid funds should be widely understood so that taxpayers and Medicaid clients have the opportunity to examine how funds are spent in their name. However, HHSC believes portions of the proposed rules threaten to introduce unnecessary uncertainty and, in certain instances, exceed CMS's statutory authority.

HHSC supports CMS's efforts to have information about supplemental payments disseminated broadly. HHSC hopes that CMS will continue to work with stakeholders to find optimal ways to move forward with greater accountability in these vital programs.

HHSC's comments on specific provisions follow.

***42 CFR § 430.42 Disallowance of claims for FFP***

*Comment*

The proposed amendments to 42 CFR § 430.42 "alter the means of communication with regard to the disallowance reconsideration process from one based on registered or certified mail to one based on electronic mail or another electronic system as specified by the Secretary." See 84 Fed. Reg. 63737.

The State supports the use of electronic communication in the disallowance reconsideration process but asks that CMS amend § 430.42(a)(2)(C) to provide that State submissions are considered made on the date they are *sent*, rather than the date of receipt. The State does not have control over the time of receipt. This change would also align with § 430.42(c)(4)(i) and (c)(6), which provide that the Administrator's notification is considered made on the date it is sent by the Administrator.

The State also asks that CMS reexamine § 430.42(c)(3). The new sentence added to paragraph (3) addresses when "submissions are considered made" instead of when *notifications* are considered made. Given that in this paragraph CMS is sending a request to the State, the next sentence should relate to the date on which the State is notified of that request. "Submissions," on the other hand, seems to refer to what the State provides in response to the request, which is not addressed until the following paragraph (§ 430.42(c)(4)). The State suggests revising § 430.42(c)(3) to provide that notifications are considered made on the date they are *sent* by the Administrator and revising § 430.42(c)(4) to provide that *submissions* are considered made on the date they are sent via email or electronic system specified by the Administrator.

***42 CFR § 433.51 State share of financial participation***

*Comment*

HHSC requests that CMS reconsider its proposed revision of 42 CFR § 433.51, which HHSC believes is inconsistent with statute.

Section 1903(w)(6) of the Social Security Act says that "the *Secretary* may not restrict States' use of funds where such funds are derived from State or local taxes" (italics added) unless funds transferred from units of government are impermissible donations or taxes. The statute does not limit "public funds" to tax-generated and appropriated funds. Rather, that section of the Act restricts CMS's ability to limit states' use of funds derived from certain sources. It does not address public funds derived from other revenue sources, or imply that other revenue sources are not permitted.

HHSC believes that the same legislation that enacted section 1903(w)(6) of the Act is contrary to this proposed revision. Section 5(b) of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 Public Law 102-234 (not codified) limits CMS's ability to change the treatment of "public funds as a source of State share of financial participation under title XIX" as reflected in the then-current regulations, now contained in 42 CFR § 433.51. The current regulation and its predecessors have directly authorized the use of any "public funds" (not limited to tax-generated funds), including those transferred or certified by "public agencies," as the non-federal share of Medicaid expenditures. HHSC believes that the Act does not permit CMS to limit the non-federal share of Medicaid payments beyond its specification of "public funds."

CMS intends the proposed replacement of "public funds" to clear up "confusion among states" with respect to the permissible sources of the non-federal share. 84 Fed. Reg. 63737. But the states are not confused. Congress was clear when it was considering the 1991 legislation that:

> *Current transfers from county or other local teaching hospitals continue to be permissible* if not derived from sources of revenue prohibited under this Act. (House Conference Report, emphasis in the original.)

As CMS itself explained in 1992, in connection with the interim final rule to implement Public Law 102-234:

> 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 States' 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. 57 Fed. Reg. 55119.

CMS reiterated this understanding in 2007, when it published the ''Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership'' final rule. 72 Fed. Reg. 29748.[1] CMS noted "a perceived CMS position that the provisions of the regulation require that the sources of all IGTs must be state or local taxes." 72 Fed. Reg. 29766. To dispel this perception, CMS quoted section 1903(w)(6)(A) of the Act and said this statutory language "allows" (as opposed to requires) funding derived from State or local taxes to be used for purposes of financing the non-Federal share of Medicaid payments. *See id*. CMS went on to acknowledge that units of government that are not health care providers may collect revenue from a variety of sources. CMS included a non-exhaustive list of such sources and noted that any would be "acceptable sources of financing the non-Federal share of Medicaid payments, as long as the general fund does not derive any of its revenue from

[1] This final rule was rescinded in 2010. 75 Fed. Reg. 73972.

impermissible sources (such as 'recycled' Medicaid payments, Federal grants precluded from use as State match, impermissible taxes, non-bona fide provider-related donations)." *Id*.

CMS then addressed governmentally-operated health care providers specifically:

> The governmentally-operated health care provider's account may include patient care revenues from other third-party payers and other revenues similar to those listed above. Such revenues would also be acceptable sources of financing the non-Federal share of Medicaid payments, as long as the governmentally-operated health care provider's operating account does not derive any of its revenue from impermissible sources (such as, ''recycled'' Medicaid payments, Federal grants precluded from use as State match, impermissible taxes, non-bona fide provider-related donations). *Id*.

CMS concluded by saying providers are not required to demonstrate that funds transferred are, in fact, tax revenues; a governmentally-operated health care provider is always able to access tax revenue. *Id*.

Nothing has changed in the statute since the enactment of the 1991 legislation or the implementing regulations to warrant limiting permissible state or local funds that may be considered as the state share to the sources now specified in § 433.51. To the extent the proposed amendment is similar to the 2007 final rule that was later rescinded, the proposal is against the expressed will of Congress. As CMS recounts in this proposed rulemaking, "[a]fter a series of Congressional moratoria against its implementation, Congress stated its sense that it should not be implemented." 84 Fed. Reg. 63737.

If CMS were to impose such a change, there would be serious consequences on the continued ability of many public providers to participate in Medicaid programs that benefit Texas's most vulnerable residents. Some public providers may use patient care revenues as a source of the non-federal share of Medicaid payments. Restricting the source of the non-federal share in the way now proposed leaves public providers with a choice of serving vulnerable populations or raising taxes. HHSC recommends that CMS withdraw the proposed amendments to 42 CFR §433.51 and reaffirm that as long as there is sufficient public revenue for a unit of government to transfer funds for purposes of a Medicaid payment, such a transfer of funds is permitted under the Act.

HHSC also requests that CMS confirm that the non-federal share of certified public expenditures (CPEs) need not be derived from taxes. In discussing the phrase ''transferred from or certified by''

in section 1903(w)(6)(A) of the Act, CMS says the phrase refers to both the intergovernmental transfers (IGTs) and CPEs, respectively. Further, CMS states that the statute "clearly indicates that those funding mechanisms must be derived from state or local taxes (or funds appropriated to state university teaching hospitals)." 84 Fed. Reg. 63736. CMS attempts to make this understanding plain in the revision to § 433.51(b)(2), the subparagraph that refers to IGTs, by adding "derived from State or local taxes (or funds appropriated to State university teaching hospitals)," to the provision. CMS has not added that same language in § 433.51(b)(3), the subparagraph that refers to CPEs; that provision is silent as to the source of CPEs.

HHSC believes it is unreasonable to tie a certified public expenditure to taxes in this context. A CPE is simply a statement from a governmental entity that an expenditure was made. That expenditure, being made by a governmental entity, is by definition public. HHSC requests that CMS confirm that § 433.51(b)(3) does not require that CPEs be derived from taxes.

In summary, HHSC believes the proposed amendments to 42 CFR § 433.51 are inconsistent with statute, legislative intent, and longstanding federal practice. HHSC recommends that CMS withdraw this proposed amendment and reaffirm that "public funds" is the appropriate description of what may constitute the non-federal share of Medicaid payments.

***42 CFR § 433.52 General definitions***

*Comment*

HHSC is concerned that the proposed amendments to this section introduce ambiguity and uncertainty. The relationship between the proposed amendments to 42 CFR §§ 433.54 and 433.68 and the proposed definition of "net effect" in § 433.52 is unclear. Beyond being subjective, the "totality of the circumstances" and "net effect" tests appear to be duplicative. The proposed amendments to §§ 433.54 and 433.68 provide, "Such a 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 provider (or other party or parties responsible for the donation) results in a reasonable expectation that the provider, provider class, or a related entity will receive a return of all or a portion of the donation." However, the proposed definition of "net effect" in 433.52 includes this language: "The net effect of an arrangement is determined in consideration of the totality of the circumstances, including the reasonable expectations of the participating entities…". To the extent CMS decides to retain such language, the State requests clarification regarding the interaction of these two provisions.

The definition of "net effect" includes language indicating that "reciprocal actions" will be considered. To the extent that CMS intends to consider actions among private parties in which neither the state nor local government has played a part, CMS lacks the statutory authority to do so. Please see comments related to § 433.68 for further explanation.

***42 CFR § 433.54 Bona fide donations***

*Comment*

HHSC is concerned that the proposed amendment replaces an objective test (for the existence of a hold harmless arrangement through a direct or indirect guarantee) with one that is subjective. The proposal would amend 42 CFR § 433.54(c)(3) to specify that such a guarantee will be found when "the net effect of an arrangement… results in a reasonable expectation that the provider, provider class, or related entities will receive a return of all or a portion of the donation either directly or indirectly." 84 Fed. Reg. 63739. This language comes from CMS's commentary to the February 2008 final rule titled "Medicaid Program; Health Care-Related Taxes," which introduced the "reasonable expectations" standard, and Departmental Appeals Board (DAB) Opinion No. 2886, Texas Health and Human Services Commission (2018), which introduced the "net effect" standard. If CMS adopts the proposed language, HHSC is concerned that the required analysis will be too subjective and variable to provide certainty as to what constitutes a direct or indirect guarantee. HHSC believes that criteria used to determine when there is an impermissible provider-related donation should be standardized and result in consistent outcomes.

As CMS has proposed amending § 433.54(c)(3), it appears that the new test for finding a hold harmless practice under this prong relates both to direct and indirect guarantees. Unlike the proposed amendment of § 433.68(f)(3) which says "[a] direct guarantee will be found to exist," the proposed amendment of § 433.54(c)(3) says "[s]uch a guarantee will be found to exist." However, it is not clear this is CMS's intention. The portion of the preamble that discusses this change says it applies to direct guarantees. *See* 84 Fed. Reg. 63739. Please clarify if the new language applies to both direct and indirect guarantees.

HHSC believes that the "net effect" standard is not a clarification of existing policy, but rather appears to consider the actions of unrelated third parties. *See* 84 Fed. Reg. 63739. CMS previously explained in its February 2008 final rule that "the element necessary to constitute a direct guarantee is the provision for payment by State statute, regulation, or policy." 73 Fed. Reg. 9694. Under the

proposal, however, CMS might find a direct guarantee based on the wholly private actions of unrelated third parties that are only incidentally related to any state statute, regulation, or policy.

The relationship between the proposed amendments to § 433.54 and the proposed definition of "net effect" in § 433.52 is unclear. The proposed amendments to § 433.54 provide, "Such a 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 provider (or other party or parties responsible for the donation) results in a reasonable expectation that the provider, provider class, or a related entity will receive a return of all or a portion of the donation." However, the proposed definition of "net effect" in 433.52 includes this language: "The net effect of an arrangement is determined in consideration of the totality of the circumstances, including the reasonable expectations of the participating entities…" To the extent CMS decides to retain such language, the State requests that it clarify how these two provisions interact.

***42 CFR § 433.55 Health care-related taxes defined***

*Comment*

HHSC requests that CMS provide examples of what circumstances it would consider in applying the "totality of the circumstances" provision. Such a provision exists throughout the proposal, and it is not clear what may constitute such circumstances. HHSC is concerned that the ambiguity of such a test threatens to introduce uncertainty and will change over time depending on who is applying it. As with several of the provisions in this proposal, HHSC fears the text is so broad and nebulous that it may be costly, if not impossible, to monitor on an ongoing basis, and would make it difficult for states to engage in long-term planning.

***42 CFR § 433.56 Classes of health care services and providers defined***

*Comment*

HHSC supports CMS's proposal to add "health insurer" as a class of health care service as part of 42 CFR § 433.56. However, HHSC recommends that the term be defined not to include life or accident insurance policies. HHSC does not believe CMS intends to include such insurance policies under the "health insurer" class, but would be grateful for clarification.

***42 CFR § 433.68 Permissible health care-related taxes***

*Comment*

CMS proposes two substantial amendments to 42 CFR § 433.68. Proposed amendments to § 433.68(e) create a new "undue burden" standard in the context of health care-related tax waivers. Proposed amendments to § 433.68(f)(3) create a new "net effect" standard for determining if a hold harmless practice exists within the context of a health care-related tax. HHSC believes both amendments are improper. CMS's proposed amendments to 42 CFR § 433.68(f)(3) would add language to one of the three hold harmless tests used for determining the permissibility of a health care-related tax. The tests as they currently read are taken from statute verbatim.

HHSC believes that these proposed amendments are 1) contrary to statute; 2) not merely a clarification; and 3) so subjective that they cannot be implemented.

CMS's Proposal is Inconsistent with the Social Security Act

First, the proposed amendment to 42 CFR § 433.68(f)(3) is not consistent with section 1903(w) of the Social Security Act or its enabling legislation, the Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 (Pub. L. 102-234). In the preamble describing this rule, CMS states that it will find a hold harmless where taxpayers of a health care-related tax redistribute payments among themselves. However, unlike provider-related donations, Congress established specific "hold harmless" tests for provider-related taxes, rather than simply granting the Secretary the authority to do so.

Therefore, CMS is constrained by those sections of Social Security Act. Specifically, CMS is constrained by section 1903(w)(4)(C) of the Act, which provides that there is a hold harmless provision with respect to a broad-based health care related tax if "[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" (emphasis added). Congress specified that the hold harmless standard in § 433.68(f)(3) is tied to government, rather than private, conduct. Consequently, the proposed "net effect" standard, which CMS suggests can result in the denial of federal financial participation (FFP) based on the actions of the private taxpayer, is not supported by 1903(w)(4)(C). As CMS itself notes, Public Law 102-234 was intended to prohibit FFP "for health care-related taxes where *the state* has implemented a hold harmless provision." 73 Fed. Reg. 9690 (emphasis added).

CMS states that proposed § 433.68(f)(3) "aims to thwart efforts by states to skirt hold harmless provisions by paying supplemental payments to private entities, who then pass these funds on to other private entities that have lost gross revenue due to a health care-related tax." 84 Fed. Reg. 63742. However, despite the claim that state efforts or behavior is the problem, CMS states that it is targeting agreements between private parties. CMS appears to arrive at this result by attributing private decisions among private actors to the State and penalizing the State if the private actors' decisions are impermissible according to CMS. This proposed policy seems to assume that States must be involved with such agreements. However, CMS has offered no evidence (anecdotal or otherwise) that the States are part of any agreements between private parties that pay health care-related taxes.

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." *See* § 1903(w)(4)(C). CMS simply does not have the statutory authority to require states to police arrangements between private parties.

However, even if the Social Security Act authorized CMS to implement such a regulation, HHSC believes that the proposed amendment violates established principles of federalism, rooted in the Tenth Amendment to the Constitution and "the belief that issues that are not national in scope or significance are most appropriately addressed by the level of government closest to the people," by requiring states to monitor and regulate relationships between third parties. Executive Order 13132 on Federalism (August 4, 1999). Moreover, neither Congress nor the Executive branch have power to regulate private parties through the states. Where, as here, state governments identify uncertainties regarding the constitutional or statutory authority of the national government, the national government "should be deferential to the States when taking action that affects the policymaking discretion of the States and should act only with the greatest caution." *Id.*

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. If the proposed amendment becomes final, HHSC does not know how it will legally discover, let alone restrict, any private arrangements CMS wants to eliminate.

In light of these uncertainties and the proposed policy's federalism implications, HHSC requests that CMS reconsider the legality and prudence of this part of the proposal.

The "Net Effect" Test is not a Clarification of Existing Policy

Second, CMS says that the "net effect" standard is a clarification of existing policy and would not impose any new obligations or restrictions on the States. 84 Fed. Reg. 63742. HHSC is concerned that this characterization is inaccurate. CMS previously explained in its February 2008 final rule that "the element necessary to constitute a direct guarantee is the provision for payment by State statute, regulation, or policy." 73 Fed. Reg. 9694. Under the proposal, however, CMS can find a direct guarantee based on the actions of third parties, not through the provision for payment by state statute, regulation, or policy.

Further, the claim that the standard represents existing policy is inconsistent with a 2003 HHS Inspector General (IG) report. In 2003, the HHS IG issued a report relating to the Missouri Disproportionate Share Hospital (DSH) program, of which the non-federal share was funded through a health care-related tax. *Review of Medicaid Disproportionate Share Funds Flow in the State of Missouri* (A-07-02-02097) (April 8, 2003). The report found that after the state had made DSH payments to individual hospitals in accordance with federal regulations and the State plan, the hospitals pooled the payments pursuant to private agreements, and a private association distributed the funds according to pooling formulas established by the private association to mitigate the effect of the health care-related tax. *Id.* The redistribution resulted in some hospitals receiving payments in excess of their DSH limits. *Id.* However, the IG determined that the redistribution agreements were voluntary between the hospital providers. Therefore, it could not recommend a disallowance because the federal government did not have the authority to reach such arrangements. *Id.*

In 2008, five years after the IG report was issued, CMS amended the health care-related tax provisions. 73 Fed. Reg. 9685-01. In response to comments on the proposed changes, CMS stated that it was "not aware of any state tax programs that would have been permissible under the Secretary's prior interpretation of the rules but are no longer permissible under the new rules." 73 Fed. Reg. 9690. Accordingly, Missouri hospitals' private agreements would not have been affected by the 2008 amendments. Now, however, CMS appears to believe that the new position announced in November 2019 is and always was the position of CMS. When it comes to the consistent application of the "net effects" standard, it is not possible to reconcile CMS's response to comments in 2008 and the position taken in MFAR.

The New Tests in 42 CFR §433.68 are Subjective, Leaving States in an Impossible Position

Third, HHSC is concerned that both proposed amendments to 42 CFR § 433.68(e) and (f)(3) are subjective and leave states entirely at the mercy of potentially shifting interpretations. If CMS adopts the proposed "undue burden," "net effects," "reasonable expectations," and "totality of the circumstances" language, any analysis of a health care-related tax will be subjective and variable, and HHSC believes there may be almost no certainty with regard to what will be deemed permissible. States must have certainty of, and protection under, the law in order to appropriately and efficiently operate any public program. The criteria used to determine when there is an impermissible health care-related tax should be standardized and result in consistent outcomes.

HHSC is concerned that the "undue burden" test proposed for § 433.68(e) changes what was once a quantitative analysis for health care-related tax waivers and adds an element that may lead to inequitable treatment across states. As discussed previously, the "net effects" test proposed for 42 CFR § 433.68(f)(3) is subjective and will also lead to inequitable treatment across states. HHSC recommends removing the proposed amendments to § 433.68.

In addition, as CMS has proposed amending § 433.68(f)(3), it appears that the new test for finding a hold harmless practice under this prong relates only to direct guarantees. Unlike the proposed amendment of § 433.54(c)(3) which says "[s]uch a guarantee will be found to exist," the proposed amendment of § 433.68(f)(3) says "[a] direct guarantee will be found to exist." However, it is not clear to HHSC whether this is CMS's intention. The portion of the preamble that discusses this change says it applies to both direct and indirect guarantees. *See* 84 Fed. Reg. 63742. HHSC requests that CMS clarify if, to the extent the amendments are adopted, the new language applies to both direct and indirect guarantees.

***42 CFR § 433.72 Waiver provisions applicable to health care-related taxes***

*Comment*

Although HHSC does not operate any health care-related taxes waivers, HHSC is concerned that a three-year renewal period, as proposed in 42 CFR § 433.72, is unnecessary. Such a change could be administratively burdensome and would be without justification. Such formal review and renewal of tax waivers is unnecessary, as the State already has ongoing responsibility to comply with all waivers granted by CMS. If facts have changed such that the previous approval of a tax waiver would be in doubt, a state would already be in discussions with CMS. Creation of tax programs is

highly sensitive and the specter of constant renegotiation provides no security for states or providers that must make such tax payments. HHSC recommends that CMS withdraw the proposed requirement for re-approval of health care-related tax waivers.

***42 CFR § 433.316 When discovery of overpayment occurs and its significance***

*Comment*

HHSC appreciates CMS's attempt to clarify when discovery of an overpayment occurs. However, even after the state submits the DSH independent certified audit report, changes can still occur as a result of litigation or other circumstances beyond the control of the state Medicaid agency. For example, HHSC has experienced litigation affecting the outcome of the audit. In 2013, HHSC was sued by a children's hospital regarding the appropriate calculation of the hospital specific limit. Likewise, CMS was sued by multiple hospitals regarding the same subject. Depending on the outcome of these lawsuits, HHSC might have been in the position of having to recoup payments from providers that would not otherwise be subject to recoupments once the audit report was updated. HHSC recommends that CMS make it clear that discovery of an overpayment will not be triggered if circumstances outside the control of the state Medicaid agency makes recoupments impossible.

***42 CFR § 447.201 State plan requirements***

*Comment*

HHSC has concerns that limiting variation in fee-for-service payment by eligibility category, as proposed in 42 CFR § 447.201, will have serious unanticipated consequences. All Medicaid programs must ensure that access is adequate for its members. Sometimes, a state must adopt higher rates to ensure provision of certain services to some categories of patients. For example, the rate necessary to assure adequate access for a service might be lower for an adult than it would for a child. The same could be true for an individual with intellectual or developmental disabilities. Medicaid programs often provide more complex and costly services to these individuals. However, having the same rate regardless of that important population distinction would necessitate higher rates than a state, or even the federal government, would typically find appropriate. Thus, there is a risk that in attempting to ensure efficiency, economy, and quality of care under the Social Security Act, the proposed amendment could have the opposite impact. The result of this proposed rule would be an unnecessary increase in federal and state spending.

To the extent CMS is concerned about states choosing higher rates solely on the basis on relative FMAPs, HHSC agrees that such a practice should be limited. However, states should be able to determine an appropriate rate for particular populations given the needs of those populations.

***42 CFR § 447.206 Payments funded by certified public expenditures made to providers that are units of government***

*Comment*

HHSC supports CMS's effort to make it clear that payments funded through CPEs must be limited to actual, incurred costs of providing covered services. But, section (b)(4) of the proposed new 42 CFR § 447.206 would require that the certifying entity of the CPE must receive and retain the full amount of FFP. This appears to be inconsistent with Social Security Act section 1902(a)(32) and 42 CFR § 447.10, which permit a Medicaid provider to assign a Medicaid payment to a governmental agency or entity. HHSC recommends removing Section (b)(4) of the proposed rule.

***42 CFR § 447.207 Retention of payments***

*Comment*

Proposed 42 CFR § 447.207 attempts to require that a Medicaid provider retain its Medicaid payments. In determining whether a Medicaid provider is retaining such payments, the proposal says it will consider "associated transactions." Such transactions "may include, but are not necessarily limited to, the payment of an administrative fee to the State for processing provider payments…." Texas suggests clarifying that "associated transactions" would not include an administrative fee to the state for the purpose of enhancing the state's oversight of the Medicaid program.

The preamble states, "Payment arrangements that comply with an exception in section 1902(a)(32) of the Act and the implementing regulation in § 447.10 would not be deemed out of compliance with this proposed provision." 84 Fed. Reg. 63746. The preamble also states, "We have noted circumstances in some states where participation in a Medicaid supplemental payment under the state plan is conditioned upon the state receiving a portion of that payment back…." *Id*. CMS seems to imply that conditioning participation in such a manner is impermissible. CMS's position is wholly inconsistent with the Social Security Act. Section 1902(a)(32)(B) of the Act permits assignment to a government agency. The widely accepted definition of "assignment" is "the transfer of rights or property." *See* Black's Law Dictionary (11th ed. 2019). This broad definition does not

prohibit the assignee from conditioning a thing of value on the assignment (e.g., conditioning a Medicaid supplemental payment on the assignment), and section 1902(a)(32)(B) contains no such requirement. CMS should clarify that a state may condition participation in a Medicaid supplemental payment program on an assignment under 1902(a)(32)(B).

HHSC is attempting to expand its monitoring capabilities for supplemental payments and the sources of the non-federal share. However, to do that, HHSC must pay for that increased administration. By hindering states' abilities to cover that added administrative burden, CMS sets states up for failure. CMS should allow for administrative fees scaled to benefits accrued to providers. A flat fee across a broad class of providers has a deleterious effect on smaller, often struggling, providers. For example, if the state were to charge an application fee of $100 on all hospitals that wish to participate in an upper payment limit (UPL) supplemental payment program, that $100 is far more important to a hospital that would receive a $1,000 UPL payment than a hospital that would receive a $10,000 UPL payment. Limiting Medicaid participation on the part of smaller or struggling providers limits access for patients and encourages provider concentration.

***42 CFR § 447.252 State plan requirements***

*Comment*

HHSC has two concerns regarding the proposed 42 CFR § 447.252, which creates new requirements related to supplemental payments under the state plan. First, HHSC believes the three-year re-approval of state plan-based supplemental payments is unnecessary and ill-advised. There is simply not enough certainty under the proposed rule for states to effectively operate their Medicaid programs while seeking such frequent re-approvals. Additionally, it is not clear why such programs must be re-approved at all. Currently, the federal government has tools to determine if Medicaid programs, including state plan-authorized supplemental payment programs, comply with the law. CMS operates financial management reviews and HHS IG conducts audits.

Second, the proposed monitoring plan is administratively burdensome. States typically create a program in line with the original approvals from CMS. If any changes to those programs are considered, it is part of the normal course of business for a state to compare such changes to the previous CMS approval and, if CMS approval is necessary to implement such changes, request that approval. Accordingly, a plan for ongoing monitoring is unnecessary and burdensome.

Lastly, HHSC is concerned that CMS does not have adequate administrative capacity to review and approve these new SPAs, especially if it intends to thoroughly review monitoring plans and the results of those plans. With this new responsibility, in addition to the proposed tax waiver renewals and the normal course of business, HHSC fears it will be a challenge for CMS to timely review these submissions. These administrative capacity issues could indirectly impact review of state submissions that are not otherwise related to these new rules. HHSC requests that CMS remove the required re-approvals of state plan-based supplemental payments and monitoring plans.

***42 CFR § 447.272 Inpatient services: Application of upper payment limits***

*Comment*

HHSC agrees with CMS's attempts to limit wasteful spending but is concerned that the description of UPLs contained in 42 CFR § 447.272 will have a detrimental impact on a key eligibility group in Medicaid: children. In large part, Medicare and Medicaid cover different populations. One of the largest populations covered by Medicaid is children. In Texas, roughly 62% of the more than 4,000,000 Medicaid clients are under the age of 14. Medicare is a program largely developed for those over the age of 65. The needs, costs, and expectations of the two programs are not aligned. In determining UPLs, HHSC requests that CMS consider the significant amount of care provided to children in Medicaid.

***42 CFR § 447.284 Basis and purpose***

*Comment*

HHSC requests clarification of the limitations of new Subpart D as described in this section. The text of the proposal seems to set out requirements for supplemental payments made under the state plan. However, the preamble's use of the term "supplemental payment" seems as though it can apply to both payments made through Section 1115 Waiver authority and even some managed care payments, in addition to the state plan. *See* 84 Fed. Reg. 63726. HHSC requests that CMS clarify that the requirements described in new Subpart D apply only to supplemental payments authorized through the state plan.

***42 CFR § 447.286 Definitions***

*Comment*

HHSC is concerned that the proposed definitions in proposed 42 CFR § 447.286 are vague and unduly burdensome. First, CMS seeks to define "supplemental payment" and distinguish it from "base payment." Unfortunately, it is not clear to HHSC how some payments would be categorized. CMS states in the definition that such payments "cannot be attributed to a particular provider claim for specific services provided to an individual beneficiary and are often made to the provider in a lump sum." HHSC fears that this proposed change unnecessarily introduces subjectivity and uncertainty.

For example, CMS states in the preamble that it is possible for certain managed care payments to be considered supplemental payments. HHSC agrees that pass-through payments described in 42 CFR § 438.6(d) could be considered supplemental payments. However, directed payment programs under § 438.6(c) are put in question by the proposal. All such payments are to be paid out based on Medicaid utilization, so they can be tied to services provided to an individual beneficiary. In addition, it is possible for directed payments to be made in a lump sum. HHSC requests that CMS confirm that pass-through payments described in § 438.6(d) are the only form of managed care payment that would be considered a "supplemental payment" for purposes of the proposed rule.

Second, CMS defines state and non-state government provider. HHSC is concerned that this change, too, introduces unnecessary subjectivity and uncertainty. With the exception of reporting the results of UPL demonstrations, states are traditionally relied upon to determine ownership of various health care entities. States should continue to be the entities making such determinations. In addition, CMS extends to this section the inconsistencies related to the non-federal share that HHSC has pointed out in 42 CFR § 433.51 on state share of financial participation. The proposed changes will only increase the administrative burden on states and leave states unsure as to how categorize many providers.

***42 CFR § 447.288 Reporting requirements for upper payment limit demonstrations and supplemental payments***

*Comment*

Regarding the proposed reporting requirements for supplemental payments in 42 CFR § 447.288, as previously stated, HHSC fully supports efforts to increase transparency of these payments. HHSC is

taking steps itself to make information about such payments more broadly accessible to the public on an ongoing basis.

However, HHSC has two suggestions regarding the proposal. First, HHSC does not believe reporting should be necessary more than annually. It is not clear to HHSC what benefit the public derives through quarterly reporting. Second, HHSC suggests removing the requirement that a physical address be included in the report. Given the fluid nature of provider identification numbers in relation to physical address, such information is not possible to report.

Additionally, HHSC does not act as an intermediary between providers and the Medicaid managed care organizations regarding their specific payment arrangements, except in certain circumstances as permitted under 42 CFR § 438.6(c). As such, HHSC does not believe that payments to providers made by a Medicaid managed care organization should be subject to the upper payment limit demonstration, as the provider payments made by the Medicaid managed care organization are presumed to be, as already required under §1902(a)(30)(A) of the Act, "consistent with efficiency, economy, and quality of care" and "sufficient to enlist enough providers."

***42 CFR § 447.290 Failure to report required information***

*Comment*

While HHSC supports generally the proposed reporting requirements for supplemental payments, it believes that the proposed penalty for failure to report is not consistent with the Social Security Act or existing CMS regulations.

CMS proposes in 42 CFR § 447.290(b) to reduce future grant awards through deferral if a state fails to timely, completely, and accurately report information required under 42 CFR § 447.288. Under proposed § 447.290(b), a grant award can be reduced by the amount of FFP that CMS estimates to be attributable to payments made to the provider(s) as to which the state has not reported properly. CMS gives itself authority to defer FFP even if a state submits the required report but the report fails to comply with applicable requirements. According to CMS, "[o]therwise allowable FFP for expenditures deferred in accordance with this proposed section would be released when we determine that the state has complied with all reporting requirements under proposed § 447.288." *See* 84 Fed. Reg. at 63758.

CMS says the proposed deferral under § 447.290(b) will be in accordance with 42 CFR § 430.40, but § 447.290(b) as proposed is inconsistent with § 430.40. First, § 430.40 authorizes deferred

payments only when CMS questions the allowability of the claimed expenditure and needs additional information to resolve the question; the regulation does not allow deferral as a result of noncompliance with CMS regulations (e.g., noncompliance with § 477.288). Additionally, and contrary to § 447.290(b) as proposed, a deferral pursuant to § 430.40 is not indefinite. Generally, funds may be deferred for 90 days, at which point CMS must either release the funds or take a disallowance (and provide appeal rights to the State). *See* 42 CFR § 430.40(c)(5)-(6).

Finally, CMS should not finalize § 447.290(b) as proposed because it already has the authority to impose a remedy for noncompliance with CMS regulations. The proper remedy for noncompliance with CMS regulations is section 1904 of the Social Security Act, which provides that CMS may only withhold funds "after reasonable notice and hearing to the state agency." Given the foregoing, the penalty for failing to comply with the proposed reporting requirements should be consistent with the notice and hearing requirements of section 1904.

***42 CFR § 447.297 Limitations on aggregate payments for disproportionate share hospitals beginning October 1, 1992***

*Comment*

HHSC requests that CMS adopt no proposed changes to 42 CFR § 447.297 in order to avoid inadvertently hindering states' ability to operate their programs. First, for planning purposes, it is extremely helpful for a state to know by a date certain what the DSH allotment will be for that state. For example, HHSC takes the DSH allotments into account when determining the appropriate amount of funds for other supplemental and directed payment programs. If DSH allotment dates were to slip, it is difficult for states to adjust payment timelines, which have become quite complex. It is rare for HHSC to have an open space in its supplemental and directed payment calendar due to limited administrative capacity.

Second, HHSC objects to removing the requirement that the DSH allotments be posted in the Federal Register. Nothing prevents CMS from posting the allotments in whatever electronic format it believes would be widely accessible. However, from the standpoint of continued reliability, the Federal Register is a known, regularly published source of information that can only be updated through later publicly released issues, and accordingly provides a reliable, permanent public record. Therefore, HHSC would recommend continuing to require posting of the DSH allotment in the Federal Register in addition to any other online source CMS finds appropriate.

***42 CFR § 447.299 Reporting requirements***

*Comment*

Auditors have noted that state Medicaid agencies, including HHSC, do not have access to out-of-state payment information. This has the potential to hinder the determination of the financial impact of audit findings. Will CMS require Medicaid agencies to provide out-of-state payment information to auditors of other states? If so, how will such a requirement be implemented to allow for other states to access each other's Medicaid Management Information System (MMIS)?

In addition, HHSC has no general concern with the proposed timelines for collection of overpayments and issuance of redistributions. However, there are sometimes issues outside the control of the state. For instance, as discussed in our comment on 42 CFR § 433.316, HHSC has experience with litigation that resulted in the state not collecting overpayments and issuing redistributions as that litigation directly impacted such actions. HHSC requests that CMS make allowance in rule for issues outside of state government control, such as litigation.

***42 CFR § 447.302 State plan requirements***

*Comment*

HHSC has the same concerns with proposed 42 CFR § 447.302, which creates new requirements related to supplemental payments under the state plan, as it does with 42 CFR § 447.252. First, HHSC believes the three-year re-approval of state plan-based supplemental payments is unnecessary and ill-advised. There is simply not enough certainty under the proposed rule for states to effectively operate their Medicaid programs while seeking such frequent re-approvals. Additionally, it is not clear why such programs must be re-approved at all. Currently, the federal government has tools to determine if Medicaid programs, including state plan-authorized supplemental payment programs, comply with the law. CMS operates financial management reviews and HHS IG conducts audits.

Second, the proposed monitoring plan is administratively burdensome. States typically create a program in line with the original approvals from CMS. If any changes to those programs are considered, it is part of the normal course of business for a state to compare such changes to the previous CMS approval and, if CMS approval is necessary to implement such changes, request that approval. Accordingly, a plan for ongoing monitoring is unnecessary and burdensome.

Lastly, HHSC is concerned that CMS does not have adequate administrative capacity to review and approve these new SPAs, especially if it intends to thoroughly review monitoring plans and the results of those plans. With this new responsibility, in addition to the proposed tax waiver renewals and the normal course of business, HHSC fears it will be a challenge for CMS to timely review these submissions. These administrative capacity issues could indirectly impact review of state submissions that are not otherwise related to these new rules. HHSC requests that CMS remove the required re-approvals of state plan-based supplemental payments and monitoring plans.

***42 CFR § 447.321 Outpatient hospital services: Application of upper payment limits***

*Comment*

HHSC shares the same concerns with proposed 42 CFR § 447.321 as it did with 42 CFR § 447.272. HHSC agrees with CMS's attempts to limit wasteful spending but is concerned that the description of UPLs contained in § 447.321 will have a detrimental impact on a key eligibility group in Medicaid: children. In large part, Medicare and Medicaid cover different populations. One of the largest populations covered by Medicaid is children. In Texas, roughly 62% of the more than 4,000,000 Medicaid clients are under the age of 14. Medicare is a program largely developed for those over the age of 65. The needs, costs, and expectations of the two programs are not aligned. In determining UPLs, HHSC requests that CMS consider the significant amount of care provided to children in Medicaid.

***42 CFR § 447.406 Medicaid practitioner supplemental payment***

*Comment*

Although HHSC does not currently operate any programs that would be impacted by the cap on Medicaid practitioner supplemental payments proposed by 42 CFR § 447.406, HHSC does not understand why a cap is necessary, particularly the one described in the proposed rule. In general, payments must currently be consistent with efficiency, economy, and quality of care. HHSC believes that further limits beyond those laid out in statute are unnecessary.

***42 CFR § 455.301 Definitions***

*Comment*

As noted above in comments on 42 CFR § 447.299, auditors have noted that state Medicaid agencies, including HHSC, do not have access to out-of-state payment information to determine the

financial impact of a finding related to such payments. The DSH audit rule preamble states that "(w)hen the State has the most central and current information through its MMIS (for example, data on Medicaid payments in State fee-for-service inpatient hospital, outpatient hospital and DSH payments) that system will be the best source of the information." HHSC requests that CMS clarify whether it will require Medicaid agencies to provide out-of-state payment information to auditors of other states. HHSC also requests clarification regarding how such a requirement may be implemented to allow for other states to access each other's MMIS.

***42 CFR § 457.609 Process and calculation of State allotments for a fiscal year after FY 2008***

*Comment*

While HHSC appreciates CMS's attempt to find user-friendly means of disseminating information, the CHIP allotments should officially be posted in the Federal Register. Nothing prevents CMS from posting the allotments in whatever electronic format it believes would be widely accessible. However, from the standpoint of continued reliability, the Federal Register is a known, regularly published source of information that can only be updated through later publicly released issues. As such, HHSC would recommend posting the CHIP allotment in the Federal Register in addition to any other online source CMS finds appropriate.

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE EASTERN DISTRICT OF TEXAS**
**TYLER DIVISION**

| | |
|---|---|
| STATE OF TEXAS; TEXAS HEALTH AND HUMAN SERVICES COMMISSION,<br>*Plaintiffs*,<br><br>v.<br><br>CHIQUITA BROOKS-LASURE, in her official capacity as Administrator for the Centers for Medicare and Medicaid Services; THE CENTERS FOR MEDICARE AND MEDICAID SERVICES; XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; and the UNITED STATES OF AMERICA,<br>*Defendants*. | Civ. Action No. 6:23-cv-00161-JDK |

**PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION**

**Exhibit F**

**Letter from Matthew Odom, Assistant Regional Inspector General for Audit Services, to Cecile E. Young, Executive Commissioner (Mar. 3, 2023)**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDIT SERVICES, REGION VI
1100 COMMERCE STREET, ROOM 632
DALLAS, TX 75242

March 3, 2023

Report Number: A-06-23-04005

Cecile E. Young
Executive Commissioner
Texas Health and Human Services Commission
4601 W Guadalupe St.
Austin, TX 78751

Dear Ms. Young:

The purpose of this letter is to notify you of our intention to conduct an additional audit of Audit of Amarillo County, Tarrant County and Webb County Local Provider Participation Funds as Texas' State Share of Medicaid Payments. The objective of our audit is to determine whether the State agency adhered to the hold-harmless provisions in Federal regulations.

As a recipient of U.S. Department of Health and Human Services (HHS) grant funds, (the State Medicaid agency) is subject to Office of Inspector General (OIG) audits and other reviews. Pursuant to 45 CFR § 92.42(e), OIG has the right to timely and unrestricted access to all books, documents, papers, or other records that are pertinent to the Federal grant award.

OIG performs independent reviews of HHS programs and operations pursuant to the Inspector General Act of 1978, 5 U.S.C. App. § 4(a)(l). Medicaid providers of services, under the authority contained in section 1902(a)(27) of the Social Security Act, must provide such information as the Secretary of HHS or the appropriate State agency requests regarding payments claimed for services.

When transmitting any audit information to the Office of Audit Services over the Internet, please properly safeguard the information. We request that you use the HHS/OIG Delivery Server, not email or attachments to email. Information transmitted through the HHS/OIG Delivery Server complies with Federal Information Processing Standard (FIPS) 140-2, *Security*

*Requirements for Cryptographic Modules.* We are required to report as a security breach any audit information sent to us that does not meet FIPS 140-2 requirements.

This audit will be performed under my direction and a member of my staff will coordinate with your team to arrange an entrance conference on March 6, 2023.

If you have any questions or concerns about our review, please contact, me at Matthew.Odom@oig.hhs.gov or Tony Rawlins, Senior Auditor, at Tony.Rawlins@oig.hhs.gov. Please refer to report number A-06-23-04005 on all correspondence. Thank you for your attention to this matter.

Sincerely,

MATTHEW ODOM Digitally signed by MATTHEW ODOM Date: 2023.03.03 08:55:41 -06'00'

**Matthew Odom**
Assistant Regional
Inspector General
for Audit Services

**April 14, 2023 | Press Release | Health Care (/news/categories/health-care)**

# Paxton Sues Biden Admin to Safeguard Texas's Medicaid Program



Attorney General Paxton filed a lawsuit against the Centers for Medicare and Medicaid Services ("CMS") and the U.S. Department of Health and Human Services ("HHS") challenging a federal bulletin that threatens the integrity of Texas's Medicaid program and the nearly five million citizens that it serves by imposing requirements that are neither authorized by statute nor required by existing regulations. Attorney General Paxton also filed a motion for preliminary injunction to halt CMS's efforts.

> "CMS's actions imperil not only local governments' ability to support Medicaid providers in their area, but the entire State of Texas's ability to adequately fund its Medicaid program," said Attorney General Paxton. "This unlawful policy change will endanger vulnerable Texans' access to health care and handicap local providers' ability to serve our citizens in every community across the state. The consequences of CMS's actions are both staggering and devastating. It is yet another disastrous, illegal federal policy from the Biden Administration, but we are fighting back. Despite the current Administration's inconsistency on the topic, the courts have handed Texas decisive victories on this issue previously and the law is clear: Local Provider Participation Funds are not unlawful hold harmless arrangements."

Texas's Medicaid program is funded jointly by both the state and the federal government. Local governments may also participate by providing funding to the State to enable their citizens' access to health care, regardless of income level. Additionally, since 2013 and with CMS's authorization, Texas has allowed local governments to administer Local Provider Participation Funds ("LPPFs"). Biden's CMS attempted to rescind authorization of Texas Medicaid's use of LPPFs in 2021, but the court issued a preliminary injunction against this effort.

LPPFs involve local governments collecting a mandatory assessment from healthcare providers and then transferring that money to the state to help finance Texas's share of non-federal funding for Medicaid. Such arrangements are expressly permitted by federal law.

Federal law, however, outlaws hold harmless arrangements, which are agreements between a government and a health care provider through which the government guarantees that the provider will receive its total tax payment back through Medicaid payments. CMS recently issued an unlawful

informational bulletin that would arbitrarily categorize purely private contracts involving entities that pay taxes into an LPPF as prohibited hold harmless arrangements. Nothing in federal law prohibits purely private contracts of this sort.

Though the Texas Health and Human Services Commission ("HHSC") lacks the power to do so, CMS announced in the bulletin that it intended to require HHSC to provide information regarding these private "hold harmless arrangements" as a condition for receiving federal funding, jeopardizing potentially billions of dollars to which Texas's Medicaid program is entitled. The changes are a stark departure from CMS's previous policy and represent an unprecedented expansion of the entity's authority.

To read the full complaint, click here (https://www.texasattorneygeneral.gov/sites/default/files/images/press/Complaint_0.pdf).

To read the motion for preliminary injunction, click here (https://www.texasattorneygeneral.gov/sites/default/files/images/press/Motion%20for%20Preliminary%20Injunction_0



## Related News

### Paxton Sues Biden's Department of Health and Human Services to Prevent the WHO from Exerting Alarming Authority Over the United States (/news/releases/paxton-sues-bidens-department-health-and-human-services-prevent-who-exerting-alarming-authority-over)

Attorney General Paxton, along with the State of Oklahoma, is suing the U.S. Department of Health and Human Services ("HHS") to remove an illegal regulation from federal law that cedes our sovereignty to the World Health Organization ("WHO").
**January 18, 2023 | Press Release**

### Paxton Petitions Federal Government to Reverse Unlawful and Destructive Vaccine Mandate (/news/releases/paxton-petitions-federal-government-reverse-unlawful-and-destructive-vaccine-mandate)

Attorney General Paxton has joined a multistate petition sent to the Centers for Medicare & Medicaid Services (CMS) and the Department of Health and Human Services (HHS) opposing the draconian federal health care systems vaccine mandate.
**December 20, 2022 | Press Release**

### Paxton Expands Investigation into Companies Denying Parents and Guardians Access to Their Children's Medical Records (/news/releases/paxton-expands-investigation-companies-denying-parents-and-guardians-access-their-childrens-medical)

Attorney General Paxton has announced that he is expanding the scope of his investigation into hospitals and corporations that are denying parents the ability to access the medicals records of their children by issuing a Civil Investigative Demand ("CID") to Epic Systems Corporation.
**November 17, 2022 | Press Release**

See all News (/news)

Back to Top

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE EASTERN DISTRICT OF TEXAS**
**TYLER DIVISION**

| | |
|---|---|
| STATE OF TEXAS; TEXAS HEALTH AND HUMAN SERVICES COMMISSION,<br>*Plaintiffs*,<br><br>v.<br><br>CHIQUITA BROOKS-LASURE, in her official capacity as Administrator for the Centers for Medicare and Medicaid Services; THE CENTERS FOR MEDICARE AND MEDICAID SERVICES; XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; and the UNITED STATES OF AMERICA,<br>*Defendants*. | Case No. 6:23-cv-00161-JDK |

**PLAINTIFFS' UNOPPOSED MOTION TO SET HEARING**

Plaintiffs respectfully request that this Court schedule an in-person hearing on the Plaintiffs' pending Motion for Preliminary Injunction as soon as the issue is fully briefed. *See* Docket No. 10. The parties conferred on this motion on April 26, 2023. Defendants are unopposed.

1. Plaintiffs anticipate that briefing on their Motion for Preliminary Injunction will be complete no later than May 26, 2023. *See* Docket No. 14 (granting defendants' request for extension to file a response until May 12); Local Rule CV-7(f) (schedule for replies and sur-replies).

2. Plaintiffs' motion raises complex issues related to the recent history of Texas's Medicaid program, how the Medicaid program is funded, and new sub-regulatory guidance issued by the Centers for Medicare and Medicaid Services (CMS) that threatens to reduce or eliminate essential federal financial participation funds for Texas's Medicaid program, impacting Texas, Medicaid providers, and Medicaid patients.

3. Under Local Civil Rule 7(g), parties may specifically request an oral hearing.

4. Given the complexity, breadth, and gravity of the statutory and regulatory issues involved, oral argument is likely to assist the Court in its resolution of the motion.

5. Plaintiffs request the Court set a hearing at its earliest convenience following the completion of briefing on the motion. The parties have conferred regarding dates of availability. Counsel for Plaintiffs and Defendants are available on May 24 or 25. Counsel for Plaintiffs and Defendants are also available any day during the weeks of May 29 and June 5 (excluding Memorial Day). Counsel for Defendants is unavailable the week of June 12.

6. As indicated in the Certificate of Conference, this motion is unopposed.

Dated: April 26, 2023.

Respectfully submitted.

KEN PAXTON
Attorney General of Texas

BRENT WEBSTER
First Assistant Attorney General

CHRISTOPHER H. HILTON
Chief, General Litigation Division
Tex. State Bar No. 24087727
Christopher.Hilton@oag.texas.gov

LEIF A. OLSON
Chief, Special Litigation Division
Tex. State Bar No. 24032801
Leif.Olson@oag.texas.gov

MUNERA AL-FUHAID
Special Counsel
Tex. State Bar No. 24094501
Munera.Al-Fuhaid@oag.texas.gov

OFFICE OF THE ATTORNEY GENERAL
P.O. Box 12548 (MC-059)
Austin, Texas 78711-2548
(512) 936-1700

JUDD E. STONE II
Solicitor General

*/s/ Lanora C. Pettit*
LANORA C. PETTIT
Principal Deputy Solicitor General
*Lead Counsel*
Texas Bar No. 24115221
Lanora.Pettit@oag.texas.gov

MICHAEL R. ABRAMS
Assistant Solicitor General
Texas Bar No. 24087072
Michael.Abrams@oag.texas.gov

WILLIAM F. COLE
Assistant Solicitor General
Texas Bar No. 24124187
William.Cole@oag.texas.gov

*Counsel for Plaintiffs*

## CERTIFICATE OF CONFERENCE

On April 25 and 26, 2023, counsel for plaintiffs, Lanora Pettit and Michael Abrams, conferred by email with James Bickford, counsel for defendants, regarding plaintiffs' intention to file this motion. Defendants are unopposed to the relief requested herein.

*/s/ Lanora C. Pettit*
Lanora C. Pettit
Principal Deputy Solicitor General

## CERTIFICATE OF SERVICE

I certify that a true and accurate copy of the foregoing document was filed electronically (via CM/ECF) on April 26, 2023.

*/s/ Lanora C. Pettit*
Lanora C. Pettit
Principal Deputy Solicitor General

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE EASTERN DISTRICT OF TEXAS**
**TYLER DIVISION**

| | | |
|---|---|---|
| **STATE OF TEXAS**, *et al.*, | ) | |
| | ) | |
| Plaintiffs, | ) | |
| | ) | |
| v. | ) | Case No. 6:23-cv-161 (JDK) |
| | ) | |
| **CHIQUITA BROOKS-LASURE**, *et al.*, | ) | |
| | ) | |
| Defendants. | ) | |
| | ) | |

**DEFENDANTS' MEMORANDUM IN OPPOSITION TO PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION**

**TABLE OF CONTENTS**

## TABLE OF AUTHORITIES

### CASES

**STATUTES**



**REGULATIONS**

**OTHER AUTHORITIES**

## INTRODUCTION

The Medicaid program is a jointly-funded partnership between states and the federal government, which share responsibility for medical care for low-income communities. The federal government matches certain state expenditures for medical assistance. The Medicaid statute and regulations place certain restrictions on the sources of state funds that qualify for a federal match, to ensure that states themselves are making meaningful contributions to expenditures under the program. Some of those restrictions apply when state or local governments tax health care providers. As relevant here, if health care providers are taxed, the tax must generally be broad-based and uniform, and it may not hold any provider harmless—*i.e.*, a provider cannot be assured that it will recoup its tax contributions. These rules ensure that when a state taxes health care providers, the revenue raised can meaningfully be considered state revenue—rather than simply functioning to pass dollars from health care providers to the state government, which then returns those dollars (and some more) back to the provider after the state receives a generous federal match. Without such a restriction, a substantial portion of federal Medicaid funds could be collected by states effectively providing no funding of their own, but only collecting taxes from providers in order to qualify for a federal match, and then returning the tax proceeds to the same providers. Such arrangements are clearly prohibited by statute.

For years, Texas has disputed the federal government's view that this statute, 42 U.S.C. § 1396b(w)(4), and its implementing regulations, 42 C.F.R. § 433.68(f), do not authorize federal funding when states tax hospitals that enter into collusive hold-harmless agreements amongst themselves. For example, if a county taxes its hospitals to fund additional Medicaid payments, and the hospitals that serve Medicaid beneficiaries use those payments to reimburse the hospitals that do not—which might seem attractive to Medicaid-reliant hospitals facing political opposition

to the taxes—the state may not collect federal matching funds on the basis of the county taxes. Earlier this year, in an informational bulletin published by the Centers for Medicare & Medicaid Services (CMS), the federal government "reiterate[d]" its "longstanding position" that state or local taxes featuring such arrangements are inconsistent with "the existing federal requirements."[1] The agency had said as much in the Federal Register in 2019. 84 Fed. Reg. 63,722, 63,734 (Nov. 18, 2019) (explaining that these arrangements "are inconsistent with existing statutory and regulatory requirements"). And the federal government explained its view again when Texas filed suit in this Court on a separate issue. *See Texas v. Brooks-LaSure*, 6:21-cv-191, 2022 WL 741065, at *9 (E.D. Tex. Mar. 11, 2022) (describing the agency's statutory interpretation). Yet Texas now seeks a preliminary injunction, arguing that the recent affirmation of the federal government's position is causing the State irreparable harm. This Court should deny the motion.

## BACKGROUND

### A. Statutory and Regulatory Background

#### i. The Medicaid Program

"Medicaid, established under Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq.*, is a 'cooperative federal-state program that provides federal funding for state medical services to the poor.'" *NB ex rel. Peacock v. District of Columbia*, 794 F.3d 31, 35 (D.C. Cir. 2015) (quoting *Frew ex rel. Frew v. Hawkins*, 540 U.S. 431, 433 (2004)). "The federal government and the states jointly finance the program, and the states administer it." *Louisiana v. HHS*, 905 F.2d 877, 878 (5th Cir. 1990). "States electing to participate in the program must comply with certain

[1] CMCS Informational Bulletin, "Health Care-Related Taxes and Hold Harmless Arrangements Involving the Redistribution of Medicaid Payments," at 1 (Feb. 17, 2023) ("Bulletin"), *available at* https://www.medicaid.gov/federal-policy-guidance/downloads/cib021723.pdf.

requirements imposed by the Act and regulations of the Secretary of Health and Human [Services]." *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 586 (5th Cir. 2004).

The Medicaid statute and regulations leave participating states with considerable discretion to design their own programs. Those choices are memorialized in the State plan. 42 U.S.C. § 1396a; 42 C.F.R. § 430.10. Each participating state must cover certain individuals, and may cover others if it chooses. 42 U.S.C. § 1396a(a)(10); 42 C.F.R. Part 435. Some benefits are mandatory, but others are optional. *Id.* §§ 1396a(a)(10)(A), 1396d(a). A state can set rates and pay doctors and hospitals directly for their services, *see id.* § 1396a(a)(23)(A), or it can pay managed care organizations to cover Medicaid beneficiaries, *see id.* § 1396b(m)(2)(A)(iii). In a managed care program, states can also direct increased payments to selected hospitals or other health care providers through "state-directed payments." *See* 42 C.F.R. § 438.6(c). Finally, states may request that the Secretary approve an "experimental, pilot, or demonstration project" and "waive compliance with" certain programmatic requirements. 42 U.S.C. § 1315.

Medical assistance expenditures made under a State plan are matched with federal funds according to a statutory formula. Those funds are known as "federal financial participation," or "FFP," and the rate at which they are provided is the "federal medical assistance percentage," or "FMAP." The FMAP varies from 50% to 83% according to each state's per capita income. *Id.* § 1396d(b). Approximately 60% of Texas's medical assistance expenditures are currently reimbursed by the federal government. The remainder must be covered by state funds.

The Medicaid statute allows states to raise their own funds in many different ways. In the early days of the program, that discretion was unfettered—and ultimately abused. States discovered that they could raise money selectively from hospitals serving a large share of Medicaid beneficiaries, receive federal matching funds, and then pay those same hospitals more than was

originally collected from them. In effect, this scheme allowed states to claim federal Medicaid funds without contributing any state funds, because no entity within the state ultimately bore the funding burden. By raising money in that way, states violated a fundamental premise of the Medicaid program: that federal matching funds are only provided when states are willing to spend their own money too.

There were two parts to this scheme: raising funds selectively, and then making payments to the hospitals that provided them. The chief vehicle for the selective payments was the Medicaid disproportionate share hospital (DSH) adjustment, which allows states to pay higher rates to hospitals serving a disproportionate number of low-income patients. At the time, there was no cap on DSH payment adjustments, which could be as large as a state chose. States had several ways to raise money from the hospitals that would then receive those payments. Some accepted donations from the hospitals. Others imposed selective taxes on them, or imposed taxes on all hospitals but agreed that the hospitals would be held harmless—*i.e.*, would receive their taxes back. Beginning in the mid-1980s, these arrangements spread rapidly.[2]

**ii. The Medicaid Voluntary Contribution & Provider-Specific Tax Amendments**

In the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, Pub. L. No. 102-234, 105 Stat. 1793, Congress put an end to this scheme. DSH payment adjustments were capped. *Id.* § 3, 105 Stat. 1799–1804. States remained free to accept donations from health care providers, but they would generally be deducted from a state's medical assistance expenditures and no longer matched with any federal funds. 42 U.S.C. § 1396b(w)(1)(A)(i).

[2] For discussions of this history, *see Protestant Mem'l Med. Ctr., Inc. v. Maram*, 471 F.3d 724, 726 (7th Cir. 2006); *Ashley Cnty. Med. Ctr. v. Thompson*, 205 F. Supp. 2d 1026, 1029–32 (E.D. Ark. 2002); Cong. Rsch. Serv., *Medicaid Provider Taxes* at 2 (Aug. 5, 2016), *available at* https://crsreports.congress.gov/product/pdf/RS/RS22843.

Proceeds from taxes imposed on providers would be similarly deducted unless they were broad-based and free of any hold-harmless arrangement. *Id.* § 1396b (w)(1)(A)(ii)–(iii). (The requirement of a broad base could be waived if the tax was "generally redistributive," among other things. *Id.* § 1396b (w)(3)(E)(ii)(I).) The statute provided three definitions of a hold harmless arrangement:

> (A) The State or other unit of government imposing the tax provides (directly or indirectly) for a payment (other than under this title) to taxpayers and the amount of such payment is positively correlated either to the amount of such tax or to the difference between the amount of the tax and the amount of payment under the State plan.
>
> (B) All or any portion of the payment made under this title to the taxpayer varies based only upon the amount of the total tax paid.
>
> (C) 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.[3]

Pub. L. No. 102-234, § 2(a), 105 Stat. 1797, *codified at* 42 U.S.C. § 1396b(w)(4) (1994).

**iii. Implementing Regulations**

**a. 1992 Interim Final Rule and 1993 Final Rule**

The statute authorized the Secretary to issue an interim rule, Pub. L. No. 102-234, § 5(a), 105 Stat. 1804, which he did. 57 Fed. Reg. 55,118 (Nov. 24, 1992). The regulatory definition of a hold harmless arrangement was codified at 42 C.F.R. § 433.68(f), and included a statistical test for indirect guarantees, *id.* § 433.68(f)(3). The rule explained that:

> 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.

[3] This subparagraph is now codified as 42 U.S.C. § 1396b(w)(4)(C)(i).

57 Fed. Reg. at 55,129. The "restraint" discussed in that last sentence is what was absent from some earlier funding arrangements: the requirement that states only receive federal matching funds if they are also willing to spend their own money on a given expenditure. CMS emphasized that the "use of any state payment . . . 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." *Id.*

The rule also discussed a second purpose behind the recent enactment: to ensure that the burden of health care related taxes is equitably borne by hospitals and other providers that serve fewer Medicaid beneficiaries. The rule explained that hold harmless arrangements contravene the statutory intent "to preclude use of revenues derived from taxes imposed primarily on Medicaid providers and activities."[4] CMS sought comment on the interim rule and published a final rule the following year. 58 Fed. Reg. 43,156 (Aug. 13, 1993). There were no changes relevant here.

In 2001, CMS concluded that five states had been collecting health care related taxes that featured a hold harmless arrangement. Those states taxed nursing facilities, which passed the tax burden along to their private patients; then the states provided grants or tax credits to the private patients, to effectively indemnify them against the rate increases. Said differently, the state grants or tax credits to private patients of the nursing facilities ensured that those facilities would be repaid for the taxes imposed, by passing the tax burden to their private patients. CMS disallowed federal matching funds on the basis of those taxes, and the states appealed to the Departmental

[4] 57 Fed. Reg. at 55,128. Although the Secretary can waive the requirement that a health care related tax be broad-based if the tax is "generally redistributive," 42 U.S.C. § 1396b(w)(3)(E)(ii)(I), that "waiver provision" was not intended "to provide States with the ability to design programs in which the tax burden is shifted significantly to Medicaid providers or activities." 57 Fed. Reg. at 55,128–29. With that understanding, the rule defined "generally redistributive" through formulas meant to ensure that any non-broad-based "tax is imposed more heavily on providers with low Medicaid utilization than high Medicaid providers." *Id.* at 55,128.

Appeals Board (DAB), which has the authority to hear such disputes.[5] As relevant here, the Board concluded that this taxing scheme did not guarantee to hold the taxpayers harmless. *In re: Hawaii Dep't of Human Servs.*, 2005 WL 1540188 (DAB June 24, 2005).

**b. 2008 Rule**

CMS revised its hold harmless regulations in 2008, to make clear that the Board's conclusion was in error (among other purposes). 73 Fed. Reg. 9,685 (Feb. 22, 2008). The revised regulations provide that:

> A taxpayer will be considered to be held harmless under a tax program if any of the following conditions applies:
>
> (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.
>
> (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.
>
> (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.

42 C.F.R. § 433.68(f).

The 2008 rule again explained the dual purposes behind the prohibition on hold harmless arrangements: to ensure that states meaningfully fund Medicaid expenditures, but not by placing inequitable tax burdens on the hospitals that serve the most Medicaid beneficiaries. On the one hand, "[t]he Federal statute and implementing regulations were designed to **protect Medicaid**

[5] Adverse decisions by the Board are binding on CMS, but a state may seek further review in district court. *See* 42 U.S.C. § 1316(e).

**providers** from being unduly burdened by health care related tax programs." 73 Fed. Reg. at 9,685 (emphasis added). "Health care related tax programs that are compliant with the requirements set forth by the Congress" must therefore "create a significant tax burden for health care providers that do not participate in the Medicaid program or that provide limited services to Medicaid individuals." *Id.* And on the other hand, "[t]he statutory provisions, and [implementing] regulations, are a response to States that imposed health care related taxes that had the effect of **shifting financial burdens from the States to the federal government**." *Id.* at 9,688 (emphasis added). "This shift resulted from hold harmless agreements under which providers were effectively repaid some or all of the tax burden, and the federal government was left with a disproportionate share of the tax burden." *Id.*

The 2008 preamble emphasized that, to be effective, the hold harmless prohibitions must be applied with awareness of both the health care related tax and all "associated financial arrangements . . . , including any non-Medicaid payments." *Id.* at 9,691; *see id.* at 9,690 ("We . . . believe the Medicaid statute contemplates . . . that the Secretary will carefully analyze all circumstances relevant to the creation and operation of a state health care-related tax and attendant tax relief programs in carrying out his mandate to prohibit FFP where hold harmless arrangements exist."). As CMS explained, "in the years since we first endeavored to implement Congress's prohibitions on taxes with hold harmless arrangements" the agency had learned "that it is simply impossible to anticipate every hold harmless arrangement that may be implemented by States." *Id.* at 9,690; *see id.* at 9,691 (emphasizing that the regulations "cannot address every specific circumstance and nuance"). CMS concluded that "to achieve the statutory purpose of ending hold harmless arrangements that result in shifting a disproportionate burden to the federal government, the test" set out at 42 C.F.R. § 433.68(f)(1), and the hold harmless prohibitions more broadly,

"must be applied flexibly." 73 Fed. Reg. at 9,691. "Otherwise, financing arrangements will be structured to meet the letter but not the underlying purpose of the statutory limitations." *Id.*

CMS explained that its revisions were intended as "clarifications," *id.* at 9,687, and not "to expand the test for determining when an impermissible hold harmless arrangement exists beyond the original purposes authorized by Congress and underlying the 1993 rules," *id.* at 9,690; *see id.* at 9,691 ("[W]e are not aware of any state tax programs that would have been permissible under the [original] rules, but are no longer permissible under the new rules."). In particular, CMS clarified that the arrangements at issue in the Departmental Appeals Board decision about taxes on nursing facilities paired with grants to their residents were indeed hold harmless arrangements. *Id.* at 9,691 & 9,694.

As to the third hold harmless test, which prohibits "guarantees to hold taxpayers harmless for any portion of the costs of the tax," 42 U.S.C. § 1396b(w)(4)(C)(i), CMS explained that:

> The clarification of the guarantee test is meant to specify that a State can provide a direct or indirect guarantee through a direct or indirect payment. 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).

73 Fed. Reg. at 9,694.

**c. 2019 Proposed Rule**

In 2019, CMS published a proposed rule discussing hold harmless arrangements, among other Medicaid fiscal responsibility concerns.[6] 84 Fed. Reg. 63,722 (Nov. 18, 2019). The proposal began by reviewing existing authorities, and explained that "the February 2008 final rule clarified the direct guarantee test found at § 433.68(f) by specifying that a direct guarantee to hold the

[6] The formal title of this proposal was the "Medicaid Fiscal Accountability Regulation," which Texas abbreviates as "MFAR" in its motion.

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." 84 Fed. Reg. at 63,730–31 (quoting 73 Fed. Reg. at 9,694).

The proposal then turned to developments since the issuance of the 2008 rule. CMS explained that it had "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." *Id.* at 63,734. In such arrangements, "[t]he 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 [managed care organization]) and any redistribution payment from another taxpayer or taxpayers, receive all or any portion of their tax amount back." *Id.* CMS emphasized that "[s]uch arrangements undermine the fiscal integrity of the Medicaid program and **are inconsistent with existing statutory and regulatory requirements** prohibiting hold harmless arrangements." *Id.* (emphasis added). The agency was concerned that, "[d]espite the statutory and regulatory prohibitions, . . . states, local units of government, and/or providers continue to design and execute hold harmless practices that are antithetical to federal law and regulation." *Id.* at 63,735. It therefore proposed "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." *Id.*

The proposal was not finalized, but instead withdrawn on January 19, 2021, and has not been revived. 86 Fed. Reg. 5,105. CMS made clear, however, that "[t]his withdrawal action does not affect CMS' ongoing application of existing statutory and regulatory requirements." *Id.*

**iv. Previous Litigation**

Later that year, Texas filed suit in this Court over the status of its Medicaid managed care program, which CMS had previously authorized as a demonstration project under Section 1115 of the Social Security Act, codified at 42 U.S.C. § 1315. Texas applied for an extension of that authorization, which CMS granted on January 15, 2021, and then rescinded the following April. Texas sued to challenge the rescission, which was preliminarily enjoined. *Texas v. Brooks-LaSure*, 2021 WL 5154219 (E.D. Tex. Aug. 20, 2021). CMS ultimately reinstated the extension, and the suit was dismissed. While the suit was pending, however, a dispute arose over several state-directed payments (SDPs) that Texas had proposed to make. CMS was concerned that the SDPs might be "funded by Texas through a state tax regime that . . . disqualifies the state from federal matching funds because of a hold-harmless provision." *Texas v. Brooks-LaSure*, 2022 WL 741065, at *8. As the Court explained, CMS and Texas had an "interpretive dispute regarding 42 U.S.C. § 1396b(w)(4)(C)," which prohibits hold-harmless guarantees. *Id.* CMS believed that "hospitals in certain Texas jurisdictions have likely entered into private agreements amongst themselves" in which hospitals subject to health care related taxes would be held harmless by "the other hospitals in the [taxing] jurisdiction," so that every hospital was guaranteed to recoup at least "an amount generally equal to 105% of its total tax cost." *Id.* at *9. Texas argued "that federal law does not allow CMS to limit federal funds even if there are the private arrangements described by CMS." *Id.* The state argued that "without evidence that a unit of government is involved in the indemnity agreements," they were not prohibited. *Id.* CMS responded that "the 'reasonable expectation' language in the preamble to its 2008" rule made clear that a direct hold harmless guarantee would be found when State payments were made available to a related party, with the reasonable expectation that the payments would result in the taxpayer being held harmless for any

part of the tax, through direct or indirect payments. *Id.* The Court did not resolve this "interpretive dispute," *id.* at *8, and CMS ultimately approved the SDPs while reserving its right to disallow funding later if a hold harmless arrangement was discovered.

**v. Informational Bulletin**

On February 17 of this year, CMS published an informational bulletin affirming the interpretation set out in its 2019 proposal and briefed in its earlier litigation with Texas. The bulletin was prompted by states inquiring "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." Bulletin at 1. It "reiterate[d]" the agency's "longstanding position on the existing federal requirements." *Id.* The bulletin explained that CMS had "become aware of some health care-related tax programs 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)." *Id.* at 2. CMS was encountering these arrangements "[d]uring standard oversight activities and the review of state payment proposals, particularly managed care SDPs and fee-for-service payment state plan amendments." *Id.* CMS described the arrangements as follows:

> 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 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. 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 (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. The redistributions occur so that taxpaying providers are held harmless for all or a portion of the health care-related tax. This may include the redistribution of Medicaid payments to providers that serve no Medicaid beneficiaries.

*Id.* at 2–3 (footnote omitted).

Turning to the statute and regulations, the bulletin explained 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." *Id.* at 4. Instead, "[i]t 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." *Id.* The bulletin pointed to the agency's use of "the term 'reasonable expectation'" in the 2008 rule, which was meant to address the reality that "'state laws were rarely overt in requiring that state payments be used to hold taxpayers harmless.'" *Id.* at 4 (quoting 73 Fed. Reg. at 9,694). Nonetheless, the bulletin explained, "hold harmless arrangements . . . can be based . . . 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." *Id.*

Finally, the bulletin encouraged states to "make clear to their providers that these arrangements are not permissible under federal requirements, learn the details of how health care-related taxes are collected, and take steps to curtail these practices if they exist." *Id.* at 5. The

bulletin also committed CMS "to work with states that may have existing questionable arrangements to ensure compliance with federal statutory and regulatory requirements." *Id.* at 2.

**vi. Proposed Rulemaking on State-Directed Payments**

In May 2023, CMS published a proposal to amend the regulations governing state-directed payments (SDPs), which appear at 42 C.F.R. § 438.6(c). 88 Fed. Reg. 28,092 (May 3, 2023). As relevant here, states that operate their Medicaid programs through managed care plans may, with the Secretary's approval, direct those plans to make additional payments—that is, SDPs—to hospitals serving large numbers of Medicaid beneficiaries. In the recent proposal, CMS explained that "we have identified instances in which States appear to be funding the non-Federal share of Medicaid SDP payments through health care-related tax programs that appear to involve an impermissible hold harmless arrangement." *Id.* at 28,130. "In these arrangements, with varying degrees of State awareness and involvement, providers appear to have pre-arranged agreements to redistribute Medicaid payments (or other provider funds that are replenished by Medicaid payments)." *Id.* "These arrangements appear designed to redirect Medicaid payments away from the providers that furnish the greatest volume of Medicaid-covered services toward providers that provide fewer, or even no, Medicaid-covered services, with the effect of ensuring that taxpaying providers are held harmless for all or a portion of their cost of the health care-related tax." *Id.* CMS emphasized that such agreements are hold harmless arrangements within the meaning of 42 U.S.C. § 1396b(w)(4)(C)(i) and 42 C.F.R. § 433.68(f)(3). 88 Fed. Reg. at 28,130–31. And the agency proposed to require that "each provider receiving payment under a State directed payment attest[] that it does not participate in any hold harmless arrangement with respect to any health care-related tax." *Id.* at 28,236 (proposing 42 C.F.R. § 438.6(c)(2)(ii)(H)).

**B. Procedural Background**

Texas filed suit shortly after the informational bulletin was published. Its complaint raised four claims. *First*, Texas alleged that the bulletin was contrary to the relevant statute and regulations. Compl. ¶¶ 71–76. *Second*, Texas claimed that the bulletin was procedurally invalid, because it was not issued following notice and an opportunity to comment. *Id.* ¶¶ 77–84. *Third*, Texas alleged that the bulletin was an arbitrary and unexplained reversal of earlier agency views. *Id.* ¶¶ 85–91. *Fourth*, Texas alleged in the alternative that, if the informational bulletin was an accurate reflection of the 2008 rule, then that rule was invalid as contrary to statute. *Id.* ¶¶ 92–96.

Texas then moved for a preliminary injunction, seeking to "enjoin [CMS] from enforcing the February 17 bulletin or taking other any [*sic*] actions in reliance on the bulletin." Mot. at 34; ECF No. 10 at 42. The motion rests only on the first three claims in the complaint, as it does not ask the Court to preliminarily enjoin the effectiveness of the 2008 rule. The motion should be denied, for the reasons set forth below.

**LEGAL STANDARD**

A preliminary injunction is "an extraordinary remedy that may only be awarded upon a clear showing that the plaintiff is entitled to such relief." *Winter v. Nat. Res. Def. Council*, 555 U.S. 7, 22 (2008). The Fifth Circuit "frequently cautions" that "the decision to grant a preliminary injunction is to be treated as the exception rather than the rule." *Matrix Partners VIII, LLP v. Nat. Res. Recovery, Inc.*, 2009 WL 175132, at *6 (E.D. Tex. Jan. 23, 2009) (quoting *House the Homeless, Inc. v. Widnall*, 94 F.3d 176, 180 (5th Cir. 1996)). To obtain a preliminary injunction, a movant must demonstrate: "(1) a substantial likelihood of success on the merits, (2) a substantial threat of irreparable injury if the injunction is not issued, (3) that the threatened injury if the injunction is denied outweighs any harm that will result if the injunction is granted, and (4) that

the grant of an injunction will not disserve the public interest." *Janvey v. Alguire*, 647 F.3d 585, 595 (5th Cir. 2011). Relief "should only be granted when the movant has clearly carried the burden of persuasion" on all four requirements. *Anderson v. Jackson*, 556 F.3d 351, 360 (5th Cir. 2009).

**ARGUMENT**

Texas brought this suit to challenge an informational bulletin that merely reiterated the federal government's longstanding interpretation of a statute enacted in 1991 and regulations that have been in place since 2008. CMS clearly articulated that interpretation in the Federal Register in 2019, 84 Fed. Reg. at 63,734–35; then before this Court in litigation against the State, *Texas v. Brooks-LaSure*, 2022 WL 741065, at *8–*9 (Mar. 11, 2022); and again only last week, 88 Fed. Reg. at 28,130–31. Texas now seeks a preliminary injunction to bar the federal government "from enforcing or relying on the bulletin." Mot. at 4; ECF No. 10 at 12. But Texas is not injured, much less irreparably, by the agency's legal interpretation. And even if it were, that injury would not flow from the challenged informational bulletin—which was neither the first nor the last time that CMS articulated its view—and would not be relieved by an injunction barring enforcement of or reliance on the bulletin. If CMS chooses to take enforcement action, it will rely on the governing statute and regulations, and not the informational bulletin. The preliminary injunction must therefore be denied.

What Texas appears to want, in practice, is an injunction against a legal theory it has long been aware of and long opposed. That is not how judicial review of agency action proceeds under the Medicaid statute. If CMS concludes that Texas has collected a health care related tax that includes a hold harmless arrangement, and disallows federal financial participation for the proceeds of that tax, then Texas will have a right to review by the Departmental Appeals Board, followed by review in district court. *See* 42 U.S.C. § 1316(e); *see Tex. Health & Human Servs.*

*Comm'n v. HHS*, 3:19-cv-2857 (N.D. Tex. filed Dec. 2, 2019) (seeking judicial review in this posture). At that point, a reviewing court would apply the statute and regulations to concrete factual findings, and not an abstract interpretation. Before that point, this Court lacks jurisdiction for a host of related reasons: lack of standing, ripeness, absence of final agency action, availability of an adequate alternate remedy, and the Medicaid statute's provision of a procedural scheme for administrative enforcement proceedings that culminates in the opportunity for judicial review. For all of those reasons, Texas cannot show a substantial likelihood of success on its claims.

Nor are Texas's statutory and regulatory arguments convincing. The statute at issue was passed in 1991 to end a scheme whereby states first raised money selectively from hospitals that served large numbers of Medicaid beneficiaries, then collected federal matching funds, and finally returned larger payments to those same hospitals. The statute sought to block each step of that process, discouraging the practice of raising state funds selectively from such hospitals by denying federal matching funds, and then limiting states' ability to route payments back to those hospitals. CMS has said merely that this statute and its implementing regulations also bar functional equivalents of that original scheme. Texas takes the view that the statute should be read to bar only the precise practices that prompted it, making its evident purpose trivially easy to frustrate. The agency's view is the stronger one, and Texas is therefore unlikely to succeed on the merits of its statutory claim. Because notice and comment were not required for the agency to reiterate its longstanding interpretation of existing authorities, and that reiteration was not an arbitrary reversal of earlier views, Texas's other claims under the Administrative Procedure Act are equally unlikely to succeed. And the balance of the equities does not favor the injunction that Texas seeks.

**A. Texas has not shown a substantial threat of irreparable injury.**

A preliminary injunction cannot be entered based on a mere "possibility" of irreparable harm; rather, a plaintiff must "demonstrate that irreparable injury is likely in the absence of an injunction," and likely to be avoided by the entry of the injunction. *Winter*, 555 U.S. at 22. The threat of irreparable injury must be "real," "substantial," and "immediate," not speculative or conjectural. *City of L.A. v. Lyons*, 461 U.S. 95, 111 (1983). In short, "an injunction . . . should only issue when essential to prevent an otherwise irreparable injury." *Google, Inc. v. Hood*, 822 F.3d 212, 221 (5th Cir. 2016).

Texas argues that the challenged informational bulletin requires the state to investigate whether its health care providers have agreed to indemnify each other for the costs of any health care related taxes. Mot. at 29; ECF No. 10 at 37. Texas says that it lacks authority to do so, would bear a considerable expense, and might expose itself to First Amendment liability if it complied. Mot. at 30–32; ECF No. 10 at 38–40. This argument does not come close to meeting the State's burden to show a substantial likelihood of irreparable injury, for at least two reasons.

*First*, and most fundamentally, the alleged injuries are not threatened by the informational bulletin, and would not be prevented by the injunction that Texas seeks. For years, CMS has been quite clear that when taxpayers subject to a health care related tax "enter into an agreement . . . to redistribute . . . Medicaid payments to ensure that taxpayers . . . receive all or any portion of their tax amount back," those agreements "undermine the fiscal integrity of the Medicaid program and are inconsistent with existing statutory and regulatory requirements prohibiting hold harmless arrangements." 84 Fed. Reg. at 63,734. Texas has long been aware of that interpretation, not least because CMS raised it in litigation with the State. *Texas v. Brooks-LaSure*, 2022 WL 741065, at

*8–*9 (describing the "interpretive dispute" between CMS and Texas "regarding 42 U.S.C. § 1396b(w)(4)(C)" and its implementing regulations).

CMS publishes a range of guidance documents. Informational bulletins "share information, address operational and technical issues, and highlight initiatives or related efforts." They are not intended to "establish new policy or issue new guidance."[7] And the bulletin at issue here did not do so—it simply "reiterate[d]" the agency's "longstanding position" on the meaning of the existing statute and regulations. Bulletin at 1. CMS reaffirmed that longstanding position as recently as last week. 88 Fed. Reg. at 28,130–31. Any compliance costs that may be substantially threatened therefore are not caused by the informational bulletin and would not be prevented by an injunction prohibiting CMS "from enforcing or relying on" it. Mot. at 4; ECF No. 10 at 12. Those costs—which Texas substantially overstates—are threatened, if at all, by the possibility that CMS may rely on the "existing statutory and regulatory requirements prohibiting hold harmless arrangements," 84 Fed. Reg. at 63,734, in an enforcement action.

*Second*, Texas exaggerates both the imminence and the irreparability of such potential harms. The harmful scenario that Texas seems to foresee is CMS asking the State to provide "documentation regarding arrangements involving possible hold harmless arrangements and the redistribution of Medicaid payments," Bulletin at 5, and then bringing an enforcement action if Texas does not possess the information that CMS believes it should. Such enforcement is the ultimate injury that Texas would seek to avoid by bearing compliance costs now.

But this precise scenario has played out once before, and Texas plainly was not harmed in any way. As Victoria Grady recounts in her declaration, CMS inquired about possibly

[7] The agency's description of its guidance documents can be found on the "Federal Policy Guidance" page of its website, at https://www.medicaid.gov/federal-policy-guidance/index.html.

impermissible "private business arrangements" between taxpaying hospitals in May 2019. Grady Decl. ¶ 25, ECF No. 10-2 at 9. Texas responded that "the State could not provide information about those arrangements because these agreements would be outside of the scope of federal law and [Texas] did not have authority to seek that type of information." *Id.* ¶ 26; *see id.* ¶ 27 ("[A]fter CMS sent the above-described request to Texas, . . . Texas responded that it was beyond our authority to answer and CMS' authority to ask."). The matter apparently ended there. But if CMS had chosen to issue a disallowance for noncompliance, *see* 42 C.F.R. § 433.74(d), or chose to do so in the future, Texas would have ample opportunity to defend itself, both in the administrative process and ultimately in federal court, against any accusation that it was refusing to comply with a lawful demand. 42 U.S.C. § 1316(e); 42 C.F.R. § 430.42. Texas could of course raise the limits of the agency's authority as a defense in those proceedings.[8]

Texas responded to CMS' May 2019 request for information by denying the agency's authority, or the State's obligation to comply, not by "arrogat[ing] power to itself in a way that is irreconcilable with bedrock principles of Texas administrative law." Mot. at 30; ECF No. 10 at 38. Texas could respond to the informational bulletin in the same way—and given the events that predate this litigation, there is every reason to believe that it will. To grant the preliminary injunction, this Court would have to conclude the opposite: that, in its absence, the State would make substantial, burdensome compliance efforts[9] in the months before the Court could resolve this case on its merits. It is Texas's burden to make that showing, and the State has not done so.

---

[8] Although Texas suggests in a background section that intolerable "uncertainty" would "result if the bulletin were to be implemented, and the results litigated," it does not (for good reason) argue that such "uncertainty" would impose an irreparable harm. Mot. at 16; ECF No. 10 at 24.

[9] CMS emphasizes its commitment to supporting the Medicaid safety net and working with states to help them address programmatic issues in a lawful manner. *See* Bulletin at 6 ("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.").

The challenged informational bulletin is merely an expression of CMS' view of what the law requires. The bulletin does not itself have any legally-binding effect, nor expose Texas to any new liability or legal requirements. Texas has not shown—and cannot hope to show—that it faces significant and immediate injury merely because CMS has once again articulated its interpretation of the law.[10]

**B. Texas has not shown a substantial likelihood of success on the merits.**

Even if Texas faced irreparable harm in the absence of preliminary relief, its motion should nonetheless be denied because it has not established a substantial likelihood of success. *See Byrum v. Landreth*, 566 F.3d 442, 445 (5th Cir. 2009). As discussed below, a) Texas lacks standing, b) its claims are not ripe, c) the challenged bulletin is not final agency action, and d) Texas has an adequate alternate remedy, which e) ousts this Court of jurisdiction under the *Thunder Basin* doctrine. And were the Court to reach the merits of Texas's claims, none is likely to succeed.

**i. The Court lacks jurisdiction to hear this case.**

Serious questions regarding a court's subject matter jurisdiction weigh against entry of a preliminary injunction because "potential impediments to even reaching the merits" make a plaintiff's claim less likely to succeed. *Munaf v. Green*, 553 U.S. 674, 690 (2008). Such questions abound here.

**a. Texas lacks standing.**

To establish standing under Article III, a plaintiff must demonstrate that it has suffered a concrete injury, or that such an injury is "imminent" or "certainly impending." *Clapper v. Amnesty*

[10] Because the informational bulletin does not impose any new legal obligations upon Texas, the State's reference to the "nonrecoverable compliance costs" imposed by invalid regulations is beside the point here. *Cf.* Mot. at 30 (quoting *BST Holdings LLC v. OSHA*, 17 F.4th 604, 618 (5th Cir. 2021)); ECF No. 10 at 38. Texas does not challenge the validity of any regulation in its preliminary injunction motion.

*Int'l USA*, 568 U.S. 398, 409 (2013). Moreover, "there must be 'a causal connection between the injury and the conduct complained of'" and "the injury must be likely to be redressed by a favorable decision." *Yarls v. Bunton*, 905 F.3d 905, 909 (5th Cir. 2018) (quoting *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560–61 (1992)). An abstract disagreement about the wisdom or legality of a federal policy is not the kind of "concrete and particularized" injury needed to meet the "injury in fact" requirement, *see Steel Co. v. Citizens for a Better Env't*, 523 U.S. 83, 106–09 (1998), but that is all that Texas can show here.

The publication of the recent informational bulletin did not injure the state in any way. The injuries alleged by Texas in its complaint are the same purported injuries underlying its allegations of irreparable harm: the costs of compliance with CMS' understanding of the law. *See* Compl. ¶¶ 64–69. As explained above, those injuries are not imminent because Texas is free to resist any unlawful agency demands for information—and defend itself first in the administrative process and then in federal court, if the agency disallows federal funds for noncompliance. Texas would not be injured unless and until it was found to have refused to comply with a lawful demand. Moreover, Texas's alleged injuries are not traceable to the informational bulletin, because the legal interpretation articulated there is merely the agency's longstanding view of its pre-existing authorities. Texas lacks standing to bring the claims on which its motion for preliminary injunction rests, and therefore cannot show a substantial likelihood of success on the merits.

**b. Texas's challenge is not ripe.**

The State's challenge to the informational bulletin is also unripe. "The ripeness doctrine is drawn from both Article III limitations on judicial power and from prudential reasons for refusing to exercise jurisdiction." *Nat'l Park Hospitality Ass'n v. Dep't of the Interior*, 538 U.S. 803, 808 (2003) (quotation omitted). The doctrine "separates those matters that are premature

because the injury is speculative and may never occur from those that are appropriate for judicial review." *United Transp. Union v. Foster*, 205 F.3d 851, 857 (5th Cir. 2000). It "prevent[s] the courts, through avoidance of premature adjudication, from entangling themselves in abstract disagreements over administrative policies." *Nat'l Park*, 538 U.S. at 807 (quotation omitted). It also "protect[s] the agencies from judicial interference until an administrative decision has been formalized and its effects felt in a concrete way by the challenging parties." *Id.* at 807–08. Accordingly, a party's claim "is not ripe for adjudication if it rests upon contingent future events that may not occur as anticipated, or indeed may not occur at all." *Texas v. United States*, 523 U.S. 296, 300 (1998) (quotation omitted).

There are two ways that Texas could feel concrete effects from the legal interpretation articulated in the informational bulletin. *First*, CMS could determine that the State or one of its local governments has been collecting a health care related tax that includes a hold-harmless arrangement, and disallow federal matching funds for the proceeds of that tax. That process would begin with a disallowance letter to the state setting out the "[f]indings of fact on which the disallowance determination is based." 42 C.F.R. § 430.42(a)(5). Such letters constitute "the Department's final decision," *id.* § 430.42(a)(9), subject to review by the Departmental Appeals Board, and then in district court, 42 U.S.C. § 1316(e)(2). *See Delaware, Dep't of Health & Social Servs. v. HHS*, 272 F. Supp. 3d 103, 106–07 (D.D.C. 2017) (describing this administrative process, which requires exhaustion of administrative remedies); 58 Fed. Reg. at 43,168 (noting that the process applies to reductions of federal funding on hold-harmless grounds).

*Second*, as discussed above, CMS could request documentation from Texas, the State could refuse to comply on the grounds that the demand was unlawful, and CMS could again issue a

disallowance. Texas would then have the opportunity to raise its defenses in the administrative process and, ultimately, in federal court.

Because both of those events are "speculative and may never occur," Texas's claims are not "appropriate for judicial review." *United Transp. Union*, 205 F.3d at 857. Moreover, declining to exercise jurisdiction over those claims would serve the purposes of the ripeness doctrine, by withholding judicial review until it could be grounded in detailed factual circumstances. If CMS found a hold-harmless arrangement and disallowed federal financial participation on that basis, a reviewing court would be able to assess whether a particular scheme of taxation and reimbursement violated the statute and regulations. As CMS recently explained, agreements to reimburse providers for the cost of health care related taxes occur "with varying degrees of State awareness and involvement." 88 Fed. Reg. at 28,130. As discussed below, the interpretive dispute between Texas and CMS chiefly centers on how much "State awareness and involvement" is required before a hold harmless arrangement can be found. It is entirely possible—perhaps even likely—that the facts ultimately presented for judicial review would show more "State awareness and involvement" than CMS believes to be necessary, but less than Texas believes to be required. The question presented to a reviewing court would not be whose legal interpretation was correct in the abstract, but only whether the actual scheme before it violated the statute and regulations.

Similarly, a concrete dispute over an agency demand for information might allow a reviewing court to do more than choose between competing abstract interpretations. Even if Texas denied any awareness of or involvement in a hold harmless arrangement, CMS would be within its rights to probe for such involvement (as even the State must concede). In resisting such a demand, Texas would need to show that it was not made pursuant to any lawful authority. The question before the court would be the lawfulness of the demand; answering it would not require

the court to choose between the parties' competing interpretations of the hold harmless prohibition unless the information demand could only be upheld by adopting the agency's view of the law.

For these reasons, Texas cannot show that its challenge to the informational bulletin is ripe, and therefore cannot show a substantial likelihood of success on the merits.

**c. The informational bulletin is not final agency action**

Judicial review under the APA is generally limited to "final agency action." 5 U.S.C. § 704. Such action must (1) represent "the consummation of the agency's decisionmaking process," and (2) conclusively determine legal "rights or obligations." *Bennett v. Spear*, 520 U.S. 154, 178 (1997) (quotation marks omitted). Even though the informational bulletin reflects the agency's firm (and longstanding) views about how best to read the statute and regulations, the bulletin is not final agency action because it does not determine any legal rights or obligations and does not represent the agency's final position on any specific factual circumstances.

The informational bulletin simply reminds the public of a legal view previously articulated by the agency. It "create[s] no new legal obligations beyond those the [statute and regulations] already imposed." *Rhea Lana, Inc. v. Dep't of Labor*, 824 F.3d 1023, 1028 (D.C. Cir. 2016); *see also Nat'l Pork Producers Council v. U.S. EPA*, 635 F.3d 738, 756 (5th Cir. 2011) (explaining that "guidance letters" describing existing legal obligations but with "no effect on a party's rights or obligations are not reviewable final actions"). By choosing to publish only an informational bulletin, CMS made clear that it was not "establish[ing] new policy or issu[ing] new guidance." *See supra* at 19.

"Agency action may mark the consummation of the agency's decisionmaking process if the agency action is not subject to further agency review, which occurs when the agency has asserted its final position on the factual circumstances underpinning the agency action." *Louisiana*

*State v. U.S. Army Corps of Eng'rs*, 834 F.3d 574, 581 (5th Cir. 2016) (citations and quotations omitted). But the informational bulletin does not assert the agency's "final position" on any "factual circumstances," nor compel it to reach a particular conclusion about any particular set of facts. *Id; see Data Mktg. P'ship v. U.S. Dep't of Labor*, 45 F.4th 846, 855 (5th Cir. 2022) (agency guidance is not final agency action if it "calls attention to established principles," is "informational only," and "not binding . . . with respect to any particular factual situation" (quotations omitted)).

Moreover, as discussed above, many steps must occur before any federal funds are disallowed, which makes it clear that the informational bulletin does not represent the consummation of the agency's decisionmaking process or conclusively determine any legal rights or obligations. *See Delaware, Dep't of Health & Social Svcs.*, 272 F. Supp. 3d at 106–07. And the statute expressly provides for judicial review at the end of this process. 42 U.S.C. § 1316(e).

For these reasons, Texas cannot show that the informational bulletin is final agency action, and therefore cannot show a substantial likelihood of success on the merits of its claims.

**d. Plaintiffs have an adequate alternative remedy.**

As the Fifth Circuit has recognized, Section 704 also "limits the APA to the review of those agency actions which otherwise lack an 'adequate remedy in a court.'" *Hinojosa v. Horn*, 896 F.3d 305, 310 (5th Cir. 2018) (per curiam) (quoting *Bowen v. Massachusetts*, 487 U.S. 879, 903 (1988)); 5 U.S.C. § 704. As discussed above, if CMS issues a disallowance on the grounds that Texas is either collecting a health care related tax that includes a hold harmless arrangement or refusing a lawful demand for information, CMS would need to provide written notice and, if Texas chose, an administrative hearing before an independent body, subject to judicial review. *See* 42 U.S.C. § 1316(e); 42 C.F.R. § 430.42. This administrative process "provides a direct and guaranteed path to judicial review," *Hinojosa*, 896 F.3d at 312, and thus constitutes an adequate

alternative remedy, which precludes Texas from showing a substantial likelihood of success on the merits of the APA claims it brings here.

**e. Judicial review is barred by the *Thunder Basin* doctrine.**

Where it is "fairly discernible" that an elaborate statutory review scheme for administrative enforcement proceedings was intended to create an exclusive remedy, parallel jurisdiction outside that scheme is precluded. *See Thunder Basin Coal Co. v. Reich*, 510 U.S. 200, 207, 216 (1994) (quotation omitted). When exclusivity is fairly discernible from the statutory scheme, particular claims may only proceed outside that scheme if they are not "of the type Congress intended to be reviewed within th[e] statutory structure." *Id.* at 212; *see also Bank of La. v. FDIC*, 919 F.3d 916, 925 (5th Cir. 2019). Courts "presum[e] that Congress does not intend to limit . . . jurisdiction" if (1) "a finding of preclusion could foreclose all meaningful judicial review," (2) the suit is "wholly collateral to a statute's review provisions," and (3) the claims lie "outside the agency's expertise." *Elgin v. Dep't of the Treasury*, 567 U.S. 1, 15 (2012) (citation omitted) (quoting *Free Enter. Fund v. Public Co. Accounting Oversight Bd.*, 561 U.S. 477, 489 (2010)).

To begin with, the administrative enforcement proceedings that Congress established at 42 U.S.C. § 1316(e) are plainly meant to be exclusive. And each *Thunder Basin* factor weighs in favor of the conclusion that Congress meant to limit jurisdiction over the claims at issue here. Precluding judicial review now would not foreclose meaningful judicial review later. To the contrary, as described above, a court reviewing a decision of the Departmental Appeals Board would be far better situated to resolve the legal issues at play here, because it would have a fully developed factual record. *See id.* § 1316(e)(2). Second, Texas's claims are not "wholly collateral" to the administrative review scheme, but go to the heart of the statute and regulations that CMS enforces. *Bank of La.*, 919 F.3d at 928. And third, the State's claims, which concern the proper

interpretation of that statute and those regulations, are well within the agency's expertise. *See id.* ("[T]here are precious few cases involving interpretations of statutes authorizing agency action in which our review is not aided by the agency's statutory construction.") (quoting *Jarkesy v. S.E.C.*, 803 F.3d 9, 29 (D.C. Cir. 2015)). Because this Court lacks jurisdiction to review these claims outside the context of the regulatory scheme created by Congress for administrative enforcement and judicial review, Texas cannot show a substantial likelihood of success on the merits of its claims. *Bowen*, 487 U.S. at 903 ("Congress did not intend the general grant of review in the APA to duplicate existing procedures for review of agency action.").

**ii. The challenged bulletin does not violate the Administrative Procedure Act.**

Texas challenges the informational bulletin with three claims under the Administrative Procedure Act (APA), 5 U.S.C. § 701 *et seq.* Texas alleges that the bulletin is contrary to law, was issued arbitrarily, and without the notice-and-comment procedures that the State alleges were required. None of these claims is likely to succeed.

**a. The legal interpretation reiterated in the bulletin is lawful.**

The statutory provision at issue here, 42 U.S.C. § 1396b(w)(4), was enacted to end a scheme in which states would claim federal Medicaid funds without contributing any state funds, because no entity within the state ever truly bore the burden of the levied tax. States accomplished this first by raising money selectively from hospitals serving a large share of Medicaid beneficiaries, then collecting federal matching funds, and finally paying those same hospitals more than was originally collected from them. *See supra* note 2. The hold harmless prohibition aimed to block the first steps in that process; other provisions of the statute were aimed at the final step.

There are two evident purposes behind that prohibition: 1) to ensure that states meaningfully fund Medicaid expenditures, 2) but not by placing inequitable funding burdens on

the hospitals that serve the most Medicaid beneficiaries.[11] Since at least 2019, the agency has been "aware of some health care-related tax programs 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." Bulletin at 2; *see* 88 Fed. Reg. at 28,130–31; 84 Fed. Reg. at 63,734. Such arrangements achieve precisely the end that Congress sought to avoid: allowing states to collect federal Medicaid funds without bearing the burden of raising their own state funds, because all state taxpayers are indemnified.

Texas nonetheless argues that federal Medicaid funds must be provided, notwithstanding such schemes, unless the state government itself guarantees that taxpayers will be held harmless. Mot. at 18; ECF No. 10 at 26 (arguing that "the defining feature of a hold harmless provision is a guarantee by *the government*—not a private party—to the taxpayer"). That interpretation would render the statute completely ineffective. It would allow private parties to agree to indemnify each other, and inform the state government of their agreement. The state government (or its local jurisdictions) could then make taxing policy and collect federal funds secure in the knowledge that no taxpayer would truly be burdened by the state tax. That is precisely what Congress enacted the hold harmless provision to prevent, and yet Texas contends that it must be permitted by the statute and regulations.

[11] As the agency has explained, "[t]he statutory provisions, and [implementing] regulations, are a response to States that imposed health care related taxes that had the effect of shifting financial burdens from the States to the federal government," by means of "hold harmless agreements under which providers were effectively repaid some or all of the tax burden, and the federal government was left with a disproportionate share of the tax burden." 73 Fed. Reg. at 9,688. And at the same time, the "statute and [its] implementing regulations were designed to protect Medicaid providers from being unduly burdened by health care related tax programs." *Id.* at 9,685; *see* 57 Fed. Reg. at 55,128 (explaining that the statute was intended "to preclude use of revenues derived from taxes imposed primarily on Medicaid providers and activities").

Texas is incorrect. The statute and regulations contemplate that both a hold harmless guarantee and the associated payment can be direct or indirect. The statute provides that "there is in effect a hold harmless provision with respect to a broad-based health care related tax . . . if the Secretary determines" that "[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." 42 U.S.C. § 1396b(w)(4)(C). And the regulations clarify that a hold harmless arrangement exists whenever the state "provides for any direct or indirect payment . . . such that the provision of that payment . . . directly or indirectly guarantees to hold taxpayers harmless for all or any portion of the tax amount." 42 C.F.R. § 433.68(f)(3).

When taxpayers enter an agreement to indemnify each other against the burdens of a health care related tax, each taxpayer receives a direct guarantee. When Medicaid funds are redistributed to honor that guarantee, the state has made an indirect payment.[12] As CMS has explained in the informational bulletin (and elsewhere) "[i]t is possible for a state to indirectly provide a payment . . . that guarantees to hold taxpayers harmless . . . if some or all of the taxpayers receive those payments . . . through an intermediary . . . rather than directly from the state or its . . . managed care plan." Bulletin at 4; *see* 73 Fed. Reg. at 9,686 (discussing instances of "a direct guarantee of an indirect payment to taxpayers").

The 2008 rule adopting the current regulations defines a "direct guarantee" as that which produces a "reasonable expectation that the payment would result in the taxpayer being held

[12] CMS does not contend that this arrangement presents an indirect guarantee. *Cf.* Mot. at 21; ECF No. 10 at 29. Texas seems to argue that the statute does not encompass indirect payments, *see id.*, suggesting that in the phrase "provides (directly or indirectly) for any payment . . . that guarantees," 42 U.S.C. § 1396b(w)(4)(C)(i), the parenthetical adverbs modify only the second verb. Not so: Congress clearly intended the adverbs to modify "provides . . . for," the verbal phrase it embedded them within. That intent is confirmed by subsection (A), which uses the same structure—*i.e.*, "provides (directly or indirectly) for a payment"—without any subsequent verb.

harmless for any part of the tax (through direct or indirect payments)." 73 Fed. Reg. at 9,694. The guarantee was defined in that way "because 'state laws were rarely overt in requiring that state payments be used to hold taxpayers harmless.'" Bulletin at 4 (quoting 73 Fed. Reg. at 9,694). The rule emphasized that, to be effective, the hold harmless prohibitions must be applied "flexibly" and with awareness of both the health care related tax and all "associated financial arrangements . . . including any non-Medicaid payments." 73 Fed. Reg. at 9,691; *see id.* at 9,690 ("We . . . believe the Medicaid statute contemplates . . . that the Secretary will carefully analyze all circumstances relevant to the creation and operation of a state health care-related tax and attendant tax relief programs in carrying out his mandate to prohibit [federal funding] where hold harmless arrangements exist."). "Otherwise, financing arrangements will be structured to meet the letter but not the underlying purpose of the statutory limitations." *Id.*

Texas's interpretation would defeat "the underlying purpose of the statutory limitations," and is not compelled by the text of either the statute or the regulations. *Cf.* Mot. at 17; ECF No. 10 at 25 (arguing that "neither the Social Security Act nor its implementing regulations provides a basis for CMS to define a prohibited hold harmless arrangement the way that the bulletin does"). And the State is plainly wrong to argue that when CMS proposed to amend its regulations in 2019, it "effectively conceded" that they cannot bear the agency's current interpretation. Mot. at 22; ECF No. 10 at 30. In that proposal, CMS explained that the arrangements discussed in the recent bulletin "undermine the fiscal integrity of the Medicaid program and are inconsistent with existing statutory and regulatory requirements prohibiting hold harmless arrangements." 84 Fed. Reg. at 63,734. The fact that "clarifying language" was proposed, but not finalized, is certainly not a concession to the contrary. *Id.* at 63,735.

Texas's claim that the informational bulletin is in excess of statutory authority and contrary to law is unlikely to succeed on the merits. *See* 5 U.S.C. § 706(2)(A), (C).

**b. The informational bulletin did not reverse prior agency interpretations, much less arbitrarily.**

Texas also claims that the informational bulletin represents an arbitrary, unexplained "departure from past practice." Mot. at 26; ECF No. 10 at 34; *see* 5 U.S.C. § 706(2)(A). As explained above, that is simply not so. Rather, the informational bulletin is consistent with the agency's earlier explanation of the "existing statutory and regulatory requirements prohibiting hold harmless arrangements," 84 Fed. Reg. at 63,734, as well as its subsequent litigating position in this court, *see Texas v. Brooks-LaSure*, 2022 WL 741065, at *8–*9 (discussing the "interpretive dispute" between CMS and Texas "regarding 42 U.S.C. § 1396b(w)(4)(C)," and describing the agency's interpretation).

Texas's argument to the contrary appears to rest on three legs. *See* Mot. at 28; ECF No. 10 at 36. First, Texas points to the 2005 decision of the Departmental Appeals Board, which concluded that when states 1) taxed nursing facilities, which passed the tax burden along to their private patients, and then 2) provided state grants or tax credits to the private patients, to indemnify them against the rate increases, they had not established a hold harmless arrangement. *In re: Hawaii*, 2005 WL 1540188. But when CMS amended its regulations in 2008, it made very clear that this Board decision was in error, and that these were indeed hold harmless arrangements. 73 Fed. Reg. at 9,691 & 9,694. The informational bulletin is entirely consistent with the 2008 rule, and Texas's reliance on a Board decision that CMS disavowed more than ten years ago does not show an unexplained departure from past practice.

Second, Texas points to correspondence with an agency official, which it attaches to its motion as Exhibit C. In March 2019, Barbara Eyman (a private lawyer) spoke with Kristin Fan,

who was then Director of the Center for Medicaid and CHIP Services Financial Management Group. Ms. Eyman then wrote to summarize her "understanding of [their] phone conversation." Ms. Fan did not respond. Ms. Eyman wrote again more than two weeks later, forwarding her earlier email, and Ms. Fan replied: "This is accurate. I would just add that CMS reserves the right to ask these types of questions that may help inform further policy." ECF No. 10-3 at 2. Texas argues that with those words, Ms. Fan announced on behalf of CMS that the agency did not "have statutory authority to address" hold harmless agreements of the sort discussed in the recent informational bulletin. *Id.* But even if that is a fair reading of the email—in which Ms. Fan herself said nothing about statutory authority, and gave no indication that she was focused on that aspect of Ms. Eyman's summary—CMS does not make policy through such private correspondence (to which Texas was not even party). Later that same year, CMS made clear in the Federal Register that agreements like those discussed in the bulletin "are inconsistent with existing statutory . . . requirements prohibiting hold harmless arrangements." 84 Fed. Reg. at 63,734. Texas's reliance on an earlier, ambiguous email for a view at odds with the agency's clear public statements does not show a change in agency position.

Third, and finally, Texas alleges that it "contacted CMS to seek guidance" in "early 2019," and that "CMS advised at that time that so long as neither the State nor unit of local government was providing the guarantee, there is not a prohibition on . . . private business arrangements." Grady Decl. ¶ 24, ECF No. 10-2 at 9. Texas does not provide any record of this statement, nor explain who purportedly made it. And again, CMS' position on its statutory and regulatory authority was clearly articulated in the Federal Register later that same year. Texas's reliance on earlier informal advice allegedly provided by an unnamed employee does not show an agency change in position.

Because the challenged informational bulletin is entirely consistent with the agency's public position, as announced in rulemaking and litigation, Texas cannot show a substantial likelihood of success on the merits of its claim that the bulletin was an arbitrary reversal of past practice, or made without reasonable consideration of reliance interests in that earlier practice.

**c. The informational bulletin is an interpretive rule, for which notice and comment are not required.**

Finally, the informational bulletin is not a legislative rule subject to APA notice-and-comment requirements. *Perez v. Mortg. Bankers Ass'n*, 575 U.S. 92, 96 (2015); 5 U.S.C. § 553(b). Rather, it is an interpretive rule, "issued by an agency to advise the public of the agency's construction of the statutes and rules which it administers." *Perez*, 575 U.S. at 97 (quoting *Shalala v. Guernsey Mem'l Hosp.*, 514 U.S. 87, 99 (1995)). "In contrast to legislative rules, which 'effect[] a substantive change in existing law or policy,' interpretive rules 'clarify a statutory or regulatory term, remind parties of existing statutory or regulatory duties, or 'merely track[]' preexisting requirements and explain something the statute or regulation already required." *POET Biorefining, LLC v. EPA*, 970 F.3d 392, 407 (D.C. Cir. 2020) (quoting *Mendoza v. Perez*, 754 F.3d 1002, 1021 (D.C. Cir. 2014)); *see Brown Express, Inc. v. United States*, 607 F.2d 695, 700 (5th Cir. 1979) (quotation omitted) (explaining that "[g]enerally speaking," "legislative rules are those which create law, . . . whereas interpretative rules are statements as to what the administrative officer thinks the statute or regulation means"). The APA's notice-and comment requirement "does not apply" to interpretive rules, 5 U.S.C. § 553(b)(3)(A), and so the informational bulletin was not required to undergo notice and comment before it was issued.

Texas argues that the informational bulletin cannot be a "general statement[]of policy." *Id.*; *see* Mot. at 24; ECF No. 10 at 32. But the State does not even discuss the possibility that the informational bulletin could be a "statement[] as to what the [agency] thinks the statute or

regulation means," *Brown Express*, 607 F.2d at 700, as it plainly is. The rest of the State's argument recycles assertions addressed above, insisting that the informational bulletin must be a legislative rule because it is a radical departure from prior interpretations, rather than a reiteration of the agency's "longstanding position on the existing federal requirements," Bulletin at 1. *See* Mot. at 25; ECF No. 10 at 33. But that is not true. *See* 84 Fed. Reg. at 63,734–35; *Texas v. Brooks-LaSure*, 2022 WL 741065, at *8–*9. And the fact that CMS once proposed to clarify its regulations does not show that the bulletin is a departure from its longstanding interpretation of them. *See supra* at 31. Because the informational bulletin is an interpretive rule, Texas cannot show a substantial likelihood of success on the merits of its procedural claim.

**C. Texas has not shown that the requested injunction would serve the public interest.**

Finally, Texas has not shown "that the threatened injury if the injunction is denied outweighs any harm that will result if the injunction is granted," nor "that the grant of an injunction will not disserve the public interest." *Janvey*, 647 F.3d at 595. As to the first of those factors, which merge when the federal government acts as defendant, Texas argues only that the informational bulletin is "unlawful agency action," which it is not. Mot. at 33; ECF No. 10 at 41. On the other factor, Texas argues that CMS has destabilized the State's Medicaid program by reiterating the agency's longstanding view of its existing legal authorities, and that this Court should preserve the status quo through injunctive relief. But the status quo ante was the interpretation reiterated in the bulletin. The entry of an injunction would disturb that status quo, not preserve it. Texas has not shown that the public interest or the balance of the equities favor injunctive relief, and its motion should be denied for that reason as well.

## CONCLUSION

For the reasons set forth above, the motion for a preliminary injunction should be denied.

Respectfully submitted,

BRIAN M. BOYNTON
Principal Deputy Assistant Attorney General

MICHELLE BENNETT
Assistant Director, Federal Programs Branch

*/s/ James Bickford*
JAMES BICKFORD
Trial Attorney (N.Y. Bar No. 5163498)
United States Department of Justice
Civil Division, Federal Programs Branch
1100 L Street, NW
Washington, DC 20530
James.Bickford@usdoj.gov
Telephone: (202) 305-7632
Facsimile: (202) 616-8470

*Counsel for Defendants*

Date: May 13, 2023

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE EASTERN DISTRICT OF TEXAS**
**TYLER DIVISION**

| | | |
|---|---|---|
| **STATE OF TEXAS**, *et al.*, | ) | |
| | ) | |
| Plaintiffs, | ) | |
| | ) | |
| v. | ) | Case No. 6:23-cv-161 (JDK) |
| | ) | |
| **CHIQUITA BROOKS-LASURE**, *et al.*, | ) | |
| | ) | |
| Defendants. | ) | |
| | ) | |

**DEFENDANTS' SURREPLY IN OPPOSITION TO**
**PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION**

**TABLE OF CONTENTS**

## TABLE OF AUTHORITIES

### CASES

**STATUTES**



**REGULATIONS**

**OTHER AUTHORITIES**

## INTRODUCTION

The informational bulletin does not compel states to do anything at all. Instead, it communicates CMS' longstanding view that a 1991 statute and 2008 regulations compel the federal government to reduce federal Medicaid funding whenever a state imposes a health care related tax with no real economic incidence, because all taxpayers are held harmless against it. For years, Texas has opposed this view. The State maintains that, under the terms of this jointly funded program, state and local taxes that no one ultimately pays must be matched by federal funds, so long as the state government does not first explicitly promise indemnification and then directly make the indemnifying payments. The parties previously briefed the issue to this Court, which did not "see a need to resolve" their "interpretive dispute." *Texas v. Brooks-LaSure*, 6:21-cv-191, 2022 WL 741065, at *9 (E.D. Tex. Mar. 11, 2022). Now Texas would like a resolution, and has seized upon the informational bulletin as a way to get it.

In its opposition brief, CMS explained that because the bulletin did nothing more than reiterate the agency's interpretation of existing legal authorities, Texas could not establish irreparable harm that would be avoided by the requested injunction against "enforcing or relying on the bulletin." Mot. at 4. CMS observed that such an injunction would not provide the State with any meaningful redress, and that "[w]hat Texas appears to want, in practice, is an injunction against a legal theory." Opp. at 16. Texas now agrees that this is so, and explicitly asks the Court to preliminarily enjoin CMS "from enforcing" not only "the bulletin" but also "the rule announced therein," Reply at 17—that is, the legal interpretation previously articulated in the Federal Register, 84 Fed. Reg. at 63,734, and in briefing before this Court. In broadening its requested relief, Texas also clarifies its apparent objective: to prevent the independent Office of Inspector General from issuing the results of an audit that it undertook more than a year before CMS

published the informational bulletin. But if the informational bulletin is so threatening as to merit preliminary injunctive relief—and to be clear, it is not—then an injunction against the bulletin itself must be enough to avoid the injuries threatened by it. By insisting that such an injunction would not redress the State's alleged injuries, Texas seriously undermines its arguments for both justiciability and injunctive relief. Nor are its claims likely to succeed on their merits, as CMS explained in its opposition brief and discusses again below. The State's motion should be denied.

**BACKGROUND**

In its reply (at 16–17), Texas introduces a new factual issue: the audit of the health care related tax collected by Smith County. That audit is being conducted by the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS). *See* Exh. A, Decl. of John D. Hagg ("Hagg Decl."). Governed by the Inspector General Act of 1978, such offices "are designed to be 'independent and objective units' separate from their respective departments and agencies." *Univ. of Medicine & Dentistry of N.J. v. Corrigan*, 347 F.3d 57, 60-61 (3d Cir. 2003) (quoting 5 U.S.C. app. 3, § 2). "They are directed to 'conduct and supervise audits and investigations relating to the programs and operations' of their respective agencies." *Id.* (quoting same). "The Office of Inspector General of HHS is thus an independent office with a primary function to investigate fraud and abuse" in Medicaid and other programs operated by HHS. *Id.*

At the conclusion of each audit, OIG gives its subject a private briefing on the anticipated audit findings and recommendations. Then OIG provides a draft audit report—again, privately—and gives the subject at least thirty days to respond, often more. Next, OIG prepares its final audit report, including findings, recommendations, and responses to the comments of the audit subject, and it releases that final report to the general public. *See* Hagg Decl. ¶¶ 13–15. OIG has statutory authority to make audit findings and recommendations, but it cannot disallow federal matching

Medicaid funds. *Id.* ¶ 16. Only CMS can make a disallowance, subject to review by the Departmental Appeals Board (DAB), and then in district court. 42 U.S.C. § 1316(e); 42 C.F.R. § 430.42(a). A state that appeals to the DAB may retain any disputed funding unless and until the DAB upholds the disallowance. *See* 42 U.S.C. § 1396b(d)(5); 42 C.F.R. § 430.42(b).

In November 2021—more than a year before CMS published the informational bulletin—OIG announced its intent to determine whether local governments that "use Local Provider Participation Funds (LPPFs) to generate and collect local funding to finance the State share of Medicaid supplemental and directed payment programs" are doing so "in accordance with applicable Federal . . . requirements."[1] *See* Hagg Decl. ¶ 8. This audit was initially focused on Smith County, Texas. *Id.* ¶ 10. Earlier this month, OIG gave Texas a private briefing on the anticipated findings and recommendations of its Smith County audit. *Id.* ¶ 13. OIG indicated that it expects to provide Texas with a draft audit report by July of this year, and that Texas would have an opportunity to respond. *Id.* ¶¶ 13–14. OIG does not expect to publish its final audit report before the fall. *Id.* ¶ 15.

## ARGUMENT

### A. Texas has not shown a substantial threat of irreparable injury.

Texas has not shown "that irreparable injury is likely in the absence of an injunction," and likely to be avoided by the entry of an injunction. *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 22 (2019). That is so for at least two reasons. First, because the informational bulletin merely restates the agency's longstanding interpretation of existing statutory and regulatory authorities, its publication did not threaten Texas with any injuries at all, much less imminent and irreparable

[1] The work plan for this audit is available at: https://www.oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000626.asp.

ones. Opp. at 18–19. And second, the purported injuries that Texas identifies all depend upon actions that Texas is quite *unlikely* to take in the absence of preliminary injunctive relief, as demonstrated by past encounters between CMS and the State. Opp. at 19–20. The State's responses are inadequate, and its attempts to raise new issues unavailing.

The agency's opposition brief emphasized a key distinction between this case and other challenges to agency guidance documents, which is especially relevant to the question of irreparable harm: the interpretation set out in the informational bulletin was not new, but had been consistently maintained by the agency over a period of years. In 2019, CMS said in the Federal Register that when taxpayers subject to a health care related tax "enter into an agreement . . . to redistribute . . . Medicaid payments to ensure that taxpayers . . . receive all or any portion of their tax amount back," those agreements "are inconsistent with existing statutory and regulatory requirements prohibiting hold harmless arrangements." 84 Fed. Reg. at 63,734; *see* 42 U.S.C. § 1396b(w)(4); 42 C.F.R. § 433.68(f). And in 2022, CMS and Texas briefed this exact "interpretive dispute regarding 42 U.S.C. § 1396b(w)(4)(C)" and its implementing regulations to this very Court. *Texas v. Brooks-LaSure*, 2022 WL 741065, at *8. The challenged bulletin merely "reiterate[d]" the agency's "longstanding position" on the meaning of the existing statute and regulations. Bulletin at 1. Texas therefore cannot show that the publication of that bulletin (the action challenged here) threatens the State with irreparable injury.

The premise of the State's motion is that, when CMS articulated its legal view in the informational bulletin, real harmful effects ensued immediately. But at the same time, Texas insists that earlier statements of the agency's interpretation had no effect at all. There is a fundamental incoherence to that position, which the State fails to resolve. Texas describes the Federal Register statement that hold harmless arrangements of the sort at issue here "are

inconsistent with existing statutory and regulatory requirements," 84 Fed. Reg. at 63,734, as completely ineffectual, apparently because it was made in the preamble to a notice of proposed rulemaking. And the State denigrates clear evidence, in an opinion of this Court, that it understood the agency's legal view long before the informational bulletin, on the ground that CMS did not prevail on a separate issue in that case. *See* Reply at 1, 14. More often, Texas simply ignores the agency's public statements. But the State insists that when CMS repeated the same legal interpretation in the informational bulletin, irreparable injury ensued.

There is nothing magical about a guidance document that would cause injury where other statements of the same legal position did not. If no irreparable harms flowed from the agency's earlier statements—and Texas does not allege that they did—then there is no reason to believe that they will flow from the bulletin now. For that reason alone, the State's motion should be denied.

The State's argument to the contrary rests on the assertion that, in the absence of preliminary injunctive relief, Texas will *actually undertake* burdensome compliance efforts—spending money, amending laws, inquiring into financial arrangements—that it did not take in response to earlier statements of the same legal view, and has not taken in the more than three months since the informational bulletin was published. As CMS explained in its opposition brief (at 19–20), that claim simply is not credible in light of the past history between the parties. If the Court denies this motion and proceeds to resolve the case on a standard briefing schedule, there is no reason to believe that, in the interim, Texas will undertake any compliance efforts at all. Texas does not even offer a response.

Instead, the State suggests a new harm that is neither imminent nor irreparable: the loss of federal matching funds. But the State does not face any imminent loss of funding, notwithstanding the OIG audit. As explained above, OIG will only issue a private, draft report to Texas this

summer. A final report will not follow until the fall, and only after Texas has the opportunity to submit comments on the draft. And even the final audit report will not disallow a single dollar of federal Medicaid funding, no matter what it ultimately recommends. OIG does not have the authority to disallow funds; only CMS does. And the State could retain any disputed federal funds during its appeal to the DAB. *See* 42 U.S.C. § 1396b(d)(5); 42 C.F.R. § 430.42(b). It is nearly certain that the Court would resolve this case before the DAB ruled on a hypothetical appeal from an equally hypothetical disallowance.

Texas attempts to salvage its motion by hypothesizing collateral effects of the OIG audit, but it confronts the same problem discussed above: the agency's position on the meaning of its statute and regulations has been public for many years, and yet the consequences that Texas predicts have not appeared. Nor is it apparent why an OIG recommendation that Texas return $35 million of federal funding—not the billions suggested in its motion—would cause health care providers to flee. *See* Reply at 1. The State's reply does nothing to bolster its showing of irreparable harm, and for that reason alone its motion should be denied.

**B. Texas has not shown a substantial likelihood of success on the merits.**

In its opposition brief, CMS explained that Texas has not established a substantial likelihood of success on its claims—both because the Court lacks jurisdiction to hear those claims, and because the claims are likely to fail on their own terms. Texas's reply does not successfully rebut either argument.

**i. The Court lacks jurisdiction to hear this case.**

**a. Texas lacks standing.**

Texas's standing suffers from the same defects as its arguments for irreparable injury. A guidance document that restates long-standing legal interpretations does not cause any injury,

because it does not alter the status quo. And by the same token, to enjoin the enforcement of such a guidance document would provide no redress, as Texas essentially admits in seeking broader preliminary relief. Even if Texas could challenge an informational bulletin written on a clean slate, as it insists on reply (at 3), those are not the circumstances here.

The State's argument to the contrary substantially rests on a single assertion: that, before the issuance of the informational bulletin, Texas was never "required by statute or rule to monitor and report on private business arrangements," such as one hospital that serves Medicaid beneficiaries arranging to pay another hospital that does not, in exchange for the latter hospital's political support of a tax to fund additional Medicaid payments. Reply at 3. The State claims that it has presented "unrebutted evidence" of this point, and cites three paragraphs in the initial declaration of Victoria Grady. *Id.* In the first, Ms. Grady declares that a CMS official provided assurances in "early 2019" that health care related taxes in which the taxpayers agreed to hold each other harmless from any cost of the tax would not affect the federal government's provision of matching funds. 1st Grady Decl. ¶ 24, ECF No. 10-2 at 9. The next cited paragraph acknowledges that CMS took the opposite position quite clearly and publicly later that year, when it said that such agreements "are inconsistent with existing statutory and regulatory requirements prohibiting hold harmless arrangements." 84 Fed. Reg. at 63,734. But Ms. Grady notes that Texas submitted comments disagreeing with that interpretation. 1st Grady Decl. ¶ 27. And the third cited paragraph appears to be entirely beside the point, describing the mutually-agreed conclusion of the earlier litigation between Texas and CMS, in which the Court clearly described but never resolved the parties' interpretive dispute about the contours of the hold harmless prohibition. *Id.* ¶ 39.

The State's supposed evidence does not prove its point—in fact, quite the opposite. Even if the Court credits the ambiguous allegation of private assurances in early 2019, any such

assurances were publicly repudiated later that year. The fact that Texas publicly disagreed with the agency's legal position in both rulemaking and litigation demonstrates the State's awareness of the agency's views.

The informational bulletin did not injure the State, and relief running against the bulletin would not provide the State with meaningful redress. For both of those reasons, its claims are unlikely to succeed.[2]

**b. Texas's challenge is not ripe, and the informational bulletin is not final agency action.**

CMS also explained in its opposition brief that Texas's challenge to the informational bulletin is not ripe for review, and that the challenged bulletin is not final agency action. On reply (at 4–5), Texas insists that the bulletin is ripe for review *because* it is final agency action. In making that argument, the State relies heavily on *Texas v. EEOC*, 933 F.3d 433 (5th Cir. 2019), which concerned a guidance document published by the Equal Employment Opportunity Commission. In that case, the Fifth Circuit explained that the finality of an agency action must be determined "flexibly and pragmatically," *id.* at 445, and that one significant indication of finality was a "withdrawal" of "the agency's discretion to adopt a different view of the law," *id.* at 442. Applying the required flexible, pragmatic approach here, it is clear that a guidance document restating the agency's well-established legal interpretation is not final agency action ripe for challenge—not least because such a document does not withdraw any pre-existing agency discretion. *Data Mktg. P'ship v. U.S. Dep't of Labo*r, 45 F.4th 846, 855 (5th Cir. 2022) (agency

[2] Nor can the State's procedural claim save it: vacatur of the informational bulletin on procedural grounds would provide no more redress than vacatur on substantive grounds, because both would return the agency to a status quo in which CMS interpreted the existing statute and regulations to prohibit the arrangements described in the bulletin. And even if the State had standing to press its procedural claim, that would do nothing to save its other claims.

guidance is not final agency action if it "calls attention to established principles," is "informational only," and "not binding . . . with respect to any particular factual situation" (quotations omitted)). Texas points again to the same three paragraphs of Victoria Grady's declaration discussed above, which still do not prove its characterization of the informational bulletin. *See supra* at 7.

As to ripeness, the core of the inquiry is whether "an administrative decision has been formalized and its effects felt in a concrete way by the challenging parties," or whether the challenge presents only "abstract disagreements over administrative policies." *Nat'l Park Hospitality Ass'n v. Dep't of the Interior*, 538 U.S. 803, 807–08 (2003). To be clear, the agency's view is not, *contra* Reply at 4, that pre-enforcement challenges are always barred, but only that this particular challenge is unripe. For the reasons discussed above and in the agency's opposition brief, the informational bulletin did not produce any "effects" that Texas has "felt in a concrete way." That portion of the ripeness inquiry overlaps with standing. *See Nat'l Park*, 538 U.S. at 807–08. The prudential aspect of ripeness looks to whether the quality of judicial decisonmaking would be improved by hearing the challenge at a later date. As CMS explained in opposition, withholding judicial review now would allow the Court "to assess whether a particular scheme of [health care related] taxation and reimbursement violated the statute and regulations," rather than choosing between the "abstract interpretations" offered by CMS and the State. Opp. at 24.

That would be especially valuable here, as agreements to reimburse providers for the cost of health care related taxes occur "with varying degrees of State awareness and involvement," 88 Fed. Reg. at 28,130, and such awareness or involvement is the core of the interpretive dispute between the parties. The State complains that "CMS offers no evidence that Texas has actual knowledge of any private reimbursement agreements among the State's . . . hospitals," Reply at 8, while at the same time asking this Court to enjoin an audit that might shed light on the issue. If

neither the State nor CMS presently knows the details of such agreements, it is prudent to withhold judicial review and allow those facts to emerge.[3]

**c. Texas has an adequate alternative remedy, and judicial review is barred by the *Thunder Basin* doctrine.**

In its opposition brief (at 26–28), CMS also noted that Section 704 "limits the APA to the review of those agency actions which otherwise lack an 'adequate remedy in a court.'" *Hinojosa v. Horn*, 896 F.3d 305, 310 (5th Cir. 2018) (per curiam) (quoting *Bowen v. Massachusetts*, 487 U.S. 879, 903 (1988)); 5 U.S.C. § 704. And parallel jurisdiction is precluded when it is "fairly discernible" that an elaborate statutory review scheme for administrative enforcement proceedings was intended to create an exclusive remedy. *See Thunder Basin Coal Co. v. Reich*, 510 U.S. 200, 207, 216 (1994) (quotation omitted). As CMS explained, such an adequate remedy through a statutory review scheme is provided by the governing statute. *See* 42 U.S.C. § 1316. On reply (at 5–6), the State insists that the general provisions of the APA supersede the specific provisions by which Congress structured judicial review of Medicaid disallowances, which they do not. For the reasons set forth in the agency's opposition brief, APA review is unavailable here, and Texas is therefore unlikely to succeed on its claims.

**ii. The challenged bulletin does not violate the Administrative Procedure Act.**

**a. The legal interpretation reiterated in the bulletin is lawful.**

In its opposition brief, CMS reviewed the history of the statutory and regulatory provisions at issue here. In short, 42 U.S.C. § 1396b(w)(4) was enacted to end a scheme in which states raised money selectively from hospitals serving a large share of Medicaid beneficiaries, collected federal

[3] To the extent that the State places particular emphasis on its procedural claim, it still cannot show concrete effects of the bulletin for the reasons discussed above, and that argument does nothing to show that its substantive claims are ripe.

matching funds, and then paid those same hospitals more than was originally raised from them. That scheme violated a fundamental premise of the Medicaid program, by allowing states to collect federal matching funds without a meaningful expenditure of their own funds, because no entity within the state actually bore the funding burden.

Such selective fund-raising could be accomplished in several ways: by accepting donations from hospitals serving the most Medicaid beneficiaries, for example, or imposing taxes focused narrowly on them (but not on other, similarly-situated hospitals). Hold harmless arrangements offered a way to transform an ostensibly broad-based tax into a selectively focused one, by reimbursing the hospitals that served fewer Medicaid beneficiaries after the fact, instead of exempting them from the tax in the first instance. In economic terms, it does not matter whether those taxpayers are excluded from the tax base, or included but then repaid: either way, the economic incidence of the tax falls only on the hospitals serving the most Medicaid beneficiaries. *See* Opp. at 3–4.

The statute forbids states to use such selective fundraising mechanisms to increase their federal Medicaid funding. If states accept donations from hospitals, or impose selective taxes on them—or broad-based taxes with an agreement to hold taxpayers harmless—then their federal matching Medicaid funds are generally reduced. 42 U.S.C. § 1396b(w)(1)(A). One exception to that general rule is relevant here: CMS can waive the requirements that a health care related tax be broad-based and uniform if—but only if—the tax is "generally redistributive," because its economic incidence falls more heavily on health care providers that serve fewer Medicaid beneficiaries. *Id.* § 1396b (w)(3)(E)(ii)(I). Any scheme that raises money predominantly from hospitals serving the most Medicaid beneficiaries requires a reduction in federal matching funds.

The statute and its implementing regulations thus ensure that federal funds are only provided to match Medicaid expenditures meaningfully funded by a given state, and that states do not place inequitable burdens on the hospitals serving the most Medicaid beneficiaries. As CMS has explained, arrangements in which the hospitals serving the most Medicaid beneficiaries agree to reimburse the other hospitals for their tax burden violate the statute and regulations, just as if the state or local government itself agreed to do so. CMS offered both a functional and a textual defense of that long-standing interpretation, and Texas responded to both.

Functionally, Texas suggests that arrangements in which health care providers agree to hold each other harmless do not allow states "to inflate their receipt of federal matching funds." Reply at 9. That is not so. Within certain programmatic limits, the more a state spends on medical assistance, the more it receives in federal matching funds. And to spend more, a state must find a source of additional state funds. Imposing a health-care related tax is one option for raising funds, but such taxes are often met with political opposition. A central purpose of hold harmless arrangements is to remove that political opposition by indemnifying taxpayers who would otherwise oppose the tax, because they would pay more in taxes than they received in additional Medicaid payments. With that groundwork laid, the state (or locality) can levy the tax, increase its spending, and inflate its receipt of federal funds. The scheme works equally well regardless of who provides the indemnity. This is not, as Texas would have it, a question of "what private parties can do with their own money" after they are reimbursed, Reply at 9, but rather of how much federal money they will receive in the first place. Health care related taxes supported by reimbursement agreements that free a state or local government from the political constraints that would otherwise ensure fiscal prudence do not qualify for federal matching funds.

That interpretation is entirely consistent with the text of the statute and regulations, which contemplate that both a hold harmless guarantee and the associated payment can be direct or indirect. When taxpayers enter an agreement to indemnify each other against the burdens of a health care related tax, each taxpayer receives a direct guarantee. And when Medicaid funds are redistributed to honor that guarantee, the state has made an indirect payment. Opp. at 30.

On the second point, Texas argues that it is meaningless to say Medicaid funds are redistributed, because such payments lose "the character of a Medicaid dollar" the moment they are made. Reply at 8. Money is certainly fungible, but when Hospital A receives an additional Medicaid payment that depends on a health care related tax, then pays Hospital B to ensure its support of the tax, one can hardly say that the payment to Hospital B is made from indistinct "operative revenue." *Id.* Rather, the two payments are tightly linked—to each other, and to the health care related tax. But for the additional Medicaid payment to Hospital A, the indemnifying payment to Hospital B would not occur. And but for the health care related tax, the additional Medicaid payment to Hospital A would not occur. Hospital A is willing to pay Hospital B because, if it does not do so, Hospital B will oppose the tax, and Hospital A will not receive the additional Medicaid payment. In this hold harmless arrangement, the tax and the two payments are closely dependent upon each other.

Texas also insists that, on their plain text, the statute and regulations only apply when a state or local government provides an explicit guarantee of indemnification. Mot. at 18-21. On reply (at 10), the State insists that "Congress has never ratified" the agency's contrary understanding. But that is not true. As relevant here, the 1991 statute said that a hold harmless arrangement exists when "[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." Pub. L. No. 102-234, § 2(a), 105 Stat. 1797, *codified at* 42 U.S.C. § 1396b(w)(4)(C) (1994). In implementing that definition, CMS established a regulatory test to identify "indirect" guarantees. The first half of that test looked at the taxation rate; the second half considered Medicaid payments made to the taxpayers. If the taxation rate was too high, and too many taxpayers received too much of "their total tax costs back in enhanced Medicaid payments or other State payments," then CMS would "consider a hold harmless provision to exist"—even if no entity (public or private) had made *any explicit guarantee at all*. 58 Fed. Reg. at 43,182 (promulgating 42 C.F.R. § 433.68(f)(3)(i)). Congress ratified this agency interpretation when it amended the statute in 2006. *See* Pub. L. No. 109-432, div. B, tit. IV, § 403, 120 Stat. 2922, 2994, *codified at* 42 U.S.C. § 1396b(w)(4)(C)(ii). That ratification is strong evidence against the State's unduly narrow understanding of the scope of covered guarantees.

Texas's claim that the informational bulletin is in excess of statutory authority and contrary to law is unlikely to succeed on the merits.

**b. The informational bulletin did not reverse prior agency interpretations, much less arbitrarily.**

So too is the claim that the informational bulletin represents an arbitrary reversal of agency policy. As discussed at length above, the interpretation set out in the informational bulletin has been consistently maintained by the agency over a period of years. *See* 84 Fed. Reg. at 63,734; *Texas v. Brooks-LaSure*, 2022 WL 741065, at *8–*9. Texas's arbitrary-and-capricious argument ignores or denigrates those clear public statements in favor of an ambiguous email from April 2019, to which Texas was not a party; informal advice allegedly provided on "one of [a] multitude of calls" held around the same time, 2d Grady Decl. ¶ 17, ECF No. 22-1 at 7; and 2012 testimony from someone in the Office of Inspector General, which does not make policy for CMS. *See* Reply at 12–14. The thrust of Texas's argument is that because, in the State's view, the agency's true

position could be found in these documents or recollected phone calls, and not in the agency's clear statements in the Federal Register and before this Court, it was arbitrary for CMS to adhere to its longstanding public view in the informational bulletin. But Texas does not point to a single document in which a CMS official *actually says* what the State insists was agency policy.

On reply (at 12), Texas also suggests that the interpretation in the informational bulletin is inconsistent with the preamble to the 2008 regulations, which said that payments "controlled or directed by the state" would "be considered in evaluating whether an impermissible hold harmless arrangement exists." 73 Fed Reg. at 9,694. In the example immediately preceding that statement, a state makes a payment to a nursing home resident, who transmits it to the nursing home, thus holding the nursing home harmless against a tax separately imposed by the state. The payment to the resident is "controlled or directed by the state," and there is a "reasonable expectation" that it will be used to indemnify the nursing home. *Id.* The circumstances discussed in the informational bulletin are precisely analogous: a state makes a Medicaid payment to one health care provider, which there is a reasonable expectation will be used to indemnify another provider. Nor is Texas right to suggest that "read in context," Reply at 12, only a state's reasonable expectations are relevant to the analysis laid out in the preamble. And of course, the State's position here is that even when a state reasonably expects indemnification, no hold harmless arrangement exists.

The State is unlikely to succeed on the merits of that claim.

**c. The informational bulletin is an interpretive rule, for which notice and comment are not required.**

Finally, CMS explained in opposition (at 34–35) that the informational bulletin is an interpretive rule, "issued by an agency to advise the public of the agency's construction of the statutes and rules which it administers." *Perez v. Mortg. Bankers Ass'n*, 575 U.S. 92, 97 (2015) (quoting *Shalala v. Guernsey Mem'l Hosp.*, 514 U.S. 87, 99 (1995)). Such rules "'clarify a

statutory or regulatory term, remind parties of existing statutory or regulatory duties, or 'merely track[]' preexisting requirements and explain something the statute or regulation already required." *POET Biorefining, LLC v. EPA*, 970 F.3d 392, 407 (D.C. Cir. 2020) (quoting *Mendoza v. Perez*, 754 F.3d 1002, 1021 (D.C. Cir. 2014)). And they are exempt from notice and comment.

CMS noted that the State did not even discuss such interpretive rules in its motion. On reply (at 10), Texas insists that it did and points to two pages of its motion (at 25–26) where they are not discussed. Texas then refers to its arguments that the informational bulletin effected a substantive change in agency position, which it did not for reasons discussed at length throughout the briefing on this motion. And finally, Texas points to two rulemakings in which CMS affirmed the views expressed in the informational bulletin as evidence that CMS does not actually hold those views. The State's position is untenable: proposing a regulatory change that is not adopted, as CMS did in 2019, *see* 84 Fed. Reg. at 63,734–35, does not discredit the agency's interpretation of its existing statute and regulations. The current rulemaking reaffirms that interpretation of existing authorities in the context of proposing a new attestation requirement. *See* 88 Fed. Reg. at 28,130–31. Neither rulemaking supports the State's argument, and Texas therefore has not shown a likelihood of success on its procedural claim.

**C. Texas has not shown that the requested injunction would serve the public interest.**

Texas suggests that this Court should enter an injunction "to preserve . . . the status quo as everyone has long understood it." Reply at 17. As discussed at length above and in the agency's opposition brief, the State's description of that status quo ignores years of agency statements to the contrary. And such an interest cannot possibly justify an injunction barring the independent Office of Inspector General from concluding an audit that has been under way since 2021. The public interest does not favor injunctive relief here.

**D. Any injunctive relief should be tailored to the claims and parties before the Court.**

Injunctive relief must be "narrowly tailored to remedy the specific action which gives rise to the order as determined by the substantive law at issue." *Scott v. Schedler*, 826 F.3d 207, 211 (5th Cir. 2016) (internal quotation marks and alterations omitted). "This means that an injunction cannot '. . . exceed the legal basis of the lawsuit.'" *E.T. v. Paxton*, 19 F.4th 760, 769 (5th Cir. 2021) (quoting *Scott*, 826 F.3d at 214). And where an injunction can be "tailored to address only the . . . plaintiffs in th[e] action," it must be. *Id.*

In this case, Texas brings only APA claims, and on this motion it challenges only the informational bulletin. The APA empowers courts to "hold unlawful and set aside agency action." 5 U.S.C. § 706(2). The "specific action" and "substantive law at issue," therefore, would at most support an injunction against the agency action challenged here: the informational bulletin itself, and not the amorphous "rule it contains." *See* Reply at 2. And by the same token, an injunction could be easily tailored to address only the present plaintiffs.

In any event, no injunctive relief should issue against the HHS Office of Inspector General which, as explained above, has no authority to disallow federal funds. Hagg Decl. ¶ 16. Such an injunction would be especially inappropriate in light of OIG's responsibility to inform Congress about issues in the Medicaid program, *see id.* ¶ 2, and the State's contention that congressional action would be required to address the practices discussed in the informational bulletin.

**CONCLUSION**

For the reasons set forth above and in the agency's opposition brief, the motion for a preliminary injunction should be denied.

Respectfully submitted,

BRIAN M. BOYNTON
Principal Deputy Assistant Attorney General

MICHELLE BENNETT
Assistant Director, Federal Programs Branch

*/s/ James Bickford*
JAMES BICKFORD
Trial Attorney (N.Y. Bar No. 5163498)
United States Department of Justice
Civil Division, Federal Programs Branch
1100 L Street, NW
Washington, DC 20530
James.Bickford@usdoj.gov
Telephone: (202) 305-7632
Facsimile: (202) 616-8470

*Counsel for Defendants*

Date: May 26, 2023

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE EASTERN DISTRICT OF TEXAS**
**TYLER DIVISION**

| | | |
|---|---|---|
| **STATE OF TEXAS**, et al., | ) | |
| | ) | |
| Plaintiffs, | ) | |
| | ) | |
| v. | ) | Case No. 6:23-cv-161 (JDK) |
| | ) | |
| **CHIQUITA BROOKS-LASURE**, et al., | ) | |
| | ) | |
| Defendants. | ) | |
| | ) | |

**DECLARATION OF JOHN D. HAGG**

I, John D. Hagg, hereby make the following declaration:

1. I am an Assistant Inspector General within the Office of Audit Services (OAS), which is a component of the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS). I have served in this position since March 2021. Before then, I was the Director of Medicaid Audits in OAS for nearly 17 years since April 2004.

2. The OIG is an independent, objective oversight agency with dual reporting responsibility to the Secretary of HHS and to Congress.[1] The mission of the OIG is to provide objective oversight to promote the economy, efficiency, effectiveness, and integrity of the HHS programs, as well as the health and welfare of the people they serve.

3. OIG works with HHS staff and operating divisions, the Department of Justice (DOJ), other executive branch agencies, Congress, States, and private sector representatives to achieve systemic improvements, improved compliance, successful enforcement actions, and

[1] *See* https://oig.hhs.gov/documents/root/1060/About-OIG-Fact-Sheet-December2022.pdf (last updated December 2022).

recovery of misspent funds.[2] Overseeing the Medicaid program is a critical component of that mission. Medicaid spending totals almost $750 billion, and the program serves more than 85 million individuals.

4. Pursuant to the duties and responsibilities provided in the Inspector General Act of 1978 (Inspector General Act), as amended (5 U.S.C. §§ 401-424), and other authorities, OIG advances its mission through a robust program of audits, evaluations, investigations, and compliance efforts. Within OIG is OAS, which is tasked with conducting independent audits of HHS programs and/or HHS grantees and contractors. These audits examine the performance of HHS programs and/or grantees in carrying out their responsibilities and provide independent assessments of HHS programs and operations.[3]

5. The Inspector General Act requires that OIG operate with independence from HHS and prohibits HHS from preventing or impeding OIG audits (5 U.S.C. § 403(a)). The Inspector General Act also requires that OIG obtains legal advice from legal counsel reporting directly to the Inspector General (5 U.S.C. § 403(g)).

6. In addition, as required by the Inspector General Act, OIG audits are conducted in accordance with generally accepted government auditing standards (5 U.S.C. § 404(b)(1)). These standards require that we plan and perform audits to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions. The standards also require that we maintain independence so that so that our findings, conclusions, and recommendations are impartial.

---

[2] *See* https://oig.hhs.gov/documents/root/1060/About-OIG-Fact-Sheet-December2022.pdf (last updated December 2022).

[3] *See* https://oig.hhs.gov/about-oig/organization-chart/

7. OIG develops and maintains a work plan of audits and other reviews in accordance with an internal work planning process. The work planning process focuses on matters deemed by OIG to be of high risk with respect to a variety of program vulnerabilities, including program fraud and abuse, waste of program funds, and beneficiary health and safety. This process is conducted independently and is informed by a wide variety of inputs, including internal data analysis and research, prior OIG findings and recommendations, current events relating to the public health, and reports by other oversight agencies such as the Government Accountability Office.

8. In September 2019, during an OIG audit of uncompensated care payments made under Texas's Medicaid program, OIG auditors identified potential concerns related to Texas's use of Local Provider Participation Funds (LPPFs). In 2021, OIG auditors developed a proposal to audit States' use of LPPFs as the State share of Medicaid payments. In October 2021, the audit proposal was submitted to OIG's Engagement Committee, which approved the proposal. In mid-November 2021, OIG included in its public work plan an item for the audit on the OIG website, which stated that: "In the past several years, some States and local units of governments have increasingly used LPPFs to fund the State share of Medicaid payments. As such, we will determine whether the LPPFs the State agency used as the State share of Medicaid payments were permissible and in accordance with applicable Federal and State requirements."

9. In March 2022, the OIG audit team sent an engagement letter to the Texas Health and Human Services Commission (HHSC). In April 2022, the OIG audit team conducted an entrance conference with representatives from HHSC to inform them of the planned objectives of the audit and the information to which the audit team would need access to conduct the audit.

The audit team then collected information on Medicaid payments that were matched by LPPFs that Texas claimed in federal fiscal year 2019.

10. Based on the information collected, the audit team made the decision to focus its audit on one particular Texas county, Smith County. In August 2022, the OIG sent an engagement letter to Smith County, informing it of the audit. In September 2022, the OIG audit team conducted an entrance conference with representatives of Smith County to discuss the planned objectives of the audit and the information OIG would be seeking. Shortly thereafter, OIG began reviewing the information it received from Smith County regarding, among other things, the tax assessments Smith County had collected from private hospitals in the county in connection with the local health care-related tax.

11. In November 2022, the OIG audit team identified potential concerns about whether the LPPF in Smith County complied with the hold harmless prohibitions in 42 U.S.C. § 1396b(w)(4) and 42 C.F.R. § 430.68(f). At that time, the OIG audit team decided to narrow its immediate focus on potential violations of these hold harmless prohibitions. At that time, the OIG audit team also began considering whether to audit LPPFs in other Texas localities for compliance with the same hold harmless prohibitions.

12. The OIG audit team later notified HHSC to that effect in early March 2023. At that time, the OIG audit team also informed HHSC of its decision to audit the LPPFs of two other Texas counties and one Texas city for compliance with the hold harmless prohibitions in the health care-related tax rules.

13. On May 1, 2023, the OIG audit team conducted an exit conference with representatives from HHSC concerning the audit of the LPPF in Smith County. At that exit conference, the audit team relayed its draft findings and recommendations concerning HHSC's

compliance with the hold harmless prohibitions related to health care-related taxes. The audit team also indicated to HHSC that it intended to provide a draft report of its findings and recommendations to HHSC in July 2023.

14. Government Auditing Standards require OIG to solicit comments from the auditee about the OIG's draft findings and recommendations. Auditees usually are given 30 days to provide any such comments, but an auditee may seek additional time that OIG may, in its discretion, grant. After OIG receives and considers comments from an auditee, OIG prepares a final report that includes a summary of the auditee's comments and either makes changes based on those comments or provides a response to those comments.

15. Based on these standard practices and procedures, OIG currently anticipates that it will not provide a final report of its findings and recommendations concerning HHSC's compliance with the hold harmless prohibitions in the health care-related tax rules until September 2023 at the earliest. In accordance with our standard practices, OIG will not publish any of its findings or recommendations until that final report is released.

16. Although OIG has the authority to make findings and recommendations, it cannot disallow any Medicaid payments. Only CMS officials have the authority to make disallowances.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief. 28 U.S.C. § 1746. Executed this 26th day of May, 2023.

John D. Hagg

John D. Hagg

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE EASTERN DISTRICT OF TEXAS**
**TYLER DIVISION**

| | | |
|---|---|---|
| STATE OF TEXAS, et al., | § | |
| | § | |
| Plaintiffs, | § | |
| | § | |
| v. | § | Case No. 6:23-cv-161-JDK |
| | § | |
| CHIQUITA BROOKS-LASURE, et al., | § | |
| | § | |
| Defendants. | § | |
| | § | |

**MEMORANDUM OPINION AND ORDER GRANTING TEXAS'S MOTION FOR PRELIMINARY INJUNCTION**

The State of Texas seeks to enjoin the Centers for Medicare and Medicaid Services ("CMS") from enforcing a recent bulletin addressing Medicaid funding and the redistribution of Medicaid payments.

Medicaid is a jointly funded program, under which the federal government matches state contributions for medical care for low-income patients. The Social Security Act permits states to fund their share through assessing a "broad-based" tax on health-care providers. States, however, may not fund their share through taxes that "hold harmless" providers—i.e., states may not guarantee that providers will recoup their tax contributions. A February 2023 bulletin from CMS clarifies that the agency considers certain private agreements between providers to constitute hold-harmless arrangements.

Texas argues that the bulletin exceeds CMS's statutory and regulatory authority, did not go through notice-and-comment rulemaking, and is arbitrary and

capricious because it departs from past practice and fails to consider the State's substantial reliance interests. Texas thus contends that the bulletin violates the Administrative Procedure Act and asks the Court to preliminarily enjoin its enforcement during this litigation.

As explained below, the Court finds that Texas is entitled to a preliminary injunction and therefore **GRANTS** the State's motion (Docket No. 10).

## I. BACKGROUND

This case continues an ongoing dispute between Texas and the U.S. Department of Health and Human Services ("HHS") regarding the hold-harmless prohibition.

In a prior lawsuit, Texas obtained a preliminary injunction requiring CMS to follow certain agreed-to procedures for review of the State's Medicaid programs. *Texas v. Brooks-LaSure*, 2021 WL 5154219, at *1 (E.D. Tex. Aug. 20, 2021) (Barker, J.). Texas later sought to enforce the injunction, arguing CMS ignored those procedures, among which was the requirement to work "collaborative[ly]" with Texas. *Texas v. Brooks-LaSure*, 2022 WL 741065, at *1 (E.D. Tex. Mar. 11, 2022) (Barker, J.). CMS attempted to justify its delay by asserting that it believed arrangements among Texas hospitals created prohibited "hold-harmless" guarantees. *Id.* The Court in that case explained the statutory and regulatory background of the hold-harmless issue, *id.* at *2–9, but did not "need to resolve that interpretive dispute" to grant Texas's motion to enforce the injunction, *id.* at *9–10.

Then, on February 17, 2023, CMS published an "Informational Bulletin" squarely addressing the hold-harmless prohibition as it relates to private agreements

among providers. Docket No. 1, Ex. 1 at 1.[1] In the Bulletin, the agency stated it "intends to inquire about" these arrangements and "reduce a state's medical assistance expenditures"—i.e., disallow state funds eligible for federal Medicaid matching—"by the amount of health care-related tax collections that include" these arrangements. *Id.* at 5.

Before addressing the February Bulletin, the Court explains the relevant features of Medicaid, hold-harmless provisions, and Texas's Medicaid-funding scheme.

### A. The Medicaid Program

"Medicaid, established under Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq.*, is a 'cooperative federal-state program that provides federal funding for state medical services to the poor.'" *NB ex rel. Peacock v. District of Columbia*, 794 F.3d 31, 35 (D.C. Cir. 2015) (quoting *Frew ex rel. Frew v. Hawkins*, 540 U.S. 431, 433 (2004)); Social Security Amendments of 1965, Pub L. No. 89-97, 79 Stat. 286. To qualify for federal funding, states must submit a Medicaid plan detailing how they will meet the Social Security Act's requirements. § 1396a(a).

If a state's plan satisfies the requirements of the Social Security Act, the federal government acting through HHS helps fund the program according to a matching formula. *Id.* § 1396b(a). The rate at which HHS matches a state's Medicaid expenditures for covered services ranges from 50% to 83%. *Id.* § 1396d(b). HHS

[1] CTR. FOR MEDICARE & MEDICAID SERVS., HEALTH CARE-RELATED TAXES AND HOLD HARMLESS ARRANGEMENTS INVOLVING THE REDISTRIBUTION OF MEDICAID PAYMENTS (2023), https://www.medicaid.gov/federal-policy-guidance/downloads/cib021723.pdf.

reimburses approximately 60% of Texas's medical expenditures under its state plan. Docket No. 10, Ex. 2 ¶ 6 [hereinafter Grady Declaration] (declaration of Victoria Grady, Director of Provider Finance for the Texas Health and Human Services Commission). Texas covers the remaining share.

Not all state funding qualifies for matching federal dollars, however. "In the late 1980s and early 1990s, states began to take advantage of a 'loophole' in the Medicaid program that allowed states to gain extra federal matching funds without spending more state money." *Protestant Mem. Med. Ctr., Inc. v. Maram*, 471 F.3d 724, 726 (7th Cir. 2006). States took advantage of this loophole in several ways. Medicaid Program; Medicaid Fiscal Accountability Regulation, 84 Fed. Reg. 63,722, 63,730 (Nov. 18, 2019) (proposed rule). In one common scheme, states imposed taxes on hospitals, while simultaneously agreeing to repay hospitals the amount of their tax payment. *Id.* As a result, a state could draw additional federal matching funds without having to contribute additional state money towards its Medicaid contribution. *Id.* Taxpaying hospitals too came out "harmless" in these agreements, recouping their increased tax burden through state payments. *Id.*

In response, Congress amended the Social Security Act by passing the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, Pub. L. No. 102-234, 105 Stat. 1,793 (codified as amended at 42 U.S.C. § 1396b(w)). There, Congress clarified that states may fund their share of Medicaid by assessing taxes on health-care-related items, services, or providers, but they may do so *only if* the tax is (1) "broad-based," and (2) contains no "hold harmless provision."

§ 1396b(w)(1)(A)(iii). The statute defined "hold harmless provision" in three ways, only the third of which is relevant here.[2] Under that definition—which has not changed[3]—a hold-harmless provision exists if:

> (C)
>
> (i) 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.

*Id.* § 1396b(w)(4). Congress instructed HHS to reduce matchable state funds by the amount of any revenue received from a health-care-related tax "if there is in effect a hold harmless provision (described in paragraph (4)) with respect to the tax." *Id.* § 1396b(w)(1)(A)(iii).

After the statute took effect, CMS issued rules implementing the statutory "hold harmless provision" definition found at § 1396b(w)(4). Medicaid Program; Limitations on Provider-Related Donations and Health Care-Related Taxes; Limitations on Payments to Disproportionate Share Hospitals, 58 Fed. Reg. 43,156 (Aug. 13, 1993). In 2008, the agency updated the regulations, seeking to "clarify" the

---

[2] The Bulletin references only the third definition. *See* Docket No. 10, Ex. 1 (citing § 1903(w)(4)(C)(i) of the Social Security Act, which is codified at 42 U.S.C. § 1396b(w)(4)(C)(i)). At oral argument, counsel for CMS conceded that only the third definition applies here. Hearing Tr. 6/8/2023 at 32:25–33:9.

[3] The text of paragraph (C)(i) originally constituted the entirety of paragraph (C), and has remained unchanged since the 1991 amendments. *See* § 2, 105 Stat. at 1,797 (original text of 42 U.S.C. § 1396b(w)(4)(C)(i)). Congress later incorporated by reference a test for "indirect guarantees" from an agency rulemaking. *See Tax Relief and Health Care Act of 2006*, Pub. L. No. 109-432, § 403, 120 Stat. 2,922. When Congress made this change, it relocated the text of paragraph (C) to paragraph (C)(i), without changing its substance or text. And the adopted agency rulemaking for "indirect guarantees" became paragraph (C)(ii). CMS concedes that paragraph (C)(ii) does not apply here, and instead relies only on the definition codified at § 1396b(w)(4)(C)(i). Docket No. 17 at 30 n.12 ("CMS does not contend that this arrangement presents an indirect guarantee"); Hearing Tr. 6/8/2023 at 32:25–33:11.

regulatory tests for hold-harmless provisions. *See* Medicaid Program; Health Care-Related Taxes, 73 Fed. Reg. 9,685, 9,686 (Feb. 22, 2008). Under the 2008 regulations—which are still in force today—a hold harmless provision exists under the third definition if:

> 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.

*Id.* at 9,699 (codified at 42 C.F.R. § 433.68(f)(3) (2008)).

### B. Texas Local Provider Participation Fund

In 2013, the Texas legislature authorized certain hospital districts, counties, and municipalities to collect "mandatory payments from each of those [entities] to be used to provide the nonfederal share of a Medicaid supplemental payment program." TEX. HEALTH & SAFETY CODE § 300.0001; *accord* Act of May 24, 2013, 83d Leg., R.S., ch. 1369, § 18, 2013 Tex. Gen. Laws 3,630, 3,640 (codified at HEALTH & SAFETY Ch. 288).

If the taxing entity authorizes a "mandatory payment[]" (which both parties here call a "tax"), it must assess the tax based "on the net patient revenue of each" hospital. HEALTH & SAFETY § 300.0151(a). This money is then deposited into a "local provider participation fund" and may be used for limited purposes, including intergovernmental transfers to the State to pay the "nonfederal share of Medicaid." *Id.* § 300.0103(a)–(b). Authorized taxes must be "uniform[]." *Id.* § 300.0151(b). And Texas law prohibits these programs from "hold[ing] harmless any institutional health care provider, as required under 42 U.S.C. Section 1396b(w)." *Id.*

Texas's methodologies for issuing Medicaid payments "are not correlated in any way to the amount paid by a taxpayer to a local government that has authority to operate a [local provider participation fund]." Grady Declaration at 5.

**C. Proposed Changes**

In 2019, CMS proposed a rule to amend its regulations on hold-harmless arrangements. 84 Fed. Reg. at 63,730. There, CMS explained it had

> 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 the Medicaid payments back to the taxpayers. The taxpayers enter into an agreement, which may or may not be written, to ensure that taxpayers . . . receive all or any portion of their tax amount back.

84 Fed. Reg. at 63,734. In the preamble to the proposed changes, CMS clarified that it considered such arrangements to violate the ban on hold-harmless provisions, even if "a private entity makes the redistribution" to another private entity. *Id.* at 63,735. The agency contended that a purely private arrangement still "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." *Id.*

CMS thus proposed to amend the third regulatory hold-harmless definition to specify that the agency would consider the "net effect" of a particular arrangement, described elsewhere as a "totality of the circumstances" analysis. *Id.* at 63,735. This analysis would specifically include the "reasonable expectations of the participating entities" and their "reciprocal actions." *Id.* at 63,777.

In 2021, however, CMS withdrew these proposed amendments. Medicaid Program; Medicaid Fiscal Accountability Regulation, 86 Fed. Reg. 5,105 (Jan. 19,

2021). In its notice of withdrawal, CMS noted that "[n]umerous commenters indicated that CMS, in some instances, lacked statutory authority for its proposals . . . ." *Id.* Based on the "considerable feedback we received through the public comment process, we have determined it appropriate to withdraw the proposed provisions at this time." *Id.*

The next year, in the above-described litigation between CMS and Texas, the agency echoed its position from the withdrawn amendments, arguing to the Court that private agreements to redistribute Medicaid reimbursements constitute hold-harmless provisions. *Texas v. Brooks-LaSure*, 2022 WL 741065, at *1 (E.D. Tex. Mar. 11, 2022) (Barker, J.). As stated above, the Court did not need to resolve the parties' interpretive dispute to issue a decision in that case. *Id.* at *9.

**D. CMS Bulletin**

On February 17, 2023, CMS issued the "Informational Bulletin" at issue here. The Bulletin formally adopted the agency's position from the 2019 withdrawn amendment and its 2022 litigation against Texas. Docket No. 1, Ex. 1 at 1. In the Bulletin, CMS again expressed concern about private arrangements:

> Recently, CMS has become aware of some health care-related tax programs 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).

*Id.* The Bulletin concluded these arrangements "would constitute a prohibited hold harmless provision under" both 42 U.S.C. § 1396b(w)(4)(C)(i) and 42 C.F.R. § 433.68(f)(3). *Id.* at 5. Accordingly, CMS promised to "reduce a state's medical

assistance expenditures by the amount of health care-related tax collections that include" these arrangements. *Id.*

The Bulletin also required states to collect and disclose information concerning these arrangements to CMS. *Id.* Specifically, CMS instructed states to:

- "make clear to their providers that these arrangements are not permissible under federal requirements, learn the details of how health care-related taxes are collected, and take steps to curtail these practices if they exist";
- collect "detailed information available regarding their health care-related taxes"; and
- "make available all requested documentation regarding arrangements involving possible hold harmless arrangements and the redistribution of Medicaid payments."

*Id.* Further, CMS instructed states to "condition" their providers' participation in Medicaid on the full disclosure of this information. *Id.* The agency warned that "a failure to comply with" these requirements "may result in a deferral or disallowance of federal financial participation." *Id.* (citing 42 C.F.R. § 433.74(d)).

* * *

After CMS issued the Bulletin, Texas filed suit in this Court, arguing the Bulletin is unlawful under the Administrative Procedure Act ("APA"). Docket No. 1. Specifically, Texas argues the Bulletin exceeds CMS's statutory authority, does not comport with the APA's notice-and-comment requirement, and is arbitrary and capricious. *Id.* at 26–31. Alternatively, Texas argues that CMS's 2008 regulations are contrary to CMS's statutory authority. *Id.* at 31–32.

On April 24, 2023, Texas moved for a preliminary injunction enjoining Defendants from "enforcing the February 17 bulletin or taking [any other] actions in

reliance on the bulletin." Docket No. 10 at 34. Defendants opposed the motion on the merits, and additionally argued the Court lacks jurisdiction to enter the requested relief. Docket No. 17. The Court heard oral argument on the motion on June 8, 2023.

For the following reasons, the Court finds that it has jurisdiction and that Texas is entitled to the preliminary injunction it seeks.

## II. JURISDICTION

CMS argues the Court lacks jurisdiction for five reasons: (1) Texas lacks standing, (2) Texas's claims are not ripe, (3) the Bulletin is not final agency action, (4) Texas has an adequate alternative remedy under the statute, and (5) judicial review is barred under *Thunder Basin Coal Co. v. Reich*, 510 U.S. 200, 207, 216 (1994). Docket No. 17 at 21–28. The Court addresses each argument in turn.

### A. Article III Standing

"The first jurisdictional question is whether the plaintiffs have standing" to challenge the Bulletin. *Tex. Democratic Party v. Abbott*, 978 F.3d 168, 178 (5th Cir. 2020); *see also DaimlerChrysler Corp. v. Cuno*, 547 U.S. 332, 340–41 (2006) ("If a dispute is not a proper case or controversy, the courts have no business deciding it, or expounding the law in the course of doing so."). Article III of the U.S. Constitution limits federal courts to deciding only "cases" or "controversies," which ensures that the judiciary "respects the proper—and properly limited—role of the courts in a democratic society." *DaimlerChrysler*, 547 U.S. at 341 (cleaned up); *see also Raines v. Byrd*, 521 U.S. 811, 829 (1997) ("Our regime contemplates a more restricted role for Article III courts . . . 'not some amorphous general supervision of the operations of government.'" (quoting *United States v. Richardson*, 418 U.S. 166, 192 (1974))).

"[A]n essential and unchanging part of the case-or-controversy requirement of Article III" is that the plaintiff has standing. *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560 (1992). The standing requirement is not subject to waiver and requires strict compliance. *E.g.*, *Lewis v. Casey*, 518 U.S. 343, 349 n.1 (1996). As the party invoking federal jurisdiction, Texas must establish Article III standing by showing that it has suffered "an injury that is 'concrete, particularized, and actual or imminent; fairly traceable to the challenged action; and redressable by a favorable ruling.'" *Texas v. United States*, 809 F.3d 134, 150 (5th Cir. 2015) (quoting *Clapper v. Amnesty Int'l USA*, 568 U.S. 398, 409 (2013)).

To start, Texas is the object of the Bulletin. If a plaintiff is an object of a regulation, "there is ordinarily little question that the action or inaction has caused him injury, and that a judgment preventing or requiring the action will redress it." *Contender Farms, L.L.P. v. U.S. Dep't of Agric.*, 779 F.3d 258, 264 (5th Cir. 2015). "Whether someone is in fact an object of a regulation is a flexible inquiry rooted in common sense." *Texas v. Equal Employment Opportunity Comm'n (Texas v. E.E.O.C.)*, 933 F.3d 433, 446 (5th Cir. 2019). The Bulletin explicitly commands the states, including Texas, to collect information about their "health care-related taxes" and "the redistribution of Medicaid payments[,]" and threatens to "disallow[] federal financial participation" for those states that fail to comply. Docket No. 1, Ex. 1 at 5. "Thus, by its own terms, the [Bulletin] covers Texas." *Texas v. E.E.O.C.*, 933 F.3d at 446 (finding Texas was the object of a "Guidance" regarding "entities covered by Title VII," which includes state employers).

Texas, moreover, identifies several separate injuries in fact. "An increased regulatory burden typically satisfies the injury in fact requirement." *Contender Farms*, 779 F.3d at 266. Additionally, "being pressured to change state law constitutes an injury," because "states have a sovereign interest in the power to create and enforce a legal code." *Texas v. United States*, 787 F.3d 733, 749 (5th Cir. 2015) (cleaned up). Here, Texas has submitted unrebutted evidence that its agencies currently lack the authority to investigate the arrangements identified by CMS. Grady Declaration at 7–8 (describing the ability to investigate private agreements as "beyond [Texas's] authority" and that Texas "did not have authority to seek that type of information"). Texas would thus be required to change its laws to furnish "all requested documentation regarding arrangements involving possible hold harmless arrangements and the redistribution of Medicaid payments" as required by the Bulletin. Docket No. 10, Ex. 1 at 5 (Bulletin); *see also* Grady Declaration at 7–8. This constitutes an injury. *Texas v. E.E.O.C.*, 933 F.3d at 447 (finding an injury where the "Guidance imposes a regulatory burden on Texas to comply with the Guidance to avoid enforcement actions and, consequently, pressures it to abandon its laws and policies.").

Texas has also alleged a procedural injury, which occurs when a plaintiff shows it has been deprived of "a procedural right to protect [its] concrete interests." *Summers v. Earth Island Inst.*, 555 U.S. 488, 496 (2009). "A violation of the APA's notice-and-comment requirements is one example of a deprivation of a procedural right." *Texas v. E.E.O.C.*, 933 F.3d at 447 (citing *Sierra Club v. EPA*, 699 F.3d 530,

533 (D.C. Cir. 2012). Here, Texas alleges that CMS was required to publish the Bulletin through notice and comment. Docket No. 10 at 23–26. Although CMS disputes this allegation, Docket No. 17 at 34–35, the Court "assume[s], for purposes of the standing analysis, that Texas is correct on the merits of its claim that the [Bulletin] was promulgated in violation of the APA." *Texas v. E.E.O.C.*, 933 F.3d at 447. Texas must merely show a "reasonable claim of minimal impact" in failing to adhere to proper procedure. *Kinetica Partners, LLC v. U.S. Dep't of the Interior*, 505 F. Supp. 3d 653, 671 (S.D. Tex. 2020) ("A procedural injury can suffice for standing even where the plaintiff does not prove that adherence to the proper procedure would have produced a different outcome because the likelihood and extent of impact are properly addressed in connection with the merits in a harmless error analysis."), *appeal dismissed*, 2021 WL 3377978 (5th Cir. Mar. 22, 2021). Texas has done so here. *See* Grady Declaration at 7–8 (discussing impact).

CMS argues Texas's alleged injuries are not traceable to the Bulletin, which simply represents the agency's "longstanding" interpretation of existing statutory and regulatory authorities on "hold harmless" provisions. Docket No. 17 at 22. Until now, however, CMS has maintained an equivocal stance on these agreements. *Compare* Docket No. 10, Ex. 3 (2019 email exchange in which a CMS representative confirmed there were "arrangements out there among providers" that CMS "do[es] not particularly like" but *lacks* the "statutory authority to address"), *with* 84 Fed. Reg. at 63,734 (withdrawn 2019 proposed rule stating that private agreements among providers to share tax burden "are inconsistent with existing statutory . . .

requirements prohibiting hold harmless arrangements"). The Bulletin, by contrast, formally states CMS's position and requires Texas to amend its laws to comply with the Bulletin's requirements. Thus, there is traceability. *Texas v. E.E.O.C.*, 933 F.3d at 448 (finding traceability where a "Guidance" letter pressured Texas to change its laws). And although CMS does not argue a lack of redressability, the Court finds that an injunction prohibiting CMS from enforcing the Bulletin would redress Texas's injuries, fulfilling the third and final standing requirement. *Id.*; *see also Contender Farms*, 779 F.3d at 264 ("If a plaintiff is an object of a regulation 'there is ordinarily little question that the action or inaction has caused him injury, and that a judgment preventing or requiring the action will redress it.'" (quoting *Lujan*, 504 U.S. at 561–62)).

Accordingly, Texas has standing.

**B. Ripeness**

CMS also argues Texas's claims are "unripe." Docket No. 17 at 22–25. According to CMS, the claims will ripen only after CMS disallows funds for violating the legal interpretation expressed in the Bulletin. *Id.* at 23–24.

The ripeness and standing analyses are closely related, as ripeness inquires as to "whether the harm asserted has matured sufficiently to warrant judicial intervention." *Miss. State Democratic Party v. Barbour*, 529 F.3d 538, 544–45 (5th Cir. 2008) (quoting *Warth v. Seldin*, 422 U.S. 490, 499 n.10 (1975)). "Determining whether administrative action is ripe for judicial review requires [the Court] to evaluate (1) the fitness of the issues for judicial decision and (2) the hardship to the parties of withholding court consideration." *Nat'l Park Hosp. Ass'n v. Dep't of Interior*,

538 U.S. 803, 808 (2003); *see also Braidwood Mgmt., Inc. v. Equal Emp. Opportunity Comm'n*, 2023 WL 4073826, at *11 (5th Cir. June 20, 2023).

Here, Texas advances a purely legal challenge, arguing the Bulletin violates the APA in several ways. And "a claim is 'fit for judicial decision' if it presents a pure question of law that needs no further factual development." *Braidwood Mgmt., Inc.*, 2023 WL 4073826, at *12 ("[N]o further factual investigation is required to determine whether, for example, RFRA supersedes Title VII's requirements . . . ."); *Contender Farms*, 779 F.3d at 267 ("It is unnecessary to wait for the [Bulletin] to be applied in order to determine its legality.").

Texas, moreover, faces hardship because it will need to incur millions of dollars in costs to comply with the Bulletin's requirements. Grady Declaration at 14–15 (estimating annual compliance costs of "approximately $55 million"). Indeed, Texas must comply, or face fund disallowance. Docket No. 10, Ex. 1 at 5. The Bulletin may therefore "be said to be felt immediately by those subject to it in conducting their day-to-day affairs," constituting hardship. *Contender Farms*, 779 F.3d at 267 (finding hardship where a final rule required state compliance or "face decertification" from a federal program); *Braidwood Mgmt., Inc.*, 2023 WL 4073826, at *13 (same for an agency "guidance" that required compliance of regulated parties with the threat of a "costly enforcement action"); *cf. Nat'l Park Hosp. Ass'n*, 538 U.S. at 810 (no hardship where rule "does not affect [regulated parties'] primary conduct").

Accordingly, Texas's claims are ripe for review.

**C. Final Agency Action**

CMS also argues Texas's claims do not fall within the scope of judicial review under the APA because the Bulletin is not "final agency action." Docket No. 17 at 25–26; *see also* 5 U.S.C. § 704 (granting judicial review of "final agency action"). Agency action is final if it (1) "mark[s] the consummation of the agency's decisionmaking process"—i.e., it is not merely of a "tentative or interlocutory nature," and (2) is "one by which rights or obligations have been determined, or from which legal consequences will flow." *U.S. Army Corps of Eng'rs v. Hawkes Co., Inc.*, 578 U.S. 590, 597 (2016). In evaluating whether agency action is final, the Fifth Circuit treats the finality requirement as both "flexible" and "pragmatic." *Qureshi v. Holder*, 663 F.3d 778, 781 (5th Cir. 2011) (quoting *Abbott Labs. v. Gardner*, 387 U.S. 136, 149–50 (1967)). Under a flexible, pragmatic reading, the Bulletin is final agency action.

First, courts have routinely held that guidance letters and bulletins can mark the "consummation" of an agency's decision-making process. *E.g.*, *Nat'l Pork Producers Council v. U.S. E.P.A.*, 635 F.3d 738, 756 (5th Cir. 2011) (finding "guidance letters" met the first prong and collecting cases). Here, the text of the Bulletin gives no indication that CMS considered the Bulletin to be either "tentative" or "interlocutory." Rather, CMS states that it "intends to inquire" about private, provider-to-provider arrangements going forward and "take enforcement action as necessary," among other things. Docket No. 10, Ex. 1 at 5. Accordingly, the Bulletin meets the first prong. *Texas v. United States*, 86 F. Supp. 3d 591, 648 (S.D. Tex. 2015)

(finding a "Directive" met the first prong where it required the "immediate implementation of certain measures"), *aff'd*, 809 F.3d 134 (5th Cir. 2015).

The Bulletin also meets the second prong because it "bind[s]" CMS to a "legal position." *Texas v. E.E.O.C.*, 933 F.3d at 441. CMS in fact concedes that the Bulletin takes a "firm" view on the legality of private reimbursement arrangements. Docket No. 17 at 25. The Bulletin also previews imminent enforcement actions and leaves no room for discretion once those actions are underway. Docket No. 10, Ex. 1 at 5–6. The Bulletin therefore "ha[s] practical binding effect" such that "affected private parties are reasonably led to believe that failure to conform will bring adverse consequences." *Texas v. E.E.O.C.*, 933 F.3d at 442.

CMS argues the Bulletin cannot be final agency action because it "simply reminds the public" of a "previously articulated" view and accordingly "create[s] no new legal obligations." Docket No. 17 at 25 (quoting *Rhea Lana, Inc. v. Dep't of Labor*, 824 F.3d 1023, 1028 (D.C. Cir. 2016)). To the contrary, CMS has—on several occasions—explicitly disclaimed any intention to disallow state funding for these private arrangements. *See* Docket No. 10, Ex. 3 (2019 email exchange in which a CMS representative confirmed there were "arrangements out there among providers" that CMS "do[es] not particularly like" but lacks the "statutory authority to address"); Grady Declaration at 8 (stating CMS advised Texas's Health and Human Services Commission in 2019 that private business arrangements were lawful so long as neither "the State nor unit of local government was providing the guarantee" to hold taxpayers harmless); Opening Brief for Appellant, *Kindred Hosps. E., LLC v.*

*Sebelius*, 2012 WL 248356, at *55 (8th Cir. Jan. 9, 2012) (excerpting an interview in which an HHS representative stated private "redistribution arrangement[s]" among providers do not violate any hold harmless definition codified at § 1396b(w)(4)). It is no surprise then that "several states" sought clarification from CMS on these arrangements, as the Bulletin itself describes. Docket No. 10, Ex. 1 at 1.

Accordingly, the Bulletin cannot be said to "only reiterate what has been well-established," as CMS suggests. *Cf. Nat'l Pork Producers Council*, 635 F.3d at 756 (finding guidance letter was not final action where it "only reiterate[d] what has been well established since the enactment of the [Clean Water Act of 1972]"). Rather, the Bulletin states—for the first time—a clear and "*definitive* position" that has "immediate impact on [Texas]. *Her Majesty the Queen in Right of Ont. v. Env't Prot. Agency*, 912 F.2d 1525, 1532 (D.C. Cir. 1990) (holding that the EPA's guidance letters were final agency action).

**D. Adequate Alternate Remedy**

CMS insists Texas must resolve this dispute under 42 U.S.C. § 1316(e), which permits Texas to challenge any fund disallowance to the agency's Departmental Appeals Board, and only then proceed to federal court, if necessary. Docket No. 17 at 26–27 (citing 42 U.S.C. § 1316(a), (e)). Because this statutory remedy exists, CMS contends, Texas has an "adequate remedy in a court" under 5 U.S.C. § 704, foreclosing the present availability of judicial review. The argument fails, however, because it ignores that Texas seeks to enjoin enforcement of the Bulletin, not overturn an enforcement decision like a disallowance. Hearing Tr. 6/8/2023 at 9:13–19.

To preclude review under § 704, an alternative remedy must provide the "same genre of relief." *Hinojosa v. Horn*, 896 F.3d 305, 310 (5th Cir. 2018). And an Appeals Board ruling overturning an enforcement decision is not the same kind of relief Texas seeks here. Rather, Texas wants an injunction to avoid spending money on compliance costs or amending state law. Docket No. 1 at 32–33 (request for injunction); Docket No. 10 at 30–32 (explaining harm Texas faces absent an injunction). The Appeals Board cannot award that kind of relief. § 1316(e) (describing the Appeals Board's role as only "deciding whether to uphold a disallowance"). If Texas then seeks review of an Appeals Board ruling in a federal district court, the State may not recover compliance costs there either. *See Wages & White Lion Invs., LLC v. FDA*, 16 F.4th 1130, 1142 (5th Cir. 2021) (noting the plaintiffs lacked "an avenue to recover costs from complying with the Order" because "federal agencies generally enjoy sovereign immunity for any monetary damages.").

Further, Texas "cannot initiate that [Appeals Board] process," and instead must "wait for [CMS] to drop the hammer" of disallowance before seeking review. *Sackett v. E.P.A.*, 566 U.S. 120, 127 (2012) (finding no adequate remedy where plaintiffs could not initiate review). Review under § 1316(e) thus constitutes only "doubtful and limited relief," *Garcia v. Vilsack*, 563 F.3d 519, 522 (D.C. Cir. 2009), which is insufficient to overcome the APA's "basic presumption of judicial review [for] one 'suffering legal wrong because of agency action.'" *Dep't of Homeland Sec. v. Regents of the Univ. of Cal.*, 140 S. Ct. 1891, 1905 (2020).

Accordingly, the availability of administrative review under § 1316 does not bar the exercise of jurisdiction under 5 U.S.C. § 704 here.

**E. *Thunder Basin***

Finally, CMS argues the *Thunder Basin* doctrine bars judicial review because Congress intended to create an "exclusive remedy" in the Departmental Appeals Board. Docket No. 26–28. The existence of a parallel administrative enforcement framework may preclude district court review under *Thunder Basin Coal Co. v. Reich*, 510 U.S. 200 (1994), if "Congress intended exclusivity when it established the statutory scheme." *Jarkesy v. S.E.C.*, 803 F.3d 9, 12 (D.C. Cir. 2015); *Bank of La. v. Fed. Deposit Ins. Corp.*, 919 F.3d 916, 923 (5th Cir. 2019). To discern congressional intent, the Court asks whether the "claims at issue 'are of the type Congress intended to be reviewed within th[e] statutory structure.'" *Bank of La.*, 919 F.3d at 923 (quoting *Free Enter. Fund v. Pub. Co. Acct. Oversight Bd.*, 561 U.S. 477, 489 (2010)). The Court employs the "*Thunder Basin* factors" to resolve this question. *See Thunder Basin*, 510 U.S. at 212–13. These factors ask (1) whether precluding district court jurisdiction "could foreclose all meaningful judicial review"; (2) whether Texas's "suit is wholly collateral to a statute's review provisions"; and (3) whether its claims are "outside the agency's expertise." *Elgin*, 567 U.S. at 15.

The first factor weighs against CMS. Section 1316(e) permits judicial review *only* if CMS disallows Texas's funds. § 1316(e)(2)(A) ("A State may appeal a *disallowance* of a claim for federal financial participation . . . ." (emphasis added)). If Texas abides by the potentially unlawful Bulletin, it will not receive a "final adverse order," and "may thus be left unable to seek redress." *Cochran v. U.S. Sec. & Exch.*

*Comm'n*, 20 F.4th 194, 209 (5th Cir. 2021), *aff'd and remanded sub nom. Axon Enter., Inc. v. Fed. Trade Comm'n*, 143 S. Ct. 890 (2023); *Burgess v. Fed. Deposit Ins. Corp.*, 2022 WL 17173893, at *7 (N.D. Tex. Nov. 6, 2022) (finding first *Thunder Basin* factor weighed against preclusion where "the enforcement proceeding will not necessarily result in a final adverse order"). Texas must then "bet the farm" and ignore the Bulletin before "testing [its] validity." *Free Enter. Fund*, 561 U.S. at 490. Consequently, finding that Congress intended an exclusive remedy in the Departmental Appeals Board "could foreclose all meaningful judicial review" for Texas. *Cochran*, 20 F.4th at 209. Moreover, these claims are outside CMS's expertise under the third factor. Whether CMS unlawfully issued the Bulletin is a "standard question[] of administrative law, which the courts are at no disadvantage in answering." *Free Enter. Fund*, 561 U.S. at 491. No agency "expertise is required here." *Id.* Because the first and third *Thunder Basin* factors weigh against CMS's position, the Court need not analyze the second factor. *Id.* (addressing only the first and third factors in determining that agency review provision "did not strip the District Court of jurisdiction").

Accordingly, the existence of administrative review of a disallowance under § 1316 does not preclude the Court's jurisdiction under *Thunder Basin*.

* * *

Having determined that its jurisdiction is proper, the Court now turns to the merits of Texas's motion for a preliminary injunction.

## III. PRELIMINARY INJUNCTION

"[A] preliminary injunction is an extraordinary remedy never awarded as of right." *Benisek v. Lamone*, 138 S. Ct. 1942, 1943 (2018) (per curiam). To obtain a preliminary injunction, Texas must establish:

> (1) a substantial likelihood of success on the merits, (2) a substantial threat of irreparable injury if the injunction is not issued, (3) that the threatened injury if the injunction is denied outweighs any harm that will result if the injunction is granted, and (4) that the grant of an injunction will not disserve the public interest.

*Jordan v. Fisher*, 823 F.3d 805, 809 (5th Cir. 2016). The Court takes each element in turn below.

### A. Likelihood of Success on the Merits

Texas argues three reasons it is likely to succeed on its claim for relief under the APA: (1) the Bulletin exceeds CMS's statutory and regulatory authority; (2) CMS improperly bypassed the APA's notice-and-comment requirement; and (3) the Bulletin is arbitrary and capricious because it departs from past practice and fails to consider Texas's substantial reliance interests. Because Texas is likely to succeed on its first argument, the Court need not address the remaining two. *See Flight Training Int'l, Inc. v. Fed. Aviation Admin.*, 58 F.4th 234 (5th Cir. 2023).

Texas contends the Bulletin exceeds CMS's statutory authority by expanding the definition of "hold-harmless provision" to include guarantees by private parties in private agreements. Docket No. 10 at 17–23. Under the statute, "there is in effect a hold harmless provision" when:

> The State or other unit of government imposing the tax provides (directly or indirectly) for any payment, off set, or waiver *that guarantees* to hold taxpayers harmless for any portion of the costs of the tax.

§ 1396b(w)(4)(C)(i) (emphasis added). As noted in the parties' previous dispute, the statute includes a "tight grammatical link between *the government*, as the actor providing for something, and *a guarantee*, as the thing provided for." *Texas v. Brooks-LaSure*, 2022 WL 741065, at *8 (E.D. Tex. Mar. 11, 2022) (Barker, J.).

The Bulletin, however, announces CMS will disallow funds where *private providers* "enter 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"—i.e., where the *providers themselves* guarantee to hold one another harmless. Docket No. 10, Ex. 1 at 3. CMS will thus disallow funds even where a state provides no "guarantee[]" at all. Indeed, all a state "provides for" in the Bulletin's scenario is its Medicaid payment, which makes no "guarantee" to hold anyone harmless. Docket No. 10, Ex. 1 at 2–3.

In disallowing funds where the state makes no guarantee, CMS decouples the "grammatical link" found in the statute, and conditions a state's Medicaid funding on private agreements over which states have no knowledge or control. This is undoubtedly why HHS's own Departmental Appeals Board previously held that no hold-harmless arrangement existed where CMS could not point to "any wording in the States' programs that could reasonably constitute an explicit or direct assurance of any payment to the provider taxpayer." *In re Haw. Dep't of Hum. Servs. Bd.*, DAB 1981 (June 24, 2005) (emphasis added); *see also Protestant Mem'l Med. Ctr., Inc. v. Maram*, 471 F.3d 724, 726 (7th Cir. 2006) ("[I]f the *state promises* to hold the taxpayer harmless for a portion of the cost of the tax through a direct payment or exemption

from the tax, that promise also constitutes a 'hold harmless provision.'" (emphasis added) (citing § 1396b(w)(4)(C))).

Courts routinely hold that rules like the CMS Bulletin exceed the agency's congressionally delegated authority—e.g.:

- The Supreme Court invalidated an Environmental Protection Agency rule requiring licensing of emitters under a definition of "air pollutant" that improperly expanded the Clean Air Act's definition of that term. *Util. Air Regul. Grp. v. E.P.A.*, 573 U.S. 302, 315–20 (2014).

- The Fifth Circuit set aside a Department of Labor rule that improperly expanded the statutory term "investment advice fiduciary" where the rule regulated a broader slate of financial advisors than the statute allowed. *Chamber of Com. of U.S. of Am. v. U.S. Dep't of Labor*, 885 F.3d 360, 369 (5th Cir. 2018).

- The Seventh Circuit affirmed a preliminary injunction against the Department of Homeland Security enjoining the agency from enforcing a rule that "penalizes disabled persons in contravention of the Rehabilitation Act." *Cook Cnty. v. Wolf*, 962 F.3d 208, 228 (7th Cir. 2020).

So too here. CMS "may not rewrite clear statutory terms to suit its own sense of how the statute should operate." *In re Benjamin*, 932 F.3d 293, 300 (5th Cir. 2019); *accord* Docket No. 10, Ex. 3 (2019 email from CMS representative confirming the agency "do[es] not particularly like" private arrangements among providers).

CMS argues the Bulletin accords with the statute because a state's "associated payment" can be "indirect[]." Docket No. 17 at 30 (citing § 1396b(w)(4)(C)(i)). CMS elaborates: when "taxpayers enter an agreement to indemnify each other against the burdens of a health care related tax, each taxpayer receives a direct guarantee," and when "Medicaid funds are redistributed to honor that guarantee, the state has made an indirect payment." *Id.*; *accord* Docket No. 10, Ex. 1 at 3–4. But the statute still

requires that the *state*, not a private party, provide the "payment" that "guarantees" to hold taxpayers harmless. § 1396b(w)(4)(C)(i) ("The State . . . provides . . . indirectly[] for any payment . . . that guarantees to hold taxpayers harmless . . . ."). In fact, in its 2008 rule, CMS provided an example demonstrating it shared this interpretation. There, CMS explained that an "indirect payment providing a direct guarantee would be found" where a state taxes nursing facilities and simultaneously provides grants or tax credits "*designed by the States to compensate*" the nursing residents to whom the tax had been passed along. 73 Fed. Reg. at 9,686 (emphasis added). In this scenario, the state provides the guarantee to hold harmless nursing homes by way of indirect payments through their patients—an impermissible scheme under the statute because of the state guarantee. *See* § 1396b(w)(4)(C)(i). That is very different from the purely private arrangements the Bulletin seeks to prohibit.

The Court thus concludes that the Bulletin conflicts with the statutory definition of "hold harmless provision" found in § 1396b(w)(4)(C)(i). Because courts must "hold unlawful and set aside agency action" that is "not in accordance with law" or "in excess of statutory . . . authority," 5 U.S.C. § 706(2)(A), (C), the Bulletin will likely be set aside. Texas has thus shown a "substantial likelihood of success on the merits." *Jordan*, 823 F.3d at 809.

**B. Irreparable Harm**

Next, Texas must demonstrate "a substantial threat of irreparable injury if the injunction is not issued." *Texas v. United States*, 809 F.3d at 150. For its threat of injury to be sufficiently "substantial," Texas must show that it is "likely to suffer irreparable harm in the absence of preliminary relief." *Winter*, 555 U.S. at 20. For

its injury to be sufficiently "irreparable," Texas need only show it "cannot be undone through monetary remedies." *Burgess v. FDIC*, 871 F.3d 297, 304 (5th Cir. 2017). Texas has met its burden.

Texas argues it faces an irreparable injury through "substantial compliance costs." Docket No. 10 at 29.[4] In an unrebutted affidavit, an official with the Texas Health and Human Services Commission attests the agency lacks authority over the local entities that tax providers under Section 300.0001 of the Texas Health and Safety Code, Grady Declaration at 4, and otherwise lacks the authority to seek the information the Bulletin obligates it to collect, *id.* at 8. To comply with the Bulletin, she attests Texas must first change its laws to be able to investigate private agreements, and must then spend an estimated $55 million annually to review them. *Id.* at 14.

In determining whether costs are irreparable, the key inquiry is "not so much the magnitude but the irreparability." *Rest. Law Ctr. v. U.S. Dep't of Labor*, 66 F.4th 593, 597 (5th Cir. 2023). Here, Texas's compliance costs are irreparable because CMS is immune from monetary damages. *See Wages & White Lion Invs., LLC*, 16 F.4th at 1142 (observing that the costs to comply with agency action are almost always irreparable "because federal agencies generally enjoy sovereign immunity for any monetary damages"); *Burgess*, 871 F.3d at 304. Accordingly, Texas cannot "recover

[4] Texas also argues it will also suffer an irreparable injury because the Bulletin requires it to investigate the financial relationships of private associations, which risks "transgressing the First Amendment." Docket No. 10 at 32 (citing *Ams. for Prosperity Found. v. Bonta*, 141 S. Ct. 2373, 2382 (2021)). Because the Court finds Texas will suffer an injury vis-à-vis compliance costs, it need not address this alternative injury.

the compliance costs [it] will incur if the [Bulletin] is invalidated on the merits." *Texas v. U.S. Env't Prot. Agency*, 829 F.3d 405, 434 & n.41 (5th Cir. 2016) (finding irreparable injury where Texas could not recover monetary compliance costs from federal agency); *id.* at 433 ("[C]omplying with a regulation later held invalid almost *always* produces the irreparable harm of nonrecoverable compliance costs." (quoting *Thunder Basin Coal*, 510 U.S. at 220–21 (Scalia, J., concurring in part and in the judgment))).

CMS argues the Bulletin threatens no injury because the agency, "[f]or years," has expressed its "clear" position on these arrangements. Docket No. 17 at 18. As addressed above, however, CMS's stance has been far from "clear." *See supra* Section II.C. In contrast to the 2019 proposed rule (later withdrawn) and 2022 litigation position, the Bulletin declares that Texas and other states *will* face disallowance if they fail to comply. *Rest. Law Ctr.*, 66 F.4th at 599 (finding irreparable harm where rule constituted a "new constraint" on regulated parties). CMS also argues that Texas exaggerates the imminence of any harm, because "enforcement"—and not the Bulletin—"is the ultimate injury that Texas" seeks to avoid. Docket No. 17 at 19. But the Bulletin makes clear that Texas must collect information it currently doesn't have—or face "disallowance of federal financial participation." Docket No. 10, Ex. 1 at 5. And Texas alleges it will spend millions of dollars per year to do so. Grady Declaration at 14. The Fifth Circuit "requires only that *alleged* compliance costs must be 'more than de minimis.'" *Rest. Law Ctr.*, 66 F.4th at 600 (quoting *Louisiana v. Biden*, 55 F.4th 1017, 1035 (5th Cir. 2022)). Texas's allegations are sufficient to

show that it will suffer irreparable harm absent an injunction. *Id.* at 599–600 (finding sufficient allegations of harm where plaintiff offered "estimates" of potential harm).

**C. Balance of the Equities and Public Interest**

The third and fourth factors ask whether the absence of a stay will injure other parties and whether the public interest favors or disfavors a stay. "Federal courts have considered the balance of equities and public interest factors together as they overlap considerably." *Texas v. United States*, 524 F. Supp. 3d 598, 663 (S.D. Tex. 2021) (citing cases).

Texas argues it faces irreparable compliance costs while CMS faces no harm from the requested injunction because the agency "has no legitimate interest in the implementation or enforcement of an unlawful agency action." Docket No. 10 at 33 (citing *League of Women Voters of U.S. v. Newby*, 838 F.3d 1, 12 (D.C. Cir. 2016)). CMS argues only that it faces harm because the Bulletin *is* lawful agency action. Docket No. 17 at 35. The Court finds Texas's threatened injury if the injunction is denied outweighs any harm that will result to CMS if the injunction is granted. *E.g.*, *Louisiana v. Biden*, 55 F.4th 1017, 1035 (5th Cir. 2022) (finding alleged compliance costs outweighed agency's interest in perpetuating "unlawful agency action").

Similarly, the public will not face disservice from an injunction. By contrast, an injunction will maintain the status quo for states (like Texas) that will otherwise face immediate compliance costs and funding disallowances that may jeopardize their state Medicaid programs. Grady Declaration at 14 (noting Texas faces "disallowance of [funds]" and even "complete exclusion from the Medicaid program"). The Court

finds the public will not face disservice from an injunction. *See Texas v. United States*, 809 F.3d at 187 (finding public interest favored an injunction "given the difficulty of restoring the *status quo ante*").

Accordingly, the third and fourth factors weigh in favor of an injunction.

## IV. CONCLUSION

For the foregoing reasons, the Court **GRANTS** Texas's motion for preliminary injunction. Docket No. 10.

The Court hereby **ORDERS** that, as of the date of this Order, Defendants and their agents are **ENJOINED** from implementing or enforcing the Bulletin dated February 17, 2023, entitled "CMCS Informational Bulletin: Health Care-Related Taxes and Hold Harmless Arrangements Involving the Redistribution of Medicaid Payments," or from otherwise enforcing an interpretation of the scope of 42 U.S.C. § 1396b(w)(4)(C)(i) found therein. Defendants, anyone acting in concert with Defendants, and their respective agents are enjoined and prohibited from relying on the Bulletin for any purpose during the pendency of this litigation. This includes, but is not limited to, enforcing the Bulletin through any ongoing or future Medicaid-related audits, oversight activities related to the Medicaid program, or review of state payment proposals in the State of Texas. The Bulletin also may not be used as a basis to defer or disallow any reimbursement payments made during the period this injunction remains in place.

The Court finds that Defendants will not sustain costs and damages should this injunction be found to have issued wrongfully, and, therefore, the Court

dispenses with the requirement of a bond. This injunction shall remain in force and effect until final judgment is entered in this case or as otherwise ordered by the Court.

So **ORDERED** and **SIGNED** this **30th** day of **June, 2023.**

JEREMY D. KERNODLE
UNITED STATES DISTRICT JUDGE