No. 25-40766

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

STATE OF TEXAS; TEXAS HEALTH AND HUMAN SERVICES COMMISSION,

Plaintiffs-Appellees,

v.

MEHMET OZ, in his official capacity as Administrator for the Centers for Medicare and Medicaid Services; et al.,

Defendants-Appellants.

On Appeal from the United States District Court
for the Eastern District of Texas

BRIEF OF THE TEXAS HOSPITAL ASSOCIATION AS AMICUS CURIAE IN SUPPORT OF PLAINTIFFS-APPELLEES AND AFFIRMANCE

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CERTIFICATE OF INTERESTED PERSONS

The undersigned counsel of record certifies that the following listed persons and entities as described in the fourth sentence of Fifth Circuit Rule 28.2.1 have an interest in the outcome of this case. These representations are made in order that the judges of this Court may evaluate possible disqualification or recusal.

Amicus Curiae:

Texas Hospital Association

Counsel for Amicus Curiae:

Baxter Morgan, Husch Blackwell LLP

The Texas Hospital Association is a nonprofit trade association. It has no parent corporation and no publicly held corporation owns ten percent or more of its stock. The interests of its member hospitals are the general interests described in the accompanying brief. All parties to this appeal, and their counsel, are identified in the Certificates of Interested Persons filed by the parties and are, to the best of counsel's knowledge, all governmental entities and attorneys for the government.

/s/ Baxter Morgan
Baxter Morgan
Counsel of Record for Amicus Curiae

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Appellate Procedure 26.1, amicus curiae the Texas Hospital Association states that it is a nonprofit corporation. It has no parent corporation, and no publicly held corporation owns ten percent or more of its stock.

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STATEMENT OF INTEREST OF AMICUS CURIAE

The Texas Hospital Association ("THA") respectfully submits this brief in support of Plaintiffs-Appellees and affirmance. Founded in 1930, THA is the principal trade association representing the Texas hospital and healthcare-system community, including more than 85% of the state's acute care hospitals. THA membership includes rural and urban, public and private, investor-owned and nonprofit facilities and systems. THA's members all participate in the healthcare safety-net in some manner and deliver most of the hospital care to Texas Medicaid patients.

THA's members also participate in the provider taxes at the center of this case and depend on the Medicaid reimbursement financed by those taxes for financial sustainability. THA has a direct and substantial interest in the question presented because its members, not the government, bear the operational, legal, and financial consequences of the agency's reinterpretation of these hold-harmless provisions. When the Centers for Medicare and Medicaid Services ("CMS") reinterprets what constitutes a prohibited hold-harmless arrangement, a state might face a disallowance or need to renegotiate its state-directed payment programs. Hospitals face tangible harm from CMS's actions.

But CMS's change of direction also threatens the longer-term viability of the healthcare system in Texas because it signals a lack of stability in our regulatory framework. THA's members structure capital commitments, operating agreements, and service-line decisions based on a settled regulatory architecture over decades, not year-to-year. The 2023 informational bulletin and the 2024 final rule jeopardize those settled arrangements. CMS's actions undermine the immediate and long-term financial and operational security of Texas hospitals.

The parties cannot fully present the hospital-side perspective. The State of Texas litigates as a sovereign defending its financing authority and its programs. THA submits this brief to explain how CMS's position would operate on the ground for the hospitals that depend on these programs to maintain access for Medicaid patients.

No party's counsel authored this brief in whole or in part; no party or party's counsel contributed money intended to fund its preparation or submission; and no person other than amicus curiae, its members, or its counsel contributed money intended to fund its preparation or submission. All parties have consented to the filing of this brief. *See* Fed. R. App. P. 29(a)(2).

INTRODUCTION

On November 13, 1789, Benjamin Franklin wrote to French scientist Jean-Baptiste Le Roy: "Our new Constitution is now established, everything seems to promise it will be durable; but, in this world, nothing is certain except death and taxes."[1] The hospital members of THA continue to fight the first half of that certainty; CMS appears committed to disproving the second.

The questions before the Court focus on statutory interpretation, regulatory authority, and the operational mechanics of the Medicaid program. But this case implicates the viability of Medicaid and our larger healthcare system because of the significant patient volumes and reimbursement involved. Because the stability of the Texas healthcare system is at risk, THA asks the Court to affirm.

The Court can resolve this case on one phrase, written by Congress in 1991, given settled regulatory meaning by CMS since then, and relied on by the healthcare industry for stability in our system of care.[2] A prohibited hold-harmless arrangement exists when "[t]he State or other

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[1] Jared Sparks, *The Writings of Benjamin Franklin, Vol. X (1789-1790)*, p.410, Macmillan (1856).

[2] Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, Pub. L. No. 102-234, § 2, 105 Stat. 1793 (1991), codified at 42 U.S.C. § 1396b(w).

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] The subject is the state; the verb is "provides." For decades, this sentence meant what it said. CMS now reads it to police private matters among taxpayers the state neither controls nor directs. CMS knows the statute does not say what it now claims because the agency has said so itself, repeatedly.

In 1991, CMS's predecessor tried implementing a more expansive definition of what would constitute a hold harmless; Congress responded by rebuking this approach.[4] In 2008, after proper notice and comment, CMS rejected language involving payments merely "influenced by the state" and adopted "controlled or directed by the state" as a standard, because the broader, rejected phrase implied a level of regulation Congress and CMS never intended.[5] In 2019, CMS proposed the "net effect" approach it now attempts to enforce; 4,000 comments led to

[3] 42 U.S.C. § 1396b(w)(4)(C)(i).
[4] Pub. L. No. 102-234, 105 Stat. 1793 (1991); H.R. Rep. No. 102-310, at 25 (1991).
[5] Medicaid Program; Health Care-Related Taxes, 73 Fed. Reg. 9685, 9694 (Feb. 22, 2008) [2008 Final Rule] ("We believe 'controlled or directed by the state' is a more accurate description of the types of payments that will be considered in evaluating whether an impermissible hold harmless arrangement exists.")

withdrawal of that proposed rule.[6] Among the commenters objecting was Daniel Tsai, then the Massachusetts Medicaid Director, who wrote that the approach "would represent an unprecedented federal overreach" and "exceeds CMS's statutory authority."[7] Mr. Tsai was later a CMS Deputy Administrator involved in the implementation of that very overreach, which culminated in the judgment now before this Court.[8]

The stakes extend far beyond Texas. Forty-nine states finance the non-federal share of Medicaid with provider taxes;[9] billions of dollars in Medicaid reimbursement, which ultimately must be at or below the cost of care, depend on those taxes.[10] Congress froze this system in 2025 with the One Big Beautiful Bill Act's prohibition on new or expanded provider taxes.[11] CMS's reinterpretation clouds the system and conscripts hospitals to enforce its reading of the regulation, requiring each to attest,

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[6]Medicaid Program; Medicaid Fiscal Accountability Regulation, 84 Fed. Reg. 63,722 (Nov. 18, 2019) [MFAR]; MFAR Withdrawal, 86 Fed. Reg. 5105 (Jan. 19, 2021).
[7]Letter from Daniel Tsai, Assistant Sec'y for MassHealth & Mass. Medicaid Dir., to Seema Verma, Adm'r, Ctrs. for Medicare & Medicaid Servs., at 1–2 (Jan. 27, 2020) (Comment on CMS-2393-P, Regulations.gov Docket No. CMS-2019-0169-1670) [Tsai MFAR Comment]; ROA 154.
[8]Ctrs. for Medicare & Medicaid Servs., Press Release, CMS Announces Director of Center for Medicaid and CHIP Services (June 28, 2021).
[9]KFF, 5 Key Facts About Medicaid and Provider Taxes (Dec. 1, 2025).
[10]MACPAC, Medicaid Base & Supplemental Payments to Hospitals (May 2024).
[11]One Big Beautiful Bill Act, Pub. L. No. 119-21, §§ 71115, 71117, 139 Stat. 129 (2025) [hereinafter OBBBA].

on pain of treble damages, that no implicit meeting of the minds exists among other taxpayers no hospital can observe.[12] Medicaid payments and financing go hand in hand: destabilize financing and payments are cut; cut payments and service lines close.

Four independent grounds support affirmance:

- **Consequences.** The rule and bulletin destabilize the financing system for Medicaid and expose hospitals to liability. This change harms hospitals' ability to care for their patients. CMS's refusal to confront these realities invalidates its action.[13]
- **The Statute.** This Court can read Section 1396b(w)(4)(C)(i) without deference to CMS and apply the same reading the agency has applied for 35 years: a hold-harmless arrangement requires a state actor.

[12]42 C.F.R. § 438.6(c)(2)(ii)(H); 2024 Final Rule, 89 Fed. Reg. 41,002, 41,076 (May 10, 2024) [hereinafter 2024 Final Rule].

[13] "[T]he agency must examine the relevant data and articulate a satisfactory explanation for its action including a 'rational connection between the facts found and the choice made.'" *Motor Vehicle Manufacturers Ass'n of the United States, Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983), quoting *Burlington Truck Lines, Inc. v. United States*, 371 U.S. 156, 167 (1962).

- **Administrative Law.** CMS reversed a settled interpretation without acknowledging the reversal, past regulatory statements, or the reliance interests built on the framework in place since Congress enacted this language in 1991. The Administrative Procedure Act does not permit this shortcut.
- **Spending Clause.** Medicaid conditions must be unmistakable and stakeholders in the healthcare system deserve stability. CMS's current position rejects stability.

If CMS believes private arrangements should be unlawful, the path runs through Congress, which declined to alter the statutory language governing hold-harmless arrangements just last year. The district court got it right and this Court should affirm.

ARGUMENT

I. CMS's READING WOULD DESTABILIZE THE MEDICAID FINANCE SYSTEM.

This is a legal case about CMS overreach, but it is also a real-world policy case about CMS's attempt to reduce spending on Medicaid through means that do not run through Congress. The Court has substantial briefing on the legal background, and this brief also addresses key legal issues THA wants to highlight. However, the main purpose of THA's

briefing is to address the substantial danger of CMS's policy choices for providers and Medicaid patients.

Medicaid is indispensable to the health and welfare of Texans and the providers who serve them. The program covers 4.4 million Texans; 60% are children.[14] Texas Medicaid spending totaled $57 billion in the most recent data year; the federal government supplied $37 billion of that sum.[15] Those dollars flow to the hospitals, physicians, nursing facilities, and other providers delivering care to patients across the state. The program's reach is most pronounced in maternity care, where Medicaid covered 180,000 Texas births in 2023, nearly half of the total.[16]

Medicaid is the primary payer for 61% of Texas nursing facility residents, sustaining the long-term care infrastructure on which the state's elderly and disabled populations depend.[17] Nationwide, Medicaid

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[14]KFF, *Medicaid in Texas* (May 2025), https://files.kff.org/attachment/fact-sheet-medicaid-state-TX.

[15]*Id*.

[16]KFF, *Births Financed by Medicaid, 2023*, State Health Facts, https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid/; *see also* Karen Brooks Harper, *Feds Approve 12 Months of Medicaid for Texas Moms*, Tex. Trib. (Jan. 17, 2024), https://www.texastribune.org/2024/01/17/texas-medicaid-postpartum/.

[17]KFF, *Distribution of Certified Nursing Facility Residents by Primary Payer Source, 2024*, State Health Facts, https://www.kff.org/other/state-indicator/distribution-of-certified-nursing-facilities-by-primary-payer-source/

accounts for 19% of all hospital payments.[18] A disruption to Medicaid financing reaches well beyond an abstract appropriation; it reaches the patients who rely on the program for care and the providers whose financial viability depends on its reimbursement.

A. CMS's Position Jeopardizes Medicaid Financing.

CMS implemented this posture at a time when communities can no longer use new provider tax structures to fund the Medicaid program. OBBBA prohibits new or expanded provider taxes; Medicaid expansion states are already facing reductions in the total revenue generated by provider taxes to comply with OBBBA.[19] The grandfathered structures in place on July 4, 2025 are the best and most legally grounded structures states will ever have. CMS's reinterpretation places each of them under a retroactive cloud at the precise moment Congress closed the door on replacements. There is no opportunity to pivot when a legally permissible funding structure now operates under a hard ceiling.

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[18]Medicaid & CHIP Payment & Access Comm'n, *Medicaid Base and Supplemental Payments to Hospitals* (Apr. 2024), https://www.macpac.gov/wp-content/uploads/2024/05/Medicaid-Base-and-Supplemental-Payments-to-Hospitals.pdf.

[19]OBBBA, *supra* note 11, § 71115. Prior law and regulations considered 6% a "cap" on provider taxes; OBBBA requires a reduction to 3.5% in expansion states to avoid the assumption that a tax is a hold-harmless; Texas is one of ten remaining non-expansion states.

Federal law requires provider taxes to be broad-based, uniform, and not constitute a hold-harmless arrangement, deliberately including all hospitals regardless of Medicaid volume.[20] Each community must find the right balance of resources to address the healthcare needs of all of its residents and Texas hospitals have worked together for decades to build collaborations across various cities, counties, and regions. CMS's regulatory posture means that hospitals would have to be wary of any kind of collaboration and some would simply exit the program rather than endure the resulting legal and financial uncertainty.

B. Hospitals Make Operational Decisions on a Long-Term Basis, Trying to Rely on a Stable Framework.

Texas hospitals participate in Local Provider Participation Funds across the state[21] and the state-directed payment programs, which generate billions of dollars in annual Medicaid reimbursement financed through provider taxes and intergovernmental transfers structured

[20] 42 C.F.R. § 433.68.

[21] Tex. Health & Safety Code §§ 288, 291A, 292, 292A, 292B, 292C, 292D, 292E, 293, 293A, 293C, 294, 295A, 296, 296A, 297, 298A, 298B, 298C, 298D, 298E, 298F, 298G, 298H, 299, 300, 300A, and 300C. (West 2025); https://www.hhs.texas.gov/sites/default/files/documents/lppf-enabling-legislation-and-statutory-authority.pdf ; https://pfd.hhs.texas.gov/sites/default/files/documents/lfm/lppf-overvw.pdf ; https://www.tha.org/wp-content/uploads/2023/04/HF-Local-Provider-Participation-Funds-Apr2023.pdf

around the framework in place since 1991.[22] Multi-year capital projects, emergency department expansions, behavioral health units, intensive care capacity, and obstetric services all require long-term planning that CMS's shifting policy positions would endanger. Recent increases in uncompensated care are setting hospital operating margins on a trend back toward pandemic-era lows.[23] Hospitals commit capital on the assumption of a relatively stable framework, and that stability is the prerequisite for the long-term investment that access to care requires.

C. The Attestation Creates Needless Risk Exposure.

Beginning January 1, 2028, every hospital in a directed-payment program must attest that it does not participate in a hold-harmless arrangement as CMS defines the practice.[24] The certification is not based on the statute or regulation; it is based on how CMS interprets the regulation in the preamble to the 2024 Final Rule.

[22] *See* Tex. Health & Hum. Servs. Comm'n, Comprehensive Hospital Increase Reimbursement Program Year 2024 Preprint; Texas Incentives for Physicians and Professional Services Program Year 2024 Preprint.
[23] *See* Kaufman Hall, National Hospital Flash Report (Apr. 2026) (9% year-over-year increase in bad debt and charity care; median operating margins at or under 2.5%).
[24] 42 C.F.R. § 438.6(c)(2)(ii)(H); 2024 Final Rule, 89 Fed. Reg. at 41,076.

A certification material to payment supports False Claims Act liability,[25] and the agency expressly conditions payment on this one. Scienter turns on the hospital's subjective understanding,[26] but that is cold comfort when the standard is vague and unknowable. Uncertainty invites qui tam complaints that are expensive to defeat even when wrong. The threat of treble damages and penalties[27] are generally enough to discourage participation in anything; rational parties will exit programs rather than sign.

D. The Rule Would Close Service Lines Patients Depend On, and the Agency Never Studied the Effect.

CMS's rulemaking acknowledged its approach could produce state budget shortfalls and solvency issues,[28] yet it identified no provider, no service, and no patient population that would bear those effects. For Texas hospitals, the directed payments placed at risk total almost $10 billion a year, roughly $27 million a day.[29],[30] Those dollars do not fall

[25] *Universal Health Servs., Inc. v. United States ex rel. Escobar*, 579 U.S. 176, 192–93 (2016).
[26] *United States ex rel. Schutte v. SuperValu Inc.*, 598 U.S. 739, 749 (2023).
[27] 31 U.S.C. § 3729(a)(1).
[28] 2024 Final Rule, 89 Fed. Reg. at 41,078-79.
[29] THA, CHIRP Risk Scenarios & Economic Impact, Statewide Summary (June 2026) (total loss of LPPF-financed directed payments across CHIRP, TIPPS, and RAPPS).
[30] The compounded overall losses to the state are even more stark, with an estimated 92,419 jobs and $20.49 billion in economic output lost as a result of these dollars

evenly across clinical programs, and the programs that depend on them most are the ones least able to survive their loss.

THA's analysis of Texas hospital service lines, ranked by Medicaid volume, cost share, and patient acuity, identified the programs that would close first.[31] Medicaid is fundamentally a program designed to protect pregnant women, children, and other categories of aged, blind, and disabled individuals.[32] CMS's posture strikes at the heart of hospitals' ability to provide care in those vital areas.

Medicaid covers 42% of Texas neonatal admissions and 48% of neonatal charges statewide; no commercial patient population could sustain a neonatal intensive care unit (NICU) if Medicaid reimbursement fails. Medicaid also covers 38% of obstetrics admissions[33] and covered 180,000 Texas births in 2023.[34] Federal law links these service lines to

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exiting the system. THA, CHIRP Risk Scenarios & Economic Impact (IMPLAN model), Statewide Summary (June 2026).

[31]THA, Texas Medicaid Service Line Vulnerability Index Analysis 2025 (June 2026) (composite ranking of Texas hospital service lines by Medicaid volume, cost share, and patient acuity, derived from Texas inpatient and outpatient discharge data).

[32] https://www.hhs.gov/answers/medicare-and-medicaid/what-is-the-medicaid-program/index.html

[33]THA, Texas Medicaid Service Line Vulnerability Index Analysis 2025, (June 2026). Behavioral health, cardiovascular surgery, and hospital-based dental care follow, each carrying a Medicaid share or patient acuity that leaves it economically fragile.

[34] KFF, Births Financed by Medicaid, 2023, State Health Facts, https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid/

eligibility for one of the largest reimbursement programs nationwide, critically supporting hospitals that treat a disproportionate share[35] of Medicaid and uninsured patients (approximately 40% of all hospitals)[36].

These programs cannot scale down like a factory or farm. A neonatal unit or an obstetric program cannot run at sixty percent of its revenue by trimming staff or acuity in proportion, because law and certification fix many costs. A hospital facing a thirty to forty percent revenue loss closes the program. When it does, patients do not disappear; they arrive later and sicker at emergency departments that by law cannot turn them away[37] and already absorb more than 542,000 Texas Medicaid visits a year.[38] OBBBA makes the loss permanent: with new and expanded provider taxes barred, a hospital that closes a NICU will not reopen it under a replacement structure Congress has forbidden. These fields will not lie fallow; CMS's reinterpretation operates as a one-way

[35]"[N]o hospital may be defined or deemed as a disproportionate share hospital … unless the hospital has at least 2 obstetricians … who have agreed to provide obstetric services to individuals who are entitled to medical assistance" 42 U.S.C. § 1396r-4(d)(1); https://www.medicaid.gov/medicaid/financial-management/medicaid-disproportionate-share-hospital-dsh-payments

[36] https://www.macpac.gov/wp-content/uploads/2024/03/Chapter-3-Annual-Analysis-of-Medicaid-Disproportionate-Share-Hospital-Allotments-to-States.pdf

[37] *See generally* the Emergency Medical Treatment and Labor Act (EMTALA), codified at 42 U.S.C. § 1395dd.

[38]THA, Texas Medicaid Service Line Vulnerability Index Analysis 2025 (June 2026).

ratchet, able to destroy the clinical infrastructure these payments supported with no mechanism to rebuild it.

An agency making a change of this magnitude in a cooperative federal-state program must "examine the relevant data and articulate a satisfactory explanation for its action."[39] CMS did neither. It modeled no service-line closures, identified no affected populations, and weighed no downstream emergency-department costs. It offered no basis for concluding that the benefits of its reinterpretation outweigh these losses, because it never looked. "There are no findings and no analysis here to justify the choice made, no indication of the basis on which the [agency] exercised its expert discretion."[40]

II. TEXAS DOES NOT HAVE A HOLD-HARMLESS ARRANGEMENT UNDER THE STATUTE.

Under *Loper Bright*, a reviewing court "must exercise [its] independent judgment" in deciding whether an agency acted within its statutory authority, with no deference to the agency's reading,[41] and the APA requires setting aside action that exceeds that authority.[42] Even the

[39] *Motor Vehicle Mfrs. Ass'n v. State Farm*, 463 U.S. at 43.
[40] *Burlington*, 371 U.S. at 167.
[41] *Loper Bright Enters. v. Raimondo*, 603 U.S. 369, 412–13 (2024).
[42] 5 U.S.C. § 706(2)(A), (C).

limited respect *Loper Bright* preserves for contemporaneous and consistent agency interpretations runs against CMS here. The consistent reading is the state-action reading Congress delineated in 1991, the agency ratified in 2008, and reaffirmed by withdrawing MFAR in 2021. The 2023 bulletin and 2024 final rule are the departure.

A. The State Alone Must "Provide For" the Hold-Harmless.

The statute identifies who must act: "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."[43] The state is the subject; "provides" is the verb; and the object of "provides ... for" is the very payment that does the guaranteeing. An arrangement among hospitals is not something the state provides.

The Eleventh Circuit read the provision passively: the state provides a payment, the payment guarantees the result, and the state need not touch the private redistribution that produces it.[44] If the hold-harmless payment is a private redistribution, the state did not provide it. If the operative payment is the Medicaid payment (for services), that

[43] 42 U.S.C. § 1396b(w)(4)(C)(i) (emphasis added).
[44] *Fla. Agency for Health Care Admin. v. Adm'r for Ctrs. for Medicare & Medicaid Servs.*, 161 F.4th 765, 772-73 (11th Cir. 2025).

is reimbursement for treating Medicaid patients and the alleged hold-harmless arises only later, from the private collaboration. The Eleventh Circuit's reading only works by fusing the Medicaid payment and the private arrangement into one transaction, which would also necessarily require some form of state coordination. The text does not permit the fusion. The Eleventh Circuit reading requires a statute Congress could have passed but did not and a reading CMS could have applied in 2008 or 2019 but explicitly rejected and then abandoned.

Nor does "indirectly" supply the missing authority. That word governs the manner of state action.[45] Congress used the same sentence construction in the provisions on provider-related donations, which reach payments "made directly or indirectly to a State or unit of local government."[46] Non-bona fide provider-related donations are a corollary to the concept of the provider tax hold-harmless in the area of intergovernmental transfers because both scenarios implicate recycling that increases federal financial participation. In a provider-related donation arrangement, the state must be the recipient; with the hold

[45]2008 Final Rule, 73 Fed. Reg. at 9694.
[46]42 U.S.C. § 1396b(w)(2)(B).

harmless on provider taxes, the state must be the provider. Either way the state is essential.

B. The Genesis of the State-Actor Formulation Involved Congress Rejecting the Approach CMS Now Pursues.

In 1991, CMS's predecessor, the Health Care Financing Administration, proposed an interim rule that would have reduced federal matching whenever "[t]here is linkage between payment to the provider and the tax program" and would have deemed a provider "held harmless" if there existed "an effective guarantee that its enhanced Medicaid payment from the State will at least cover the cost of the tax."[47] Congress rejected those expansive formulations, rebuking the agency for attempting to "convert the statutory provision . . . into a broad prohibition," calling the result "illogical and patently impractical."[48] This attempted link is exactly what Congress rejected when it adopted the statutory language still in effect today. CMS cannot use preamble commentary to achieve what Congress rejected.

[47]Medicaid Program; State Share of Financial Participation, 56 Fed. Reg. 56,132, 56,137 (Oct. 31, 1991).
[48]Pub. L. No. 102-234, 105 Stat. 1793 (1991); H.R. Rep. No. 102-310, at 25 (1991).

C. **CMS's 2008 Rule Ratified the State-Action Requirement.**

CMS confronted this exact question in 2008 and answered it through notice and comment. The rulemaking responded to a 2005 Departmental Appeals Board decision involving five states that taxed nursing facilities while administering state grant programs compensating private-pay residents for the pass-through; in every case the state itself created the offsetting program.[49] In the context of what kind of payment would constitute a positive-correlation hold harmless, CMS initially stated "as long as the payment is from a source controlled or influenced by the State, it will be considered in determining whether it has been made available as compensation for the tax."[50] In this context, CMS was stating that state influence was sufficient to show a hold harmless.

But in the Final Rule, in responding to comments, CMS agreed that "'influenced by the state' is too broad a term" and held that "'controlled or directed by the state' is a more accurate description of the types of payments that will be considered in evaluating whether an

[49] *Hawaii Dep't of Human Servs. Bd. et al.*, DAB No. 1981 (June 24, 2005), *reconsideration denied* DAB No. 2006-1 (2006); *see* 2008 Final Rule, 73 Fed. Reg. at 9685–86; Medicaid Program; Health Care-Related Taxes, 72 Fed. Reg. 13,726 (Mar. 23, 2007); 2008 Final Rule, 73 Fed. Reg. at 9686.

[50] 72 Fed. Reg. 13,726, 13,729 (Mar. 23, 2007).

impermissible hold harmless arrangement exists."[51] CMS made this statement in response to issues involving an indirect hold harmless, but also referenced a separate section of the regulation addressing the positive correlation test. Both sections use the same operative language for who must act to show a prohibited arrangement: the state. The concept of the hold harmless and the movement of money is the same for all parts of the hold harmless provision in the statute and the regulation: the state is the actor, controller, or director.[52]

The 2023 bulletin and 2024 rule revive the rejected reading, asserting that private redistribution without state knowledge or involvement "constitute[s] a prohibited hold harmless provision."[53] That is not conduct controlled or directed by the state. A CMS illustration in the 2008 Final Rule confirms the limit. It points to a tax paired with a grant program run by the Governor's office, holding that a state cannot escape review by routing the offset through a different branch of state

[51]2008 Final Rule, 73 Fed. Reg. at 9694.
[52] 2008 Final Rule, 73 Fed. Reg. at 9694; see 42 C.F.R. § 433.68(f)
[53]CMCS Informational Bulletin, Health Care-Related Taxes and Hold Harmless Arrangements Involving the Redistribution of Medicaid Payments, at 5 (Feb. 17, 2023) [hereinafter 2023 Bulletin].

government; the analysis is internal to the state, not an erasure of the state-action requirement.[54]

D. CMS's Examples Involve State Action.

Hawaii paired taxes with state grants.[55] Alaska used proportionate-share agreements the state itself signed and funded.[56] The 2023 bulletin identifies no actual private arrangement anywhere; it regulates by hypothetical, gesturing at providers who "redistribute" payments under arrangements the bulletin cannot name.[57] An agency cannot adopt a sweeping change without a record demonstrating the need for it.[58] The asserted authority to police purely private relationships has no factual predicate in the agency's record. In reality, hospitals across the country collaborate to address the needs of the indigent community and the scope of CMS's position would strike down all of those efforts for fear of running afoul of restrictions on Medicaid, regardless of the purpose or effect.

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[54]2008 Final Rule, 73 Fed. Reg. at 9694 (tax paired with grants "the Governor's office control[s]"; "all of the money" is "state money").
[55]DAB No. 1981, *supra* note 49.
[56]*Alaska Dep't of Health*, DAB No. 2103, (July 31, 2007).
[57]2023 Bulletin, *supra* note 53, at 5.
[58] *Motor Vehicle Mfrs. Ass'n v. State Farm*, 463 U.S. at 43.

III. CMS's REINTERPRETATION VIOLATES THE ADMINISTRATIVE PROCEDURE ACT.

In addition to the statutory issues, the rule fails procedurally. CMS reversed its settled view, after trying and failing to adopt the same position through notice and comment, without acknowledging the prior position, the failed attempt, or the reliance built on the old framework.

In finalizing the 2008 rule, CMS confirmed the rule disturbed no existing program: "We are 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."[59] In 2019, MFAR proposed "totality of circumstances" and "net effect" tests that would have recharacterized private conduct as a state guarantee.[60] CMS eventually withdrew the rule in January 2021, acknowledging commentary that it "lacked statutory authority for its proposals."[61]

A. The Record Includes Admissions from the Official Who Promulgated the Rule.

Among the MFAR objectors was Daniel Tsai, then the Massachusetts Medicaid Director. He wrote:

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[59]2008 Final Rule, 73 Fed. Reg. at 9686-87.
[60]MFAR, *supra* note 6, 84 Fed. Reg. at 63,776–78.
[61]86 Fed. Reg. at 5105–06.

> If implemented, the rule would represent an unprecedented federal overreach.[62]
>
> This proposed rule exceeds CMS' statutory authority.[63]
>
> 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 .... These provisions are highly susceptible to arbitrary and capricious application, particularly across administrations ....[64]

Mr. Tsai also identified a structural defect: MFAR required "reporting on the business dealings of private entities that are not available to the state."[65] If the state cannot see the private arrangement, the state cannot have "provide[d]" anything within the meaning of the statute. Mr. Tsai became Deputy Administrator of CMS in July 2021 and held that office throughout the 2023 bulletin and the 2024 final rule.[66] The official who wrote that this approach exceeds the agency's statutory authority is the official who eventually promulgated it.

B. CMS Failed to Address the Change in Direction.

An agency changing position must display awareness of the change and supply a reasoned explanation, with particular attention to "serious

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[62]Tsai MFAR Comment, *supra* note 7, at 1.
[63]*Id.* at 2.
[64]*Id.*
[65]*Id.* at 4.
[66]CMS Press Release, *supra* note 8.

reliance interests" the prior policy engendered.[67] Ignoring those matters is itself arbitrary and capricious.[68] The 2024 rule does not acknowledge the "controlled or directed by the state" formulation, does not engage the MFAR withdrawal, does not answer the contemporaneous objections, and describes the codified attestation as a mere "clarification" of existing law.[69] The regulatory history defeats that label: CMS proposed the change, withdrew, and then implemented it by commentary. Even an explained reversal fails when it ignores reliance.[70] First principles of administrative law require CMS to offer states, providers, and beneficiaries an explanation; CMS offered nothing.

IV. THE SPENDING CLAUSE CLEAR-STATEMENT RULE ALSO REQUIRES A STATE-ACTION READING.

Medicaid is Spending Clause legislation, "much in the nature of a contract," and conditions on federal funds bind only if Congress imposes them "unambiguously," judged from the recipient's vantage when it accepts the funds.[71] The requirement extends to every funding recipient:

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[67] *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009); *Encino Motorcars, LLC v. Navarro*, 579 U.S. 211, 221–22 (2016).
[68] *Encino Motorcars*, 579 U.S. at 222 (quoting *FCC v. Fox*, 556 U.S. at 515).
[69] 2024 Final Rule, 89 Fed. Reg. at 41,075–76.
[70] *Encino Motorcars*, 579 U.S. at 224.
[71] *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981); *Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 296 (2006).

a party is exposed to liability only if it had notice "that, by accepting federal funding, it exposes itself to liability of that nature."[72] This clear-notice demand applies explicitly to Medicaid.[73] Hospitals are funding recipients and did not have notice of CMS's conditions.

Spending Clause conditions bind only when the statute speaks with unmistakable clarity, and an agency may not enforce a condition the statute does not unambiguously impose.[74] The agency's own record answers the question. Congress rejected CMS's path in 1991; CMS rejected a broad reading in 2008; CMS abandoned the proposal in 2021 after MFAR (after thousands of comments urged that it exceeded the agency's authority).[75] A statute the agency has read one way, proposed to read another, and then retreated from is not unmistakable. The Eleventh Circuit asked whether the statute could bear the agency's reading rather than whether it unambiguously compels it.[76]

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[72]*Cummings v. Premier Rehab Keller, P.L.L.C.*, 596 U.S. 212, 219 (2022).
[73]*Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 577 (2012) (plurality opinion); *South Dakota v. Dole*, 483 U.S. 203, 207 (1987).
[74]*Medina v. Planned Parenthood South Atlantic*, 606 U.S. 357, 375 (2025); *Health & Hosp. Corp. v. Talevski*, 599 U.S. 166, 186 (2023).
[75]2008 Final Rule, 73 Fed. Reg. at 9694; 86 Fed. Reg. 5105.
[76]161 F.4th at 772–73.

Nor should the Florida case carry weight beyond its posture. The Eleventh Circuit reviewed a denied preliminary injunction under a likelihood-of-success standard on an undeveloped record, expressly declining to "conclusively decide the merits."[77] That limited ruling left dispositive issues unaddressed. The panel never engaged the 2008 "controlled or directed by the state" formulation, the standard CMS adopted because it found "influenced by the state" impermissibly broad. It never addressed the MFAR history: the identical "net effect" proposal, the 4,000-plus comments asserting a lack of authority, and the unrefuted 2021 withdrawal. It never grappled with the objections of the official who directed the proceedings and had called this approach "unprecedented federal overreach" exceeding statutory authority. It never analyzed if the agency can enforce a condition the statute does not unambiguously impose. The district court here granted summary judgment on the full record;[78] this Court reviews that final judgment de novo, free to give the agency's inconsistent history the weight it deserves.[79]

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[77]*Id.* at 768–70.
[78]*Texas v. Adm'r, Ctrs. for Medicare & Medicaid Servs.*, No. 6:23-cv-00161 (E.D. Tex. Sept. 24, 2025) (slip op.).
[79]*See, e.g.*, *Carcieri v. Salazar*, 555 U.S. 379, 396 (2009).

CONCLUSION

CMS's new reading would destabilize the Medicaid financing system at the very moment Congress cut off other options, while exposing hospitals to unmanageable financial liability. The statute requires state action; CMS said so itself in 2008 and proved it again by retreating from MFAR in 2021. The agency reversed that settled position without acknowledgment or explanation, in violation of the APA. The Spending Clause forbids enforcing a condition the statute does not impose. Stakeholders need the certainty that a consistent interpretation of this statute and accompanying regulatory guidance can provide. The district court got it right. The Texas Hospital Association respectfully urges this Court to affirm.

Date: June 24, 2026

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CERTIFICATE OF SERVICE

I certify that on June 24, 2026, I electronically filed the foregoing brief with the Clerk of the Court for the United States Court of Appeals for the Fifth Circuit using the CM/ECF system, which will serve a copy on all counsel of record.

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CERTIFICATE OF COMPLIANCE

1. This brief complies with the type-volume limitation of Federal Rule of Appellate Procedure 29(a)(5) because it contains 5,405 words, excluding the parts exempted by Rule 32(f), and therefore does not exceed the 6,500-word limit for an amicus brief.

2. This brief complies with the typeface requirements of Rule 32(a)(5) and the type-style requirements of Rule 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Word in 14-point Century Schoolbook font, with 12-point font footnotes per 5th Cir R. 32.1.

3. This brief complies with (1) required privacy redactions under 5th Cir. R. 25.2.13; (2) the electronic submission being an exact copy of the paper document under 5th Cir. R. 25.2.1; and (3) the requirement that the document has been scanned and is free of viruses.

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